

---

The Incarcerated Pregnancy:  
An Ethnographic Study of  
Perinatal Women in English Prisons

---

**Laura Jane Abbott**

Submitted to the University of Hertfordshire in partial  
fulfilment of the requirements of the degree of  
Doctor of Health Research (DHRes)

February 2018

---

# Contents

---

	<i>Page</i>
Contents .....	i
Abstract .....	vi
Acknowledgements .....	vii
Abbreviations .....	viii
Glossary .....	ix
List of Tables and Figures .....	x
<b>1: Introduction and Background .....</b>	<b>1</b>
Demographics of female prisoners in the UK .....	1
Historical perspective .....	3
Women in current UK prisons .....	3
Existing knowledge about pregnant women in prison .....	4
Theoretical perspectives: Criminology .....	4
Minor disorders of pregnancy: normal physiological response .....	7
Rights of the pregnant woman .....	8
Midwifery care in prison .....	10
Personal motivation .....	10
Research aim .....	11
Chosen methodology .....	11
Summary .....	11
Chapter one: introduction and background .....	11
Chapter two: literature review .....	11
Chapter three: methodology .....	12
Chapter four: findings .....	12
Chapter five: discussion .....	12
Chapter six: conclusion .....	12
<b>2. Literature Review .....</b>	<b>13</b>
Introduction .....	13
Literature search strategies .....	13

Inclusion and exclusion criteria .....	14
Results .....	15
The demography of the pregnant woman in prison .....	16
Measuring the health outcomes of pregnant women in prison through systematic review .....	17
Scoping reviews: adding to the evidence .....	19
Retrospective health outcomes for pregnant women in prison .....	21
Staff views on pregnant women in prison .....	22
Intervention programs for pregnant women in prison .....	23
Qualitative research into pregnant women’s experience of prison .....	24
Connectedness with the unborn baby .....	25
Loss and grief .....	25
Psychological findings .....	26
Separation trauma .....	27
Loss of control .....	27
Grey literature .....	28
Research from doctoral studies .....	28
Conclusion .....	30
Research question .....	33
Summary of chapter .....	33
<b>3. Methodology .....</b>	<b>34</b>
Research aim .....	34
Research methods: a naturalistic approach .....	34
Institutional ethnography .....	35
Feminist theories .....	36
Ethical approval and access.....	37
Storage of data .....	38
Issues of consent .....	38
Negotiating entry .....	39
Prison research approach .....	40
Self-presentation .....	41
To hold keys or not to hold keys? .....	41
Pilot study .....	42
Population and sampling techniques .....	42
Sample .....	43
Incentives .....	44

Sample characteristics .....	44
Snowball sampling .....	47
Data collection .....	47
Fieldnote books .....	47
Audio-recording .....	49
Non-participant observation .....	50
Prison life .....	51
Experiences of being an outsider .....	52
Reflexivity .....	53
Interview arrangements .....	56
Interviewer approach .....	57
Rapport and empathy .....	58
Follow-up interviews with women .....	59
Prison staff interviews .....	59
Interview transcription .....	60
Coding data .....	60
Data analysis .....	61
Chapter summary .....	64
<b>4. Findings .....</b>	<b>66</b>
Introduction to findings .....	66
4.1 The prison environment and the pregnant prisoner: .....	67
a) Initiation to prison life .....	68
b) Deprivations .....	75
c) Expectations versus reality .....	82
d) Impact of deprivations on health .....	83
e) Coping strategies .....	92
f) Experiences of the MBU environment .....	100
4.2 Equivalence of health care: .....	101
a) Women's expectations .....	101
b) The reality of health care provision inside .....	101
c) Lack of access to trained professionals .....	102
d) Lack of access to medication .....	103
e) Lack of basic provisions .....	104
f) Lack of access to antenatal classes and resources .....	107
4.3 Giving birth and anticipatory anxiety: .....	108
a) Desire for control .....	108

b) Desire for support .....	110
c) Desire for information .....	111
d) Staff responses to pregnant women .....	111
e) Fear of separation from the baby .....	118
f) Degradation of the pregnant prisoner .....	122
4.4 Cell Births: .....	128
a) Layla's story .....	129
b) Staff experiences of cell births .....	131
c) Staff encounters .....	134
4.5 Staff and pregnant prisoner relationships .....	136
4.6 Looking ahead: resilience and strength .....	141
Summary of findings .....	146
<b>5. Discussion .....</b>	<b>148</b>
Introduction .....	148
Conceptual frameworks: .....	148
• Pains of imprisonment and mortification .....	149
• Institutional thoughtlessness: .....	150
Deprivation of food, comfort, fresh air and basic provisions .....	152
Embodiment, security and deprivation of liberty .....	154
• Institutional ignominy: .....	157
Dehumanisation .....	160
Anticipating separation from the baby .....	161
Cell births: mortification of self .....	163
• Coping: .....	164
Resilience .....	166
• Bureaucratic layers: .....	167
Staff experiences .....	168
Midwifery relationship .....	169
Summary .....	170
<b>6 Conclusion .....</b>	<b>174</b>
Building on existing knowledge .....	174
Original contributions to knowledge .....	175
The pregnant woman as an anomaly in a patriarchal system .....	175
The pregnant prisoner as a public spectacle of shame .....	176
Pregnant women's layering of identity as a way of coping .....	176

‘Red tape’ disguising the rights and entitlements for pregnant women	
in prison .....	176
Unexpected findings .....	177
Personal Growth .....	178
Impact .....	178
Recommendations for future research .....	179
Broad recommendations from findings of this study .....	181
Recommendations for the Ministry of Justice and implications for policy .....	181
Recommendations for the Prison Inspectorate .....	183
Recommendations for health care, midwives and maternity services .....	183
References .....	185
Appendices: .....	210
1.1 Ethics approval – National Offenders Management Services .....	210
1.2 Ethics approval – University of Hertfordshire .....	214
1.3 Application to bring a prohibited article into prison .....	215
1.4 Information sheet .....	216
1.5 Consent form .....	219
1.6 Timeline of accessing prisons .....	221
1.7 Interview schedule – woman .....	222
1.8 Participants’ demographics in table format.....	223
1.9 Iolanthe Midwifery Trust Award details .....	225
1.10 Staff interview schedule .....	226
1.11 Early jottings from fieldnotes .....	227
1.12 Prison routine (Prison A) .....	228
1.13 Confidentiality agreement with transcriber .....	229
1.14 Early coding in NVivo .....	230
1.15 F35 form .....	231
1.16 Published articles in <i>MIDIRS</i> and <i>Nursing Ethics</i> .....	232
1.17 Prison Service Order - Women Prisoners .....	240
1.18 Prison Service Instruction - Mother and Baby Units .....	249
1.19 Birth Charter for women in prisons in England and Wales .....	262
1.20 Impact: papers, presentations and funding awards related to	
DHRes research .....	265
1.21 Article of the month published by <i>The Practising Midwife</i> .....	268
1.22 Handmade thank you card .....	272

---

## Abstract

---

The UK has the highest incarceration rate in Western Europe, with pregnant women making up around 6% of the female prison population. There are limited qualitative studies published that document the experiences of pregnancy whilst serving a prison sentence. This doctoral thesis presents a qualitative, ethnographic interpretation of the pregnancy experience in three English prisons. The study took place during 2015-2016 and involved semi-structured interviews with 28 female prisoners in England who were pregnant, or had recently given birth whilst imprisoned, ten members of staff, and ten months of non-participant observation. Follow-up interviews with five women were undertaken as their pregnancies progressed to birth and the post-natal phase. Using a sociological framework of Sykes' (1958) 'pains of imprisonment', this study builds upon existing knowledge and highlights the institutional responses to the pregnant prisoner. My original contribution to knowledge focuses on the fact that pregnancy is an anomaly within the patriarchal prison system. The main findings of the study can be divided into four broad concepts, namely: (a) 'institutional thoughtlessness', whereby prison life continues with little thought for those with unique physical needs, such as pregnant women; and (b) 'institutional ignominy' where the women experience 'shaming' as a result of institutional practices which entail their being displayed in public and characterised with institutional symbols of imprisonment. The study also reveals new information about the (c) coping strategies adopted by pregnant prisoners; and (d) elucidates how the women navigate the system to negotiate entitlements and seek information about their rights. Additionally, a new typology of prison officer has emerged from this study: the 'maternal' is a member of prison staff who accompanies pregnant, labouring women to hospital where the role of 'bed watch officer' can become that of a birth supporter. This research has tried to give voice to pregnant imprisoned women and to highlight gaps in existing policy guidelines and occasional blatant disregard for them. In this sense, the study has the potential to springboard future inquiry and to be a vehicle for positive reform for pregnant women across the prison estate.

---

# Acknowledgements

---

I would like to thank my doctoral supervisors: Dr Tricia Scott for her continuous support, encouragement, and guidance so that I may see the multitude of dualisms in my work; Dr Kathy Weston for her unwavering belief in me and the importance of this study, for her patience, wisdom, and attention to detail, and for her immeasurable support; and to Professor Fiona Brooks for her guidance in the embryonic stages of my research. I also wish to acknowledge the encouraging role of my DHRes cohort and all the staff on the DHRes teaching team, especially Professor Hilary Thomas for reminding me that 'writing is thinking', Professor Brian Littlechild and the late Dr Geraldine Byrne. I would also like to thank the network of criminologists who helped me to find my feet in the subject of criminology, especially Lucy Baldwin and Sinead O'Malley for their camaraderie and shared passion, and The Prison Research Network and Dr Ben Crewe for lending their expertise and encouragement.

Grateful thanks go to all the staff in the three prisons for their hospitality and time, and for making me feel welcome in their workplace. My gratitude goes to the inspirational women who work, volunteer and offer peer to peer support for the charity *Birth Companions* and who have stood beside me and championed my research throughout. Heartfelt thanks go to my psychotherapeutic supervisor, who will remain anonymous, whose wise counsel helped me to 'hold on to the light whilst I often entered the darkness' and kept me going through my fieldwork.

I would like to thank the *Iolanthe Midwifery Trust* and *The Royal College of Midwives*, who have supported my research through their generous Jean Davies and Midwives Awards, which funded my travel, attendance at conferences and a temporary reduction in working hours, and who contributed to the dissemination of *The Birth Charter*. Grateful thanks go to The University of Hertfordshire for their Impact Award which contributed to the print costs for *The Birth Charter*, travel and transcription services. Appreciation goes to my work colleagues, past and present, at The University of Hertfordshire for their encouragement and comradeship.

My gratitude and love go to my three sons who have spent much of their childhood living through the gestation of my doctoral work: Josh, Ben and Toby have kept me going with their unconditional love, sense of fun and praise; from when I spent many nights away from home, to encouraging me to do my 'homework' as I wrote and refined this thesis. I hope I continue to inspire my sons as they motivate and inspire me. Grateful appreciation goes to my husband Graham, who has often been both Mum and Dad to our boys whilst I was 'in the field', loyally supporting and encouraging me.

Finally, and most importantly, this thesis is dedicated to the women who gave authentic and candid descriptions as they accessed the darkest hours of their prison experiences.



---

# Abbreviations

---

ACCT	Assessment Care in Custody Teamwork
BAME	Black, Asian and Minority Ethnic
CJA	Criminal Justice Act
CJS	Criminal Justice System
CPS	Crown Prosecution Service
HMPPS	Her Majesty's Prison and Probation Service
IOM	Integrated Offender Management
IPP	Indeterminate Public Protection (sentence)
MAPPA	Multi Agency Public Protection Arrangements
MBU	Mother and Baby Unit
MOJ	Ministry of Justice
NGO	Non-Government Organisation
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NMC	Nursing and Midwifery Council
NSPCC	National Society for the Prevention of Cruelty to Children
OM	Offender Manager/Management
OMU	Offender Management Unit
PSI	Prison Service Instruction
PSO	Prison Service Order
PSR	Pre-Sentence Report
ROTL	Release on Temporary License
RCM	Royal College of Midwives
SO	Senior Officer
YOI	Young Offender Institution

---

# Glossary

---

**Antenatal** Before birth, pregnancy.

**Basic** A penalty level for a prisoner's non-compliance with rules and regulations in prison.

**Barnardo's** A charity in the UK providing support for vulnerable children.

**Bed watch** When one or two prison officers accompany and keep watch or guard over a woman when she is an inpatient in hospital.

**Breech** When the baby is presenting bottom first.

**Footling breech** When one or both baby's feet is presenting first.

**Hyperemesis Gravidarum** Severe nausea and vomiting of pregnancy leading to weight loss and dehydration.

**Intrapartum** During labour.

**Lock-down** The confining of prisoners to their cells, typically to regain control.

**Multigravida** A woman who has already birthed one or more babies.

**Nulliparous** A woman who has not birthed offspring.

**Parity** Defined as the number of times a woman has given birth to a live or stillborn baby over the gestational age of 24 weeks.

**Perinatal** Refers to the antenatal (pregnancy), intrapartum (labour and birth) and postnatal (early weeks of motherhood) stages of childbirth.

**Post-partum depression** or **Post Natal Depression** A mental health condition occurring following childbirth, effecting around 15% of women.

**Pre-eclampsia** A specific pregnancy condition which can be fatal, typified by high blood pressure, protein in the urine and headaches.

**Pre-term/premature** A baby born before 37 completed weeks of pregnancy.

**Primigravida** A woman pregnant for the first time.

---

# List of Tables and Figures

---

Table 1 – Keywords searched

Table 2 – The Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool

Table 3 – Inclusion and exclusion search criteria

Table 4 – Literature

Table 5 – Sample criteria: women

Table 6 – Sample criteria: staff

Table 7 - Pseudonyms, and location of interviews

Figures 1 – 6 Charts representing sample characteristics:

Figure 1 – Percentage of women participants by prison location

Figure 2 – Age of woman

Figure 3 – First time or multiple times in prison

Figure 4 – Category of offence

Figure 5 – Parity

Figure 6 – Placement of baby

Figure 7 – Fieldnote books

Figure 8 – Example of hierarchy of nodes under 'coping' theme

---

# Chapter 1: Introduction and Background

---

***“Yes, I'm a criminal, but that doesn't matter, I'm still human like everybody else... But it's not just me, it's my unborn child... That's all I care about... my unborn child.”***

This thesis describes the pregnancy experiences in three English prisons of 28 women, 22 of whom were interviewed while incarcerated and six following their release. Women and girls in prison make up approximately 2-10% of the global incarcerated population, and their numbers have increased by 50% since the year 2000 (Walmsley, 2013). The United States has the greatest number of imprisoned women at 12 per 100,000 of the national population, and Denmark, at 2.6 per 100,000 of the national population, has the lowest (Walmsley, 2013). The UK has the highest prisoner population in the European Union, with England and Wales having one of the highest figures at 6.7 per 100,000 of the national population (Gerry & Harris, 2016). Numbers of female prisoners have been rising slowly since 2015, and broadly represent 5% of the overall UK prison population. A review of women's prisons in 2006 found that most women prisoners were mothers, some were pregnant, and many came from disadvantaged backgrounds (Corston, 2007). Accurate numbers of pregnant women held in UK prisons are not recorded, though it is estimated that 6% to 7% of the female prison population are at varying stages of pregnancy and around 100 babies are born to incarcerated women each year (Albertson et al., 2014; Kennedy et al., 2016; Prison Reform Trust, 2017). There is little known about the experiences and conditions for pregnant women in British prisons, so the existing body of knowledge is sparse. This study hopes to change that. Adopting an ethnographic approach over a period of ten months, this research took place at a time of deep turmoil for the UK prison estate: the prison system was noted to be the 'worst on record' for suicides, overcrowding and self-harm and has been described as being at 'crisis point' (Doward, 2016). This thesis provides a rare insight into the experiences of the pregnant prisoner during such turbulent times.

## **Demographics of female prisoners in the UK**

A substantial number of women in prison have been victims of crime and many have multiple complex needs and difficult lives. Current statistics suggest that: 46% have violent partners; 53% may have suffered sexual abuse and rape; 66% are substance abusers, and 80% suffer some form of mental-health disorder (North, 2006; Corston, 2007; Gullberg, 2013; Baldwin et al., 2015; Prison Reform Trust, 2017; Baldwin & Epstein, 2017). In 2006, the Home Secretary of the UK Labour

government requested an evaluation of women in the criminal justice system following reports of six suicides over 13 months in one prison. Baroness Jean Corston undertook the review of the UK female prison estate over a period of nine months (Corston, 2007). Analysis of the findings demonstrated that most women in prison were disadvantaged either through poverty, mental illness, historic abuse, addiction, or ill health. It was reported that the majority had children, and several were pregnant. The Corston report made 43 recommendations, taking a '*radical new approach*' to improve the criminal justice system for women including taking a holistic stance towards imprisoned women and the opening of more community centres to use as an alternative to prison sentences. Evidence suggests that women are more likely to commit non-violent crimes compared with men, and most women serve sentences of less than six months in duration (Carlen & Worrall, 2004; Walklate, 2004; Carrington, 2014; Baldwin & Epstein, 2017). Oakley (2016) asserts that criminal behaviour is usually seen as a masculine act, while female crime (such as shoplifting) is more likely to be a response to anxiety. Research undertaken by Baldwin and Epstein (2017) adds to the Corston review, giving further examples of short custodial sentences imposed for non-violent crimes; for example, the imprisonment of a mother of three in the latter stages of pregnancy who was in a violent relationship; and a woman suffering from post-partum depression who was incarcerated for shoplifting nappies and formula milk.

Efforts were made to reduce the female prison population following The Corston Report, and prisoner numbers did reduce between 2007 - 2015. However, by 2017 only two of the 43 recommendations had been implemented, with the majority either not executed at all or only partially applied (Moore et al., 2017). In 2016, 12 women committed suicide in prison, significantly more than when Corston first commissioned her report into prison conditions (Doward, 2016; Prison Reform Trust, 2017). Interest was shown in the welfare of new mothers and babies in prison by the UK Conservative government in 2016 (Brown, 2016); yet, between the years 2015-2016, the Howard League for Penal Reform reported that suicide rates in prison were the highest they had been since records began in 1978 (Bulman, 2017). Of note, two of the prisons where this current research was undertaken registered seven suicides in total between the years 2014-2016. Another prison reported the suicide of a perinatal woman, five days after the birth and subsequent removal of her third child<sup>1</sup> (Parveen, 2016). Furthermore, the independent investigation into this suicide found that miscommunication and the lack of multi-disciplinary planning may have contributed to her distress (Newcomen, 2016). In Prison A, where the majority of the current research was undertaken, there were two suicides during the fieldwork period. Whilst reasons for such a high death rate are not yet understood and are outside

---

<sup>1</sup> Most new-born babies subject to compulsory care orders are separated from their mothers at under seven days' old. The numbers of babies removed soon after birth have risen from 800 to 2000 per year since 2008 (Broadhurst et al., 2015).

the scope of this thesis, the bleak picture of despair that is depicted forms an important backdrop to this research.

## Historical Perspective

Historically, women offenders were held within male prisons where they were employed as cleaners, cooks or weavers. Prior to the advent of single-sex prisons in the 19<sup>th</sup> century, women were often left without supervision, particularly at night, and prostitution was common (Zedner, 1998; Bosworth, 2000). Moral judgements upon the types of women imprisoned were usual in the 16<sup>th</sup> and 17<sup>th</sup> centuries (Zedner, 1998; Bosworth, 2000). Callahan (2013) reported that women in the late 18<sup>th</sup> and early 19<sup>th</sup> centuries would sometimes pay to have their abdomens filled with fluid to make them look pregnant ('pleading their bellies') to avoid hanging. Women prisoners in the 19<sup>th</sup> century were in a minority compared to men, often receiving short sentences for petty crimes (Zedner, 1998; Bosworth, 2000). Pregnancy was commonplace, especially for women prostitutes or those exploited by male guards whilst inside prison. The catalyst for political change in the 19<sup>th</sup> century came after reports of pregnant women giving birth inside prison, and recommendations ensued that appropriate care for women in the latter stages of pregnancy was to be provided outside of jail (Mayhew & Binny, 2011). British activists like Elizabeth Fry were instrumental in implementing prison reform in the 1800s, segregating prisoners by gender and advocating the employment of female wardens (Zedner, 1998; Bosworth, 2000; Sharpe et al., 2009). Division by gender was made law in the USA in 1828 after a pregnant woman, who conceived whilst in prison, was flogged to death in solitary confinement (Craig, 2009). The separation of women from their babies was often used as punishment alongside other methods employed to enforce control, such as branding, handcuffing and strapping (Garland, 1985). Policy was sporadic and inconsistent with regards to pregnancy and motherhood with no standardised care or timelines agreed for mother and child separation.

## Women in current UK prisons

There are 12 women's prisons in the UK, of which six have Mother and Baby Units attached (MBU<sup>2</sup>), with 54 MBU places available nationally (Ministry of Justice, 2017). Women prisoners may be held as one of four security categories: Category A, Restricted Status, Closed Conditions, or Open Conditions<sup>3</sup>. Ten of the female estates in the UK are closed prisons<sup>4</sup>, holding women who are

---

<sup>2</sup> A mother and baby unit places women who have successfully applied for a place, with their babies up to 18 months of age.

<sup>3</sup> **Category A prisoners** are deemed the most dangerous prisoners who require the strictest security conditions. **Restricted status** is any woman on remand or sentenced who poses a serious risk to public safety. **Closed conditions** are for women who are too substantial a risk for open conditions although requiring less security. **Open conditions** are for women who can be trusted and are a minimal risk to the public. PSI 39/2011.

<sup>4</sup> A closed prison is maximum security holding Category A, restricted status, closed conditions and remand prisoners.

categorised as 'A: restricted status' and 'closed conditions'. There are two open prisons<sup>5</sup> (D Category) where women are sentenced if they meet the requirements or prior to resettlement into the community. Category D prisons have 'open conditions' where women can go towards the end of their sentences or if qualifying for open conditions. The number of women held in UK prisons has been increasing since this research began and, as of December 2017, the population had risen to 4,048 (Ministry of Justice, 2017). Due to unavailability of collated figures on pregnant women and new mothers in prison, it is impossible to confirm whether these women are currently being held in open or closed estates. Many women enter the system already pregnant and this is often only discovered at the initial health assessment on reception to prison (North, 2006; Corston, 2007 and Gullberg, 2013). However, exact numbers are unknown nor, indeed, whether their pregnancies are unplanned or intentional.

### **Existing knowledge about pregnant women in prison**

Globally, there are limited studies that reveal women's experiences of being pregnant in prison, and no ethnographic studies - which use a combination of interviews and non-participant observation - have been located. Contemporary understanding through qualitative exploration of pregnant women's experiences is scarce. Research has relied upon second-order interpretation through scoping exercises and interviews with prison staff, exposing inconsistencies in care (Price, 2005; Edge, 2006; Albertson et al., 2012; O'Keefe & Dixon, 2015). Additionally, the literature uncovers women's utterances around 'connectedness' with their unborn baby (Wismont, 2000; Chambers, 2009) and anticipatory grief when pre-empting compulsory separation at birth from their unborn baby (Shroeder & Bell, 2005; Gardiner et al., 2016). Fertszt and Clarke (2012); Fritz and Whiteacre (2016); and Gardiner et al. (2016) reveal further evidence to demonstrate the limited access to support, pre-natal education and appropriate nutrition. More recently, research in the UK has exposed the difficulties of gaining a place on a MBU and, if a place is denied, the complexities of the appeal process (Sikand, 2017). Existing literature reveals significant anecdotal evidence conveying the stress, fear and anxiety caused by prison conditions for the pregnant woman.

### **Theoretical perspectives: Criminology**

Leder (2016:209) talks of the public perception of a prisoner as a 'social caricature as savage, bestial and sub-human'. Feeling dehumanised and the sense of losing personal identity is defined by scholars as synonymous with the experience of being a prisoner (Wood, 2016; Zimbardo, 2016; Halliday et al., 2017; Michalski, 2017; Watkins, 2017). The 1971 Stanford Prison experiment investigated prison psychology, monitoring the psychological effects of extreme power in a simulated

---

<sup>5</sup> An open prison is a minimum-security prison where women can undertake outside work and are trusted with minimal supervision.

prison setting by dividing college students into either 'prisoners' or 'guards' and then observing them. 'Prisoners', identified by their numbers, underwent a process of dehumanisation (Haney et al., 1973; Zimbardo et al., 2000) and 'othering' (Given, 2008), whilst assigned 'guards' adopted an authoritative role demonstrating power and control. Miller (2008:708) describes 'otherness' as *'the condition of being different or "other," particularly if the differences in question are strange, bizarre, or exotic'*, therefore placing the person at the periphery. Indeed, adaptation to prison life has been observed, with prisoners *'moving backwards as well as forwards'* through distinct phases of acclimatisation, with some remaining in the first, 'liminal stage' unable to move towards acceptance of the system (Harvey, 2007:58, 61). The experience of prison can lead to new, adapted identities - a phenomenon described by scholars where prisoners may redefine themselves, often in a religious context (Maruna et al., 2006; Booker & Dearnley, 2016). The criminology literature also suggests that imprisonment can be a 'catalyst for desistance'<sup>6</sup> especially when life events (such as becoming a parent) elicit a 'turning point' in prisoners' lives (Maruna, 2001; Maruna et al., 2006; LeBel et al., 2008; Sharpe, 2015; Paternoster & Bachman, 2017).

The criminology literature is rich with evidence relating to the emotional response to the prison experience of inmates, staff and researchers (Crawley, 2004; Knight, 2012; Crewe et al., 2015; Knight et al., 2016). Institutional spaces are described by Goffman (1961) as segregation and emotion 'zones' eliciting a wide array of emotions. In prison, women's embodiment frequently represents the psychological pain held internally, as scars of self-harm often demonstrate (Walker, 2009; Walker et al., 2016; Chamberlen, 2015). Liebling (2004:50) discusses how criminologists argue about the bodily existence set within the principles of life in prison, which includes 'proper sanitation' in the list of standards for prison life, implying a potential lack of appropriate sanitation which has health implications for pregnant women. Loss of identity is a common experience for male and female prisoners (Jones & Schmid, 2000; Maruna et al., 2006; Harvey, 2007; Liebling & Maruna, 2013). Nonetheless, Crewe et al. (2017) examined the 'gendered pains of imprisonment' and found that women were more likely to be affected by loss of privacy, autonomy and control than male prisoners.

The loss of liberty and autonomy has been labelled as a 'pain' of imprisonment from a sociological perspective (Sykes, 1958/2007:67). Crewe et al. (2017) found that loss of control was a greater 'pain' for imprisoned women than men. This may also trigger a sense of crisis and therefore impact upon stress levels, making it a struggle to retain mental wellbeing. Focusing upon the female estate, Rowe (2015) found that prisoners were creative in how they directed the system they were held within,

---

<sup>6</sup> Desistance is the termination of offending behaviour (Maruna et al., 2012).



'navigating' ways to 'alleviate the pains of imprisonment'. Rowe reported that women were especially good at identifying the prison officers who were 'true carers' (Tait, 2011), thus knowing whom to approach. The literature defends the notion of women supporting other women in prison and the building of strong friendships (Carlen & Worrall, 2004; Cantora et al., 2016; Wulf-Ludden, 2016).

In relation to prison food, the literature suggests that the monotony and limited choice can feel like an extra layer of punishment when incarcerated (Smith, 2002; Godderis, 2006a; Godderis, 2006b; Smoyer, 2015a; Smoyer, 2015b). The evidence recognises that this is a concern for all prisoners (Godderis, 2006a). The symbolism of food as power (Brisman, 2008) and the theoretical link between food and violence in prison (Bohannon, 2009) demonstrates the importance of understanding the impact of food for the pregnant woman<sup>7</sup>. There is limited, if any, research into the perinatal women's experience of food in prison. Specific recommendations for pregnant women in prison include: following national guidelines (Department of Health (DH), 2004; National Institute for Health and Care Excellence (NICE), 2010, 2014); considering gastro-intestinal discomforts associated with pregnancy and allowing for the exchange of acidic foods; access to food outside of the prison regime; and access to fresh water (Shlafer et al., 2017). It is estimated that 66% of pregnant women in prison are smokers (Knight & Plugge, 2005a). This is a significantly higher percentage than the average among pregnant woman in the community: in the USA the overall prevalence of smoking in pregnancy is 8.4% (Curtin & Matthews, 2016) and in the UK it is 11.4% (Szatkowski et al., 2015; Forey et al., 2016). Female prisoners are more likely to be smokers than are women in the community (Graham & Hunt, 1994). A study measuring particulate pollution in four English prisons found that very high levels of smoking pollutants were present in cells and on the prison wings (Jayes et al., 2016). The entitlement for pregnant women (or any prisoner) to reside in a smoke-free environment is not written into the Prison Service Instruction for women.

Prison Officer (PO) typology has been described by prison researchers (Gilbert, 1997; Liebling et al., 2010; Tait, 2011; Shannon & Page, 2014). Bakker and Heuven (2006) describe the work of the police and of nurses as keeping an 'emotional distance' whilst demonstrating compassion and caring; similarly, types of prison staff can be categorised as 'true carers' (Tait, 2011) and 'reciprocators' who like to help (Gilbert, 1997). The stress involved in prison work has been suggested to increase the likelihood of amplifying prisoners' suffering, especially when POs' stress levels are high (Scott, 2008; Shannon & Page, 2014). The typology of 'avoider' - where a member of staff avoids prisoner contact and is often the last on the scene of an emergency - may arise from such enhanced stress, and similarities of this typology are seen in health care settings (Gilbert,

---

<sup>7</sup> The current spend on food per prisoner per day in England is £2.02 (MoJ, 2015, Freedom of Information request from Prison Reform Trust).

1997). Liebling (2011) groups together POs who show certain traits, such as humour, solidarity, suspiciousness and cynicism, bringing staff together through their characteristics whilst keeping a distance from prison management.

Criminology scholars describe prisoners' resilience and ways of surviving, noticing they often find ways of coping through religion, sport and friendships (Gravett, 2003; Maruna et al., 2006; Harvey, 2007; Zamble & Porporino, 2013). Wright et al. (2016) explored the psychoanalytical concepts of 'suppression, sublimation and denial' as ways of coping for long-term prisoners, suggesting that the old-style pains of imprisonment may be obsolete (Sykes, 1958 / 2007). Clough and Strycharczyk (2012), and Naples (2014), suggest that resilience is determined by personality traits, with some prisoners feeling overwhelming anguish, whilst others continue to face their challenges. Negative life events and the ability to cope, be resilient and develop characteristics of mental 'toughness' are associated with the individual's response to harsh conditions and have been referred to throughout history, especially in experiences where human suffering is extreme (Scarnati, 2000; Tec, 2004). Naples (2014) explains that some individuals deal better with hardship, with a person's individual characteristics and the degree of their own 'mental toughness' significant in how a person survives adversity.

### **Minor disorders of pregnancy: normal physiological response**

The increase in the hormone progesterone, coupled with the squeezing of internal organs as the pregnancy progresses, can lead to symptoms of heartburn, abdominal discomfort and the need to eat frequent meals in smaller quantities (Body & Christie, 2016; Bartholomew, 2017). Pregnancy hormones can lead to hypersensitivity of taste and smell (Brown & Toma, 1986; McNabb, 2017). Nausea and vomiting can be a normal, albeit distressing, physiological symptom in early pregnancy (Niebyl, 2010; Bartholomew, 2017). Some women suffer from a distressing condition called hyperemesis gravidarum<sup>8</sup> (HG) where constant vomiting can lead to serious illness due to deficiency in nutrients essential for electrolyte balance (Verberg et al., 2005; Bartholomew, 2017). Appropriate and adequate nutrition in pregnancy is important for the unborn baby's development and future long-term health as well as for maternal wellbeing (Ho et al., 2016; Jewell, 2017). Smoking in pregnancy can pose a number of risks for the mother and her unborn baby including those that increase mortality, such as placenta praevia<sup>9</sup>, placental abruption and stillbirth (Bjørnholt et al., 2016; Shobeiri et al., 2016; Tong et al., 2017). The hormones produced during pregnancy relax muscles and joints and can cause discomfort as the pregnancy progresses (Vermani et al., 2010; McNabb, 2017). The

---

<sup>8</sup> Hyperemesis Gravidarum is a severe form of nausea, vomiting and weight loss in pregnancy.

<sup>9</sup> Placenta praevia is where the placenta partially or completely covers the cervix.

normal physiological responses of the hormones relaxin, progesterone and oestrogen mean that the lower back, pelvic girdle and other joints and bones in the body expand and move in preparation for labour, often causing discomfort as the pregnancy progresses (Kristiansson et al., 1996; Buckley, 2015; Nyange & Cphi, 2017; McNabb, 2017). Towards the latter weeks, a woman can feel especially tired and uncomfortably warm with swollen lower limbs and 'heaviness' (Nyange & Cphi, 2017). Embodiment during pregnancy has been discussed by scholars in terms of the medicalisation of childbirth, the woman's lack of empowerment, choice and autonomy over their pregnant body and labour choices (Young, 1984; Shilling, 1997; Davidson, 2001; Walsh, 2010; Oakley, 2016). The concept of salutogenesis<sup>10</sup> has been theoretically applied to the notion of pregnancy embodiment and empowerment, with the suggestion that multidisciplinary teams should work together with salutogenesis as a central goal (Antonovsky, 1987; Downe, 2010; Sinclair & Stockdale, 2011).

### **Rights of the pregnant woman**

In the UK, there is a statutory recognition that *all* prisoners should receive an equivalence of health care to that provided in the community (Council of Europe, 2006; Rogan, 2017). Furthermore, the United Nations (UN) Bangkok Rules (2013) state that women in prison should be given gender-specific care (UN, 2013). Nonetheless, current conditions in prison can create barriers to delivering adequate care for pregnant women (North, 2006; Corston, 2007; Kennedy et al., 2016). Article 3 of the Human Rights Act<sup>11</sup> (United Nations (UN) General Assembly, 1948; Feldman, 1999; Citizen's Advice Bureau, 2017) has a strong, legal basis in the UK and every woman has the right to make decisions about her body during pregnancy and to receive respectful treatment (Player, 2007; Schiller, 2016). Article 8 protects the right to private life and ensures that 'choice' has a legal basis, the principle of dignity being prioritised. Economically, responsibility for health funding lies with the Department of Health (DH) and the Strategic Health Authorities (SHAs). More recently, private health care providers such as *Care UK*<sup>TM</sup> have been contracted as providers of prison health care for 21 prisons in England and Wales (Plimmer, 2016). There is no known requirement for midwives to be positioned as permanent members of staff in health care departments in prison, but community midwives do visit women in prison to provide antenatal and post-natal care. It is a legal violation for anyone other than a Registered Midwife or Medical Practitioner to attend women in childbirth, except in 'sudden or urgent necessity' (Nursing and Midwifery Order, 2001).

---

<sup>10</sup> Salutogenesis is an approach to health that focuses upon wellbeing rather than pathology (Antonovsky, 1996) .

<sup>11</sup> Article 3 of the Human Rights Act states: '*you must not be tortured or treated in an inhuman or degrading way. Inhuman treatment is ill-treatment which causes you severe mental or physical suffering. The ill-treatment does not have to be deliberate or inflicted on purpose. Degrading treatment is treatment which is grossly humiliating or undignified*' (Citizens Advice Bureau, 2017).

The UK Prison Service has issued guidance for the treatment of pregnant women and new mothers in prison within a Prison Service Order (PSO)<sup>12</sup>. There is no specific PSO for pregnant women, but they are mentioned in more generic guidance (National Offender Management Services, 2014: **Appendices 1.17 and 1.18**). It is specified that suitable nutrition and rest are required but guidance states that staff should be mindful that perceived 'special treatment' may leave a woman open to becoming a target for bullies. Guidance states that handcuffs should *not* be used after arrival at hospital or clinic appointments and women should not travel in cellular vans, due to potential risks inherent in being locked in a confined space. The guidance directs the Prison Service in making adequate provisions for women wishing to breastfeed their babies and suggests that careful planning should take place when women are being separated from their babies due to the risk to their mental health (ibid). The Royal College of Midwives (2016) recommends that all pregnant inmates should receive the same quality of care as if they were on the outside<sup>13</sup> and have issued guidance in relation to incarcerated pregnant women and new mothers. There is no specific direction from organisations such as the National Institute for Health and Care Excellence (NICE) in relation to pregnant prisoners. However, NICE guidance *does* refer to female prisoners in broader guidance relating to smoking cessation, substance misuse, alcohol addiction and complex social needs (NICE, 2010, 2014). The recent confidential enquiry into maternal deaths in the UK - *Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK* (MBRRACE-UK, 2017) - found that two-thirds of the women who died had 'pre-existing physical or mental health problems' and states that medication in pregnancy should not be stopped 'without consulting a specialist'. The importance of access to care for vulnerable women in society, adopting a multi-disciplinary team approach, and having specially trained midwives for women with complex social needs is recommended (ibid).

A woman who is pregnant in prison, although in receipt of health care, has little or no choice over place of birth, birth partner or whether the baby remains with her (Albertson et al., 2014; Sikand, 2017). An example of disempowerment for a woman in prison is when she attends hospital for an ultrasound scan. The ultrasound scan may be seen as a social occasion for women and families (Earle & Letherby, 2003) or can also be viewed as an unnecessary observation which further medicalises pregnancy (Howson, 2013). However, a woman in prison will not be told the date of her scan for security purposes and will be accompanied by Prison Officers rather than a partner or family member. Due to the limited number of female prisons, it is likely that a woman will give birth far away from her home in an unfamiliar hospital (Albertson et al., 2014; Galloway, et al., 2015). She may

---

<sup>12</sup> A Prison Service Order (PSO) or Prison Service Instruction (PSI) is guidance on how prison services are regulated.

<sup>13</sup>'On the outside' is a phrase used to describe being away from or not inside an institution such as a prison.

have some provisions for labour in place, but these will be vetted by the prison service prior to transfer. Attending hospital appointments or labouring as a prisoner, accompanied by guards, adds an extra layer of scrutiny from the public where a woman may feel '*judged*' and '*embarrassed*' for her 'maternal conduct' (Howson, 2013:136) and her prisoner status as a woman perceived as aberrant to society. Separation of the baby from its mother further takes away a woman's rights, with society directing who is an appropriate parent for the child (Sikand, 2017).

### **Midwifery care in prison**

Midwifery as a profession concentrates on pregnancy and birth as a normal process, with empowerment, partnership and the locus of choice as central philosophies (Hunt & Symonds, 1995; Sandall, 1995; Mander, 2011; McCourt, 2013; Nursing & Midwifery Council, 2015). Indeed, promotion of choice and reduction of inequalities by using care models such as case loading and team midwifery has been recommended in England as part of the 2016 *Better Births* initiative, in the form of a five-year plan to move towards continuity of midwifery care for all women (Cumberledge, 2016). Midwives, usually based in local community teams, provide antenatal care in a prison, monitoring the pregnancy and wellbeing of the women and visiting them post-birth in order to provide post-natal care. Scans and specialist referrals are usually facilitated in the local hospital and women are usually accompanied by two prison officers unless she has been given permission for a hospital visit, released on temporary license. When a woman's labour begins in prison, either by her having regular contractions or if it is suspected that her membranes have spontaneously ruptured (waters breaking), she will be transferred to the local hospital in a taxi or prison van, usually accompanied by prison officers. Following birth, dependent on whether a woman has been allocated a place on a prison MBU, she will return either to the MBU with her baby, or to the general prison without her baby. Within the prison environment, women have reported feeling a loss of autonomy over their environment and choices, which can lead them to make medicalised birth choices (such as opting for a Caesarean section, rather than await spontaneous labour) to try to ensure some control and to negate her perception of being left to labour alone in a cell (Marshall, 2010; Kennedy et al., 2016).

### **Personal motivation**

As a qualified nurse and midwife by professional background, and prior to lecturing, I had worked for several years as an Independent Midwife (IM) providing midwifery care outside of the traditional NHS model. The women I cared for as an IM often had histories of childhood abuse, difficult previous experiences of childbirth, and/or had consent and trust issues. The women choosing IM care were often viewed as an anomaly to conventional norms, albeit empowered in their own choices. Intrigued by trying to access a marginalised group of women, my curiosity and midwifery experience were the initial motivators to propose researching the pregnant woman's experience in prison. Although also seen as a societal anomaly and invisible group, pregnant women in prison often have a background

of trauma yet, unlike the women I provided care for as an IM, they have limited autonomy by nature of the setting in which they are held. Identifying a gap in the evidence, I chose to try and understand the pregnant woman's experience within the English prison system. As I conducted my research, I realised what huge scope there was to improve policy, care and outcomes for both mother and child, and this has become an additional motivation.

## **Research aim**

The principal aim of this research was to examine the pregnant woman's encounter with the English prison estate and the associated conditions through:

- Semi-structured audio-recorded interviews with pregnant women, both women prisoners who had experienced pregnancy in prison and staff.
- Deconstructing the daily patterns and consideration of the impact upon the pregnant woman, including observation of the spaces, rooms and prison wings.
- Interactions with significant people and the milieu that the pregnant prisoner was exposed to.

## **Chosen methodology**

To comprehend the experience of pregnant women in prison, it was important to understand the sociology and climate of the prison estate and processes. Previous qualitative health research often focuses on narratives without observing the milieu (Liebling, 1999). With the setting so intrinsic to the imprisoned pregnant woman's experience, ethnography was the obvious methodological approach to understand fully those experiences.

## **Summary**

### **Chapter One: Introduction and background**

Chapter One introduces the research question following contextualisation of the global, historical, criminological, midwifery, sociological and the current political landscapes in order to provide a background to the research setting. Justification for researching the experience of pregnant women within an English prison system has been provided and the aims of the study briefly specified. Outlines of the remaining chapters are presented.

### **Chapter Two: Literature review**

Chapter Two contains the literature searching technique and review undertaken to evaluate the evidence specific to the research question and aims of this study. The chapter provides a critical debate, identifying what is already known and the gaps in knowledge in relation to the experience of the pregnant woman in prison, leading to justification of the proposed naturalistic research design.

### **Chapter Three: Methodology**

Chapter Three concentrates on the methodological phases of the research, describing the steps taken during the study and determining why the qualitative method was suitable for meeting the research aims. Negotiating access, ethical considerations, sampling techniques, recruitment approaches, reflexivity and challenges faced are deliberated, and specifics relating to the process of thematic analysis are described.

### **Chapter Four: Findings**

Chapter Four details the findings of this research, including the embedded narratives of the 28 women interviewed. Staff and field observations usefully elucidate the experience of these pregnant prisoners. The experience of pregnancy is illuminated through a range of processes detailing entry into prison, the environmental impact upon the woman, her expectations versus reality, access to provisions, the effect of deprivations on health, and coping strategies. The reality of health care provision, accounts of degradations, struggles, resignation and despair, and the experience of cell births and staff/prisoner relationships are revealed. This chapter concludes with descriptions of looking to the future and how some women learn to cope over time through their resilience and strength.

### **Chapter Five: Discussion**

Chapter Five discusses the central themes which arose from the research findings and how conceptual frameworks brought fresh insights by connecting with the theories of Sykes (1958:67) 'pains of imprisonment', Goffman's 'mortification of self'; 'stigma' and 'total institutions' (Goffman, 1959; 1961:67; 1968:27), and Laing's (Laing, 1960) 'divided self'.

### **Chapter Six: Conclusion**

The concluding chapter draws together inferences from the research. It incorporates reflections on the strengths, limitations and impact of the study and provides recommendations for future research, proposing suggestions for the benchmarking of care provision for the pregnant woman in prison.

---

## Chapter 2: Literature Review

---

### **Pregnant women's experience of prison: a critical review of the research evidence**

#### **Introduction**

This chapter will evaluate the literature specific to the research question and aims of this study. The search criteria will be explained to demonstrate how the literature review was attained. Hart (2007:27) submits that one of the determinations of a literature review is to '*distinguish what has been done from what needs to be done*'. A critical debate will explore the studies that expose the experience of pregnancy in prison, critiquing the methodology used, and identifying any gaps in knowledge. Throughout the literature review, I signpost myself in the first person as it was important to inhabit the literature from the outset by adopting an ethnographic stance (Creswell & Poth, 2017).

#### **Literature search strategies**

An extensive literature search was required to understand the range of seminal texts, research studies and supporting literature to ensure full coverage of the subject area. At the outset of the doctoral programme, I understood very little about women's experiences of being pregnant in prison. In order to develop a pertinent research question, I sought to connect with the distinct nature of this experience by reading the relevant literature. A preliminary search was undertaken in September 2012 to identify the possible range of relevant search terms in preparation for a robust literature review. Further literature reviews were undertaken on a regular basis until June 2017 to ensure current research was included. Medical Electronic Subject Headings (MeSH) terms of 'pregnancy and prison' were searched for, in conjunction with different phonetic word formations such as 'incarceration', 'jail', 'gaol', and sentences using words such as 'maternity', 'perinatal', 'antenatal', 'pregnancy', 'post- natal' and 'birth' (Table 1). Boolean operators were excluded to ensure greater focus, and truncation broadened the search. The question: 'what is the experience of being pregnant in prison?' identified key words that would cultivate the search. The combinations provided only a small number of hits and many of those comprised 'grey literature'<sup>14</sup>. In the first instance, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed Health databases were searched for articles dated between 1980 and 2017, in order to explore the most recent studies. Databases such as Google Scholar and The Cochrane Library were searched alongside criminology

---

<sup>14</sup> Grey literature is a 'range of published and unpublished material which is not normally identifiable through conventional methods of bibliographical control' (Hart, 2007:95).



and psychology databases such as CINCH and PsychINFO. The SPIDER research tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was used to enhance the literature search for qualitative studies. It was used as an 'alternative search strategy tool' specifically to make the search more responsive (Cooke et al., 2012:1436) and proved to be a clear-cut way of probing deeper into the data, revealing recent studies that traditional searches did not bring to light (**Table 2**).

The scarcity of research looking specifically at a woman's experience of pregnancy in prison at a global level meant that numerous research trips were required, including visits to the British Library and the Cambridge Institute for Prison Research. Informal networking with academics was useful in gathering unpublished research in the latter days of the research process, and PhD databases and Thesis UK were also searched. For example, I accessed a PhD thesis that explored the experience of being pregnant in prison (Canvin, 2000) as well as an unpublished Master's project documenting the observation of mothers and babies in prison from a psychotherapeutic perspective (Windham-Stewart, 2016a). Another, more recent, Master's project (Fiander, 2016) was found serendipitously and this involved a case study of one woman who had been pregnant in a Canadian prison. Maya Sikand, a human rights barrister, also shared her funded, small-scale study which examined the process of application and denial of MBU places from a human rights perspective.

All references from the literature search were stored methodically using a software system (EndNote web). Books and articles that were unavailable in libraries were purchased using funding from the *Iolanthe Midwifery Trust* (**Appendix 1.9**). Literature was continually reviewed throughout the research process, and small-scale studies as well as additional literature were uncovered with the help of networks developed throughout the doctorate journey. Grey literature can be used to identify a topic to investigate and to develop a research question (Gerrish & Lacey, 2010; Bowling, 2014,). Supplementary publications from a range of organisations contributed to the research process: *Birth Companions* (Marshall, 2010); *Women in Prison* (Gullberg, 2013) and the *Prison Reform Trust* (2017). The latter has produced several reports about women's experiences of incarceration (including the differences in male and female offending), of being pregnant and giving birth in prison and subsequent recommendations, as well as general facts and figures.

### **Inclusion and exclusion criteria**

The literature review inclusion criteria encompassed all written works relating to women's experience of being pregnant or being a new mother in prison (**Table 4**). The criteria included systematic reviews, scoping exercises, and all original research of any design which looked at the health outcomes and experiences of pregnant women in prison in any country. Publications not written in English were excluded. The search identified 754 papers.

## Results

After de-duplication and assessment of relevance, 11 full text research papers, including two quantitative studies, six mixed methods, and three qualitative studies, were assigned to a Critical Appraisal Skills Programme (CASP) (Walsh & Downe, 2006) for evaluation (**Table 4**). Analysis of the available studies by using principles of data examination techniques (Denscombe, 2014) helped to identify themes and codes. Qualitative research was appraised using Walsh and Downe's (2005:114-115) 'summary criteria' for judging the quality of qualitative research. The search terms were revisited at the end of the fieldwork period to identify any new research that had been published. Re-reading articles and gaining deeper familiarity with the available evidence helped to code the diverse concepts which emerged from the literature. The inclusion of systematic reviews, scoping exercises and reports provided context in this under-researched area. Seven of the available UK studies included original research and scoping reviews; one study is from Australia and five are from the USA. Only four exclusively qualitative studies were retrieved which specifically focused on the pregnant woman in prison, one of which was undertaken in Scotland in 2016 (Gardiner, 2016). Nevertheless, most of the studies explored the experiences of pregnancy, birth and motherhood in prison from a staff viewpoint, including the scoping exercises. No ethnographic research of the experience of the pregnant woman in prison had been undertaken in any location, which highlights the need to conduct this study. The dearth of studies exploring women's experiences of being pregnant in prison was apparent at the beginning of the literature review process; nevertheless, significant themes emerged from the found evidence and from policy, research, and quantitative data. These comprise psychological complexities of anticipation of separation from a new-born (Wismont, 2000; Shroeder & Bell, 2005; Hutchinson, 2008; Chambers, 2009 and Gardiner et al., 2016) inconsistency in maternity care provision in the UK (Price, 2005; Albertson et al., 2012 and O'Keefe & Dixon, 2015); and limited access to support in pregnancy (Fritz & Whiteacre, 2016; Gardiner et al., 2016). The grey literature added themes pertaining to the conditions of the prison environment, including hunger, fear, stress, and separation anxiety.

**Table 1: Keywords searched**

<b><i>Main keyword</i></b>	<b><i>Potential variations included:</i></b>
<i>Pregnancy</i>	Prison
<i>Perinatal</i>	Incarcerat*
<i>Antenatal</i>	Imprison*
<i>Birth</i>	Offend*
<i>Mother</i>	Detention
<i>Midwife</i>	Inmate

**Table 2: The Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool** (Cooke et al., 2012)

<b>Sample</b>	Pregnant women
<b>Phenomenon of Interest</b>	Prison
<b>Design</b>	Observation, interviews, focus groups, surveys, case studies, diaries
<b>Evaluation</b>	Experiences
<b>Research type</b>	Qualitative, mixed method, scoping reviews and grey literature

**Table 3: Inclusion/exclusion search criteria**

<b>Inclusion</b>	<b>Exclusion</b>	<b>Limitation</b>
<b>English language only</b>	Non-English language only	Potential to omit relevant studies
<b>Literature awaiting publication</b>		Potential to overlook current studies
<b>1985 onwards</b>	Pre 1985	Potential to omit key studies
<b>Systematic reviews</b>		Not primary research and potential author bias
<b>Scoping reviews</b>		Limited in analysis

### **The demography of the pregnant woman in prison**

One of the earliest large-scale studies surveying the demography of pregnant women and new mothers in UK prisons was commissioned by the UK Home Office in 1997 (Caddle & Crisp, 1997). This two-stage study was considered valuable in that it was one of the earliest to profile, on a large scale, the perinatal woman in prison. Whilst not necessarily being able to provide ‘cause and effect’, surveys offer a snapshot of a moment in time (McKenna et al., 2010). Their findings included the percentage of women who were either pregnant or the mother of a child under the age of 18 (61%).

Demographics revealed that 30% of the 1,766 women were under the age of 25, 18% were from an ethnic minority and the majority of the sentenced women were incarcerated for non-violent crimes. The study included in-depth screening interviews with women on their reception to prison. It was reported that 75% of women were depressed and over 50% described feelings of loneliness, which underlines the vulnerability of the women surveyed. The focus in interviews with women was mainly upon care arrangements for their children. Sixty-three of the women interviewed were pregnant and results indicated that the majority had not attended antenatal preparation classes. The women who had access to such classes reported feeling more content with the quality of care provision. Bowling (2014) suggests that surveys allow the researcher to collate precise information, signifying that Caddle and Crisp (1997) adopted an appropriate way to collate the data they required. However, it can be argued that that research missed an opportunity to elaborate further on the care provided for pregnant women and new mothers. Although recommendations were made, including greater provision of more MBU places to facilitate the mother and baby remaining together, the survey did not include narratives of the women.

### **Measuring the health outcomes of pregnant women in prison through systematic review**

Systematic reviews are considered to be a superior way of drawing conclusions from literature where bias has been reduced by rejecting studies considered to be of inferior quality (Moher et al., 2015). Two systematic reviews were retrieved which assessed the health care outcomes of pregnant women and their babies in prison (Knight & Plugge, 2005b; Bard et al., 2016). A further systematic review by Shaw et al. (2015) focused specifically upon the maternity experiences and outcomes for pregnant women and their babies in prison.

In 2005, Knight and Plugge (2005b) undertook a critical exploration of the research evidence by comparing the health outcomes of pregnant prisoners and their babies to a similar vulnerable group of women who had multifaceted needs and who were not in prison. On further comparison with a healthy non-prison population of women, it was found that poorer outcomes were common for imprisoned women. However, when compared to similar disadvantaged groups of women who were not in prison, physical outcomes for the babies, such as birth weight and risk of stillbirth, were improved. Nonetheless, the babies of women in prison were more likely to be born prematurely, although the explanation for this was not forthcoming. The findings suggested that having access to health care, basic nutrition and shelter, as well as being away from violent partners, together with the unavailability of drugs and alcohol, may have led to improved outcomes. Still, these conclusions were drawn through assumption, and the quality of care received by women was not considered. Concerns were expressed about the recidivism of the mothers who were separated from their babies but, again, the potential reasons were not discussed. The use of qualitative papers in this review

may have helped to explain or propose a hypothesis about why, when women were supposedly experiencing better health, their babies were more likely to be born prematurely.

A second systematic review added to Knight and Plugge's findings by giving a more holistic overview through the inclusion of rigorous qualitative research (Shaw et al., 2015) which reviewed incarcerated women's experience of maternity care and assessed health outcomes for both the mother and her baby. Studies with a focus on the human rights of pregnant incarcerated women were initially considered, though no scoping exercises or studies had been conducted. The review encompassed seven studies, including two qualitative and one mixed-methods study. The daily routine and the negative impact upon the pregnant woman in prison was discussed in the review. Noting the dearth of qualitative studies, the overwhelming recommendation from Shaw et al. (2015) was that it was important to hear the women's individual narratives. Shaw et al. identified gaps in the study of pregnant women in prison, noting the scarcity of rigorous research, recommending a robust look at prisons with and without MBUs, and suggesting that there is an opportunity for maternity services to undertake more intervention studies to glean a greater understanding of the needs of imprisoned pregnant women.

Returning to the same review criteria as Knight and Plugge (2005a, b), Bard et al. (2016) appraised the evidence in relation to pregnant women in prison. Comparable to previous reviews, the evaluations were outcome-based. Limited qualitative studies were retrieved, possibly due to the unattainability of rigorous research, and pregnancy outcomes were again explored rather than the emotional health of the women or the long-term health of the baby. Given the recommendations from the previous reviews, it would have been useful to draw conclusions about the quality of care contained within the qualitative responses of the incarcerated women, yet limited availability of studies meant that this was impossible. As to the grey literature, many of these articles were deemed to be of mediocre rigour and therefore were not included. The review by Bard et al. (2016) added further analysis to the 2005 review in concluding that there were several missed opportunities to improve the health of pregnant women whilst they were incarcerated. It could be argued that by excluding the qualitative studies, the reviewer lost scenarios where the narratives of women describe the prison environment. Also, there may have been lost opportunities to contemplate questions about recidivism, premature births and why opportunities to improve health outcomes are missed. The design of large-scale studies in prison was recommended in their conclusions. However, the potential explanation for the scarcity of the studies was not explored, and consideration was not given to the general inaccessibility of the prison system, i.e. incarcerated women are an especially hard to reach and vulnerable group. Further discussion is therefore needed to explore questions relating to how, and by whom, such studies will be carried out, considering the specific skills and access required in order to gather quality data. The authors also excluded valuable scoping

exercises by researchers such as Albertson et al. (2012) and the descriptive study by Price (2005). The findings of all three systematic reviews noted that data on the numbers of pregnant women in prison are not routinely collected and concluded that this data should be collected. An appraisal of the reviews demonstrated that not only is there a shortage in qualitative studies, but those limited studies which were considered were of inadequate rigour.

### **Scoping Reviews: adding to the evidence**

Scoping reviews are said to be especially relevant in health research and for informing policy (Peterson et al., 2017). Unlike systematic reviews, scoping reviews include all material related to the research question, although some studies and grey literature may be of inferior quality (Peterson et al., 2017). Nevertheless, Moher et al. (2015) advocate the use of scoping reviews when addressing wider issues, such as the questions relating to the pregnant incarcerated woman. Scoping exercises add substance to systematic reviews by including grey literature and theses, and follow a systematic format: unlike systematic reviews, they do not judge the value of the research but are especially useful to studies with 'emerging evidence' (Levac et al., 2010).

Edge (2006) reviewed Prison Service provision, detected gaps in the literature, and made recommendations for practice and future research areas in a scoping evaluation on perinatal health and health care in prison in England and Wales. Edge concluded that there was an underrepresentation of the service user/woman's experience/voice. Like Knight and Plugge (2005b), Edge (2006) further found that no routine data regarding pregnant women in prison had been collected. Edge (2006) highlighted the limited knowledge and understanding that staff had of the roles of various care providers and systems: i.e. prison staff did not understand health care processes and health care staff did not understand prison processes. Her key recommendation was to include the voices of the women, taking into consideration their experiences of being perinatal women in prison, especially young offenders and foreign national women who comprise a significant minority.

A scoping exercise in the Yorkshire and Humber Region of the UK recognised a dichotomy regarding the knowledge of staff caring for the pregnant prisoner, their understanding of the prison system, and the levels of risk that pregnant prisoners may pose (Albertson et al., 2012). Albertson and colleagues initiated a consultation with health care professionals and prison staff to elicit their views on pregnancy provision, the MBU experience, partnership working, and MBU processes for the separation of mother and baby as well as processes for keeping mother and baby together. The consultation was prompted by the publication of the Marmot Review, *Fair Society Healthy Lives*, which considered health inequalities with special consideration for the socially disadvantaged (Marmot, 2010). Albertson et al. (2012) included findings from one-to-one interviews with MBU

managers, a multi-agency workshop, and focus groups that explored topics such as partnership working and the separation of mothers and babies. The findings included evidence that pointed to inconsistency in care provision and communication breakdowns. As in previous reviews, it was reported that routine data was not collected, including accurate numbers of pregnant women in prison. Albertson et al. (2012) exposed how the prison system often negated information-sharing and collaborative working due to issues around data protection, the prison not wishing to share information about prisoners. Usefully, good practice was highlighted that enhanced the service provision for pregnant women and new mothers - especially through NGOs and charitable organisations - which could be used as a benchmark. Again, the voice of the women was underrepresented, though this was considered 'unavoidable'. No reason was given for why women's narratives were not sought, and it is left for the reader to speculate on the reasons. Nonetheless, the report recommends that the experiences of such women should be a topic for future research.

Concurring with Galloway (2015) and colleagues, O'Keefe and Dixon (2015) developed some of Albertson et al.'s (2012) recommendations and originated a collaborative mixed-method small-scale research project in conjunction with *Action for Prisoners' and Offenders' Families* and the *Hallam Centre for Community Justice* at Sheffield Hallam University. The aims of the study were to expose gaps in knowledge of professionals, to record existing care provision for perinatal women throughout the female prison system in the UK, and to note examples of good practices. Twenty-two members of staff were asked their views about pregnant women and new mothers, using questionnaires and semi-structured interviews. The questionnaire response rate was poor, with only 10 being returned across the whole estate. The researchers assumed that the poor response rate was due to tension and pressure in the prison service; however, further explanations would have been worthy of analysis. Members of staff were asked for their views, and this added bias (e.g. one manager stated that "*being in an MBU will be the best time of their [women's] lives*"). These perceptions repeat findings from Canvin's (2000) PhD study where staff supposed the women's experience of care in pregnancy was of a high standard, contrary to the women's views. The focus of this study was on staff experience, with staff often speaking about - and sometimes for - the female prisoners. Not including the women prisoners' voices in this project was another missed opportunity, especially as the literature review and the Albertson et al. (2012) report suggest that the lack of women's narratives is a common and concerning theme. Findings included the importance of staff understanding attachment theory, opinions about the perceived inappropriate sentencing for some women, good practices of NGOs, separation of women from their babies, and the recommended need for further research on the separation of mother and child. Further recommendations of the review included that National Offender Management Services (NOMS) should recognise childbearing women as a unique subgroup of women with unique physical and psychological needs, and tailoring care and support appropriately, rather than their being generalised into the whole female estate. Further

research looking at why MBU acceptance rates are so low, alternative sentencing, and the evaluation of recidivism rates in conjunction with alternatives to custodial sentencing, should be considered.

Drawing upon the study undertaken by Albertson et al. (2012), the NSPCC and *Barnardo's* included the criminal justice system in their '*Spotlight*' series, researching areas of disadvantage affecting children in the UK. Galloway et al. (2015) accepted one such collaborative study focusing on the criminal justice system. Demographic data was collected about prisoners in England and Wales with a focus on perinatal women, as well as babies and new mothers. The data was collected from female prisons in England and Wales and pregnant women and new mothers were interviewed. Replicating previous findings from Caddle and Crisp (1997), Edge (2006), and Albertson et al. (2012), it was found that no accurate figures of the numbers of pregnant women were kept and there was no precise record of how many women gave birth whilst incarcerated or how many new babies were affected. The report draws on the Albertson (2012) review and echoes the findings on women's experiences of food and hunger, stress, and anticipation of separation from their babies.

'*Baby Steps*', the NSPCC prison-led programme for mothers and fathers, was also evaluated. The report concluded that outcomes such as parental attachment were reportedly improved when emotional support and parenting groups were facilitated. As with Albertson (2012), areas of good practice - such as the support of NGOs and some MBU programmes - were highlighted. These outcomes build upon findings from Albertson et al (2012) and O'Keefe and Dixon (2015), where policy suggestions are made, including replicating good practice - e.g., support packages and programmes supporting healthy relationships and building self-esteem - to enhance the health and wellbeing of pregnant women. Although some interviews with women were included in this report, the policy omitted to consider the personal narratives of the women, and numbers of participants were not declared. Concerns were expressed by the researchers about the lack of midwifery care for a woman in prison, especially when she commences labour where security protocols may lead to delays in a transfer to hospital, as well as subsequent delays concerning her transfer to hospital and midwifery assessment. It was noted that babies had been born in prison without a Registered Midwife in attendance although who was in attendance and what training they had in midwifery was not explicit. The implications of this violation of the UK statutory framework regarding the requisite knowledge, skills and qualifications to safely support the labouring woman warranted greater depth of exploration (Nursing and Midwifery Order, 2001). This should include statistics and reports of the outcomes for these women and babies.

### **Retrospective health outcomes for pregnant women in prison**

An exploration of retrospective data of incarcerated pregnant women and new mothers in Australia offered further insight into the health outcomes and demographics as previously explored in the UK



by Caddle and Crisp (1997), and Edge (2006). A retrospective cohort study entitled: '*Mothers and gestation in custody (MAGIC)*' explored the perinatal outcomes for incarcerated women in New South Wales, Australia (Walker et al., 2014). The records of 558 pregnant prisoners who had been incarcerated for at least five days were accessed in order to study the consequence of imprisonment on pregnancy. Outcomes for mothers and babies were found to be linked to mental health disorders and drug and alcohol addiction over a six-year period. The study findings that there was no connection found to incarceration improving perinatal outcomes contradicted the conclusions of previous systematic reviews. Such studies are useful when measuring outcomes (Bryman, 2015), but they can add bias due to being historical in nature. McKenna et al. (2010) suggest that cohort studies should usually follow a homogenous group over an agreed period; however, due to the transient nature of the prison population, it is acknowledged that this would be difficult to undertake. Their sample was unique in that all participants were pregnant incarcerated women. However, Bowling (2014:221) suggested that cohort studies can reveal bias due to the historical 'conditions' under which the sample is analysed. Conversely, Walker et al. (2014) found that imprisoned women and babies were more likely to have poor health outcomes, including a greater risk of a baby being admitted to neonatal intensive care for five days or more, and babies being of low birth weight. Unsurprisingly, one conclusion is that the prison service is not adequately prepared to provide appropriate health care for the perinatal woman.

### **Staff views on pregnant women in prison**

Ferszt and Clarke (2012) surveyed staff members representing 19 prisons in the USA about the health care provision of pregnant incarcerated women. The survey response rate was 38%, which may have affected the validity of the findings. The convenience sampling technique used is one that is most common when trying to access a hard to reach group with multifaceted problems. However, in quantitative research, a survey response rate of below 60% is considered deficient, according to Bowling (2014). Ferszt and Clarke (2012) found that most respondents stated that they were unable to access adequate nutrition in the form of fruit or vegetables and that there was limited access to antenatal support or pre-natal classes. Almost half of the prisons reported that restraints such as handcuffs were routinely used during labour. The results offer a useful insight into health care provisions for pregnant prisoners. Nonetheless, caution should be exercised against generalising from the findings of data with a low response rate (Bowling, 2014).

In one of the only studies to be undertaken in the UK, Price (2005) used mixed methods and descriptive research to explore service provision for the pregnant prisoner. Price's study elicited the views and experiences of 15 midwives working with pregnant women in prison. The methodology included collecting data via a postal survey delivered to each of the 15 named midwives working in prisons in the UK, and the 12 responses received were analysed. The services available for women

in prison were found to show a vast variation, as well as difficulties encountered in delivering midwifery-focused care. The results included profiles of the pregnant women, where 52% were described as 'substance abusers'. Complexities in accessing maternity services was a common finding. The midwives reported that pregnant prisoners did not have 24-hour access to maternity care and, as found in Caddle and Crisp's (1997) study, antenatal classes were limited and complicated to organise. Hence, perinatal women prisoners were not given the same level of information about pregnancy and birth choices as women receiving maternity services in the community.

Mixed methods studies are said to be useful because they explore both qualitative and quantitative data, contributing a depth of understanding to a phenomenon (Bowling, 2014). Most of the studies relating to the pregnant woman in prison employed mixed methods approaches. It is argued by Simons and Lathlean (2010) that two paradigms may lack parity, and one tactic should always be central when adopting a mixed methods approach. The epidemiology lacked analysis of the how and why, although clear patterns and a timeline were demonstrated. Although Price's study (2005) revealed the current provision of maternity care for incarcerated women in the UK, weaknesses were demonstrated in the study design; although described as 'mixed methods', Price did not collect data using face-to-face interviews with the midwives or involve the women who were pregnant and using maternity services. Price (2005) examined the services available and found a vast variation in the service provision, as well as the difficulties that some midwives had in providing care for incarcerated women. Price (2005) explains that prison is an overwhelmingly male environment, where women are disadvantaged due to their gender. Price's deliberations focused upon the gender inequalities and how the patriarchal system negatively affects the health care needs of pregnant women. However, limited evidence, if any, is drawn from criminology theories in relation to gender which would have enhanced multi-disciplinary discussions. Price (2005) had indicated that a further published paper would yield additional findings and further discussion, but the second article was not published, leaving a hiatus in her research conclusions.

### **Intervention programmes for pregnant women in prison**

Shroeder and Bell (2005) designed a study using mixed methods, developing an intervention programme whereby pregnant woman in prison were assigned a doula<sup>15</sup> for labour. Fourteen semi-structured interviews were conducted with women and 40 surveys collected from nurses and physicians who attended the labours of the women supported by doulas. All surveys indicated high satisfaction rates regarding care provided by doulas. Shroeder and Bell (2005) surmised that in the

---

<sup>15</sup> A doula is a woman who provides support and gives advice to pregnant, birthing and post-natal women. Doulas are usually mothers themselves but have no professional qualification in midwifery.

USA, where this kind of service is offered to incarcerated pregnant women, elevated levels of satisfaction were recorded. The prison staff perceived the service as 'supportive' as they were able to proceed with their security role and felt less out of their depth when faced with the requirements of the pregnant inmate. Women reported their satisfaction of the additional support during labour. Themes from the interviews with women included the anticipation of loss following separation from their babies, hopes for the future, and satisfaction regarding the support given by the doulas. Linking the qualitative and quantitative elements would have strengthened Shroeder and Bell's (2005) research findings, enabling a more accurate appraisal. However, the quantitative data from the staff surveys was neither published nor reported, leaving the reader unable to evaluate the strengths and limitations of the study in its entirety.

Shlafer et al. (2015) built on the work of Shroeder and Bell (2005) in a feasibility study that paired doulas with 18 pregnant incarcerated women. Support during labour was facilitated by the doulas, who kept journals detailing their observations and experiences as they supported the women. Although the doulas were asked about their experiences, the pregnant women were not interviewed in this study, unlike with Shroeder and Bell. However, whilst the importance of support for the women was clear, the study demonstrated that doulas - or birth supporters of any kind - may themselves require extra support when caring for women who are separating from their babies. The often-poetic diary entries: "*my client loved to smell the sweet smell of lavender*"; "*I could not be a witness to her tears anymore*", demonstrate a use of analogy/metaphor in the narrative, which may have been quite unlike the women's stories. Nonetheless, with limited research exploring the experience of those who support such complex women in labour, Shlafer's study adds to the body of knowledge relating to caring for the caregivers, even though the women's own experiences were not sought.

### **Qualitative research into pregnant women's experience of prison**

Four qualitative studies from the USA which elicit pregnant women's experiences of incarceration were discovered through literature searches. The research aims of all the studies carried out in the USA followed a similar pattern and exposed themes within the maternal relationship with their unborn babies (Wismont, 2000; Chambers, 2009; Fritz & Whiteacre, 2016). One UK qualitative study undertaken by Gardiner et al. (2016) sought the views of pregnant women and mothers in an MBU in Scotland. No published studies analysing specifically the experience of pregnant women have been undertaken in the UK, except for one PhD research project by Canvin (2000). No ethnographic methodological approaches have been undertaken in any of the qualitative studies. The qualitative findings from Shroeder and Bell's (2005) mixed methods research were useful in developing themes mirrored by qualitative studies by Wismont (2000), and Chambers (2009), by enhancing understanding of loss, grief and the trauma experienced when babies are removed immediately following birth.

## **Connectedness with the unborn baby**

Wismont (2000) used phenomenology to examine a sample of twelve pregnant incarcerated women from one American prison to uncover feelings relating to maternal and foetal attachment. The USA and the UK have different systems for the provision of maternity care, and Wismont's (2000) study looked purely at women separated from their babies immediately following birth. The aim of phenomenology is to understand the structures of the lived world for the participant, analysing in depth their 'lived experience' (Horrigan-Kelly et al., 2016). The advantage of this approach is that a substantial 'human experience' unique to an individual can be captured and articulated (Todres & Holloway, 2010:185). Wismont (2000) encouraged women to use journals to record their thoughts, and followed up with semi-structured recorded interviews which led to a detailed data analysis of the writing. Bowling (2014) has proposed that diary methods are a valuable way of recording inner thoughts, diminishing inhibitions, and of valuing participants as partners in research. Wismont (2000) uncovered themes of grief and loss but also found a deep relationship between the incarcerated women and their unborn children. This 'connectedness' was expressed despite the impending separation from the baby. There are some interesting themes that exposed the women's fear of getting to the hospital in time when in labour; however, this recurring theme could have been explored in greater depth. Wismont (2000) appeared focused on psychological meaning, given her chosen methodology of Giorgi's (1997) phenomenology, an approach to uncover psychological depth rather than straightforward descriptions of the phenomena (Giorgi, 1997). The title of the study, '*The Lived Pregnancy Experience of Women in Prison*', seems misleading as the research was specifically about maternal/foetal attachment rather than the 'lived pregnancy experience in prison', which implies the whole life encounter rather than the minutiae of separation. Greater rigour could have been applied and further lines of enquiry into women's fears about giving birth could have been explored in greater detail at interview. Nevertheless, the small sample obtained offered a unique, in-depth examination of an aspect of pregnancy in prison and is one of the few qualitative studies of its kind. Of note was the women's sense of feeling valued and being able to keep their diaries, which may have enhanced their feelings of self-worth while suffering the pain of loss.

## **Loss and grief**

Chambers (2009) enlisted participants from an American prison. Interviews were undertaken looking specifically at maternal-foetal bonding for women who would be forcibly separated from their babies at birth. Twelve respondents were recruited to participate in semi-structured face-to-face interviews on days one, two or three post-partum. Bowling (2014) recommends face-to-face interviews to allow for searching questions and in-depth information gathering. Sample size is dependent upon the qualitative approach used by the researcher. Chambers' (2009) sample would be considered at the lower range of validity according to Mason, (2010), if used as a constructivist inquiry. However, the

population that Chambers researched was an unusual and hard to reach group, and therefore its validity could be said to be sustainable due to the smaller sample. Findings from data analysis developed into four main themes, including 'a love connection'; '*everything was great until I birthed*'; '*feeling empty and missing part of me*' and '*I don't try and think too far in advance*'. Akin to Wismont's findings, the theme of 'connectedness' was strong and of note: the threat to that 'connectedness' came with the birth of the baby whereas, in the non-prison birthing encounter, this bonding and connectedness is amplified at birth. Loss, grief, the inability to let go or to face impending separation were articulated emotions. Interestingly, another finding exposed the staff/prisoner relationship: where the relationships with prison staff were more positive, the experience of separation from the baby was deemed less stressful.

### **Psychological findings**

Hutchinson et al.'s (2008) research of 25 women took a phenomenological approach comprising semi-structured audio-recorded interviews and a self-report questionnaire. Twenty-one women were pregnant at the time of the interview and four had given birth in prison a few months earlier. The research sought to understand the experience of pregnancy in prison from a psychological perspective. The interviews were held in one large room and conducted by four interviewers to include open-ended questions and administration of psychological tests. These methods included tests which measure maternal/baby bonding, psychological distress, and the Beck Depression Inventory (Beck et al., 1996). Although data from such questionnaires can produce precise information (Bowling, 2014), the interviews would have benefitted from being less structured, especially as there is so little known about the experience of the incarcerated pregnant woman. This limitation and its potential to restrict answers was recognised by the research team. Findings included the fear of separation from the baby at birth, increased feelings of hostility in pregnancy, and prison as an opportunity to elicit changing behaviours when pregnant. The reaction of 'hostility' was discussed at the outset of the study and was specifically measured using psychological testing tools; this assumption may therefore have added bias to the study. However, loneliness, stress, and depressive symptoms were consistent findings with all the women, suggesting that pregnant women in prison have specific difficulties that need enhanced support. There was limited exploration of prison conditions reported by participants in relation to the exacerbation of their hunger and tiredness. Findings focused heavily upon the psychological reactions of the women, yet the researchers acknowledged that participants may have responded selectively. The study recommendations included: future research to understand the specific strains experienced by incarcerated pregnant women within this unique environment; longitudinal studies following up women through pregnancy and post-release; and more unstructured research whereby women may have opportunities to express their attitudes about their pregnancy experience. The study endorses supportive interventions and encourages women to express themselves using journal writing.

## **Separation trauma**

The previously mentioned Scottish qualitative study entitled '*The Rose Project*' pursued the views of staff and women about the experience of pregnancy and becoming a mother in prison (Gardiner et al., 2016), which concur with the assertions of Albertson et al. (2012) and O'Keefe and Dixon (2015) by sourcing the views of a variety of professionals. However, unlike in previous UK research, prisoners were also included in the study, adding some depth to the body of qualitative research. The methods included one-to-one interviews and focus groups. Only three women were included in the sample: one woman was pregnant, one had birthed in prison and had been separated from her baby, and one woman resided with her baby in an MBU, having given birth as a prisoner. Eight members of staff were interviewed individually, and four took part in focus groups. Findings from interviews included women feeling especially vulnerable in prison, the stress of being in the mainstream prison population, and the isolation of being a new mother on an MBU. The trauma of separation from the baby was a consistent theme described by staff and women. Although the numbers of women in the study are small, the narratives of women are included throughout the report, illuminating their experiences. The recommendations replicated previous studies: the opportunity to use the experience of incarceration as a catalyst for change; additional and tailored support from professionals; alternatives to custody for pregnant women and mothers; as well as further research with the wider family members such as fathers and grandparents.

## **Loss of control**

Twenty-seven formerly incarcerated women took part in semi-structured interviews about their perinatal experience in prison in the USA (Fritz & Whiteacre, 2016). The participant group comprised fifteen women who had been part of a prison nursery scheme and twelve women who had left prison prior to the instigation of the scheme. Fritz and Whiteacre (2016) found that the health care needs of incarcerated pregnant women were often left unmet, reflecting similar findings to those of Ferszt and Clarke (2012). Twenty of the women reported negative experiences of antenatal care. The expectation of the women that they should receive better treatment than non-pregnant women was not met. The loss of control over their pregnancies was identified by most women as they experienced delays in receiving appropriate antenatal care, and felt as though they were on an 'assembly line'. More than 50% of the women stated they had no friend, birth supporter or family member to support them in labour. This, coupled with not knowing dates for scheduled caesarean operations or induction of labour, left women feeling stressed and out of control. Women who were to be separated from their babies were less likely to breastfeed and more likely to experience feelings of grief, although the percentage of such women was not specified. The success of prison nurseries where mother and baby could remain together was conveyed by participants and, where prison officers were supportive, women experienced higher rates of satisfaction. Pregnant women

conveyed their feelings of stress and dehumanisation, especially when handcuffed during hospital visits and throughout labour. One woman commented on how: *“the handcuffs made me feel inhuman”*. Concurring with studies by Wismont (2000) and Chambers (2009), the participants expressed feelings of anguish when anticipating separation from their new-born babies, using particularly negative descriptors such as: *“I was bawling, sobbing”*. The lack of communication about who was going to take care of their baby exacerbated their distress. Measurable health outcomes of the women and babies were not recorded. However, considering the inadequate quality of care experienced by women, findings from previous measurable results based on the systematic reviews by Knight and Plugge (2005a, 2005b) and which included quantifiable outcomes, all strengthen the view that qualitative studies should be included when examining the perinatal experience.

### **Grey literature**

The use of grey literature in this study was considered pertinent due to the scarcity of findings which included women’s narratives; and to provide a wider range of societal material. Grey literature is commonly included in scoping exercises and can help to answer wide-ranging questions (Peterson et al., 2017). Enkin and Jadad (1998) made the case that anecdotal evidence can be complementary to more vigorous research, especially in health care. The grey literature included commentary, opinions and newspaper reports which highlighted common themes and anecdotes from pregnant women in prison. With the shortage of qualitative research studies, the grey literature helped to formulate the research question and interview guide, and further highlighted the gaps in knowledge. Previous commentary has included: journalistic stories regarding a midwifery team providing care in a London prison (Leifer, 2003), and a case study describing the care of Miss A, a woman with a history of substance abuse who experienced good medical care in prison, superior to that which she received on the outside (Clarke & Adashi, 2011). Hotelling (2008) reports both on the positive effects of doula care in reducing reoffending and in enhancing good parenting skills for incarcerated women in the USA, and on more sensational reports from the USA which include the experiences of women giving birth in shackles and the emotional trauma they encountered (Ferszt, 2011).

### **Research from doctoral studies**

Three projects published as part of PhD, Master’s or funded small-scale projects were sourced. Canvin’s (2000) PhD study explored provisions for pregnant women in prison in the UK and how women were treated by prison staff. Canvin’s research, despite being undertaken twenty years ago, is of importance today because she captured the views of twenty-five pregnant women in prison: themes such as the loss of autonomy, feeling watched, the punitive impact of prison, and the physical effects of a poor diet were all described. In contrast, questionnaires completed by prison staff suggested that the care of these women was of high standard, and they viewed the women’s overall experiences positively. The positive staff view is supported by Galloway et al. (2015). Unfortunately,

no published articles have been written by Canvin, and her thesis is therefore the only account of her research. Fiander (2016) undertook a Master's project chronicling the experience of a Canadian woman (Julie) who gave birth in her prison cell. The stresses of experiencing prison as a pregnant woman culminated in the realisation of her worst fears - giving birth in a prison cell to a premature baby. Although a case study of only one woman, the in-depth understanding of the impact of the prison experience on her pregnancy concurs with findings from systematic reviews (on premature birth) and Galloway et al. (2015) where birth occurring in a prison cell, without qualified assistance, was noted. Sikand (2017) interviewed 16 mothers on an MBU (12 of whom were pregnant at the time of interview) about the process of application for and denial of MBU places, researching from a human rights perspective through a university funded small-scale study. It was found that women frequently found out very late on in their pregnancy whether or not they had been given a place, and that those who appealed against a negative decision were unlikely to have the decision overturned. Although Sikand's research determined the fairness of MBU applications, the experiences of pregnant women enduring elevated levels of stress due to this specific difficulty of their prison experience corresponded with similar findings from O'Keefe and Dixon (2015), and Galloway et al. (2015).

Marshall (2010) draws upon her experience of supporting the pregnant prisoner through the charity *Birth Companions*, where women are supported through the perinatal period by female volunteers who are trained as birth companions. Women reported an overwhelming need to feel 'normal', to feel like individuals, rather than simply as prisoners. Marshall's (2010) evidence arises from reports from women, volunteers and service users, especially women's anonymised stories of support they received from the charity. In addition, the women reported an overwhelming sense of isolation due to separation from their families and friends when in prison, particularly felt by those who were young, due to separation from their families and friends when in prison.

Windham-Stewart (2016b) described pregnancy and early parenting groups in prison in the context of forensic psychiatry, and the complexity of women's emotions and managing the groups were also explored. Some pregnancy groups encourage a connectedness with the unborn child and the examination of attachment and bonding - whether the mother was remaining with or separating from the baby - and this adds useful insight, echoing findings by Wismont (2000) and Chambers (2009) relating to connectedness with the unborn baby. Marshall (2010) and Windham-Stewart (2016b) report anecdotal encounters that mirror findings by Fritz and Whiteacre (2016) and Gardiner et al. (2016) that women report significant higher stress levels due to being pregnant amongst the general prison population. Although care needs to be taken in order to avoid mistaking anecdote as contributing evidence to research, experience and stories do create a powerful accessory, especially in a group of women that so few can access (Enkin & Jadad, 1998). Although face validity is an



issue, the authenticity of accounts from those who support pregnant women in prison enhances the research studies, and adds to the body of knowledge.

## Conclusion

The literature review exposed the dearth of studies looking specifically at the experience of pregnancy in prison. The search inclusion criteria encompassed all written works relating to women's experience of being either pregnant or a new mother in prison. This included: systematic reviews, scoping exercises and all original research of any design, written in English, which looked at the health outcomes and experiences of pregnant women in prison in any country. Using principles of data examination techniques, analysis of the available studies likely to support evidence for my research proposal helped to identify themes and codes. An extensive literature search revealed 13 key studies, four of which were qualitative. Systematic reviews and scoping exercises clarified the profile and demographics of the incarcerated pregnant woman. The grey literature was useful in providing further background to inform the research question. Researchers noted the scarcity of studies, and made recommendations which included undertaking further qualitative studies to illuminate women's narratives (Edge, 2006; Albertson et al., 2012; and Shaw et al., 2015).

**Table 4: Literature**

Title	Type of study, country & sample	Findings	Strengths	Limitations	Recommendations
Caddle, D., & Crisp, D. (1997). Home Office research study 162: Imprisoned women and mothers. <i>London: Home Office.</i>	Survey: UK	<ul style="list-style-type: none"> <li>- Demographics</li> <li>- Loneliness</li> <li>- Limited access to antenatal classes</li> </ul>	Large scale survey including interviews with women	Lack of depth re narratives of women	Provision of more MBU places for women
Knight, M., & Plugge, E. (2005b). The outcomes of pregnancy among imprisoned women: a systematic review. <i>BJOG: An International Journal of Obstetrics &amp; Gynaecology</i> , 112(11), 1467-1474.	Systematic review: UK	Higher birth weight of babies born to incarcerated women	Looked at health outcomes	Exclusion of qualitative studies	<ul style="list-style-type: none"> <li>- Greater health care access</li> <li>- More studies to be undertaken</li> </ul>

O'Keefe, C., & Dixon, L. (2015). Enhancing Care for Childbearing Women and their Babies in Prison	Mixed methods collaborative study: UK interviews and focus groups with 22 staff members, questionnaire from 10 staff members	<ul style="list-style-type: none"> <li>- Women have a good experience of care</li> <li>- Inconsistency across the estate</li> <li>- Separation from baby is difficult</li> </ul>	Variety of methods to elicit staff views	<p>No women's narratives</p> <p>Based upon staff perceptions</p>	<ul style="list-style-type: none"> <li>- Further research into why MBUs are underutilised</li> <li>- Recognition by NOMS that pregnant women/new mothers are a unique sub group</li> </ul>
Shaw, J., Downe, S., & Kingdon, C. (2015). Systematic mixed-methods review of interventions, outcomes and experiences for imprisoned pregnant women. <i>Journal of Advanced Nursing</i> .	Systematic review: UK <ul style="list-style-type: none"> <li>- Maternity experience and health outcomes</li> </ul>	Negative impact of daily routine	Included qualitative studies	No women's narratives	To undertake qualitative research into women's experiences
Galloway, S., Haynes, A., & Cuthbert, C. (2015). All Babies Count – An unfair sentence: Spotlight on the criminal justice system. In: London: NSPCC.	Collaborative study: UK - sample size unclear	<ul style="list-style-type: none"> <li>- Inconsistency of information</li> <li>- Not shared between agencies</li> <li>- Lack of midwifery care especially during labour</li> </ul>	Narratives of women	Draws heavily on Albertson's report	Enhancing policy
Wismont, J. M. (2000). The lived pregnancy experience of women in prison. <i>Journal of Midwifery &amp; Women's Health</i> , 45(4), 292-300.	Qualitative, phenomenology: 12 women: USA Purposive sample	<ul style="list-style-type: none"> <li>- Connectedness with unborn</li> <li>- Fear of separation</li> <li>- Apprehension</li> <li>- Grief</li> </ul>	Diary written by women, and semi-structured interviews	<p>Small sample</p> <p>Focused on relationship with unborn and no other facets of pregnancy</p>	Revision of policies and practices to incorporate gender details
Shroeder C., & Bell J. (2005). Labor support for incarcerated pregnant women: The Doula Project. <i>The Prison Journal</i> , 85(3), 311-328.	Qualitative intervention project, USA: <ul style="list-style-type: none"> <li>- 18 pregnant women:</li> <li>- Interviews with 14 women</li> <li>- Survey of 38 staff (health and officers)</li> </ul>	<ul style="list-style-type: none"> <li>- Doula support increases satisfaction for women and professionals</li> <li>- Stress of pregnancy in prison</li> <li>- Hunger</li> <li>- Discomfort</li> <li>- Inconsistent medical care</li> <li>- Loss and grief</li> </ul>	The only intervention project	Interviews with staff would have highlighted details on the survey: limited analysis on findings with staff	<ul style="list-style-type: none"> <li>- Pregnancy as optimum time for changing behaviour</li> <li>- Doula programmes and early interventions to help facilitate changing behaviour</li> <li>- Considering release of women</li> </ul>

Price, S. (2005). Maternity services for women in prison: a descriptive study. <i>British Journal of Midwifery</i> , 13(6), 362-368.	UK: Mixed methods:  Midwives' view 12 responses	- Inconsistency in care provision - Profile of pregnant women	Only study looking at midwifery services in UK	Small sample  No interviews therefore doubting methodology	- Consistency of care - 24-hour access to midwifery services
Chambers, A. N. (2009). Impact of forced separation policy on incarcerated postpartum mothers. <i>Policy, Politics, &amp; Nursing Practice</i> , 10(3), 204-211.	Qualitative interviews, USA: 12 women in post-partum period	- Connection with unborn, - emptiness following birth, - denial of emotions when considering separation	Focus on infant bonding	Small sample, all women post-partum	Gender specific policy to incorporate pregnant women
Hutchinson, K. C., Moore, G. A., Propper, C. B., & Mariaskin, A. (2008). Incarcerated women's psychological functioning during pregnancy. <i>Psychology of Women Quarterly</i> , 32(4), 440-453.	Mixed methods, interviews, USA: 25 women in antenatal and post-partum period	- Fear of separation - Increased hostility - Prison as opportunity to change - Isolation	Focus on psychological testing	Five interviewers  Structured interviews	Endorsement of supportive interventions
Ferszt, G. G., & Clarke, J. G. (2012). Health care of pregnant women in US state prisons. <i>Journal of health care for the poor and underserved</i> , 23(2), 557-569.	Survey: USA Convenience sampling	- Inadequate nutrition - Limited antenatal support - Routine use of restraints	Looked at antenatal care and support and health care provision	Low response rate No pregnant women included	Greater access to good nutrition and care
Fritz, S., & Whiteacre, K. (2016). Prison nurseries: Experiences of incarcerated women during pregnancy. <i>Journal of Offender Rehabilitation</i> , 55(1), 1-20.	USA: 27 Semi-structured interviews with ex-prisoners:	- Delays in receiving care - Expectation of having special treatment unmet	Experience of perinatal care in prison Exposed reflections of experience	No women in study currently in prison or pregnant	More prison nursery programmes
Gardiner, A., Daniel, B., Burgess, C., & Nolan, L. (2016). The Rose Project: Best for Babies - Determining and supporting the best interests and wellbeing of babies of imprisoned mothers in Scotland.	Qualitative: UK (Scotland) Staff and women's views of pregnancy and becoming a mother in prison	- Trauma of separation from baby - Stress of prison environment	Staff and women interviewed	Small sample of women	- Tailored support from professionals should be enhanced - Further research including wider extended families and fathers

## **Research question**

The literature review has uncovered the scarce number of qualitative studies. There is a critical unanswered question of why there is a shortage of research exploring women's experience of pregnancy in prison in the UK. Most of the studies recommend that perceptions of women be sought, yet the larger scale quantitative research tended to focus on the staff viewpoint. There is a lack of qualitative data and much of the information that has been collected by researchers has been sourced from records and secondary data analysis. The qualitative studies that have gathered women's perceptions focus on connection with the unborn baby (Wismont, 2000; Chambers, 2009) and reflections of the pregnancy experience post release (Fritz & Whiteacre, 2016). The gap in the evidence prompted the research question: '*What is women's experience of pregnancy in prison?*', the aim being to capture subjective accounts leading to an understanding of women's own experiences of their pregnancy whilst incarcerated, and from their perspective. An ethnographic methodology taking a holistic view that involves an examination of how being pregnant in prison might impact on the individual woman is therefore an appropriate way to answer the research question. Taking an ethnographic stance offers a fresh and original perspective unlike any previous research into the experiences of pregnant women in prison. Personal reflections and fieldwork giving a comprehensive overview of the milieu will expose the setting, viewed through the unique lens of midwife/prison researcher. In deconstructing the daily patterns within a closed institution - the props, the spaces, the interactions with significant people, and the closed environment that the pregnant prisoner is exposed to - a broad representation of the experience of pregnancy in prison will be revealed. A qualitative, naturalistic - rather than quantitative - approach will lead to an understanding of the sociological perspective impacting on the lives of the women, gradually unravelling their experiences, and adding to the body of existing knowledge.

## **Summary of chapter**

The current studies relating to pregnant women in prison have been critically appraised and significant themes have been acknowledged. Persistent themes from such research include: the absence of collecting routine data about pregnancies and births in prison; the inconsistencies and contradictions found in care provision; and the emotional turmoil of separation of mothers from their babies. The perceptions and experiences of pregnant incarcerated women remain largely unwritten, rendering them invisible throughout a life-defining process. This absence is recognised as a sub-theme of all the research reviewed. Validation of the research questions that have been selected has therefore been established. The following chapter will critically appraise and defend the methodology and determine the qualitative method used in meeting the aims of the research.

---

## Chapter 3: Methodology

---

A gap in the research was identified by the literature review, necessitating a study into pregnant women's encounters of an English prison. In this chapter, I critically evaluate and justify the methodology selected for the study and determine why the naturalistic, qualitative, inductive approach was suitable to meet the research aims and why institutional ethnography was chosen as a suitable framework. Negotiating access, ethical considerations, sampling techniques, recruitment approaches, reflexivity and challenges faced are deliberated. Specifics relating to the process of thematic analysis are explained. The fieldwork was undertaken in three prisons: Prison A<sup>16</sup>: a closed prison with no Mother and Baby Unit (MBU); Prison B: a closed prison with an MBU; and Prison C: an open prison with an MBU. Data collection methods consisted of fieldwork diaries and audio-recorded semi-structured interviews with women who were currently pregnant, those who had been imprisoned during pregnancy, and prison staff.

### **Research aim**

The overall aim of this research was to examine the pregnant woman's encounter with the English prison estate and their experience of the associated conditions, through:

- Semi-structured audio-recorded interviews with pregnant women, women who had experienced pregnancy in prison, and prison staff.
- Deconstructing the daily patterns and consideration of their impact upon the pregnant woman, including observation of the spaces, rooms and prison wings.
- Interactions with significant people and the milieu that the pregnant prisoner was exposed to.

### **Research methods: a naturalistic approach**

The research necessitated a naturalistic qualitative, rather than positivist quantitative, approach to understand the sociological perspective of the lives of the women and to unravel the core and essence of their experiences (Hammersley, 2013). Bowling (2014:363,364) defines qualitative research as a "method of naturalistic enquiry...study(ing) people in their natural social settings...to collect naturally occurring data". To uncover the 'truth', a subjective approach to gain in-depth

---

<sup>16</sup> A closed prison has maximum security holding category A, restricted status, closed conditions and remand prisoners. An open prison is a minimum-security prison where women can attend outside work and are trusted with minimal supervision.

understanding required ontological relativism to appreciate that different views and beliefs mean that there may not be one superordinate truth. Irrefutably, Derrida (1967) advocates that research should expose multiple truths, concerned with the 'between', 'multiple voices' and the various ambiguities that expose dichotomy and 'difference'. My epistemological position needed declaring to accommodate my subjectivity. The depth of self-awareness and knowledge of one's own values are required to avoid a "detached attitude" (Bryar & Sinclair, 2011:21). Indeed, Bryar and Sinclair (2011:43) consider how theory fortifies professional knowledge, yet state that reflective practice and 'self-knowledge' should be a central tenet, underpinning midwifery practice. I am a qualified and experienced midwife, a midwife teacher, woman and mother. My predisposition is declared at the outset of my research and the awareness of this ensured that the interpretation of participants' experiences was rigorous. Grounded in the theories of Derrida (1982), Linstead (1993) examined the theoretical underpinnings of ethnography and suggests that the ethnographer should acknowledge his/her world from the onset, arguing that ethnography will always be subjective because rich description is a central principle. Sinclair (2007) recommends harnessing accessible theories as a foundation to research, likening the planning to a 'travel map' in order to carefully and effectively navigate the journey to an 'endpoint'. Furthermore, Creswell (2016:19) emphasises the need for researchers to step outside of their comfort zone, suggesting that they do not research their 'own backyard'. Affirming my position from the beginning therefore injects neutrality and attempts to reduce any personal bias. My core intention was to uncover a wealth of comprehensive depictions of 'phenomena' by detecting certain repetitions, beliefs and associations that link together the environment and experience (Welford et al., 2012:72).

### **Institutional ethnography**

Previous research demonstrated a reliance on second order interpretation by mainly exploring women's experiences from the point of view of the prison staff (Price, 2005; Ferszt & Clarke, 2012; Albertson et al., 2012; O'Keefe & Dixon, 2015; Gardiner et al., 2016). An understanding of the women's experiences required deeper exploration by hearing from them directly. Hammersley and Atkinson (2007) suggest that ethnography is a useful methodology, as data can be saturated in the field until the researcher fully understands the phenomenon. Prison research experts also recommend ethnography as a way of triangulating data (King & Wincup, 2008; Liebling, 1999). To fully understand the whole experience, becoming immersed in observing the environment together with conducting interviews has been recommended as a means to generate high quality data (Hammersley & Atkinson, 2007; Walby, 2007; Jefferson, 2015; Van Maanen, 2011; Harvey, 2015). Derrida (1982) espouses that ethnographers should study an environment in order to expose power relations, to reduce barriers, cultivate understanding and reveal concealed voices.

Having a 'constant presence' as an ethnographer could ensure that the research was not a 'superficial picture' of prison life (Harvey, 2015). Undeniably, in order to understand the experience, it was important to observe the sociology of the environment that the women were living in (Campbell, 1998; Smith, 2005). It would not have been possible to separate the notion of institution from researching women's experience of pregnancy in prison yet, according to Liebling (1999), health research undertaken in prison often omits to consider theories relating to 'prison as an institution'. Ervine Goffman's concept of 'total institutions', based on his study of a mental hospital with similar characteristics to a prison, is beneficial in understanding the system and power relationships; to fully examine the actions of the women, who were under the control of the staff; and the staff and other inmates who may exert their power (Goffman, 1961). Stauffer (2015) articulates this succinctly stating: 'institutions have procedures, rules and standards, or they quickly cease to be.' (Stauffer, 2015:83). Barbour (2013), likens institutional ethnography<sup>17</sup> (IE) to mixing a pot of people, things and places all inextricably linked within power relations. An examination of IE as a framework informed my strategies, drawing upon methods employed by Campbell et al. (2006); Smith, (2005) and Darlington and Scott, (2003). Campbell (1998) utilised IE within her own research describing the work of nursing assistants in a long-standing care setting, stressing the importance of understanding day and night happenings within the real world. Van Maanen (2011) suggests that ethnography is like a piece of 'impressionist' artwork where the scene is conveyed through the eyes of the researcher. Similarly, Campbell and Gregor (2002) propose that within IE, interpretation of the setting is conveyed by the researcher.

## **Feminist theories**

Due to the specific gender issues involved, women's acceptance of their position often leads to a position of fatalism<sup>18</sup>. Scrutiny of feminist research methods enriched the methodology (Oakley & Roberts, 1981; Ribbens & Edwards, 1997). To uncover women's voices, the qualitative approach was informed by feminist theories. It cannot be ignored that the prison environment has been designed by men, for men, and is therefore gendered without the needs of women in mind (Gelsthorpe & Morris, 1990; Liebling & Maruna, 2013). Smith (2005) developed the concept of IE with the 'standpoint of women' as her focus, with the perspective of women's subordination and 'suppression' as a key component (Campbell, 2003). Reinharz (1993) explained that, even as a woman it is difficult to gain access to other women, especially those of a different perceived social class, life style, job, marital status and/or economic status. The chosen methodology required my own reflection upon the sense of power and disempowerment of the women's world. The literature

---

<sup>17</sup> Institutional ethnography was developed as a method of social research by Dorothy Smith which seeks to understand social interactions contextualised within institutions from a woman's standpoint.

<sup>18</sup> Fatalism is defined as having no control over one's destiny and having no power to change things.

supports the view of feminist research representing the voice of women without power (Kirsch, 1999). Nonetheless, Brayton (1997) suggests that the adoption of a feminist lens should also raise questions and issues of concern whilst challenging patriarchy and power imbalance, and unravelling inequalities. Bryman and Cassell (2006) surmise that undertaking research from a feminist perspective means that the main goals are to hear women's voices, to reduce objectification and oppression and ultimately to contextualise the women's stories, viewing them as empowered individuals.

King and Wincup (2008) found that applying feminist methodology did not always go far enough to counterbalance the inherent power relations and dynamics, especially those between participants and gate keepers. However, the argument remains that to undertake a quality piece of research using feminism as a starting point, emotional and reflective self-awareness of my personal world needed to be understood to make sense of the women being studied. Ribbens and Edwards (1998) espoused the viewpoint that women have a public and private way of being, yet privacy is limited within the prison setting and therefore it is questionable whether the research process can truly be enabling for women. The challenge of listening to voices that may be silent or invisible is a critical area for the feminist researcher to consider (Reinharz, 1993; Ribbens & Edwards, 1998; Kirsch, 1999) and is therefore an essential foundation of researching women in prison. Whitehead (2006) discusses the need for the political empowerment of women in prison to be balanced with the subjective stance of the feminist researcher and the need for this framework to inform the political agenda of women's imprisonment. Stanley and Wise (1993) challenged the need to break away from the subjective in feminist research and instead to move towards more evaluative tactics, thus becoming less emotional and reflective. Kleinman (2007) disputes their claims by suggesting that a researcher must reflect upon their own status within a patriarchal society or risk being hindered by personal beliefs when exploring issues relating to inequality. Certainly, through reflexivity and the declaration of my own emotional responses as a woman, mother, and midwife by using field notes and diaries may have reduced my subjectivity, especially when analysing participants' voiced experiences.

### **Ethical approval and access**

Favourable ethical opinion was granted by the National Offender Management Services (NOMS) on 25<sup>th</sup> September 2015 (2015-209) through the Health Research Authority Integrated Research Application System (IRAS) (**Appendix 1.1**) and permission to proceed was granted by the University of Hertfordshire on 8<sup>th</sup> May 2015 (HSK/PG/UH/00384) (**Appendix 1.2**). Permission to audio-record interviews with women still in prison was granted by the Governing Governor of each prison (**Appendix 1.3**). Ethical attention when undertaking research in prison or with participants who may have complex social issues has been widely explored by academics spanning health, qualitative



research and criminology disciplines (Oakley & Roberts, 1981; Liebling, 1999; Lee-Treweek & Linkogle, 2000; Christopher et al., 2011; Jewkes, 2012; Gilbert & Stoneman, 2015; Hotham et al., 2016). Navigating the complexities of the prison world as I accessed the setting required careful attention. The prison setting also adds a potential additional risk to personal physical and emotional safety. Liebling (1999) warns that prison staff may see the researcher as another hazard that requires management. Taking personal responsibility for my safety was important in order to reassure the staff and Ethics Committees. Understanding the prison setting also prepared me, to some degree, for the impact the environment would have on me, and therefore I arranged monthly clinical supervision sessions (privately paid) with a psychotherapist, and completed self-defence training facilitated by prison officers. Evidence supports the use of personal clinical supervision when working with vulnerable women in demanding situations (Fontes, 2004). Harvey (2015:399) suggests that the worth of supervisory reflection goes further than merely supporting the researcher as he questions the valuable contribution such reflections may add to the 'thick descriptions' of facets of 'prison life'. Developing an understanding of prison language and the regular acronyms used by women and staff (e.g. released on temporary licence (ROTL<sup>19</sup>); pad mate; roll call) was helpful in gaining credibility and lessening my naivety (Waldrum, 1998). Although not explicit in ethical guidance from NOMS or the University, an important ethical issue was to tell the women I was not coming back at the end of my project. It is understood that many women in prison have complex and chaotic existences (North et al., 2006; Albertson et al., 2014; Baldwin & Epstein, 2017); therefore, I ensured that I did not inadvertently abandon the women through an abrupt departure, which potentially would have created the conditions for them to re-enact their distress.

### **Storage of data**

In compliance with requisite anonymity and confidentiality, all data collected was stored in a locked filing cabinet in a locked office. Hard copies of consent forms were locked in a separate filing cabinet in the same locked office to ensure data protection of participants. Fieldnote books were also kept in a locked cabinet, separated from the transcripts. All electronic data has been encrypted, backed up to an external hard drive and password protected. Audio recordings were deleted after completing each transcription, as required by the Prison Service and Ethics Committees.

### **Issues of consent**

Informed consent of participants should be sought in all research (Oakley & Roberts, 1981; Polit & Hungler, 2001; Mason, 2002; Silverman, 2013; Barbour, 2013; Gilbert & Stoneman, 2015) however, the complexities of prison research required special consideration. Commonly, women in prison have

---

<sup>19</sup> ROTL is an acronym for: 'Released on temporary license', where a prisoner may be granted leave from the prison for a brief time.

themselves been victims (Carlen & Worrall, 2004; Kennedy et al., 2016) and their consent may have been denied in past relationships (Corston, 2007). I was mindful that some women may have suffered moments when they could not exercise freedom from coercion and that this may have been an issue throughout their lives (North et al., 2006; Britain, 2013). Women who declined an interview were thanked for their time and offered an opportunity to ask any questions about my research, and care was taken to not approach them again. Women approached for potential participation were invited to consider the information leaflet (**Appendix 1.4**) prior to giving written consent (**Appendix 1.5**). King and Horrocks (2010) suggest sensitivity and planning are key issues when questioning participants about sensitive subjects. Obtaining informed consent was vital in protecting human participants from emotional harm and enabling choice over whether to participate. NOMS were clear that a strategy needed to be devised in case of distress or behaviours which may have potentially triggered concerns of self-harm or suicidal ideation. Strategies such as referral to psychological services, a mental health nurse or to a prison 'listener'<sup>20</sup> were documented in the ethics application but for this eventuality to be correctly managed, I needed to understand the referral routes and support offered in the prison environment and to make plans in case of distress.

### **Negotiating entry**

Restricted access to the prison setting for research purposes is well-documented, requiring a persistent determination to overcome obstacles (Liebling, 1999; Carlen & Worrall, 2004; Harvey, 2008; Crewe, 2009; Piché et al., 2014). Commencing this area of research required a personal tenacity to gain access to an environment unfamiliar to me as I had no contacts or networks at the outset (**Appendix 1.6**). Although the National Offender Management Services (NOMS) granted favourable ethical opinion, access was not guaranteed: that decision was devolved to individual prisons (**Appendix 1.1**, highlighted).

Prior to formal access, I undertook three activities:

- Trained and volunteered as a Birth Companion<sup>21</sup>.
- Visited five UK prisons to shadow midwives responsible for perinatal care.
- Conducted several prison visits with a forensic psychotherapist, participating in pregnancy and early years groups.

Familiarisation of the setting informed my pilot interview schedule, research questions and understanding of this highly routine-driven, closed environment. To satisfy security protocols, each

---

<sup>20</sup> Prison listeners are volunteers trained by the Samaritans charity to listen to fellow inmates who are in distress.

<sup>21</sup> *Birth Companions* are a UK charity providing support, antenatal classes and early parenting groups in two UK prisons.

prison visited required Enhanced Disclosure and Barring Service (DBS) clearance. Such applications were a time-consuming negotiating process, requiring fresh application at each prison. Rules and security and the importance of minimal prison milieu disruption was paramount (Glaser & Strauss, 1969/2011). Despite the groundwork, the prison Governors<sup>22</sup> initially approached declined my applications, giving reasons such as staffing levels. Undeterred, I approached all twelve UK female prisons and was initially granted approval in two closed prisons. Unfortunately, in the same week that I was granted approval for one of the prisons, its closure was announced and therefore authorisation was withdrawn. The remaining prison was four hours from home and negotiations were still required to set up an initial meeting with staff. Phone calls and e-mails were often unanswered, and no answering machine facility was available to leave messages. The despondency and frustration I experienced then turned to acceptance of the reality of negotiating a closed institution. Eventually, I spoke to a manager in Prison A who had been instructed to contact me by the prison Governor, and a date to meet was suggested. A plan was put into place whereby I would visit Prison A on a weekly basis. Barbour (2013:164) talks of the 'constant renegotiation' required and Harvey (2008:488) describes 'gaining access as an ongoing business' when accessing an unfamiliar setting. Re-negotiation continued throughout the period prior to applying for NOMS Ethical approval and was unrelenting during the fieldwork, with ongoing challenges arising. On each visit to Prison A, I would bring biscuits for the staff, which was welcomed. I became absorbed into prison life as I was invited to meetings and staff training. I would join staff at break times and would also join prisoners having a tea break where the minutiae of prison life was discussed and sometimes issues concerning staff and other inmates were revealed. Six months into my research in Prison A, I was granted approval at two more prisons - one closed prison with an MBU attached (Prison B), and one open prison with an MBU attached (Prison C); again, both were a considerable distance from home.

### **Prison research approach**

Liebling (1999:151) likens prison fieldwork to entering an alternative planet and speaks of feeling 'cut off' from communication. Crewe (2009:484) reiterated this sensation by saying that moving from the outside to the inside environment of prison felt like going 'from one world to another', generating a variety of emotions. Piche et al. (2014) echo this feeling of otherworldliness but also state that accounts must represent the experience, and the collective sphere of the prison must be understood in order to undertake prison research. Liebling (1999) urges those who undertake prison research to be cautious about the stresses and burdens on the self, suggesting that it is not possible to have a whole career in undertaking prison research and intimating that many do not have the tenacity to endure the challenges. Jewkes (2012:67) espouses the need to rebuild coping strategies and

---

<sup>22</sup> Prison Governors are responsible for the management and security of prisons.

endorses 'long gaps' between research projects. 'Isolation' is identified as an element of all qualitative research but it is suggested that this is more in relation to the process of transcription and analysis of data (Creswell, 2016:28). Whilst in partial agreement with Creswell (2016) that analysis and transcription is a lonely business, in prison research the 'isolation' comes from the bleak environment and long journeys following on from emotionally exhausting days in the field. This feeling of going into another world is something that I identified with and tried to make sense of through my diaries. The struggles I had with the prison environment, where women's unravelling stories permeated through me, was complicated by my need to be fluid in my other roles as mother, wife, teacher, midwife. I coped with the encounters through regular monthly supervision with a forensic psychotherapist where I discussed the difficulties in managing my separate roles and shared challenging interactions in confidence. At times, fieldwork took its toll on my mental wellbeing as some of the women's anguish penetrated me and caused insomnia and dark dreams about prison life. I often felt an overwhelming sadness about the women's tragic circumstances, which in turn made me feel grateful for my own liberty and family life.

### **Self-presentation**

The outward presentation of self has been described as requiring careful consideration by prison researchers (Rowe, 2014). Indeed, I gave much thought to how I should present myself in response to the environment and people within. I decided to wear the same bland, baggy, dark coloured clothes for visits; I wore minimal make-up and no jewellery to blend in as much as possible and to create a sense of equality in order to help enhance rapport. Prior to receiving my prison identification - consisting of an ID card on a lanyard - I was issued with a wrist band at each visit which differentiated me from the prisoners. However, the wrist band and the lanyard that I eventually received were the only markers that I was neither permanent staff nor a prisoner.

### **To hold keys or not to hold keys?**

Carrying keys can have benefits and drawbacks when undertaking prison research (Liebling, 1999). The wearing of a belt with chain and keys acts as a symbolic prop representative of the prison environment, a closed institution (Goffman, 1961). From media images on news reports and television dramas, the sounds of the jangling chain and the key turning a lock with echoed distinctiveness is as synonymous with the prison experience as the tension you feel as you walk through the prison wings. In Prison A, where I spent most of my fieldwork time, induction training, keys training, personal safety and counter-intelligence training were required in order to achieve 'staff status' and be issued with a prison identification. However, by the time I had received my training, I had already undertaken several interviews with women. In Prison A I could have been a key holder if I had chosen, yet I decided not to accept keys. That decision may have led to building a more balanced and trusting relationship with the women, perhaps enhancing the depth of the

interview data. I, too, was rendered to a state of disempowered subordination compared to the staff who held keys. Although having keys would have been more convenient, I was aware of the potential barriers they could embody in prison where positions of power are the mainstay of the environment. My extensive experience as a health care professional meant that I had considerable communication skills with which to build rapport with the women. Nonetheless, the openness and richness of the interviews with prisoners were partially due (in my opinion) to the balance of appearing more equal because I had abandoned the costume and props associated with the custodial system.

### **Pilot study**

Pilot studies have been recommended to develop research questions, '*identify potential practical problems*' and '*collect preliminary data*' (Van Teijlingen & Hundley, 2002). Interviews with three women who had been pregnant in prison were undertaken in their own homes in the pilot phase and used as preliminary data. I had been invited to charity service user forums and presented my research proposals to women (who had been pregnant in prison) and volunteers who gave feedback on my plans. Each woman was given a participant information sheet to read (**Appendix 1.4**) and was encouraged to contact me if she was interested in participating. Early interviews were valuable in building a picture of prison life prior to my entering the field and informed the interview schedule (**Appendix 1.7**). I mastered qualitative research skills such as the use of the audio-recorder, interviewer style, and transcription. Van Teijlingen and Hundley (2002) suggest that pilot studies in qualitative research are 'progressive' - procedures improve, especially in relation to interviewing. Indeed, my own performance did improve, due to gaining confidence in my competences as a qualitative researcher.

### **Population and sampling techniques**

Identifying the approximate number of pregnant women in prison nationally informed the sampling techniques. I sought to secure a convenience sample of 24 women to represent 4% of a population of approximately 600 women in order to enhance generalisability (Sandelowski, 1995). Morse (2000) recommends that ethnographers should have a sample size of 30-50 participants; however, with the variable number of pregnant women in prison, my aim was slightly under that recommendation. Sampling techniques included what Barbour (2013:87) describes as 'research network sampling', especially as this was a hard to reach group of women. Using a smaller sample with abundant, in-depth data that highlighted what was specifically important to the women being interviewed provided greater understanding of their world and what was of most consequence (Mason, 2010; Barbour, 2013; Silverman, 2013). Each prison compiled a 'pregnancy list' of all their pregnant women. In Prison A, this consisted of a handwritten list of names in a small notebook. Pregnant women were not grouped on one prison wing, which meant that seeking out potential participants was a complex task at first. Health care staff and officers were my main gatekeepers in accessing the women, as

were other women prisoners whom I encountered on a regular basis. Staff would help me to locate the pregnancy list and we would set about finding out where women who met the inclusion criteria were located. A ‘movement slip’<sup>23</sup> was issued to women who agreed to have a preliminary conversation with me, where I would explain my research and give them a participant information sheet to take to read. Most participants were incarcerated in Prison A (**Figure 1**). In Prisons B and C, women on the MBUs were approached as well as accessing the list of pregnant women.

## Sample

In total, 28 women participated in audio-recorded interviews: 22 whilst incarcerated and six following release from prison (three of whom informed the pilot study). One woman declined to be audio-recorded but consented to be interviewed while notes of her responses were written. Five of the women who were still incarcerated agreed to follow-up interviews. Ten staff members consented to audio-recorded interviews, including six prison service staff and four health care personnel.

**Table 5: Sample criteria: women**

Inclusion criteria	Exclusion criteria	Rationale
<b>English speaking</b>	Unable to speak fluent English	No translation services available
<b>18 years or older</b>	Under 18 years	Ethical considerations of interviewing under-18-year olds
<b>Continuation of pregnancy planned</b>	Planning a termination of pregnancy (TOP)	Inappropriate to interview women planning a TOP, and not meeting research aims.

**Table 6: Sample criteria: staff**

Inclusion criteria	Exclusion criteria	Rationale
<b>Worked in the female prison estate for 12 months or longer</b>	Less than 12 months’ experience	Have a working knowledge of prison systems and likely to have worked with pregnant women.
<b>Prison staff member, working as prison officer or health care staff</b>	Agency staff	Consistency of employment and knowledge of prison system.

<sup>23</sup> A ‘movement slip’ is a permission document for an appointment allowing the temporary release of a woman from work, education or from her room.

## Incentives

Women interviewed in their own homes were given a gift token to thank them. I was not able to offer a gift to women in prison as strict protocols prevented this. However, I did write to each of the women who remained in prison, thanking them. I gave staff in Prison A a small thank you gift in appreciation of their cooperation over a length of time.

## Sample characteristics

The characteristics in the sample were representative of the general female prison population as a whole (Walmsley, 2013, **Appendix 1.8**). Twelve women were at various stages of pregnancy at the time of the interviews and the remainder were interviewed post-birth. Most women were aged between 30 and 39 years (Figure 2), and 21 women were in prison for the first time (Figure 3). The majority of the women (N=21) had been sentenced for a non-violent crime and were generally serving a sentence of six months or less (Figure 4). Sixty eight percent of women had given birth prior to interview (multigravida) and 32% of women were nulliparous (Figure 5). Thirty-two percent of the pregnant women did not know whether they had gained a place on an MBU, 14% of the women had been separated from their baby and 13% were having a planned separation from their baby following birth (Figure 6). Two women were awaiting trial and were on remand in Prison A.

## Charts representing sample characteristics

Figure 1:

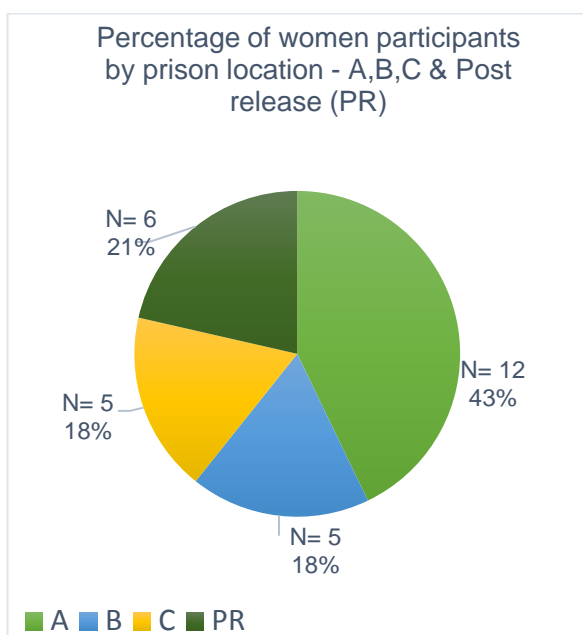
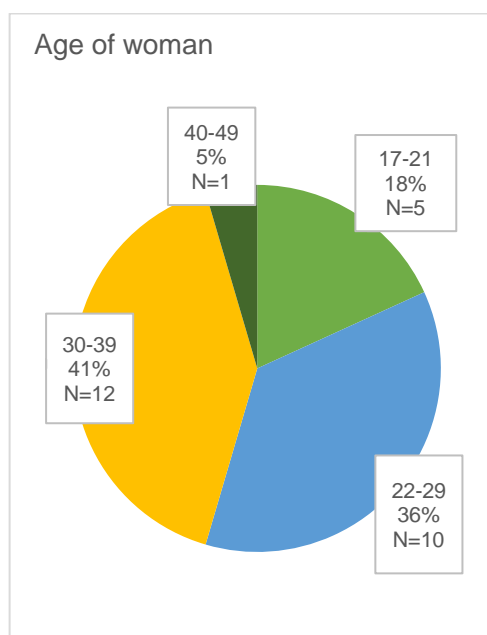
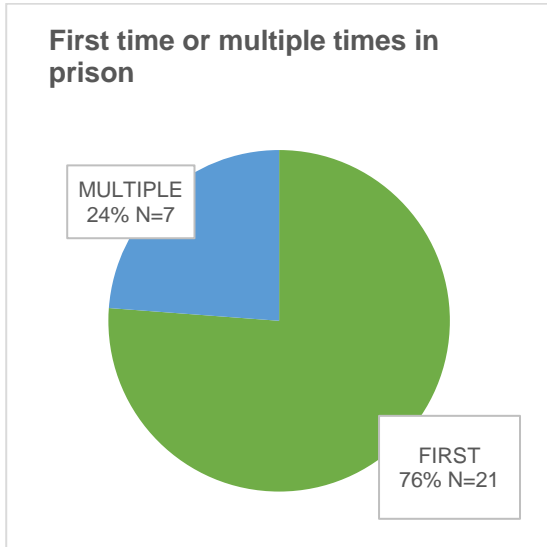


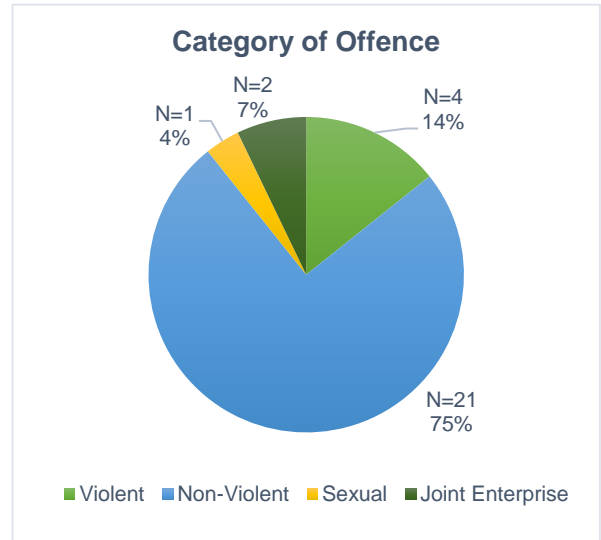
Figure 2:



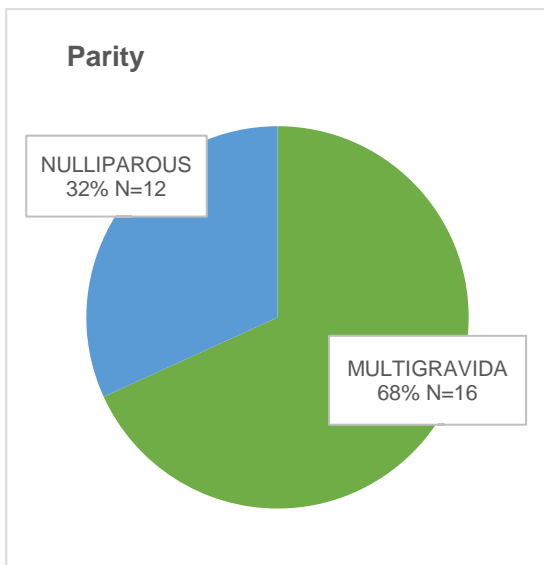
**Figure 3:**



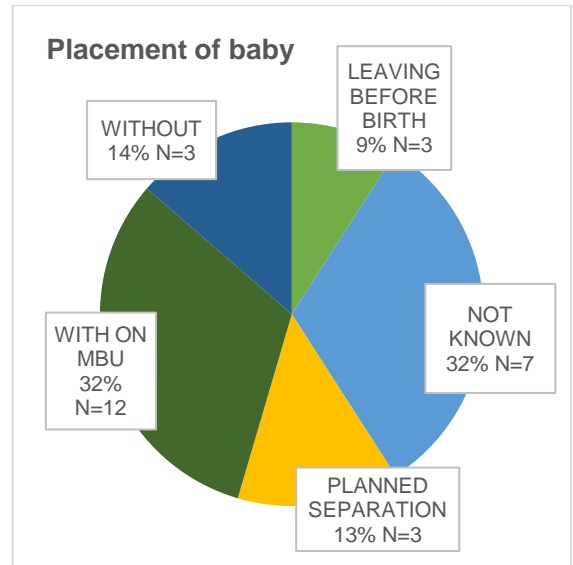
**Figure 4:**



**Figure 5:**



**Figure 6:**





**Table 7 – Pseudonyms, and location of interviews**

Pseudonym	Prison A, B, C, or post-release (PR)	Pregnant (P) or post-partum (PP) at time of interview	Number of interviews
Abi	A	P	5
Angel	A	P	1
Boo	A	P	1
Caroline	A	P & PP	7
Cleo	PR	PP	1
Daniela	A	P	3
Debbie	B	PP	1
Ellie	C	PP	1
Elsa	B	PP	1
Frances	PR	PP	1
Jane	PR	PP	1
Jolene	A	P	1
Karis	PR	PP	1
Kayleigh	A	P	1
Krystal	B	P	1
Layla	C	PP	1
Linda	C	PP	1
Lola	B	P	1
Mercy	PR	PP	1
Pamola	PR	PP	1
Sammy	C	PP	1
Sharon	A	P	1
Sinead	B	PP	1
Susan	A	P & PP	5
Sylvia	A	PP	1
Tammie	C	PP	1
Tracey	A	P	1
Trixie	A	P & PP	5

## Snowball sampling

Standing (1998:188) advocated snowball sampling when accessing groups of women who may be 'vulnerable and stigmatised in everyday life'. Furthermore, Creswell (2016:111) proposes that one of the purposes of adopting the snowball method is discovering 'information rich... cases of interest from people in the know'. The skills of navigating the prison system and communicating with women and staff, which I developed prior to commencing fieldwork and during the pilot phase, enabled me to maintain credibility and allow weekly access to Prison A. Spending over 260 hours in the prison setting meant that women and staff alike got to know me. As the research progressed some women would seek me out, having heard about my research. The phenomenon of snowball sampling was not limited to Prison A: in Prisons B and C, although I had less time to spend there, women heard about my research and approached me to talk about their experiences.

## Data Collection

### Fieldnote books

Twenty-five fieldnote books (**Figure 7**) were collected as data, recording the minutiae of prison life. My fieldnotes would contain frequent descriptions of my interpretation of the prison milieu: e.g. "*the smell of sour milk; the tension, the thick air, the angry atmosphere, it's claustrophobic. I want to get out of here; it feels oppressive*". I tried to capture the atmosphere through description and reflection to give context to the women's experiences. Nonetheless, my fieldnotes also hold the mundane and the intricacies of prison life and associated artefacts:

*"...Plastic knives, forks and spoons, coffee and tea mugs. The movement slips, yellow walls, blue-speckled non-carpeted flooring. The echoed noise of the clinks of keys and chains jangling. The exclusive prison language and the sounds of the shouts from the officers: 'Own room, ladies, own rooms, bang up time'..."* (Fieldnote entry, November 2015).

It is advised that time is set aside to capture fieldnotes and jottings, which I usually wrote up in full within 24 hours of an observation (Fielding, 2008; Barbour, 2013). Lofland and Lofland (2006) state the importance of writing up fieldnotes as soon as possible to maintain freshness and to ensure that emergent themes will be uncovered, and advise that even in the most basic form, fieldnotes should be written up. Nevertheless, Hammersley and Atkinson (2007) warn that the researcher is unable to capture everything; the emotional demands of prison fieldwork meant that exhaustion would often overtake the need to write up notes.

My early jottings from time in the field seem far removed from being the pieces of art suggested by Van Maanen (2011) (**Appendix 1.11**) and give a sense of a chaotic disorder like pieces of a complex

jigsaw puzzle, possibly mirroring my inner muddles. Kvale (2008) suggests that a researcher should be without bias and be able to tell a story through excellent communication skills. However, all the nuances and complexities of the prison environment meant that achieving impartiality was challenging and my written notes, especially in the initial stages, were disarrayed and chaotic. Writing fieldnotes contemporaneously was sometimes complicated. I learnt to use key words and mind maps as suggested by Darlington and Scott (2003), who advocated brief notes are written during an observation with deeper fieldnotes written up later. I would usually take a new notebook to each visit, or remove the written jottings from a previous visit - this was mainly due to my own heightened sense of fear of losing a notebook, or forgetting it or having it confiscated on the way in or out. I did feel like an investigator at times and was slightly uncomfortable about writing notes about my observations, although I carefully coded any stories shared by informants and always used aliases. I admit that, when commencing my fieldwork, I did not have a system for writing observations. After a while, I realised the value of designing an 'observation protocol' as recommended by Creswell (2016:19) and using 'contact summary sheets' for each observation, such as those suggested by Silverman (2013:245). This organised my jottings into more manageable summaries that showed the people involved, main themes and what 'research question did the contact bear most centrally'. On reflection, this should have been organised sooner, yet the messy 'puzzlements' do reflect the environment and my inner emotions whilst being in a closed institution (Lofland & Lofland, 2006:78).

Many of my jottings use comparisons and metaphorical language and this style of writing notes has been encouraged in qualitative research (Alvesson & Sköldberg, 2009). Confusion and 'puzzlements' should be the focus and I, as the researcher, should give meaning and analysis to any data, starting with reflections and analysis of the situation before writing up any fieldnotes (Lofland & Lofland (2006:78). Gomm (2008) discussed how value judgments can skew data, yet it can be argued that judgments and reflexivity, especially within a closed institution, add to the depth of the research and data generated. My early fieldnote books tend to focus on my felt sensations of shock: *'I am struck by the thinness of the women, the claustrophobia and smell'*. At times I found myself stumbling for the right words and phrases to write. I admit, in the early weeks the overwhelming feeling of astonishment may have generated self-doubt, causing anxieties in writing my observations accurately; yet as an ethnographic researcher my role was to report authentically and not sanitise any observations. As time progressed, greater certainty in my credibility as an ethnographer increased the confidence I had in my relationship with the data. As I became more accustomed to prison life, my language became less personal and subjective and more focused on tales from informants and observations of happenings, such as movement around the prison and the language of staff. Towards the end of my time in the field, I entered a kind of anticipatory mourning and began to write more poetically, noting the contrasts and the visual nature of the freedom of animals seen

as I drove to and from the prison. On my last day at Prison A I wrote some field observations from outside one of the prison wings:

*"...You can hear the birds singing and these little birds had made a nest in the roof of one of the prison wings. They were flying in and out, freely...you could sense their freedom as they're flying, taking the tiny twigs and worms for their baby birds. Yet the women are locked up inside, their babies taken away from them..."* (Fieldnote entry, August 2016).

The representation of the freedom of the birds contrasting with the incarceration of the women, as I prepared to leave and escape back to my own reality of being midwife, mother and teacher, was poignant and symbolic. The subsequent reflections inspired a journal submission relating to reflections on leaving ethnographic fieldwork and closing prison relationships in an ethical way (**Appendix 1.16**, Abbott & Scott, 2018).

**Figure 7: Fieldnote books**



### **Audio-recording**

A precedent had been set by researchers such as Crewe (2009) regarding the use of audio-recording devices in prison, and for this research permission had to be granted in writing by each prison Governor (**Appendix 1.3**). Permission to take a recording device into prison needed careful negotiation and required agreement to certain conditions. Audio recorders are a banned list "B" item (**Appendix 1.1**) in prison so my recorder was inspected, and its serial number recorded prior to

commencing my research. An application to bring in a prohibited item was completed and signed by managers and held at the prison gate. At each visit, the recorder was again checked, and permission granted to take it inside the prison. I ensured I carried permission paperwork with me at all times, as recommended by King and Liebling (2008). The location of the recording device during interviews was important in that it should be close enough to record the conversation without distracting the participant. Prisons are noisy places and the recorder needed to be of superior quality to pick up the interview dialogue. The recording of participants created ethical considerations due to the potential that women may be reminded of a police interview. King and Horrocks (2010) recommended that the researcher be mindful of the triggers a recording device may produce in the participant who has been in the criminal justice system. Nonetheless, my 'social remoteness' due to not being part of the prison system may have encouraged greater candour from participants (Harvey, 2008). Liebling (1999:158) describes the 'exhaustion' of prison interviews for both participant and interviewer, with responses spanning from abrupt answers to deep narratives with shared tears. Funding awarded by *The Iolanthe Midwifery Trust* (**Appendix 1.9**) enabled me to purchase a high quality, encrypted recording device. King and Horrocks (2010) advise turning the recorder on as soon as possible after consent and to be familiar with the equipment so that it becomes less of a distraction for the participants. On one occasion, I forgot to turn the recorder on and only noticed this 30 minutes into an interview with a member of staff, which was embarrassing for me and frustrating for the staff member. However, it was of value to have made a mistake - it prevented a repeat occurrence, and some interview content was available from my fieldnote entries.

### **Non-participant observation**

Ensuring I 'determined my role' as an observer from the outset is recommended by Creswell (2016:121), yet my relief at gaining access, especially in the earlier fieldwork phase, meant that I did not give as much thought to my observer role as I should. A prison is a place of work for staff but is also the living space or home for the prisoners. Darlington and Scott (2003), Smith (2005) and Campbell (1998) proposed that observation informs patterns and routines in everyday lives. Mapping the social experiences of pregnant women through observation and taking the prison as the institution uncovered the typical day, a term described by Smith (2005:67) as 'everydayness'. (See **Appendix 1.12** for prison routine). The environment of prison was observed by me as a non-participant spectator. On examining the political paradigms within any organisation, Smith (2005) and Campbell (1998) assert that social constructs should be disentangled. Polit and Hungler (2001) suggest that, through observation, rich data can be acquired, and Guba and Lincoln (1994) expand on this by suggesting that the process of deconstructing social realities can lead to new knowledge and beliefs. I carried out most of my fieldwork in Prison A. Access to Prisons B and C was negotiated towards the end of the study and therefore less time was spent there. I observed the milieu of each prison; however, as the weeks progressed, I was able to move around Prison A more freely due to

the staff's increasing familiarity and my regular presence. This added to the depth of the observations but also meant that I needed to manage carefully the closure of the research in order to uphold the ethical research principle 'do no harm' and to ensure the women did not feel 'abandoned' as I left the field (Abbott & Scott, 2018).

The field work was framed within IE to gain the full picture of the pregnant woman in prison (Darlington & Scott, 2003; Smith, 2005; Campbell et al., 2006). Observation involved greater depth of what Smith (2005:27) describes as the 'ruling relationships' within the institutions studied. Spending time in Prison A with staff and women mapped their entwined lives with other prisoners, prison officers and health care staff. These associations have been described by Smith (2005:28) as 'work relationships'. Having not previously worked in a prison, nor having been a prisoner, meant that I lacked knowledge about the social constructs, such as the culture of individual prisons, and relationships between prison staff, health care staff and women. Crewe (2009) explained his position as prison researcher as being like an unwelcome bystander. This is what Liebling (1999:154) described as 'reserved participation'. Crewe submitted that it can feel more emotionally comfortable to interview inmates than to observe. This was true for me in the sense that interviewing felt purposeful, rather than frequently placing myself in an often-awkward position as observer. However, as familiarity grew, and I became more comfortable with the environment, my skills of observation were also nurtured. The 'faulty interference' (Polit & Hunger, 2001:277) of my own anxieties coupled with environmental tensions were reduced and I observed more outwardly, rather than focusing on my own worries. I could observe the prison in the daytime, usually between 0800 and 1800 hours. My request to be in prison at night was refused. When presenting my findings to a group of ex-prisoners, one woman asked whether I had observed prison at night. I was met with the remark: "*you will never truly understand what it is like to be in prison if you haven't been there at night*". Having been forbidden from entering the prison at night-time meant I could not glean a round the clock understanding of the prison landscape; it was therefore important to ask women about their night experiences to gain a deeper appreciation of the nocturnal setting which I was unable to access as an observer.

## **Prison life**

Observation meant that I regularly encountered prisoners and workers who would not be a formal component of my research. However, these inmates and employees gave a rich backdrop to the prison as a culture and helped to piece together the jigsaw of prison life and environment. Over the ten months I spent in the field, the number of contacts grew as I became a familiar face in Prison A. Prison is a monotonous place bound by rigid rules and tight security. For the women inmates it is boring, and time passes slowly; consequently, having someone to chat to was often an effective way for them to pass the time. For me, these conversations provided insight into the tones of prison life.

I found the stories fascinating (sometimes verging on mawkishness) and, as they sentimentalised their lot, I built bonds with many of the women. My fieldnotes include descriptions of the women's appearances, including the deep scarring from self-harm of several women. The dramatic effect that a prison suicide had upon the women and staff was recorded in my notebooks. Prison members' words provided and reinforced context to the evidence from the literature about the female prison population (Carlen & Worrall, 2004; Dolan et al., 2013; Dolan, 2016). I often found that wing cleaners would be the most willing to tell me what was going on. Moreover, it appeared that wing cleaners had greater access to observing the happenings of prison life than I did as an ethnographer and therefore their perceptions were insightful. I always introduced myself, explained what my research was and that I was observing the prison environment as well as interviewing women. Women prisoners on life sentences were keen to talk about their experiences of motherhood. Prison staff would tell me about their lives and families but were often less candid and perhaps more suspicious of me than were the prisoners. Some women would seek me out to talk about their children and their births, although they were not eligible as participants. The potentially cathartic nature of the research interviews had been discussed by women on the wings and hence women were sharing their stories with me. In one case, a woman came to talk with me, whilst I was on one of the prison wings, about her experience of having two stillborn babies before she entered prison. I acted on a human level, listening to her experiences. I was aware I could be potentially breaching boundaries as a researcher, yet the woman agreed with my suggestion of bereavement support. These women helped to weave a rich tapestry of prison life and culture into the research. In Prisons B and C, it seemed that officers were keen to keep me away from the main prison, perhaps because I had not had the time to build up the same trusting relationships and rapport as I had in Prison A.

### **Experiences of being an outsider**

Naples (2003:49) argued that there is a 'fluidity' in being an outsider and that the position is not 'static'. However, unlike Oakley and Roberts (1981:55), as much as I may have wished to be considered by the women to be an equal, that was impossible due to my liberty and their prisoner status. I could walk out of the prison freely leaving the women inside, so creating a tangible power imbalance and I therefore incessantly maintained the role of outsider in a physical sense. During volunteering there were two occasions where entry to the prison was denied at the gatehouse and visitors were not able to question or dispute the reason. The frustration and upset I felt, having driven many miles, was compounded by the distress of not being able to apologise to the women I had arranged to see. Having been refused entry during volunteering prepared me for the possibility of this reoccurring. On one occasion, following a five-hour drive, a booked week of fieldwork was disrupted through being denied access to Prison B. Previous experience helped me to regain perspective and not to give in to paranoid feelings of this being personal, and I understood that perhaps the level of tension in the prison or a disruptive event had triggered the denial. Incidents

such as being refused entry, although exasperating at the time, were helpful later in accessing the right support at the right time and aided the notion of 'becoming an insider' (Burns et al., 2012). My reflective diaries proved instrumental in helping to unravel the complex feelings of disempowerment that I felt when denied entry. During clinical supervision, I explored my sense of helplessness, and this helped me to clarify the power relations of the prison system, therefore enabling me to consider the feelings of powerlessness that women and their families may also feel.

On occasion I may have been perceived as a helpful addition to meetings, especially if pregnant women were discussed. I was careful to clarify the boundaries of my role so that staff and women knew that my professional background was midwifery but that my primary role there was as a researcher. Boundary setting as a researcher, rather than as a midwife, was difficult at times especially when staff asked midwifery-related questions. Women were accepting of my researcher role as I made this clear at the beginning of each interview. One woman who declined an interview with me stated that if there was nothing I could do for her as a midwife, there was no point in her talking to me. Nonetheless, there was a dichotomy in that as I became more of an insider with the staff, I felt less of an insider with the women. I confess that I often felt more affinity with the women than the staff and this led to internal struggles from a human perspective as well as a professional one. Burns et al. (2012) suggest that having a dual role as a health professional means that often research participants will view the professional role as superior to that of researcher. Harvey (2015) reflected upon his role as 'outsider' when undertaking research in a young offenders' institution. Being able to 'ask naïve questions, be curious and reflect' meant that he could appreciate the young offenders' experiences 'rather than work with them' (Harvey, 2015:393). Interestingly, I felt more able to maintain boundaries with staff than with women. This was due in part to the need to become an advocate in certain situations where professional and researcher boundaries became blurred (e.g. a woman feeling unwell during the interview). Further, my status as 'outsider' was sometimes blurred with my professional standing and women would sometimes ask midwifery questions. Whilst reiterating my researcher role, I understood that the imprisoned women would not have the same access to information as they would on the outside.

## **Reflexivity**

Reflections on my emotions were important to acknowledge and were useful for framing interview questions and triangulating data (e.g., I could draw some parallels with my own feelings of fear and anxiety when a woman described a similar feeling on her initial encounter with prison). Jewkes (2012) indicates that experiencing fears are essential when undertaking prison research in order to imagine what incarceration may feel like. An underpinning philosophy of IE (Campbell, 1998; Smith, 2005) requires the researcher to be reflective within the context of the environment. Smith (2005)



encourages the researcher to explore the regime both from a woman's and a researcher's vantage point. Gulick (2003:15) suggests that:

*'Life in the field involves the same emotions as life at home with the added necessity of being continually on alert... likely to force a heightened awareness of facets of one's personality of which one had not been aware of before'.*

My sense of discomfort was a key component to enhance understanding as I stepped inside a world that a pregnant woman may find herself imprisoned within. Leaving the prison after each visit was often described in my diaries and in clinical supervision as feeling like being 'concussed'. This sensation of confusion helped inform interviews with staff about their coping mechanisms. Staff often used metaphorical language about 'leaving the prison at the gatehouse' as a way of compartmentalising their experiences as they left work. However, as a researcher I needed to take the observations and voices of the women away with me to analyse and to make sense of what I had seen and heard. This made fieldwork particularly challenging within such a pitiless setting, where the women's stories were often hard to internalise due to the magnitude of their situations and my feelings of impotence regarding my capacity to help them. I often felt internal struggles when my professional midwifery identity collided with my researcher identity: being a Registered Midwife, skilled in ensuring that women are empowered when making informed decisions about their birth choices, it was particularly delicate to manage this collision at times, especially when women perceived that they were not receiving their entitlements. Although the NMC (2015) code offers clarity for acting in emergency situations, and this should have been straightforward to manage from an ethical perspective, I struggled sometimes when I felt I could have been more of a midwifery advocate or advisor for my research participants. Participants' emotions were often the focus of my reflections and fieldnotes as I tried to carefully manage my role as researcher, midwife and counsel, whilst making sure that I was not the cause of harm or opening the women to distress from questions that they may have considered to be too probing:

*"I'm finding after my visits I cannot sleep, and when I do, I dream, and I wake thinking of prison. Dreaming of the women: feeling haunted and permeated by their lives. It's so alien to me. I imagine myself in their shoes and think how would I cope? I'm finding that I still feel concussed every time I leave; it's confusing and a heavy weight. I need to talk about it. There have been times where I have needed to switch hats, especially with listening and offering a therapeutic, compassionate ear. Taking tissues with me for a woman to take back to her cell if she gets distressed, has been useful advice.*

*I'm there, someone to listen, ongoing, especially with the follow-up interviews. But I must take care, re dependency, yet it's a dichotomy- there's no other support in prison" (Field diary, April 2016).*

The importance of incorporating the researcher's emotion is championed by scholars such as Liebling (1999), Jewkes (2012) and Bosworth (1996) who propose that emotions create data. Bosworth (1996) submits that prison researchers must acknowledge their own emotions or else risk covering their own reactions, thus stifling analysis of their findings. Knight (2014) suggests that empathy is important from an organisational viewpoint when undertaking prison research to understand the system rather than place reproach upon individuals. Jewkes (2012) states that researchers must document the truth of prison research to ensure genuineness and demonstrate the reality of researching in prison. Knight (2012) suggests that thinking can be disturbed by being suppressed and encourages researchers to talk about their reactions. The psychotherapeutic supervision I received was an essential part of my research journey, yet some qualitative scholars warn against too much reflexivity and 'naval gazing' (Barbour, 2013). Plummer (2001) cautions that, whilst acknowledging that reflection has a place in qualitative research, one can become too reflective, which may border upon becoming egotistic. Crewe (2009) suggests that too much self-reflexivity may detract from the prisoner's own experience. Nonetheless, I concur with Jewkes (2012), Crewe (2009) and Liebling and Maruna, (2013) that in prison research, reflexivity and taking an auto-ethnographic stance is critical in order to maintain a stable state of mind and to increase objectivity. Writing a reflexive diary through fieldwork was indispensable to me and, at times, left me feeling emotionally drained. Following each visit, I would add my thoughts and reflections - totalling approximately 60 separate entries - which helped unravel a sense of feeling misplaced in an alien environment. One entry explains:

*"I felt slight anxiety, slightly out of place, slightly 'guilty' for being there... uncomfortable in my own skin, a real outsider...a bit like having done something wrong" (Early diary entry).*

Discussing in psychotherapeutic supervision sessions my frustrations with the lengthy car journey helped me to contextualise a woman's experience of being hours away from her family which meant visiting was expensive and difficult:

*"My journey had been four hours long and I had waited about 30 minutes to be collected. The woman who collected me was not aware I was coming although I had been 'booked' at the security gate" (Early diary entry).*

Some journal entries were deeply personal and, although ethical consideration for confidentiality was essential for the women and staff, some of my self-disclosure through reflections and diary entries are disseminated publicly with no protection of my own identity. This has been suggested as a risk for ethnographic researchers who become vulnerable through auto-ethnography (Almack, 2008). In contrast to Crewe's (2009) unease with self-reflection, Lofland and Lofland (2006) stress the difficulties and inner turmoil that researchers may feel and the importance of finding an outlet. However, the shock and apprehension I felt, together with symptoms of nervousness that I masked with a false air of confidence, were important sensations to monitor, especially as they relate to the 'entry shock' that is synonymous with a prisoner's first encounter with prison (Harvey, 2007; Jewkes et al., 2016). My reflections on how much of the prison world I absorbed, especially in the initial phases of the fieldwork, were important if I was to liberate the voices of pregnant women in prison. In my reflections, as I released the discourse for women, getting to the core and essence of their experiences, I reflected upon how I, too, found my own voice. King and Wincup (2008) talk of contextualising feelings as an imperative to research into criminal justice but suggest ways of managing emotions, internal conflict and power dynamics. Lofland and Lofland (2006) champion the importance of examining one's own preconceptions in order to maintain some objectivity when reporting findings.

My years of experience with inherent caring roles intertwined meant that I struggled at times to maintain the researcher role. Lofland and Lofland (2006) warned against the potential for outrage that a given situation may generate. I needed to differentiate between my own feelings of dismay and dampen down the potential for me to sensationalise issues. This was especially true in situations where women's stories were distressing in an environment which is punitive by nature. The need for transparency was carefully balanced as I managed myself, protecting myself from self-inflicted inner conflict.

### **Interview arrangements**

Liebling (1999) discussed interview room arrangements which require sensitivity, 'relying on staff advice' to ensure physical safety. In Prison A, I was provided with a small room in the health care department in which to interview women. The interview room doubled as a coffee room and store cupboard; it was cluttered with equipment but quite spacious and light with windows that looked out onto a small, well-maintained garden. The few interruptions from staff as they collected equipment were in addition to the noise of shouts from other women; alarms and radios were sometimes a distraction and could be heard when listening back to the audio recordings. The tension and atmosphere of the prison could not be gleaned from audio recordings, but my reflective diaries described the strains of the atmosphere and the sense of anxiety I felt by being in an environment where fights among prisoners would sometimes take place nearby. In Prison B, the interviewing

arrangement was a little more ad-hoc and I interviewed women either on the MBU or in the prison association room<sup>24</sup> and some of the interviews were in the presence of a prison officer. Although having an officer present was given as a pre-requisite to my permission being granted, it did not appear to affect the candour of the women interviewed, although it made me feel a little more uneasy as a researcher. In Prison C, I interviewed women on the MBU which was a large, attractive space with a well-stocked nursery and outside play area. The main distraction during interviews in Prison C was the women's babies who you could often hear babbling on the audio recording. During interviews, women would often show a mix of emotions such as sadness, frustration and anger. I ensured I had small packet of tissues with me at each interaction for the woman to take with her if she became tearful. I reflected upon why women would be so candid with me, showing their emotions, releasing tears, and considered this may be due to the suppression of their feelings. Having someone they could talk to openly, who was interested in them as individuals and who was not part of the prison system led to tears being commonplace at interview, especially for women with whom I had several meetings.

### **Interviewer approach**

My interview style was warm and friendly, and this led to rapport being developed quickly with most of the women. Academics stress the importance of having knowledge and depth of understanding of qualitative interview research techniques in order to gain true meaning (Guba & Lincoln, 1992; Kvale, 2008). Interviewer style can have an impact on the level of engagement of the participant (Kvale, 2008; King & Horrocks, 2010). The interviews with post-release women had honed my skills but had not prepared me for some of the challenges. Most of the women had thick regional accents, quite different from my own. I noticed that I sometimes interrupted women and at times asked leading questions due to my personal tendency to interject in conversations. The interview schedule was approved by NOMS (**Appendix 1.7**); however, most of the interviews deviated from the schedule and could be defined as 'frank discussions' (Fielding & Thomas, 2008:249). It was important that rapport was built up with the women and I tended to use open-ended questions, which led to delving deeper by 'expanding the question' (Fielding & Thomas, 2008:249). Due to the setting, it was often not possible to close an interview in a relaxed style, as suggested by Bowling (2014) and Creswell (2016), due to women being summoned back for 'roll call'<sup>25</sup>. Nevertheless, most interviews were an hour or more in length and it was commonplace for a woman to be summoned back to her room, and therefore a hasty goodbye was the norm. Prison security demands limited self-disclosure

---

<sup>24</sup> Association is where prisoners have social free time to mix with other prisoners.

<sup>25</sup> Roll call is the calling out of names to establish attendance. This is undertaken several times during the day in prison.

(Crewe, 2009) and my training emphasised the need to ensure that I limited what I divulged about my own personal experiences. Dickson-Swift et al. (2009) talk of the importance of researcher self-disclosure to enhance the relationship as non-hierarchical, yet the complexity of the women and the prison regulations meant that my disclosures should not be identifiable. Nevertheless, I could draw upon my wealth of communication experiences as a health professional to enhance my personal skills where intrusive questions were asked whilst interviewing women.

Some interviews were difficult even with open questions and my honed communication skills. One woman was especially antagonistic, and I struggled to probe to any depths due to her hostility (e.g. on asking about relationships with staff she responded angrily: "*they're all cunts*"; and most of her responses continued in the same manner). Another woman instructed me to ask her questions as she did not like the open style of questioning I had adopted, and wanted to answer either 'yes' or 'no'. Reflecting on these two audio-recordings, I winced as I listened to my responses and had to turn the device off at several junctures due to my own embarrassment, perceiving how poorly I had performed as an interviewer. Both scenarios caused discomfort, but I noticed how I drew upon my professional skills of appearing calm and confident (adopted usually in emergency situations) whilst inside, I was nervous and a little perplexed! My interviewing expertise developed as the months progressed. Oakley and Roberts (1981) warned that losing the conversational warmth and friendliness needed to become an interviewer can be counter-productive within feminist research, but in general I found that my open style was largely well received and stimulated sincere responses. I also reflected that my warm and open style inadvertently may have antagonised the two difficult interviewees; they may have viewed such 'niceness' with suspicion, although both had freely consented to interviews.

### **Rapport and empathy**

Power relations have been discussed in the literature relating to qualitative research (Mullings, 1999; Brinkmann & Kvale, 2005; Kvale, 2006; Barbour, 2013). Mullings (1999) discussed positionality in relation to status and gender in that the subtleties of the meeting between researcher and participant should not be underestimated: my skills in building a rapid affinity with people have been refined over years. Empathy is particularly important in qualitative research (Oakley & Roberts, 1981; Letherby, 2002; Alvesson & Skoldberg, 2009): for me to express empathy was helpful in building rapport (King & Horrocks, 2010). Moreover, Creswell (2016:139) advises that 'mistrust', especially amongst marginalised participants, may produce 'poor participation or unreliable data': participants seemed especially aware that I understood their predicaments as we shared our experiences while waiting for a key holder to lock or unlock the room. I have no doubt that had my personality been more prescriptive, I would not have had such success in reaching into the lives of so many participants. Building rapport and trust was crucial to spreading the word that a researcher was keen

to find out about experiences of being pregnant in prison. Rapport is discussed by King and Horrocks (2010) who suggest that it is an essential skill which enables participants to 'open up'. Within the prison setting, rapport with staff, women and informants was helpful when positioning myself as a researcher. Building rapport with staff and becoming a familiar face in the prison was invaluable when obtaining the sample of women required. I came across individuals whom I did not like and women with whom I could not build an affinity; however, Lofland and Lofland (2006) state that the researcher may often discover much more richness in research with those individuals they do not care for, rather than those with whom they have a deep connection or sympathy.

### **Follow-up interviews with women**

A way of triangulating the findings and going back to the richness of the data was by holding follow-up interviews with participants. The use of follow-up interviews in qualitative research can enhance trust and rapport, enabling one interview to end, and revisiting themes later following a period of reflection (Oakley & Roberts, 1981; Earthy & Cronin, 2008). Five women agreed to follow-up interviews. Harvey (2008:491) suggests that in prison ethnography, follow-up interviews can be useful as greater data can be gleaned. The main advantage of follow-up interviews was originally thought to be in following their women's journey through pregnancy, birth and post-birth. Further, the therapeutic effect for the participant is manifested in the 'importance of listening'. Knox and Burkard (2009) warn of the risk of the relationship between researcher and professional becoming distorted; nonetheless, for some women, the interviews had been therapeutic, and a card from a participant thanking me was testament to this (**Appendix 1.22**). In the prison setting, follow-up interviews yielded rich data and meant that the potential for prison routine interrupting our conversation was less of an issue, as women knew I would be returning for subsequent interviews. This approach uncovered themes around the struggles in accepting institutionalisation, the physiological impact of various stages of pregnancy and, with two participants, their experience of labour, birth and consequent separation from their babies. The depth of divulged thoughts and feelings, the establishment of trust and the importance of closure emerged with women who participated in several interviews.

### **Prison staff interviews**

Ten members of staff, with a variety of roles, consented to audio recorded interviews (**Appendix 1.10** for staff interview schedule). In Prison A, interviews took place in the same coffee room as used previously. Interruptions were from prison radios, and audio recordings clearly pick up the disruption. In Prison B, interviews took place in the MBU office, which was a small room looking out on the main play area of the unit and which was located within the main prison, divided by a tall wall that surrounded the area, with a locked metal door restricting entry from the main prison population. In Prison C, interviews took place in the light and airy staff office with less disturbance from radios.

Staff were usually open, chatty and helpful and appeared to enjoy being asked about their role with the pregnant women.

### **Interview transcription**

For the interviews to be an accurate representation of the women's experience they needed to be transcribed verbatim (Kvale, 2008). It was important as analysis commenced that transcription allowed for the peculiarities, the swearing and the distress and for it not to be edited out (Barbour, 2013). Transcripts were broken up with pauses if a woman cried: '*(voice breaks)*'; '*(voice breaks with emotion, quietly crying, long pause)*'; '*(sniffs)*'; '*(sobs)*'; '*(pause)*'. Standing (1998:188) argues that sanitising scripts may dilute a woman's voice and therefore lose its 'authenticity'. Certainly, censoring profanity with symbolic substitution was considered, but to sanitise the women's voices contradicted the ethnographic premise of revealing reality. The pilot interviews were transcribed by me. A specialist transcriber with expertise in prison research was recommended by Cambridge University after consultation with the Deputy Director of the Prisons Research Centre, who had extensive experience of prison research. The transcriber was employed, confidentiality agreements were drawn up and signed and interviews were uploaded onto a secure server and deleted from my audio-recorder immediately after upload. Maintaining confidentiality and anonymity was paramount, not only to protect participants but also due to the potentially sensitive exposure of women who may have had their cases and trials presented in the media during the research timeframe (**Appendix 1.13**). Interview transcripts were anonymised by removing any classifying features such as real names or geographical locations. The transcripts were initially reviewed, and primary notes were made about characteristics and any individual differences from field notes gathered at the time of the interview (e.g., '*sat with arms tightly around her body*', '*closed posture*', '*thin with small abdomen for dates*', '*scarred arms from self-harm*'). The transcripts underwent a second review where notes were made about the semantics used by the participants, such as negative descriptors and intonation of voice, to ensure I understood what the woman was expressing (e.g. sarcastic tone, hushed tone, upbeat tone).

### **Coding data**

Data collected included audio-recorded interviews and written observations. Lofland and Lofland (2006:190) categorise the early coding systems as a way of keeping 'order', naming this process: 'housekeeping coding'. Similarly, Ritchie et al. (2013:278;285) suggest that coding is 'part of a classification system' where codes are organised, indexed and 'grouped together' as common categories connected through 'mapping linkage' (see **Appendix 1.14**, examples of early coding). Classifications of each participant were recorded, categorising variables such as age, parity, sentence and whether the crime was violent or non-violent. Codes were identified by looking at word frequencies and recurring patterns among participant transcriptions. Piecing together data from my

observations made within interviews ‘triangulated’ the sources by comparing data, led to conclusions and the eventual development of concepts (Hammersely & Atkinson, 2007:183; Ritchie et al., 2013). A line-by-line approach to the transcripts allowed me to submerge myself in order to see patterns in the narratives (Barbour, 2013). Emerging patterns were colour coded and repeated themes were noted (Kleinman, 2007).

To support the early manual colour coding, NVivo, a computer-assisted qualitative data analysis software (CAQDAS) was selected to help to organise the data. I had substantial amounts of transcribed interviews (58 interviews in total) and NVivo offered a way of managing this volume of information in one place. I attended a two-day CAQDAS course prior to data collection and therefore was able to start inputting data from an early stage. I did have initial reservations due to my lack of confidence in software technology but, as the amount of data grew, NVivo became invaluable as an organisational tool. Although laborious, the coding process allowed great depth of engagement with the data. It was also reassuring to have the data password-protected and securely stored on my designated computer and backed up to an external hard drive. Substantial amounts of data have been described as ‘daunting’ for qualitative researchers but as familiarity with NVivo grew, I felt less overwhelmed with the amount of data collected (Ritchie et al., 2013:289); using the software provided a way of coding themes and organising my data within a hierarchical tree indexing system and has been recommended by several qualitative researchers (Lofland & Lofland, 2006; Fielding & Thomas, 2008). The amount of verbal data and unstructured data sets generated for this study required using several tactics for analysis. Whilst some warn that such software packages encourage ‘short cuts’, NVivo made analysis more organised and helped to limit confusion between sources (Ritchie et al., 2013:289). Memos were helpful in describing what each code was for. Endorsed by Lofland and Lofland (2006:192), memos helped to provide ‘distinction between initial and focused coding’ and were a way of ‘elaborating’ coding as I built upon my own conceptual knowledge and ideas (e.g. building upon existing research, such as Crawley’s (2005) ‘institutional thoughtlessness’, and adding new concepts as recurring themes materialised, such as ‘institutional ignominy’ and ‘public shame’).

## **Data analysis**

Hammersley and Atkinson (2007) and Barbour (2013) suggest that data should be revised and revisited until saturation point occurs. The iterative process of reviewing the data and reducing the themes commenced towards the end of the fieldwork and took ten months to complete. The amount of data collected meant that analysis was demanding, and objectivity was difficult to maintain at first (Fielding, 2008). Thematic analysis is contended as not being an analytical ‘approach in its own right’, as it is not specifically linked to an academic discipline or philosophy (Ritchie et al., 2013:291). However, this made thematic analysis attractive to me as I could discover ‘clusters of meaning’ and



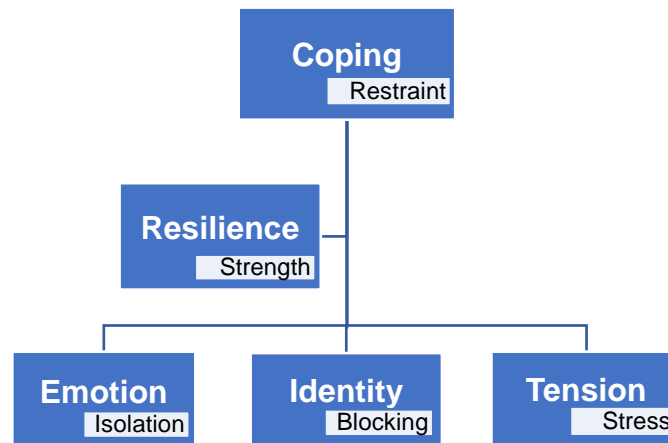
identify links to several theories (Ritchie et al., 2013:291). Lofland and Lofland's (2006:191) theoretical premise suggested that 'housekeeping' moves towards 'category saturation and subdivision' where analysis is complete due to the decrease of routine coding and reaching capacity with deep analysis of the data. Drawing links to current knowledge and theory was useful in connecting with previous research and developing new ideas. Of significance was the need to analyse inductively from within the data and to avoid speculation and contamination through prejudice. Although each woman possessed distinct characteristics, behaviours and opinions their stories all had a similar thread and their experiences were comparable as they explored the physiological experience of being a pregnant woman in prison. Prison as a 'safe haven' was categorised for some participants in that they experienced prison as a sanctuary away from chaotic and destructive lives arising from mainstream society. This concept meant that I could label 'safe haven' women as a separate code and compare their responses with other participants.

Gilbert and Stoneman (2015) propose that concealed values are sought out by discourse analysis and looking at what is being said (language) in conjunction with innermost recollections (memories). The variety of ways of uncovering and analysing data revealed the whole picture of what it is to be a pregnant woman in prison. Having to delete audio recordings immediately following transcription meant that the notes I kept of the nuances, body language, appearances and interruptions became vital to help recall the content. This is where field notes helped to triangulate the sources; they allowed me total immersion reminders of the milieu allowed me to visualise the background, women and staff as I analysed the information. Assigning pseudonyms early on was valuable as each alias would evoke my thoughts about the individual woman without fear of committing breaches of confidentiality (e.g. when I visualise 'Jolene', I see an angry, thin, attractive 30-something woman, with closed body language, arms folded, slumped into the chair opposite me). I can picture Jolene - as I can similarly visualise all the women in the study - just by seeing her assigned name.

Originally, by using NVivo, 736 nodes were established linking to 72 categories. Ensuing modification condensed the data to a more practical state with 178 nodes relating to 24 categories. To avoid duplication, some nodes such as 'room descriptions' were transferred to a sub-category of 'environment'. Other nodes, such as 'hunger', were relocated to the sub-category of 'food'. The categories of 'environment' and 'food' then became one of the nine child nodes under the main theme of 'institutional thoughtlessness'. This process was adopted for the remaining nodes. For example, 'fear' became one of the 16 child nodes under the parent node of 'emotion'. Emotion was then relocated under the central theme of 'coping'; 'handcuffs' became one of the 13 child nodes under the parent node 'stigma' which was relocated under the central theme of 'institutional ignominy'; 'maternity leave' was a child node under the parent node of 'rights and entitlements', which subsequently became the central theme of 'bureaucratic layers'. Follow-up interviews were stored

under 'collections' in NVivo to organise comparisons. A further notion of an 'institutional shrug' was deducted from analysis of the follow-up interviews, to define how some women adapt their identity over the passage of time, from initial dismay at becoming a prisoner, to a sense of resignation and institutionalised indifference.

**Figure 8: Example of hierarchy of nodes under 'coping' theme:**



Hammersley and Atkinson (2007:184) suggest that analysis is undertaken by 'interpreting meanings' and engendering perceptions. Barbour (2013) discusses the emergence of themes appearing in research and suggests that when data is being analysed, patterns need to be uncovered to aid analysis. Hammersley and Atkinson (2007:183) describe a process of 'triangulation' when analysing data in ethnographic research so that a focus is not just in one area but from a variety of different points and never at the initial starting place. The triangulation method was helpful as it encouraged the adoption of a variety of approaches to analyse ethnographical data (Hammersley & Atkinson, 2007) and has been recommended by prison researchers (King & Liebling, 2008). A feminist lens was inextricably linked to analytical methods whereby research leads to the central social variation of the findings (Reiter, 2012). Kirsch (1999) championed the representation of the voices of women who may be disempowered. More recent research has pursued the voices of women; indeed, Lawson and Marsh (2017) suggest that qualitative research complements quantitative research methods by adding the 'underserved' woman's voice, and Fitzgibbon and Stengel (2017) sought to use photography in their participatory research to help illuminate women's voices.

Follow-up interviews with the same participants were compared for emerging patterns to arrive at an inductive theoretical synthesis of the women's dialogue and interwoven research reflexivity. According to Kirsch (1999), Fitzgibbon and Stengel (2017), Lawson and Marsh (2017), and Oakley and Edwards (1981), research should empower and give voice to women who may be oppressed. Frustration was a common emotion in women who felt they did not have a voice and, as previous

research often focused upon the staff view of women's experiences, it was significant to check that I had captured individuals' experiences as authentically as possible. It was imperative to take care not to misinterpret the voices of the women with what Kirsch (1999:49) describes as 'interpretative conflict'. Additionally, Tisdell (2008) argues that it is essential that women's voices are not distorted by researchers, to ensure feminist research achieves its given aim of appropriately serving the women it intends to understand. To authenticate each woman's voice, I ensured I presented my research findings in a variety of settings. Hammersley and Atkinson (2007:178) propose that researchers should pay heed to how the 'audience' shapes the analysis and concepts. Some concepts arose 'spontaneously' (Hammersley & Atkinson, 2003: 163,178); however, some were shaped through discussions, such as those arising with criminology scholars who were an 'audience' at one of my presentations. Presenting and - more importantly - listening to the feedback of others helped me to notice such perceptions as I could 'draw back and withhold judgement', allowing the whole picture to be looked at as analysis evolved (Lofland & Lofland, 2006:203). This type of engagement was especially important as I was neither a criminologist nor an experienced prison researcher. I returned to Prison A seven months after my data collection and offered my findings to an audience comprised of prison staff, participants in my study and other women prisoners. Following the presentation, I asked participants whether I had interpreted their experience correctly. I received a hand-written letter from one of the interviewees which verified that I had suitably interpreted her experience, thus adding further validity to my findings:

*"You really did reflect the key messages about the experience of being pregnant in prison...it wasn't at all painful to be reminded about my pregnancy, it's something I have had to live with every day since coming to prison, so actually, I was just happy that my experiences have been put to good use".*

## **Chapter summary**

This chapter has justified the methods applied to research the pregnant woman's experience of prison. To meet the aims of this research, a qualitative inductive approach has been supported and institutional ethnography selected as a suitable framework. The methodological framework of IE has been defined and considerable evidence from key methodological literature, prison researchers and feminist theorists supports the assertions. The qualitative methodology has been inspected, critically reviewing how methods were applied to researching the woman's experience of being pregnant in an English prison. The routes into prison social life have been explained and my epistemological position as outsider has been contemplated, leading to consideration and decisions regarding e.g., access, departure, holding keys or not holding keys. The complexities of fieldwork in prison have been reflected upon. Ethical concerns have been highlighted, arising whilst assessing the

environment and vulnerability of the women. Sampling techniques have been scrutinised and the demographics of participants have been described. Reflections on interviewer style, methods of non-participant observation and difficulties encountered have illuminated and critiqued the process of gathering research data. Thematic analysis processes have been examined looking at coding methods and how themes were developed from the initial stages using rudimentary analytical methods through to using the computer software package NVivo. Decisions made to refine the dataset led to a wholesome and authentic coverage of the women's experiences. The ensuing **Chapter 4** elucidates the findings, and resulting thematic analysis, and includes embedded accounts of the 28 women interviewed, with field observations and staff interviews that help to inform and answer the research question - examining the pregnant woman's encounter with the English prison estate and her experience of the associated conditions.

---

## Chapter 4: Findings

---

***“I feel like I've got through one stage, I've got through the pregnancy stage and I'm starting to feel more like a prisoner now. Whereas before I was a pregnant prisoner, now I'm just like everybody else. So, I'm now experiencing prison life as me, not as me the pregnant woman.”***

### Introduction to findings

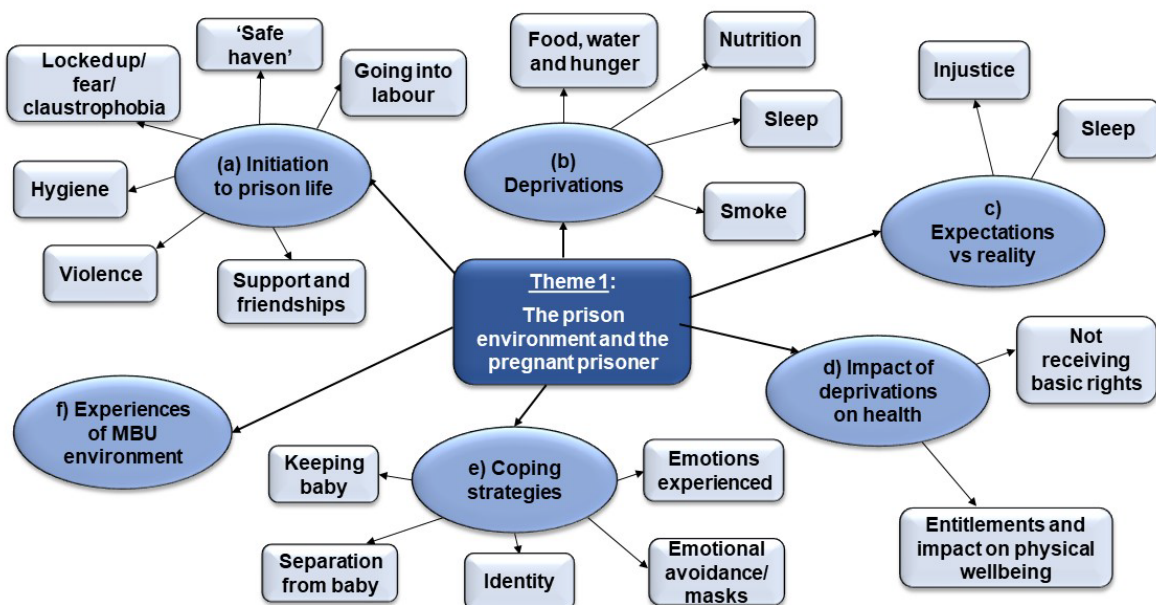
This chapter details the findings following thematic analysis and includes embedded narratives of the 28 women interviewed. In addition, staff and ethnographic field observations are integrated to usefully illuminate the experience of the pregnant prisoner. The experience of pregnancy describes the woman’s entry into prison, the environmental impact upon her, her expectations versus reality, access to provisions, the deprivations on her health, and her coping strategies. The actuality of health care provision, accounts of degradations, the experience of cell birth and staff/prisoner relationships are all portrayed. This chapter concludes with women’s aspirations and predictions regarding their futures, e.g. how some learn to cope over time by accumulating resilience and strength. Thematic maps (Braun et al., 2012) are depicted at the beginning of each theme to demonstrate how they are connected. Pseudonyms were assigned, and women and staff quotations are demarcated by: ‘Prison Officer’ (PO) or ‘Health care’ (HC) and whether they work in Prison A, B or C: i.e. Prison Officer working in Prison A will be symbolised as ‘(PO A)’. Quotations are labelled detailing each woman’s pregnancy status and whether a primigravida or multigravida (see table of terms below):

Term	Definition	Example used
<b>Parity</b>	The number of times a woman has given birth to a live or stillborn baby over the gestational age of 24 weeks.	P = Parity G = Gravida E.g.: If this is a first pregnancy G1, P0 (first pregnancy, no previous births) E.g.: If this is a second pregnancy and the woman has previously given birth over 24 weeks’ gestation: G2, P1 E.g.: If a woman had two early miscarriages or terminations of pregnancy: G3, P0 (third pregnancy, no previous births)

<b>Primigravida</b>	A woman giving birth for the first time.	E.g.: G1, P0 = Pregnant for the first time  E.g.: G2, P0 = Pregnant for second time, but first baby miscarried, or termination of pregnancy before 24 weeks.  E.g.: G3, P0 = Pregnant for the third time, but first and second baby miscarried, or termination of pregnancy before 24 weeks.
<b>Multigravida</b>	A woman who has already birthed one or more babies.	E.g.: G1, P1 = has birthed one baby  E.g.: G2, P1 = has birthed one baby and has miscarried or had a termination of pregnancy  E.g.: G3, P2 = has birthed two babies etc.
<b>Trimester</b>	A normal pregnancy is divided into three trimesters:	1 = 0 to 13 weeks  2 = 13 to 27 weeks  3 = 27 to term (between 37 and 42 weeks)

#### 4.1 The prison environment and the pregnant prisoner

*"I don't want to be locked behind my door, because it's hard enough being without (my) baby."*



### a) Initiation to prison life

Twenty-one participants were in prison for the first time. Negative descriptors used such as “*shock*”; “*horrible*”, “*fear*”; “*evil*” described their perceived environment, mirroring responses from previous research into entering the prison environment (Van Hoven & Sibley, 2008; Zamble & Porporino, 2013). My own first reactions to the prison atmosphere were helpful in contextualising the experience of incarceration and in documenting the normal responses of women to being imprisoned. Women described their first nights and first impressions:

*“It was how you see it on the TV...metal doors banging, girls screaming, it was noisy, dark, cold... it was just the worse thing I have ever been through and I couldn't even eat, it's just the whole experience, you get given one plate, one cup, a set of plastic cutlery, a bar of soap, a sachet of shampoo, a plastic toothbrush with plastic bristles and you are just left to your own devices”* (Caroline, G4, P3).

Caroline was articulating her feelings and the process of entering the prison, revealing her initiation to prison life. The noise of prison life is expressed in my fieldnotes:

*“...the echoes, clinks and slams of metal against concrete, the jangling of keys, the shouts of ‘bang up time ladies’ leaves you craving quiet”* (Field Notes, October 2015).

The feelings of stress and the suppression of emotions meant that women felt sensations of fear and panic: “*I just went into panic*”; “*I was just really overwhelmed*”; “*I was getting anxious*”. Feelings of despair were expressed: “*I couldn't take it anymore*”; “*I was at the end of my tether*”, and also of desperation: “*I begged them for some cold water*”. A common emotion was homesickness and the longing to go home: “*I just want to go home*”. Expressions from women who had birthed their babies in prison and were transferred to an MBU with their new baby reflected their desperation and anguish: “*I was absolutely distraught*”; “*I was panicking*”; “*I was scared*”; “*it was fear*”; “*I was frightened*”. These negative descriptions are synonymous with those expressed on reception into prison and mirror evidence from the criminology literature pertaining to ‘entry shock’, which can be the most emotionally vulnerable time for a prisoner of either gender (Gibbs, 1982; Harvey, 2007). However, confusion and disempowerment coupled

with immense concern about their unborn baby were common experiences for women entering prison, especially when their incarceration occurred in the third trimester<sup>26</sup> of pregnancy:

*“I didn't know what to expect, I didn't know any information they were giving me. It didn't sink in. I was frightened. It was fear. I didn't know anything. I think I cried for 24 hours”* (Ellie, G4, P3).

Several women expressed their worries in terms connected with fear, typically from the anxiety about other inmates: *“I was really scared, petrified”; “I was on edge”; “fear of the unknown”; “the feeling makes your blood run cold”*. Women would describe initiation into prison life as: *“gloomy and miserable”; “bitchy”; “chaotic and hectic”; “people are really loud”*. The constant surveillance consumed the women because they felt permanently watched, with one making an Orwellian reference to the fictional character: ‘Big Brother’ (Orwell, 1949), more recently used in a television gameshow where all ‘housemates’ are under constant scrutiny: *“It's like Big Brother!”*. Other women empathised with the depth of pain and suffering experienced by fellow inmates: *“there's so many damaged women in prison - they need help”*. The hierarchy of the institution was a normal component of prison culture: *“you have got girls in here think they run the place, and it's their wing”*. While gathering awareness of prison life, my fieldwork allowed me into this unique world. Most of the participants in Prison A thought the prison they were in was the “worst”, suggesting that English prisons are comprised in a scale of severity: *“apparently, this is one of the worst”; “maybe they should just not send any pregnant women to (Prison A)”*.

Entries from my diaries exposed the environment and give examples of smells, sounds and general observations:

*“There's a long corridor with rooms either side; it smells very strongly of tobacco, it's very smoky. One of the women I've been interviewing has a room there. There's no fresh air”* (Fieldnotes, November 2015).

Alongside the sensory overload from noise, the need for fresh air is tantamount to the prison experience, and this is also depicted in my fieldnotes as I described taking a *“deep gulp of air”* on leaving the setting. The sense of air hunger, due to the lack of fresh air or not having windows to open was especially difficult for pregnant women:

---

<sup>26</sup> The third trimester of pregnancy is the last two months of pregnancy: from week 28 to birth.



*“Upstairs they’ve got a window they can open, and it only opens to like that much (gesticulating approximately four centimetres with her hands), but it lets a bit of fresh air in. Downstairs we haven’t got a window, we’ve just got a metal cage thing that you can turn to maximum. And it’s like in the car, how you’ve got the little cage things for the air” (Boo, G2, P1).*

My reflective journals often included divergences as I would drive up to prison and describe similar emotions to Crewe’s from feelings of ‘*dread*’ on arrival at the prison and a sense of ‘*release*’ as I leave (Crewe, 2009:484). The following entry articulates the contrasts in coming from outside into Prison B:

*“There’s a huge contrast as you drive up to the prison and breathe in the summer air, take in the rolling hills, the peaceful environment, noting the cattle grazing, the horses ambling through the hills. The divergence is so stark from the liberating English countryside to this infinite prison behind huge, metal walls with barbed wire nestling at the top. You go further into the prison, deeper, and into the rotten bowels of the jail to where women are housed with the sloping, uneven floors and narrow corridors. The tiny cells, and young women who may be quite heavily pregnant, sharing with three or four others in a very confined, dark, dingy, smoky, dirty place. Many of the women I see are very thin. One woman was almost due to have her baby, but you would never know. The environment literally stinks. Coming out of the wing was a similar feeling to how it was walking out of a smoky pub in the 90s. You take a gulp of air as you exit the wings. You see the staff do this too. How must this feel for the women?” (Field notes, June 2016).*

Loss of autonomy and feeling powerless is a common ‘gendered pain of imprisonment’ (Crewe et al., 2017) and although being locked in is representative of the prison experience, the claustrophobic sensation was enhanced for some pregnant women. Within the context of pregnancy, being locked in took on a unique pregnant ‘pain of imprisonment’ (Sykes, 1958/2007). Several participants were locked behind the cell door all day, especially in their latter stages, due to being unable to work. The feelings of isolation: *“It’s mainly when we’re locked in when it (impending separation from baby) hits me the most”*; claustrophobia: *“I get panic attacks, and I start getting them when I’m closed in”*; and concerns about being locked in alone, during labour: *“If I’m in a slow labour I’m going to be locked behind my door, that’s my only worry”*. Being locked in also made the physiological symptoms of pregnancy, such as morning sickness, harder to manage: *“I needed to be sick, and every time I have to beg to have*

*my door open, so I can go to the toilet*". With pregnancy as a standpoint, being locked in generated feelings of anxiety and discomfort:

*"I was 30 weeks... I was locked up for 23 hours. I had sciatica, swollen feet and I couldn't fit my feet into my trainers, I couldn't even go on the exercise yard, so I didn't see outside for about four weeks. I begged them for some cold water, because - you know what it's like, you've got swollen feet, you're out here and you're just dying, and you get nothing"* (Sammy, G2, P1).

The sense of being locked up was especially difficult at night, particularly in the latter weeks of pregnancy:

*"I hate being locked up, I hate it. Even if I could have the door unlocked, know it was unlocked, I would not come out but it's horrible. I have never had anxiety before I came here. It's horrible cos you think if anything were to happen, would they get me out in time, cos my door's locked. 'Cos the night staff don't have keys"* (Sharon, G1, P0).

When the prison was in lock down<sup>27</sup>, women would be in their cells for up to twenty-three hours a day, making it difficult to maintain hygiene or keep cool. Susan described a recent lock down where she could not shower for two days: *"there's only one lock-in they've let us have a shower"*. Trixie was interviewed several times during her pregnancy and her descriptions of being locked in changed at each interview. At first it gave her a feeling of safety, being away from other prisoners by whom she often talked of feeling threatened. This led to feeling "caged" and uncared for behind her door; and escalated to her being sensitive to the delayed responses from prison staff as her pregnancy progressed. To reclaim some sense of personal autonomy, Trixie chose a caesarean birth, rather than await a normal spontaneous labour:

**Interview 1:** *"I kind of liked my door locked over there, if I'm honest, like I'd rather be safe"* (Trixie, G2, P1, 27 weeks pregnant).

**Interview 2:** *"You feel like a caged animal, yeah, because they're (prison officers) probably up sitting and eating pizza, watching DVDs, and you're stuck down there (in the cell) and they don't even give a damn"* (Trixie, 34 weeks pregnant).

---

<sup>27</sup> Lock down means when prisoners are confined to their cells and unable to leave, usually to maintain security or when an emergency has happened.

**Interview 3:** *“If I was at home I probably would have had it (a normal birth), because I'd know that I'd feel safe and I wouldn't be locked away, and I wouldn't have to wait for them to answer the buzzer, because you just wait in here”* (Trixie, 36 weeks pregnant).

In contrast, seven women categorised as viewing prison as a ‘safe haven’ were more accepting of being locked in: *“Jail is jail, isn't it? It doesn't really bother me”*. Previous acclimatisation to prison life and the temporary release from chaotic lives in the community emulated findings from Bradley and Davino (2002) as ‘safe haven women’ described the environment more positively:

*“I just had enough being on the streets, it's drugs and abuse, when I went to prison it was the first time I'd had my own bed, I finally got a routine back, I used to love having my bed... it was the best thing that happened to me”* (Karis, G6, P3).

Women returning to prison following the birth and separation from their babies would experience distress: *“you overthink things”*. Unable to work or go to education, post-natal women were locked in their cells for most of the day, aggravating the sense of isolation and exacerbating the risk of post-natal mental illness:

*“They try and lock me in, but I don't want to be locked behind my door, because it's hard enough being without (my baby), without being locked behind my door thinking about her all the time”* (Susan, G1, P0).

Boredom and the slowness of time is a common phenomenon for all prisoners (Wahidin, 2006): *“... same thing every day, same faces, same food, same people”*; *“it's like we're stuck in forever”*, experiencing the *“...same shit everyday”*; *“it's just boring”*; *“counting down”* and *“a month feels like a year”* were common expressions. However, passing time revealed the concept of counting down prison time in *“pregnancy weeks”* for some participants. Whilst this is common for all pregnant women (Downe & Dykes, 2009; McCourt, 2013), for the prisoner, counting down pregnancy weeks rather than counting down time until the baby arrived, was also a way of helping the prison term pass:

*“I don't count down the days, but I am counting down my pregnancy weeks”* (Sharon, G1, P0).

A common fear expressed was a pregnant woman not getting timely help when in labour or in an emergency. However, disclosures from women about life in the cell offered additional insight into a milieu where women feared being attacked physically, with no protection, due to the distinctiveness of their pregnancy:

*“Your panic button is by the door, it’s a silly place to have it ‘cos...if you felt intimidated or under attack and you wanted to press your cell bell you’d have to get past them (other prisoners). And for a pregnant woman – if I’m in agony on the bed, its gonna take me a lot to get to my bell” (Trixie, G2, P1).*

Looking at prison life through the lens of a pregnant woman, a new perspective emerged, exceptional from previous research. The woman’s pregnancy was physically visible so, while wishing to blend in, her growing abdomen ‘marked’ her out. Showering left women feeling particularly exposed: *“When I first came in here I was scared to get in the shower with other people”*. The notion of pregnancy being an oddity in prison became synonymous to the pregnancy experience as women described others as *“normal prisoners”* and themselves as *“pregnant prisoners”*. For some women, pregnancy marked them out for threats to their safety. Angel had been in prison several times and noted the difference in being imprisoned for the first time as a pregnant woman:

*“...and some of the girls got a bit more manners towards you and are a bit more careful around you. Because sometimes there’s a lot of them - I’m not saying I’m perfect but there are some rotten ones in here” (Angel, G1, P0).*

The tense environment sometimes leads to fighting and arguments. This can be a normal experience for all prisoners (Bottoms, 1999); however for the pregnant woman, this added a supplementary layer of suffering. Trixie described how another inmate had *“wished (her) baby dead”* and this experience left her feeling afraid for the safety of her baby. Another woman (Sharon) was fearful that she would be *“sliced”* (attacked with a knife). The worry about having possessions stolen or damaged was a reality for some of the women:

*“Your tea would get nicked, things would go missing from your room, you’d get my leggings have holes cut in them when they were in the laundry. It was horrific!” (Pamola, G1, P0).*

The crimes committed by other women were often contextualised into feelings of disgust, especially if the crime was towards a child: *“being pregnant and on a wing with someone that’s molested a child, it’s horrible”*. Trying to escape the fights was common for a pregnant woman:

*“Girls are arguing and fighting on the wing; I don't really like that, so I'll just, usually go in my room and read”*. The degree of violence in prison was made manifest during a period of fieldwork, when the prison was in lock down due to a woman being attacked and raped by three female inmates who thought the victim had drugs inserted into her vagina. This attack scared several of the pregnant women who worried about their unborn babies: *“they'd actually pinned her down and got the stuff out of her insides”*. The story of the violent attack was relayed to me by prisoners and some research participants (at interview); however, when approached, staff were silent on the issue. Trixie articulated a situation where she was threatened and said she should have felt *“safe in (her) room”* as an inmate verbally attacked her and made threats against her baby:

*“She was shouting at me, and I tried to shut the door and she slammed the door, like opened it on me, so I had to quickly catch it and hold the door shut. And she kept trying to push the door on me, and I just told her to go away and she just kept saying that... ‘I wish your baby dies’”* (Trixie, G2, P1).

Trixie's fear was compounded by the sense that she would have nobody to help her if she was attacked, and complained that the officers had done nothing: *“the officers can't do anything without their armour, so they'll just stand there or watch it”*. Fights and arguments were usually split up by other prisoners rather than by officers: *“it's just a quick punch or something, but because they get split up by the prisoners and not the officers, it's just cut short”*. Nonetheless, for the pregnant woman, feeling threatened would leave her feeling powerless: *“what am I supposed to do if she attacks me? No one will be saving me”*. Participants were mainly worried for their unborn babies, whether or not they were going to be separated following birth:

*“I was scared only because I'm pregnant, and I don't want anything to happen to him. If I wasn't pregnant I wouldn't be bothered”* (Lola, G2, P1).

The feeling of needing to protect the unborn baby caused some women to think they would do anything to avoid harm: *“I'm not a violent person, but if I had to protect myself I'm going to protect myself”*. Lola suggested that a male prison would have been a better environment: *“Lads will fight it out, lasses won't...it's just girls they're bitchy. I'd rather be in prison with lads”*. Conversely, some participants saw pregnancy as a layer of protection against violence: *“I feel like safe, because I'm pregnant”*; *“Most people won't touch you while you're pregnant”*. Nevertheless, several women talked about: *“watching your back”* and *“acting hard”* as a deterrent:

*“When you're around certain people you can't show, I think, weakness. I got that straightaway that if you showed weakness, you got taken advantage of”*  
(Pamola, G1, P0).

The literature supports the notion of women supporting other women in prison and the building of strong friendships and social networks (Carlen & Worrall, 2004; Cantora et al., 2016; Wulf-Ludden, 2016). Yet for the pregnant woman, this seemed especially important in helping to value her pregnancy: *“Some of the girls here have knitted clothes for the baby, like little boots and gloves, and a hat and stuff for her”*. However, following separation, these relationships would sometimes become strained as post-partum women wanted to forget:

*“I've got all the girls on the wing really happy going, 'Oh, you had him, how much did he weigh?' and I know they're just asking out of concern... But it's just I keep on a brave face and they ask me, 'How was your labour?' and I tell them about the labour... But then when I go back to my room I'm just thinking I wish they would stop asking me, because I don't want to keep thinking about it all the time because I miss him”* (Caroline, G4, P3 - PP).

Friendships varied with women: *“I do get on with the girls on my wing, and I've got people who are friends”*; *“It's like being back at school. No friends”*. Friendships were often transient as women moved on: *“you get new people moving on and no two days are the same”*. Some women preferred to keep their distance: *“I keep myself to myself”*. A common expression from the women concerned support offered from other women; women who were older were described as *“mother-ish”* and *“really nice people”* and the pregnant woman's *“pad mate”*<sup>28</sup> was often the main support for her. There was also shared humour and a sense of fun when women bonded: *“she's only been my pad mate since yesterday, but you know what? I have had so much fun”*. Equally, some women found the notion of sharing a room difficult: *“I had quite a few upsetting people when I was in a dorm, it was very difficult to live in”*; *“there is some weird people in here you know, not like real people”*.

Worries about the lack of hygiene in prison were commonplace amongst several of the pregnant women. One woman remarked on how: *“she'd gone downstairs and she's actually poo'd on the floor in the cell”*. Perceived risk of infection from other women was also a concern: *“she wet herself and because she'd had HIV everyone refused to share a pad with her”*. One woman talked about the lack of hygiene from her pad mate:

---

<sup>28</sup> A pad mate is slang for the person / people with whom one shares a cell in prison.

*"I think it's just the hygiene for me...She's just not clean. It's horrible...when you're in such a confined space and you've only got very little room, you need it to be clean and sterile when you're pregnant"* (Krystal, G1, P0).

## **b) Deprivations**

A key finding was the way that 'institutional thoughtlessness' of the prison towards pregnant women was present in many aspects of their daily lives as deprivations and 'pains of imprisonment' (Sykes, 1958/2007). The concept of 'institutional thoughtlessness' was originally referred to by Crawley (2005) in relation to imprisoned elderly men: she defined the phrase as, 'The ways in which prison regimes simply roll on with little reference to the needs and sensibilities of the old.' During interviews, all participants were asked about their living conditions. They described the setting, the people they lived alongside, their rooms, and being locked in. The environment and prison conditions superseded the woman's pregnancy as a priority for her and was often more in the forefront of her mind than being pregnant: "you are always on guard and you forget you are pregnant". Thoughtlessness extended into the experience of: equivalence of health care, food and nutrition, comfort, and clean air. All women in the sample found the quality and timing of prison food problematic with several women reporting hunger and weight loss. Prison bedding amplified discomfort for most women, and sharing rooms or wings with smokers heightened anxieties about their wellbeing. Interviews with most participants revealed that there was inconsistency amongst prisons concerning the procurement of 'pregnancy mattresses'. Some pregnant women, such as Krystal and Lola, were issued with two mattresses (one placed on top of the other). However, this appeared to be more through coincidence than planning, suggesting some confusion in the roles and responsibilities of staff. Kayleigh outlines the confusion between health and security staff roles when it came to requesting an extra pillow:

*"I asked the officer could I have an extra pillow for my belly, because of the way the baby's lying. And they asked the nurses, so then I asked the nurses, and the nurses were like, whoa, you've got to ask the officers"* (Kayleigh, G2, P1).

Sitting on prison mattresses myself, and feeling the rigidity and shallowness of the material where women sleep, helped to understand the experience of bedding for pregnant women whose home is a prison cell. The below diary entry was written after spending time with Caroline in her cell:

*“The bed has a long, thin mattress and I sat on it; it's really hard, like a park bench. She said to me, 'And that's with the duvet on it,' the duvet is green and there are two pillows, but they're not really like pillows, they're plastic foam-fillers, they're very hard and made of foam, like a gymnast's blue mat”* (Field notes, February 2016).

Prison mattresses and pillows are custom-made and fire retardant and therefore adhere to the Prison Service Instruction in relation to fire safety. Women would often describe the mattresses and pillows they were sleeping on: *“It's got a big dip in it”; “so many people have slept in that mattress”; “it's killing my back”; “they're blue and horrible”; “the pillows are rock-hard”; “I didn't have a pregnancy mattress”; “it felt like I was sleeping on the base”; “mine is worn out now, it hurts my sides”; “the pillows aren't proper pillows”*. Sleep disruption whilst pregnant was common to all participants and was often caused by uncomfortable bedding. Whilst night waking can be a normal occurrence in pregnancy (Ward, 2017), the discomfort caused by mattresses and pillows were given as the reason for sleep deficiency: *“I couldn't get comfy”; “you could feel the metal-framed bed underneath, so I didn't get much sleep”; “you can feel the wood under the mattress”; “I've got backache from it”; “I lay on my dressing gown”; “if you've got acid you can't be lying flat”; “I have bad pain, because I am not comfortable”; “it sinks right in and it touches the wood”*. Some pregnant women described the difficulties in trying to sleep and breaches in prison policy (pregnant women should sleep on the bottom bunk):

*“My belly was hurting... I'm on the top bunk, because my bottom pad mate's too fat to get on the top, so I'm climbing up and down those bloody ladders... I feel like I'm lying on that wooden table. It just sinks in. But they don't care. They haven't got to sleep on it, have they? I can't fucking breathe, and my back's breaking”* (Jolene, G3, P2).

Sammy described her anguish of physical pain when trying to sleep, because the bedding was so uncomfortable:

*“When I first got there, I slept on the floor and then the second night I begged for a different mattress, and the pain is just unbelievable and when you can't sleep you just cry with frustration, because you're in that much pain”* (Sammy, G2, P1).

Krystal described her mental tussles with pain which were caused by the discomfort of her bedding, yet worrying that tablets dispensed to her by the prison nurse and failures to address the problem may affect her unborn baby:



*"I've been to the nurse so many times over it, and she just gives you paracetamol, but I don't like taking any tablets, you know, with being pregnant. So, most of the time I've just said, oh, its fine... I've never taken drugs, I think they're going to be really, really strong on my system, so I don't..."* (Krystal, G1, P0).

A high percentage of women in prison are smokers yet there is no research looking specifically at the pregnant woman's exposure to tobacco smoke in prison. Seven women talked to me about their smoking behaviours. One woman started smoking while in prison and others described the smoke-filled environment of their prison wings and the impact upon them. Some smokers would try to cut down and found that support was greater than 'on the out'. Several participants found the smell of tobacco exacerbated their symptoms of nausea. During the fieldwork period, it was noted that smoking was allowed inside cells in English prisons. In Prison A, there was one designated non-smoking wing. All mother and baby units (MBUs) are non-smoking areas and some MBUs will not accept mothers who smoke. Several women continued smoking throughout their pregnancies. Boo told me about trying to cut down. Lola insinuated that the reason she had not been able to cut down was because of the disruption caused by being in prison. Trixie shared a cell on a non-smoking wing and spoke about other pregnant women in the prison: *"I think there's five pregnant people in here, and there's only me that's on the non-smokers' wing"*. Similarly, Krystal spoke to me about the tension that she was under leading her to seek solace in cigarettes, in the third trimester of her pregnancy:

*"I didn't smoke before I come to jail; I might have tried it when I was like 14, but I've never actually smoked. And then when I've come here I've started smoking, because of the stress"* (Krystal, G1, P0).

Some women like Sharon stopped smoking when in prison due to nausea and also because cigarettes are so expensive:

*"I couldn't stand it; it made me feel sick, so I just stopped. The smell of it's horrible, the smell here is of different fags... stronger and you can only smoke in your cell. It's the only place you are allowed to smoke, in your cell"* (Sharon, G1, P0).

Susan and Trixie were housed on the non-smoking wing in Prison A. Several women expressed difficulties about having to choose between being on a non-smoking wing and sharing a cell versus being on a smoking wing and having a single cell. This suggested that privacy meant

more to the women than being in a smoke-free environment. Trixie talked about her conflict with other prisoners on the non-smoking wing and sought help from an officer:

*"It's confusing and we haven't got a clue, and we just can't argue, and you can't question it, because they say, 'Don't like it, go onto a smoker's' wing"*  
(Trixie, G2, P1).

For the pregnant women, not being able to take control of their nutritional wellbeing was especially difficult. Food in prison is an overriding issue because of the various physiological changes in pregnancy which directly affect the digestive system. All women interviewed for this research discussed prison food when asked about their experiences of being pregnant in prison. Most women used negative descriptors to articulate their feelings of food and nutritional deprivation, emotional frustration and hunger. Food would dominate their urges for some women as their hunger trumped all other needs. When questioned, Mercy articulated this during her interview where sharing her experiences of prison repeatedly returned to food:

*"Every Friday I was going to see the midwife they would tell me to go and see the midwife. To check me. But the problem is the food"* (Mercy, G3, P1).

Women would describe prison food as: "horrible"; "gross"; "disgusting"; "shit" and "boring". Metaphors and comparisons to dog-food were made by several women in all three prisons: "food from another world"; "most of the meals are stodge"; "It was awful, awful food... Like slop". Many women said that most food consisted of carbohydrates (usually potatoes):

*"It's disgusting, ham is like spam but a cheaper version, like them packets of dog food, it's disgusting, its vile...you get boiled burgers and half the food is never cooked properly. I'm surprised the whole jail hasn't got food poisoning. I don't eat meat here... It's not meat. It is horrific, it's disgusting, I wouldn't even feed it to my dog. It's really bad"* (Sharon, G1, P0).

Overwhelmingly women expressed concern about the quality and quantity of food, which is a common finding with all prisoners. Although Ellie accepted food as "standard prison shit", Kayleigh, who had been in prison a number of times, had different concerns because she was pregnant:

*"I am absolutely starving...it is bloody terrible...it's HMP, Your Majesty's Pleasure...rations...I'm hungry all the time, because I'm pregnant, they don't*

*give you enough. I'd be happy with rations, that's how bad it feels*" (Kayleigh, G2, P1).

The perception that there was not enough food was commonplace. A number of women who saw prison as a safe haven, such as Angel, Kayleigh and Ellie, nevertheless protested about the quantity of food: *"I've nothing bad to say about prison except the food"*; *"there is not enough food"*; *"You're supposed to get snacks and stuff like that, but I've never had any of those yet"*. It struck me how unhealthy many of the women looked. My fieldnotes detail descriptions of the thinness, pallor and the sadness emanating from women in Prisons A and B, reminiscent of times when I had nursed sick patients on hospital wards. Specific food cravings were often articulated by women: *"sweet potatoes"* and *"dairylea cheese triangles"* (Susan); *"spaghetti"* (Daniela); *"potato wedges"* (Abi); *"cocopops"* (Cleo). Cravings were often left unmet as a normal physiological pregnancy symptom. Jane told me how she suppressed her physiological yearning:

*"The cravings. You can't have cravings in there. You can't get anything. It's horrible. I don't know if it was because I was in prison and my body knew it couldn't (have cravings)"* (Jane, G1, P0).

I would often join the women who were working as orderlies for their tea breaks. Food was always the first thing they talked about: *"It's atrocious"*; *"I lost weight in here"*; *"Not put on any weight"*; *"there's no money for canteen"*:

*"An orderly asked me to smell the teabags: 'smell these tea bags' and then she said, 'They're not like tea'"* (Fieldnotes, December 2015).

This statement about tea bags highlights the inferior quality of food and resonated with me when women talked in interviews about the otherworldliness of the food. When I visited Caroline's room, she showed me some of her food and also asked me to smell it. She had some sardines in tomato sauce, but it smelt unpalatable: I could not have eaten it. Caroline and the orderly (above) were keen for me to smell the food to get a sense of their food experiences. In contrast to the food that women receive were the staff eateries in Prisons A and B where prison employees buy food cooked by prisoners. The prisoners were not allowed to eat the food they had cooked for staff.

Participants would sometimes receive a pregnancy pack which consisted of a small carton of extra milk, a small packet of cereal and a piece of fruit, such as a pear. Women are also meant to receive extra food in the post-natal period; however, Caroline told me how her pregnancy

pack had been stopped, despite her expressing breast milk for her new-born. Several women would often talk about the milk being lukewarm and in cartons, making it difficult to drink because of the lack of freshness: *“it’s in the cartons, the tubs, I don’t drink it”*; *“I have it on my cereal, but I don’t drink it”*. In Prison A, some women received extra toast:

*“I get toast every meal, that’s only if I want it. I have toast in the morning now for breakfast, which is better. So, yeah, it’s a bit extra I suppose, but nothing else”* (Susan, G1, P0).

However, the experience of receiving a pregnancy pack and additional food was arbitrary: *“I was 37 weeks and I finally got some fresh milk”*; *“I get extra milk and that’s it!”* The inconsistency in the frequency and quality of the supplementary food was indiscriminate: *“other people they get extra fruit, but I don’t”*; *“I got two cartons of full fat milk and that was the only added extra”*; *“all I get is semi-skimmed, two small cartons and two fruits. That’s supposed to feed me!”* My field notes describe a pregnancy pack:

*“There was a pear, bread, muesli and milk, however, it’s all compressed tightly together, wrapped round and round in cling film. The milk is squashing the bread and the pear together, making the bread soggy and damp so it’s inedible. It’s interesting to see how everything is put together without thought”* (Field notes, March 2016).

Women’s heightened sensitivity to taste and smell may have led them to dislike the taste of the water in prison. However, the potential for dehydration was an additional anxiety for some women: *“I need cold, fresh water otherwise I’ll be dehydrated”*. The notion of the tap water being unnatural, containing unhealthy chemicals, sometimes led women to drink inadequate amounts of fluid: *“I tend to drink a lot of water but in there I didn’t...it was coming out of crusty old taps.”* Women complained about the taste and temperature of the water: *“I can’t drink prison water, because it’s horrible and warm.”* The perception that unhealthy water would pass through the placenta to the baby also created anxiety:

*“That was a big thing for me, the water, it tastes all metallic, so you don’t know what you are putting into your body...it’s all going through your placenta, it’s all going through to your baby isn’t it?”* (Abi, G3, P2).

Economics had an impact upon pregnant women’s nutritional wellbeing and buying extra food was dependent upon their financial circumstances: *“I’ve got money in my bank, but I can’t transfer it over to here”*; *“if you don’t get private cash and you’re pregnant, you’re going to be*

*hungry*". Pregnant women often relied on family members to top up their prison bank accounts to buy extra food. However, for foreign national women and women who had no family financial help, it was often difficult to buy extras. Some women felt guilty for asking family members for money: *"I don't like asking my Dad for money"*. Women could buy food such as cereals and noodles but also needed to buy other items such as washing powder and cigarettes: *"You need it for shampoo, and you need it for everything"*. Some women made choices to buy tobacco over buying food: *"I didn't have any money; I'm a smoker, so the first thing I bought was cigarettes"*. Being unable to eat the food provided by the prison meant that some women would only eat food bought from the weekly canteen: *"I don't really like to eat stuff here...I just buy it all on the canteen"*. With no cooking facilities, the food bought on the canteen was often confectionary or packet foods such as pot noodles and cereal: *"You can only buy sweets and chocolate on the canteen, and noodles"*. The inconsistencies between prisons were articulated by women as they compared food experiences in different estates. Sammy told me about going from one prison where she had no extras, to being moved to a prison MBU where she had greater access to food:

*"When I first got there and at 11 o'clock I was standing making toast, and I felt ooh! I was so happy...I was like feeding, feeding. But when we first got there the food obviously was nice, because we compared it to X. But then after a while it was like, oh, dry potatoes again"* (Sammy, G2, P1).

### **c) Expectations versus reality**

A common experience amongst *all* participants was their sense of injustice when they did not receive what they believed they were entitled to as pregnant women. Their status as 'pregnant prisoner' meant women would try to negotiate their nutritional needs as a survival mechanism. It was apparent that the pregnant women in this study distinguished themselves as *different* from the 'normal' prison population, often with a sense of outrage, with one woman exclaiming: *"How can you deprive a pregnant woman of food?"*. Some women were astonished that they had to eat the same food as non-pregnant prisoners: *"You know, you get the same food as other people who are not pregnant!"*. Women would voice their indignation at not being afforded 'special treatment'. Sammy expressed her frustration:

*"I'm pregnant, how can you just not give me a little bit of extra fruit or food at 11 o'clock at night because I couldn't eat at tea because I had heartburn?"*  
(Sammy, G2, P1).

The concern for special status may have been directly related to their perception of their unborn baby's suffering as all participants felt deprived of nutrients: *"You don't get enough fresh fruit,*

*fresh veg that you need*"; *"I'm a pregnant woman and the baby is gonna be starving*"; *"my baby not getting any food, because I'm always dehydrated*"; *"You get two extra full fat milks that weren't even half a pint, which isn't enough*"; *"my baby won't get any nutrients*". The prison environment exacerbated tiredness for many women, a normal accompaniment to pregnancy especially in the first and third trimesters (Rafiq, 2017). However, the lack of sleep, poor diet and stress were demonstrated in utterances of: *"I am knackered. Absolutely knackered*"; *"I feel so drained*"; *"I am so tired it's unbelievable*"; *"I haven't slept properly since I've been here*"; *"And more than anything I just needed sleep."* Some women talked about symptoms of physical pain, such as in the back or stomach, yet women in prison felt categorised as *"just a criminal"*, with their pregnancy symptoms denied and pain often disregarded:

*"Yes, I'm a criminal, but that doesn't matter, I'm still human like everybody else, you know what I mean? I'm still in pain like everybody else. But it's not just me, it's my unborn child, do you know what I mean? That's all I care about is my unborn child"* (Kayleigh, G2, P1).

Sleep disturbances during pregnancy are normal, especially during the latter weeks, because of pregnancy hormones (Ward, 2017). Insomnia was a common experience for most participants. Whilst recent research findings suggest that sleep deprivation in women's prisons are commonplace (Dewa et al., 2017), pregnant women were often left feeling extraordinarily exhausted and stressed due to lack of sleep. Women reported feeling frightened: *"I hear the footsteps coming, so I get the duvet straight over my face"*, the noisiness: *"you have girls who are detoxing so they are awake all-night banging on the doors"*, and night staff waking women up: *"the night staff shine a torch in my eyes"*. Being locked in with someone they found unpleasant led to frustration in some women: *"my pad mate's underneath me snoring her head off; I felt like stamping on her head"*. Night time affords no special consideration to the pregnant woman's need for sleep and rest:

*"Some officers are noisy, they have their radios turned loud, and boots that wake me up. Some turn the light on, and shine torch in my face and it wakes me up"* (Daniela, G2, P1).

Although I requested to undertake some fieldwork at night, none of the Governors would sanction this due to staffing levels and security concerns. Instead, women would tell me about their nocturnal experiences and explained the effects of the noise, the helplessness and the isolation. When disseminating my research findings to a group of participants, one woman remarked that I would *"...never understand the whole experience if I haven't been in prison at*

*night*”, highlighting the intensity of the night time experience for women and identifying a potential limitation of my research.

#### **d) Impact of deprivations on health**

The main frustration that was articulated by all participants was not receiving basic rights and entitlements, e.g. nutrition, fresh air, medication and suitable bedding. The bureaucratic barriers facing the pregnant woman make her different from any other prisoner. The inconsistencies in receiving what she was entitled to as a pregnant woman varied across the prisons and was often dependent on individual staff knowledge. Entitlements for pregnant women in Prison A were outlined in a document called ‘the F35’ (**Appendix 1.15**); however most participants did not know about this form and it appeared that staff were also unclear of what an F35 was or what it contained. Where there was guidance, it was often hard to access because it was not routinely circulated, and not all staff were aware of the contents or where to access it. Indeed, my own search for the elusive F35 took several weeks and required asking several staff members about its contents and whereabouts:

*“I went to my wing officer I said, ‘Can I have a copy of the F35 form?’ he said, ‘I’ve never heard of it, but I’ll ask health care’. So, he rang over to health care to ask for the F35 form, and then he didn’t get a response back until the next day saying, ‘There’s four different versions, which one do you want?’”*  
(Caroline, G4, P3).

However, when pregnant women and staff knew their entitlements, it still did not guarantee they would receive what they were entitled to:

*“Well, apparently, you get two extra pillows, which I haven’t got; you get extra milk, which I don’t get; you get extra fruit, which I don’t get; you get night snacks, which I don’t get; and you get use of a toaster at dinnertime, which I don’t get. So, loads of good things that you just don’t get”* (Jolene, G3, P1).

Post-natal care provision in prison demonstrated a lack of staff awareness of the individual needs of women who needed support with breast feeding or essentials such as breast pads: *“I had to put tissue in my bra”; “all I’m asking for is a bit of help”; “I’m not going to cause them any trouble”; “it seems to be really so complicated for them”; “breast pads aren’t something that you can put on prescription”; “I put an app<sup>29</sup> in requesting breast pads”*. Pregnant women perversely

---

<sup>29</sup> An app is prison language for making a request or an application.

needed to rely on a system that was often failing to meet their basic needs: *"I just have to go by what the prison are telling me"*. Staff were often blamed by women for not knowing what the entitlements were for pregnant women:

*"I think they know parts of it (the Prison Service Instruction), but they don't know all of it. It's just not right, do you know what I mean? They say, 'Oh, we'll sort it,' and then six months later, another eight months later and it still hasn't been sorted"* (Debbie, PP).

The appropriate provision of entitlements for women were not confined to simply being in prison. Sammy described how the court *'forgot'* she was pregnant, and she was therefore transported in a standard prisoner security vehicle:

*"The people in court forgot I was pregnant. They didn't bring a special van for me, which is something they were supposed to have done. I got to (Prison X) and they were like, 'What the hell are you doing here? You weren't supposed to come here, you were supposed to go somewhere else'. But, obviously, they can't arrange that transport from there, so what was meant to be like a one-week pit stop to take me somewhere else, ended up being until I was in labour"* (Sammy, G2, P1).

The frustration experienced by women who were not receiving their entitlements were commonly expressed by all participants: *"I am just fighting and fighting"*; *"it feels like I am just banging my head against a brick wall"*; *"they control everything about you"*. Pregnant women described the nutritional and material entitlements they were lacking: *"I'm supposed to have a bag of healthy snacks every day which I've never had"*; *"I've always been told you've got your maximum amount of clothes"*. Yet others did not know what their rights or entitlements were: *"nobody has actually told me what my entitlements are"*; *"I am not given the information"*; *"they just literally just assumed that you knew everything"*. Some women, were reduced to pleading with staff for what they were entitled to:

*"I begged for a different mattress"* (Sammy, G2, P1).

Not knowing their rights felt disempowering for women:

*"They don't tell you: 'Right, you're pregnant, you can have an extra mattress, or you can have an extra pillow, or you can have this, or you can have that'. They don't tell you these bits of information"* (Ellie, G4, P3).



Women would often discover their entitlements through serendipity:

*“I found out last week that there is a list that the prison put together for pregnant prisoners for things that I am entitled to whilst I am here, and I am 35 weeks pregnant now and it is only because I happened to bump into another pregnant woman that she said have I had the list? And I said no”* (Susan, G1, P0).

Women having to find out information for themselves was a common theme: *“You have to find out for yourself and nothing is offered, you are not told anything”*; *“You don’t get told really, you just have to pick bits and pieces up”*; *“I just happened to overhear her talking to someone else”*. For a pregnant woman, entering prison late on in pregnancy, and not knowing her entitlements about applying for a place on an MBU was especially distressing, mirroring findings by Sikand (2017):

*“I didn’t know there was an M&B, I didn’t know the ins and outs of the M&B, it was the other prisoners that told me that there was a Mother and Baby Unit and that you can apply for it. And none of the officers spoke to me about it, nothing, I just had to go off and do it all myself”* (Layla, G2, P1).

Entitlements denied to participants had a direct impact upon their physical wellbeing. It is common for pregnant women to have heightened sensations due their normal pregnancy hormonal response. Several participants described the lack of fresh air: *“downstairs we haven’t got a window”*. The majority of participants worried about being trapped in a cell in labour: *“my biggest fear is not getting me out”*. Normal symptoms of pregnancy were exacerbated for most participants: *“I had to swallow my sick just to get an officer to open my door”*. I interviewed Abi five times during her pregnancy and her symptoms of nausea and vomiting were so extreme that she had been hospitalised twice with hyperemesis gravidarum (HG). Each time I met Abi she sank down into a chair, arms held tightly around her body or with her head in her hands, looking pale and sad. Abi would often cry during our interviews and she found it difficult to think about anything other than her nausea. She had a small cup to spit in as even the sensation of her own saliva in her mouth made her nauseous. Abi’s nausea was a constant presence and therefore exacerbated any feelings of hunger or discussions around prison food. She told me: *“The smell of food just puts me right off and I can’t (eat it), I can’t. I hate it”*. Several women experienced nausea and vomiting which, although unpleasant, are normal physiological responses to pregnancy and usually are not debilitating. Nonetheless, Abi, suffering from HG,

found that her extreme bodily symptoms were often disbelieved by staff, despite her losing weight, her relentless vomiting and inability to eat anything or even to swallow her own saliva:

*“I really feel ill; it's horrible, and they just still make you do things. They must think, oh, you're pregnant, you're going to feel sick. No, I promise I feel really ill, and I can't eat. I wish I could eat! And I'm scared that my baby will die or something, because it won't get no food”* (Abi, G3, P2).

Abi's bodily pain and distress was amplified by the fear of receiving a 'negative' on the Incentives and Earned Privileges (IEP)<sup>30</sup> system because of not wanting to go to work because she felt so ill. Abi remained in a smoking wing despite her feeling so unwell: *“I don't like the smell of smoke. it makes me feel sick”*. Her perception of being: *“punished for feeling ill”* was enhanced by the regular threat of 'negatives' which serve to punish bad behaviour and remove privileges:

*“They keep giving me a negative, then they'll put me on basic<sup>31</sup> and I won't have any TV, then that'll make it worse. I will get all my stuff taken off me and I won't be allowed out. I can't win, that'll send me even madder. Then I'll think too much, and then I'll get anxiety and the panic attacks. If I haven't got a TV I'll have a panic attack, because all I'll do is think”* (Abi, G3, P2).

The lack of recognition of Abi's pregnancy symptoms as extraordinary and distressing enhanced her bodily suffering. The view that a woman was pregnant, and not unwell, meant that she was treated as a 'normal prisoner'. She was viewed as 'manipulative' by staff: *“she's putting it on”* and therefore elicited little sympathy, yet her condition put her health at risk and her suffering made her consider termination. Interestingly, Susan, also in Prison A but on a different wing, had access to toast, demonstrating the inconsistencies not only across the prison estate but within the same prison. The lack of control and frustration at the negation of their symptoms were described as women expressed their fears: *“I want to be in control, I don't want to be buzzing people for them to get an ambulance”*; *“My biggest fear is leaving me in that room”*; *“they left me for an hour”*; *“I know people that have died in labour”*; *“I'm just scared of going in labour in here”*; *“they just leave you”*. Women described how they were often unable to get help, especially if they were feeling unwell or in pain:

---

<sup>30</sup> Incentives and Earned Privileges (IEP) system rewards good behaviour in prison and can lead to loss of privileges when receiving a 'negative'.

<sup>31</sup> 'Basic' is the most punitive level a prisoner can be allocated on the IEP system where a loss of privileges includes possessions, money available to spend, the wearing of prison issue clothing and longer time locked in.

*"I said, 'I need to see the nurse,' I said, 'I'm pregnant and I'm feeling rough'. Do you think anybody come back to me? Not one person. Left me there; sat there like a cunt"* (Jolene, G3, P2).

Abdominal pain can indicate that a woman may be suffering a pregnancy complication that is putting the health of the woman and her baby at risk. As a smoker and substance abuser, Kayleigh would have been considered at 'high risk' of premature birth, still birth or placental abruption. Pain could have indicated Kayleigh was experiencing a placental abruption<sup>32</sup> or that she was going into premature labour, and this would have been a 'red flag' for a trained midwife prompting urgent referral to an NHS hospital obstetric-led unit. Kayleigh described how, at 26 weeks pregnant, she was in pain but unable to get any health care help:

*"I had pain in my lower stomach...absolutely agony...I ring the buzzer. The night officer comes, and I say: 'Officer, I'm pregnant, I'm in pain, can I get some painkillers?' Officer comes back and says to me, 'The nurse says you can't get painkillers whenever you want them.'" (Kayleigh, G2, P1).*

Prison rules and protocol mean that women cannot know when they are leaving the estate to go for scans, consultant appointments or a planned caesarean or induction of labour. Trixie was having a planned caesarean section but was anxious about not knowing the date:

*"It's stressful, because I just don't feel prepared. Anyone else at home would be able to know and get ready, and to count down, but it's just I haven't got a clue. I don't know what to expect, all I know is that they're going to come to me at ten o'clock at night asking me to have a tablet, and tell me to pack my stuff" (Trixie, G2, P1).*

There was no clear guidance regarding maternity leave for prisoners. Some women were working up to and beyond their expected date of birth: *"I'm overdue now, and they're only just looking into it"*; *"It's not so much about the money, it's the principle"*; *"prison just seems to make up their own rules"*; *"they do what they want"*. For Susan, working in the laundry relieved her boredom, but other women such as Caroline could not afford to go on leave. Caroline, held on remand, was *"ten days overdue"* when her maternity leave started and had told me that she was: *"exhausted"* because *"I have to get up every day to go to work"*. She had been given conflicting advice about maternity leave from several members of staff:

---

<sup>32</sup> A placental abruption is a serious complication and obstetric emergency whereby the placenta can separate from the uterus, depriving the foetus of oxygen, causing internal bleeding dangerous to the mother and baby.

*“She (Solicitor) said, 'Why are you still working?' and I says, 'Well, I was told I had to'. And she says, 'No, you're entitled to the same maternity leave as if you weren't in prison' and I says, 'Well, I've been told the complete opposite that I have to work all the way up’” (Caroline, G4, P3).*

When Caroline did go on maternity leave, it was through chance rather than forward planning: *“I went back to work in the afternoon, the head of education came to see me and asked me, 'Oh, would you like to take some maternity leave now?’”*. Caroline returned to prison following separation from her baby; she was told she could not work, yet she wanted to “keep busy” to avoid thinking about her grief:

*“I've asked if I could go back to work and I've been told that I have to be signed back on to work. I have to be signed as fit for work, and the mental health nurse that I see hasn't put me fit for work yet” (Caroline, G4, P3 - PP).*

Whilst some women were verbally told that they were ‘entitled’ to the same maternity leave as those in the community, the alternative was being locked in a cell for several hours at a time and having their pay reduced:

*“I was 30 weeks they wouldn't let me go to work, they wouldn't let me go to education, so I was behind my door locked for 23 hours” (Sammy, G2, P1).*

Susan was anxious to stay working for as long as possible to ease her boredom and to get paid: *“You don't get paid; you get less pay, and I don't have much money sent in from home, I need the money”*. Susan was also concerned about returning to prison without her baby, anticipating that this may give her too much time to think about her baby:

*“I don't want to lose my job and then come back from hospital and not have anything to do” (Susan, G1, P0).*

There were some complimentary descriptions of care and support from health staff and officers: *“As soon as I rang my buzzer they were there within ten minutes”; “since I've come back they've all been quite nice”; “really supportive”; “I was seen by a nurse and the midwife once every week”; “It's not the health care that has been the issue at the night...it's the (prison) staff that are on the nights”:*

*“Within half an hour the ambulance was here, and I was off. When we left the prison, the number one Governor was at the gate and she stopped, and she*

*said good luck. And so that was really nice from her as well, because she doesn't have to do that” (Susan, G1, P0).*

When women did get what they were entitled to (such as being able to sleep on the bottom bunk) this could expose them to animosity from other prisoners:

*“I didn't look pregnant...I'd got privilege to the bottom bunk, and I was in with somebody older and she went out telling everybody I'm making her sleep on the top bunk. So, then I had a roomful of people saying, 'What are you making her sleep on the top bunk for?' and I went, 'I'm pregnant, I've been told I have to sleep on the bottom bunk,' you know what I mean?” (Ellie, G4, P3).*

A pregnant woman getting what she was entitled to would sometimes seem as though prison staff were doing her ‘a favour’:

*“I've been relying on people to send me information...the prison always makes it feel like ‘well, it's only if we can or if we let you’ sort of thing if they'll do me a favour, you know” (Boo, G2, P1).*

Non-smoking participants expressed frustration, revulsion and anxiety about the health of their unborn baby. Jane spoke of her repugnance:

*“They put me in a smoking cell and there were no windows. They should make sure you have a window, for opening, and someone smoking in your cell, you might as well smoke with them. I think that is disgusting as well, disgusting! You are sharing a cell, you know there is four or five of us in a cell, and they were all smoking” (Jane, G1, P0).*

Abi talked to me about how the smoky environment exacerbated her symptoms of HG:

*“I don't like it, because its smoking and I don't like the smell of smoke. It makes me feel sick. You know when you're pregnant you can smell things, and I can smell it. I don't like it, it makes me feel sick” (Abi, G3, P2).*

In subsequent interviews with Abi, she shared her fears that moving to a non-smoking wing would mean she lost her privacy. With her high-risk prisoner status<sup>33</sup>, Abi was not deemed suitable to share so her only option was a single cell on a smoking wing. Caroline was also a 'high risk' prisoner and had a single cell on a smoking wing and shared similar fears to Abi of losing her privacy if she were to move to the non-smoking wing. She told me that she got used to the smoke, although she expressed concerned about the health of her unborn baby:

*"I did notice it when I first came onto to the wing, definitely when I first came to prison. I was coughing a lot.....and now I don't cough, and now I don't smell it. Sometimes passive smoking is worse than being a smoker yourself"*  
(Caroline, G4, P3).

Weight loss was concerning to the women and increased their anxiety about the wellbeing of their unborn babies, above their own health. Being able to observe and be with women, especially over several months, I could see that some were thin and losing weight: *"I was tiny"; "I'm just drained and ill and I've lost a stone"; "I'm losing weight and you're meant to put it on"; "In six weeks I've lost a stone. It might be more"*. Heartburn and hunger are normal physiological responses to pregnancy but in prison all women found these symptoms particularly difficult and confusing to manage: *"In the morning I'm hungry"; "I'm hungry, but I don't know what I'm hungry for"; "the food they give me I don't like"; "I feel like I am hungry, hungry, hungry"; "Hungry! I am always, always hungry"; "I get hungry at night"*. Kayleigh told me about how hungry she was and although she was 26 weeks pregnant, she was very thin, and her abdomen appeared small for her gestation. She had had no breakfast on the morning of our interview, then had been given a vitamin tablet on an empty stomach:

*"You're supposed to eat on a vitamin tablet; I've had nothing to eat. I had to take the tablet and I'm hungry. I'm going to be sick. I've had a vitamin tablet and I've had nothing to eat. [Wretches] That happened yesterday as well when I took my vitamin tablet"* (Kayleigh, G2, P1).

The narratives of women in this study relating to the rushed nature of mealtimes echo the findings from Smoyer and Lopes (2016); however the inflexibility of prison regime impacted upon meeting pregnant women's nutritional needs: *"I couldn't eat at tea (evening meal) because I had heartburn"; "you were eating in the biggest rush"; "you never fully digested your food...I wasn't eating properly at all"; "I'd never got to digest my food properly"; "You get it at five (dinner)*

---

<sup>33</sup> A high-risk status is a category assigned to a prisoner determined by the crime they have committed and the security risk they pose.

*and then the next day it's half eight before you get food"; "as though you were in the biggest rush you've ever had in your life"; "I didn't eat the right amount"; "when you rush your food you can't eat that much...and then it's like, 'Right, everybody back behind your door'". Exacerbation of the physiological changes in the digestive system led to feelings of anxiety. Kayleigh told me the timings of the meals led to confusion: her hunger led to her eating during the night the breakfast that had been provided the previous day:*

*"Because sometimes when you're pregnant you're not hungry at that time. Sometimes if you feel a bit sick...but you can only eat at that time. You can't take your food back, and you've got to eat it there and then" (Kayleigh, G2, P1).*

#### **e) Coping strategies**

The feelings of guilt about the effect of prison on their unborn baby and family was commonly voiced by women in interviews. My findings broadly mirror those of Crewe's (2009) in that emotions such as empathy, self-regulation, self-awareness, motivation, are common in prisoners. Emotional responses to the pains of incarceration as a pregnant woman were a thread throughout the interviews with women. Shame and humiliation, loneliness, regret, anger were also emotions voiced ubiquitously. Most interviewees mentioned feeling frustrated, sad, lonely and suppressed. Most of the pregnant women would describe how they suppressed their emotion: *"blocking it out"; "I felt like I couldn't really show my emotions"; "keep a lid on it"; "I blocked my emotions"; "it's a wall"; "its avoidance tactics". Women were fearful that by showing their emotion they would lose their baby: "you are on guard and a lot of all that you forget you are pregnant"; "I felt that if I showed my emotions they would tell me that I wasn't fit to get him back"; "I didn't want them to use anything against me"; "part of you wants to blow up but...if you blow up, your baby gets taken from you"; "I try and be strong so they think I'm strong... I cry when I get to my cell". The prison environment felt frightening to many of the women, because they were pregnant. Women described acting "tough", "hard", walking with a "swagger" and being in a state of constant vigilance:*

*"Always watching your back, not just with the girls but with the prison officers, watch what you say be careful what you say" (Frances, G1, P0).*

Sammy was threatened with psychiatric treatment if she had an extreme emotional reaction to being sentenced, thus having to pull herself together:

*"I just assumed that from court I'd be taken to a mother and baby unit... And I wasn't, so when I was in a little bit of a hysterical fit just after being*

*sentenced, I just had a bit of a breakdown. And then you get told you better sort yourself out, otherwise they'll put you on a funny wing, so you have to be strong from that moment. That's the only way that you can cope with it"* (Sammy, G2, P1).

Many participants described that the reason for them "*behaving*" and putting on a "*mask*" was due to the fear that if they showed their candid emotions, an MBU place would be denied and they could face losing their baby: "*your place is not secure, it all depends on how you act, and how you behave*"; "*you just have to be up their bum, anything they say you just jump*"; "*you just wanted to tell somebody to jump off a cliff, you couldn't do that, because you could jeopardise your place, and they kept reminding you of that fact*".

*"I had to just continue as normal and just get with the regime, and not really show any emotions. Because beforehand I had suffered with depression, so I didn't want them to use anything against me to say that I couldn't have my son back"* (Tammie, PP).

Women talk of putting on "*a front*"; "*not showing any weakness*" and therefore "*covering emotions*" with 'deep acting' (Hochschild, 2003:56) when out on the wings, yet reverting to feelings of isolation when back in the cell where they would: "*sit there and cry*"; "*When I'm in my cell on my own and I'm on my bed, I'm literally crying like a baby*". The dichotomy of having to balance blocking emotions, especially those of frustration and anger, were difficult for some women to manage:

*"To get anything then you need to stamp your feet like a toddler. You need to create and make a big scene, and make a big fuss. Well, I was in a predicament as if I'd have started doing that, then I would have been seen as aggressive, or not being able to control my temper. Which then, in turn, I wouldn't have got my place on the Mother and Baby Unit, and I wouldn't have been able to keep my daughter"* (Layla, G2, P1).

Layla partly blamed her 'surface acting' for the ultimate pain of birthing her baby in a prison cell (see 'Cell Births'). Women recognised that the denial or suppression of their emotions was causing them potential mental harm. On the one hand, Layla had feared that if she made a "*scene*" she could lose her daughter, yet having to be "*respectful and polite*" translated to passivity. Layla blamed this submissiveness for the fact that subsequently her labour was ignored by staff as she felt she was perceived as someone who "*wasn't bothered*". The sensation of hiding emotions was also articulated by Sinead:



*"I do think I obviously, will feel a lot better if I spoke to someone, because if I keep bottling it up and bottling it up, I will just flip. Like not flip to be violent, but I'll just end up having - I think I'd have a breakdown, to be honest"* (Sinead, G2, P1).

Feelings of stress was expressed by most participants: *"you're constantly worrying all the time"; "your mind's just ticking over all the time"; "I was stressed all of the time"*. Concern about the effects of stress on the unborn were commonly described by all participants who were in prison for the first time. 'Safe haven' women and those who had been in prison before appeared to express less stress. Participants were very aware that they should not be *"stressing out"* in order to prevent harm to their babies, yet they felt intimidated by the environment and other inmates, often leaving them in a state of hypervigilance. The impact of stress in pregnancy on the unborn baby was thought to have caused longer term harm:

*"He's got something wrong with him; I don't know if that's anything to do with the stress, my pregnancy being stressful. I think it probably did, because if the mums stressed the child's stressed"* (Linda, PP).

Suppressing emotion could be perceived as an element of protection against stress:

*"It might be a protection mechanism as well from myself, and for the baby as well. I'm aware that when you're pregnant and you're stressed, stress can transfer to the baby now. So, I don't like getting upset, because I don't like that negative energy going to him"* (Caroline, G4, P3).

Worry and stress was often internalised, usually when a woman was alone at night, unable to sleep:

*"I can't sleep, and I need something, I'm stressed'. I don't want my baby to be stressed. But if I'm stressing will my baby be stressed as well? If I'm worrying the baby is going to be worrying. When I'm tossing and turning and thinking, oh, what's going to happen? It's like it's just going around my brain... and I'll try and shut my brain off, but I can't"* (Abi, G3, P2).

The sense of frustration as feelings were blocked, coupled with lost autonomy, was overwhelming for several women:

*"It is really frustrating, and obviously when you're in pain and you can't get pain relief, when you're pregnant it stresses the baby out, so that's not good."*  
(Boo, G2, P1).

Some participants said they were not coping: *"I hate it! I hate it!"* (Lola). Lack of sleep was a contributory factor for pregnant women feeling as though they could not cope: *"when I feel like I haven't had enough sleep I get really emotional and you've still got to keep with the regime"*. Sinead, had been separated from her baby and admitted she was not coping, yet she hid her distress to help her pregnant friend:

*"I'm still not coping very well, but obviously, my friend's going through the same thing, so I've got to help her; I've got to show her that you can get through it"* (Sinead, G2, P1).

Shifting between identities as a non-pregnant prisoner to a pregnant prisoner was a 'status passage' for some women who had been in prison previously (Glaser & Strauss, 1969/2011). Kayleigh had been in prison several times as a *"normal"* prisoner but not as a *"pregnant prisoner"*. Kayleigh expressed her anger at how she was being treated as a pregnant woman, demonstrating a shift in her identity due to her protectiveness towards her unborn baby:

*"Just the fact that I'm pregnant, and the way that they are operating, it stinks! It's horrible! If I wasn't pregnant I wouldn't care. If I wasn't pregnant I would do my time, right? But I am pregnant, there is another little human being in here who I've got to take care of. That's how I've got to think of it now, I'm not on my own. I am number two, this is number one"* (Kayleigh, G2, P1).

Sharon had also been in prison previously and was pregnant with her first baby when I interviewed her; she spoke of how this differed:

*"I think last time I was quite loud, wild and gobby and I did what I wanted to do when I wanted to do it and this time I am quite quiet, just keeping my head down, doing my time"* (Sharon, G1, P0).

The changes in Sharon's identity from prisoner to pregnant prisoner appeared to be an incentive for a change in her behaviour, demonstrating a potential 'turning point' and 'catalyst for desistance' (Maruna et al., 2006; Sharpe, 2015; Paternoster & Bachman, 2017). Whether this was through restraint due to wanting to be given an opportunity to keep her baby or because simply being pregnant caused her to mature and quietly complete her sentence are concepts

worth considering. Women who changed their status and identity as a pregnant prisoner to being a “*normal prisoner*” meant they could be just “*like everyone else*”. Being able to blend in more would offer some relief from the attention that a visible pregnancy would bring in prison. Caroline outlines her changing identity from pregnant prisoner to prisoner:

*“For me, it’s... I feel like I’ve got through one stage, I’ve got through the pregnancy stage and I’m starting to feel more like a prisoner now. Not...whereas before I was a pregnant prisoner, now I’m just like everybody else, I’m just a prisoner like everybody else. So, I’m now experiencing prison life as me, not as me the pregnant woman, if that makes sense?”* (Caroline, G4, P3 - PP).

For many participants, their pregnancy was secondary to their identity as ‘prisoner’. Women would commonly try and block out their pregnancy, stating: “*I block it out*”, or “*a part of you forgets*”. The reasons for this were complex but, like Jane, pregnancy denial appeared as a way of coping with the “*horrible*” experience of being in prison for the first time:

*“You know, although you are pregnant, a part of you forgets that you are pregnant. Because you’re in there because there’s a lot to deal with. It’s terrible really because you don’t focus on what you should be focusing on. It all goes out the window”* (Jane, G1, P0).

Utterances of: “*I’m not made for jail*”; “*someone else is in control of my life*” meant the identity as prisoner surpassed the identity as pregnant woman, who therefore tried to mentally block out the pregnancy:

*“Although I was pregnant in there and I knew I was pregnant. Because I was in prison, I shut it out...I just couldn’t (acknowledge pregnancy) because I was in prison, I just couldn’t”*. (Pamola, G1, P0).

Trixie’s fears of physical violation willed her to hide her identity as a pregnant woman:

*“Even though I don’t speak to a lot of people, I am kind of scared and that’s why my tops are big, so you can’t see I’m pregnant. Because you don’t know who you’re living with in here, not at all”* (Trixie, G2, P1).

Women who had children talked of losing their identity as a mother, echoing findings from Baldwin and Epstein (2017): ‘*90 per cent of me is being a parent*’. The confusion of losing the

role of mother, doing “*normal mum stuff*”, together with the struggle of not wanting to accept the identity of being a prisoner and being pregnant led to their feeling misunderstood, probably due to the complexity of the situation. Some women would exclaim: “*you don’t understand*”, as they tried to make sense of what being a pregnant woman in prison meant. Wanting to be “*known as a person*” highlighted the struggles of depersonalisation that women experienced. Women would feel isolated and alone when saying: “*I am totally alone*”; “*Everything’s taken away from you here, everything*”; “*I sit behind my door with nobody to talk to and I feel very isolated*”; “*There is nowhere to go and nobody to talk to*”.

*“Horrible. It’s like being back at school. I was absolutely alone and it’s just the worse thing, even when you’ve had the baby and you see people in their beds and their family are coming with balloons and you know...its gut wrenching”* (Lola, G2, P1).

Emotional responses were often blamed on the perinatal state of the woman and their pregnant or post-natal hormones: “*maybe I’m just postnatal*”; “*my body’s confused*”. However, confusion with the “*natural instincts*” felt during pregnancy were often united with feelings of guilt and internal struggles. Caroline explained her distress at suppressing her natural urge to ‘nest’ in the knowledge that she would not be bringing her baby home:

*“I’m getting quite anxious because every time I have like a midwife check, it’s really emotional, I am having to listen to the heartbeat. I’ve already done the whole nesting thing and I have just cleaned the room from top to bottom and it is almost like what is the point because, I haven’t been able share the experience with anyone, my children. I feel like it’s my fault they are missing out”* (Caroline, G4, P3).

Hearing the baby’s heartbeat was difficult for Caroline, yet other women would express pleasure at the usual physical responses of pregnancy such as the baby’s movements, even when faced with separation from their baby: “*I feel her moving and its lovely, proper kicks that wake me up*”. Positive feelings such as optimism were also coupled with anxiety, suggesting an emotional roller coaster: “*I try and think about the best of things and try not to get stressed*”. Ellie describes her amazement of being with her new-born baby, juxtaposed with the fear of her child being removed:

*“Amazing! It was amazing and then I didn’t sleep for the first five days, because I was just so fearful. I couldn’t take my eyes off her and I was just*

*so scared this might have been all I was going to get with her, and I just wouldn't waste any second"* (Ellie, G4, P3).

Ellie's emotions of wonder, dread and calm suggest that the uniqueness of women's incarcerated pregnancy reactions make for an extraordinary experience. The emotions of fear and defencelessness were directly related to women's pregnancies:

*"If I wasn't pregnant I wouldn't be so scared, but knowing that I can't defend myself being pregnant, it makes it a whole lot different and I just feel vulnerable"* (Trixie, G2, P1).

Women would talk about crying alone in their rooms: *"when I'm in my cell on my own...I'm literally crying like a baby"; "When I go back to my cell I cry"; "I cry every morning, just but only in my cell"; "crying my eyes out"*. The release of emotion through crying was concealed from staff, other women and families during visits. Women would try to express their emotions and used negative descriptors such as: *"torment"; "its proper emotional"; "heartbroken"* and *"distraught"*. Participants who were known to be separating from their babies felt grief and pain as they described their anticipated loss as: *"I just feel empty"*. Caroline, although usually articulate, found it especially difficult to find the words that accurately expressed her anguish:

*"For the first time in years I've actually cried because I've missed my mum as well. And I was sitting there thinking to myself yesterday, and I was thinking, well, I'm nearly 35 and if I'm missing my mum at this age... [Respondent becomes upset] I just need to be out of here and I can't take anymore. Oh, and I'm just missing my baby so much"* (Caroline, G4, P3).

Feelings of 'depression' were repeatedly voiced by all women: *"I think that was the lowest point in my life"; "I was just really depressed"*, yet support was limited in the prison environment. A quota of eight counselling sessions was offered in Prison A, no matter the length of the sentence, and the waiting list for talking therapies was many months. Wanting to escape from the pain and grief of being forcibly separated from her baby was expressed by Tracey, who wanted to get back to prison as soon as possible after giving birth to help suppress her anguish:

*"It broke my heart, I was heartbroken, I just wanted to get the fuck out of there as that is where I had been with my baby for five days... I wanted to come back here!"* (Tracey, G1, P0).

The love and connection with the unborn baby and new-born child was expressed by most participants, despite the suppression of feelings: *"I love her"; "I love him"; "I didn't know how strong the bond would be"*. However, the love women felt for their baby was tinged with despair and grief and longing for those who would be separating: *"He's part of me, and I can't imagine someone just taking him away"*. Time with the baby was treasured yet also distressing for women separating, yet these memories were so important in this brief time prior to the baby being taken away:

*"They said, 'Oh, you've got ten minutes or so with her,' so, obviously, that's when I dressed her and put her in her going away stuff, and give her last cuddles and kisses and stuff. And it was hard, and I come back, and I was really, really upset and I couldn't sleep or nothing, and I didn't eat at first"*  
(Sinead, G2, P1).

Women remaining with their babies would also express emotional pain when thinking about what might have happened if they had lost their baby in separation or in labour: *"If I'd have had to do a separation, how disturbing that would have been"*. Women separated from their babies, such as Sinead, Tracey, Susan and Caroline, would express feelings of envy, resentment and jealousy post-separation in seeing other pregnant women: *"I didn't wanna be around pregnancies"; "I was jealous because I wanted it to be me"*. Vulnerability was expressed by women who felt the loss of agency: *"The people who can help me are the ones who don't want to help me, and the people who want to help me are the people who can't help me"*. Waiting for answers to questions about whether a woman would keep the baby, or who would accompany her in labour, led to feelings of helplessness in all participants who did not know whether an MBU place had been granted: *"I just I feel really helpless"; "I need to know now"; "It's my baby, I want for her to tell me if I'm allowed my baby or not"*. Some women appeared to gain a deeper insight due to their own experience. As Susan neared the end of her prison sentence, she expressed empathy for others in the same predicament:

*"If I saw a prisoner now with officers at a hospital, I would think differently than I would have thought before, because obviously, I've been through it. I mean, we're not all mass murderers. Instead of just being like looking and thinking, oh, I bet they're murderers, I wouldn't think that, and I wouldn't stare, because it's uncomfortable when people stare at you, it's not very nice"*  
(Susan, G1, P0).

Even when a woman was known to have committed a crime involving violence or child neglect, empathy was articulated: *"you don't know, when her door is shut how she is actually feeling"*;

*“the sad things when you see the girls and their kids, like that's sad”*. Empathy from women towards pregnant prisoners would often take the form of sharing food or kindness:

*“Sometimes when they look at me and I say, 'Oh no, I'm sad' and the food is not good, and I put it in the bin. They say, 'Come here, I'll give you my, I'll give you half from mine”* (Daniela, G2, P1).

#### **f) Experiences of the MBU environment**

The focus of the ethnographic component of my research was in the mainstream prison environment and experiences of pregnancy; however, seven women were interviewed whilst resident on an MBU in Prison B or Prison C, and five post-release women had experienced being on an MBU with their babies. Indeed, the MBU was quite different from the main prison environment; however, the challenges were unique. The considerably smaller numbers of women confined to an MBU meant cliques were created, which could lead to isolation and exclusion for others: *“the other residents were really bitchy”*. Boredom was common, and some women longed to get back to the main prison as they missed their friends. The anxieties of being a new mother on an MBU were exacerbated by the milieu with the noises, atmosphere, post-natal emotions and having to cope with a new baby. This highlighted their remoteness, of being away from family, and the impotence a new mother felt in not being able to control her environment:

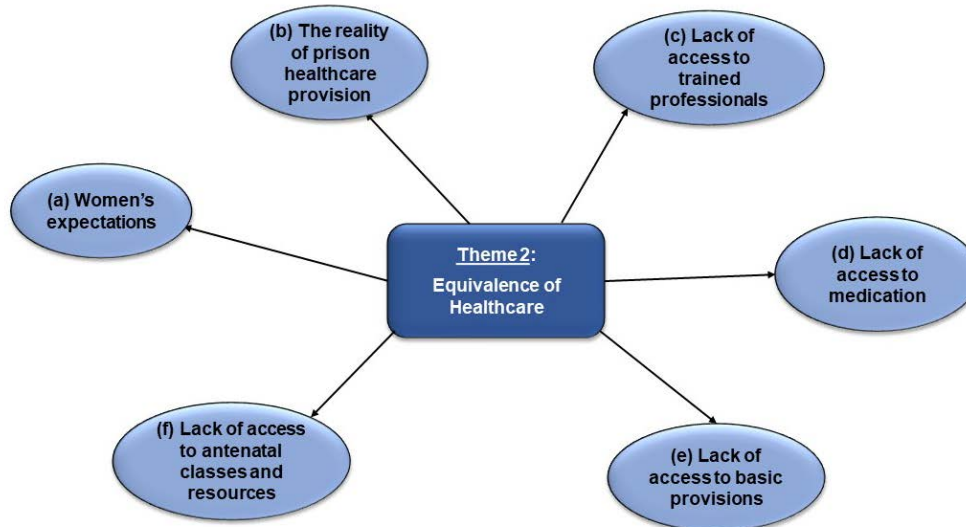
*“I'd just brought my new born baby home and I had to listen to rap music until 12 o'clock at night. I didn't want to have it be the first thing that she heard. There was no consideration for babies sleeping, I don't know whether it's to do with geography and that particular area, or because they were younger, and they were a bit rowdier”* (Sammy, G2, P1).

The units were not locked: *“because you can't lock babies in”*. Officers spoke of the differences between the MBU environment and the main prison:

*“They have to be in their rooms by a certain time, but apart from that if they wake up in the night and need to make a bottle, they can do. The unit is not locked, their rooms aren't locked. I don't think they're supposed to, but I think if they've woke up at three o'clock in the morning and can't sleep, they want to grab a cig, they'll get up and go. There's no issues with that”* (PO C).

## 4.2 Equivalence of health care:

*“I just don't feel like I could get the medical care that I would need here.”*



### a) Women's expectations

Some women expressed indignation at not having 'special' status as 'pregnant woman' which was considered to be a deprivation when having their health needs met. Women who did not receive their entitlements (e.g., a pregnancy pack, specialised bedding) were outraged at the lack of consideration shown to their pregnancy. Some participants found being offered illegal drugs potentially threatening: *“everyone was offering me crack and they knew I was pregnant, and I was just disgusted”*. Some pregnant women perceived their pregnancy should be a protection against prison life: *“I don't think they should put pregnant people with four other people in the room”*, yet the special status usually afforded to pregnant women in mainstream society was mainly absent in prison. For pregnant women to be treated the same way as non-pregnant prisoners appeared to them an additional pregnant pain of imprisonment - their pregnancy afforded no special treatment.

### b) The reality of health care provision inside

Most research participants described situations that were linked to equivalence of health care (such as receipt of medication, access to timely midwifery advice and appropriate assessment by a trained midwife). The care put in place for pregnant women and new mothers was generally in the form of security protocols or procedures, such as opening ACCT<sup>34</sup> documents to keep

---

<sup>34</sup> ACCT (Assessment, Care in Custody and Teamwork) is a series of documents opened in response to concern that a prisoner is at risk of self-harm or suicide.



women from self-harm. However, rather than this feeling like a support mechanism for women, being 'on suicide watch' - as one woman exclaimed: *"having a light shone in my eyes every 15 minutes through the night"* - was distressing, especially for those returning to prison following separation. Women would sometimes talk about how they would 'mask' their emotions to avoid this process being applied. Jane explains what being on an ACCT was like:

*"When I was sentenced, I was so shocked I cried 'I prefer to be dead than go to prison' and you know when you say these things, they put me on suicide watch. I had to shake a leg every hour! Every hour for two weeks, I had to shake my leg every hour to show I was still alive"* (Jane, G1, P0).

Nonetheless, prison staff view an ACCT as a supportive process: *"They return, and they've got no baby, and they're automatically placed on suicide watch, to assist them through the first couple of days"*. Women are more likely to commence spontaneous labour at night (Glattre & Bjerkedal, 1983; Olcese et al., 2013), yet at night all women were locked in and there were no doctors or midwives on duty: *"the staff don't have the keys, so you've got to wait (until morning)"*.

Drug dependency was a common aspect of care that the midwife and health staff were required to support. The midwife spoke about inconsistency with methadone dosage given for heroin withdrawal in the prison compared with in the community setting. The recommended dose is between 60mg and 100mg (Fullerton et al., 2014) yet the midwife stated that the dose women were given in prison was less than this, leading to a risk of premature birth.

### **c) Lack of access to trained professionals**

The experience of midwifery care was described by women and staff, highlighting experiences of maternity provision in the prison setting. Experiences of midwifery care were variable amongst participants: *"horrible"*; *"awful"*; *"it's more like a check-up"*; *"there is not much they can do"*; *"it's not like being pregnant on the outside"*; *"she can tell me what the process is, but she can't implement it"*; *"because the midwife isn't based here, she doesn't have a lot of jurisdiction about what happens"*.

*"I should be entitled to antenatal classes; the midwife hasn't gone through my birthing plan with me. She hasn't said that this is going to happen, that's going to happen. She's a good midwife, but I just think they're slow here"* (Trixie, G2, P1).

The relationship some women built up with the midwife was positive: *"she has been really nice"*; *"she makes sure the prison pulls out all the stops"*; *"out of everybody she seems to be the one"*

*that's most upfront and tells me what's going to happen*". Relying on only one midwife in Prison A meant that there was no cover when she went on holiday, and the security, training and protocol requirements of prison meant that no preparation was made for an alternate when the midwife was absent.

**d) Lack of access to medication**

A common cry from all women was the difficulties in getting medicine that they had been prescribed *"on the out"*. These medicines included antidepressants, anti-hypertensive drugs, and vitamins and medicine which would relieve minor disorders of pregnancy, such as creams and indigestion medicines: *"They won't let me have it (anti-depressants) because I'm pregnant"; "I have to wait for my anti-sickness"; "I don't know if you're allowed them when you're pregnant"; "I've got eczema and I'm still waiting for my cream"; "I've not had my aspirin"; "I reported heartburn to my midwife... I was prescribed Gaviscon<sup>35</sup> four weeks later"; "I haven't had any folic acid"; "I got told to stop it, but I've been on antidepressants for years"; "On the out I'm on antidepressants"; "I can't have my antidepressants"; "I waited three days for paracetamol and I was in agony"*. Trixie had been taking anti-hypertensive<sup>36</sup> drugs to prevent pre-eclampsia<sup>37</sup> but since arriving in prison she had not received her medication:

*"My Mum had a brain haemorrhage, through high blood pressure, so that's why I'm worried in here with my high blood pressure. They said they have to wait for confirmation from my doctor...you don't understand, I need it"* (Trixie, G2, P1).

In the second interview with Trixie, she told me she had started receiving her prescribed aspirin; however, she was being asked to swallow it without the tablet being dissolved - *"health care was giving me an aspirin tablet raw"* - against the approved formulary mode of administration. An unannounced inspection took place in Prison A within the timeframe of this study and it corroborates some of my findings detailing concerns about 'lack of confidentiality, poor supervision at medicines hatches and poor access to prescribed medicines' (HM Chief Inspector of Prisons, 2016:39). This poor access to medication was detrimental to the pregnant women's

---

<sup>35</sup> Gaviscon is a liquid medication available to buy over the counter for the relief of heartburn.

<sup>36</sup> Anti-hypertensive medication reduces blood pressure.

<sup>37</sup> Pre-eclampsia is a serious pregnancy complication characterised by high blood pressure and fluid retention which, if untreated, can lead to eclamptic fits and cerebral vascular accident (stroke).

physiological wellbeing. Kayleigh had been taking anti-depressants but, since coming into prison, she had not received any medication for her mental health:

*“I asked to be padded up<sup>38</sup>, because I get stupid thoughts, I get suicide thoughts, but that's what they are, thoughts. I mean, I don't act on them, I can't act on them because I'm pregnant. I won't act on them”* (Kayleigh, G2, P1).

Boo was asthmatic, and told me of her experience of not getting the respiratory medication she relied upon:

*“I've had asthma since I was born, and my chest keeps getting tight...they don't know how long it's going to be until they'll give me one (inhaler), but I've got to wait and have another asthma test done”* (Boo, G2, P1).

Women in Prison A spoke about having to queue up outside the pharmacy building for medication that, in the community, they would have had in their possession. The ‘hatch’ was a window from the pharmacy where the women queue to receive their medicine; I would regularly see the women queuing outside in all weathers for medicine and at times tensions were fraught, with occasional fights breaking out between prisoners. If it was raining, women would get wet because umbrellas were not allowed in prison. For the pregnant woman, the frustration of not being able to have tablets in their possession led to further disempowerment, as Caroline describes:

*“I have four different blood pressure medications and iron...I was having to queue up outside in the rain...you are not allowed umbrellas here you can't have coats with hoods, so you literally have to queue up outside in the rain and whatever the weather. I was doing that three times a day to get my medication”* (Caroline, G4, P3).

#### **e) Lack of basic provisions**

Women found it difficult to take care of their body, skin and hair in prison. For some women, the inferior products they had to use caused additional stress, making them feel devalued and unfeminine:

---

<sup>38</sup> To be ‘padded up’ is slang for being placed in a padded cell with cushioned walls to stop someone from hurting themselves.

*“My hair was dry because of the water and the products that no one uses it, it’s just Tesco value, it’s just the stuff you would never use. It’s just all that kind of rubbish. It dries out your skin, it’s just all these little things”* (Jane, G1, P0).

Several women in this study described their experiences of discomfort caused by poor bedding, exacerbating muscle and joint discomfort. Lola described her first night in prison and how she was unaware that her allocated bedding would be stored in her pillowcase. Whilst this lack of knowledge may be a common occurrence for all prisoners on their first night, the pregnant woman appeared especially vulnerable to anxiety:

*“On the night time, they didn't tell me that my bedding was in my pillowcase, and I thought that I had no bedding. Until my friend told me the next day...I didn't know what to do. I didn't know, I thought that was the pillow”* (Lola, G2, P1).

The inconsistencies between basic bedding provision in different prisons was noted amongst the women interviewed: *“I will be getting a new one, but not yet”*; *“people were saying the new ones are worse than the old ones”*; *“they're dead hard”*; *“somebody told me that I could get a pregnancy mattress”*; *“I was using my own clothes to slide underneath the mattress just for a bit of extra cushion”*; *“I spoke to the midwife...She said that she would get the mattress; I still haven't got the mattress”*; *“They tried to get me a new one, but there wasn't any left”*; *“I've got two mattresses, but it still dints in”*; *“you sink in”*. Sammy had spent her prison sentence in three different prisons and highlights the differences:

*“They gave me one of their old mattresses, at least it wasn't one of those blue ones, which we got when we were in (D). The ones in (E) were actually nicer and you'd think it'd have been the other way around. The ones in (D) were like wood, sleeping on wood”* (Sammy, G2, P1).

When pregnant women could order clothes, they often had to wait for many months. It was a common perception that women had no rights, even if pregnant: *“you're just a prisoner, you have no rights”*. Receiving parcels and packages from outside was difficult for pregnant women who required larger clothes and maternity bras: *“you're only allowed one package a year in this jail”*; *“It takes so long and then you don't end up getting the clothes because they're out of stock”*; *“I either get ignored or I get a message back saying you've already had your parcels”*; *“They wouldn't allow me to have a parcel in...that's a legal document that they should abide by, and they don't”*; *“I'm entitled to maternity clothes and they've been ignored”*; *“I've seen a girl and her*

*belly's hanging out...her clothes are too small because she's pregnant"; "they won't let me have a jacket"; "when my stuff did come up, they (prison staff) had taken some of the toiletries". Prisoners sometimes felt that knowledge of entitlements was deliberately kept from them, with the system relying on prisoners not knowing their rights: "It's like if we don't know, we can't ask"; "I get right pissed off and I'm thinking, why are they withholding this information from us?" Women commonly talked about waiting for provisions:*

*"Everything is a waiting game here, everything takes so long, you could be dying, and you would still be waiting" (Sharon, G1, P0).*

Clothes were often ill-fitting due to weight loss or incorrect sizing: *"I don't like wearing these (baggy clothes) when I've lost weight. I might have lost more than a stone". Other women talked about the quality of the clothes: "Because, obviously, you have to hand wash them, your knickers fall apart". Women would use baggy clothes to hide their pregnancy and so blend in and not draw attention to themselves: "When I've got my top off I can see a bump", or to ensure they felt protected from harm from other prisoners:*

*"I've got baggy tops, so I just always have to hide my bump, and like most people couldn't recognise that I'm pregnant, so that's a good thing. So, I'm glad I'm not like out here (gestures) I want it hidden, because I don't know who's who and who is in for what" (Lola, G2, P1).*

Suppression of bodily functions was a common finding in all women who were lactating<sup>39</sup>. In Prisons A and B women were unable to access basic provisions to soak up excess milk: *"I just had to put tissue in my bra"; "I get pushed from pillar to post for breast pads"; "breast pads aren't something that you can put on prescription"; "put an app in requesting breast pads"; "weeks of asking for breast pads"; "I cut them (sanitary towels) in half and stick them in my bra"; "I was cutting up pads and putting them down there". Sylvia, sentenced at 41 weeks pregnant, went into labour whilst she was in court. She was sent straight from prison reception to hospital where she gave birth, was separated from her baby and returned to the prison, all within 24 hours. Trixie described what she saw when Sylvia was received onto her wing:*

*"A girl that's come on our wing, she was just sent here, without her baby, and all her breasts were leaking and everything...she didn't even have a bra...no one wants to even see that, let alone be that person and go through it.*

---

<sup>39</sup> Lactation is the secretion of milk from the breasts.

*Everyone's sitting eating their food, and she's sitting there with big wet patches. I'm shocked. It's just like someone bleeding everywhere” (Trixie, G2, P1).*

Trixie’s observations and subsequent astonishment that a woman could be left to seep breastmilk appeared to be something that prisoners noticed but staff overlooked. Sylvia consented to an interview and I asked her about how she was managing her leaking milk:

*“I've asked for breast pads, but they haven't given me anything. I've been told (by prison staff) to just rip a pad in half and just put each side on each breast” (Sylvia, G5, P3 - PP).*

The fact that even if Sylvia had breast pads she would have no bra to hold them in place was not considered by health care staff. The wrong advice was often given by staff and there were no provisions of breast pads for lactating women in Prisons A or B. Caroline had been advised to use surgical gauze for her leaking breasts, though the seepage of milk was excessive; she told me about this in our sixth interview when she was five days’ post-birth:

*“Well, that woman (nurse) who gave me the gauze, there's no way she's had children... One of the girls told me that she used to have to use the new born nappies and put them in her bra. Because she used to leak that much, that even breast pads weren't enough, she used to have to put nappies in” (Caroline, G4, P3 - PP).*

#### **f) Lack of access to antenatal classes and resources**

In the community, women can choose to access antenatal classes; in Prison A there were no such classes: *“They've not offered me any antenatal classes”*. The midwife stated that she did try to spend time discussing labour and birth: *“I think they need antenatal classes...I do try and spend some time discussing it”*. In Prison B, antenatal classes were facilitated by the MBU staff and health visitors, and in Prison C women could access classes in the community should they choose this: *“anything that they could access in the community they can access here”*. The findings demonstrate the inconsistencies for pregnant women across the female prison estate. Women who had accessed antenatal classes run by volunteers found them valuable:

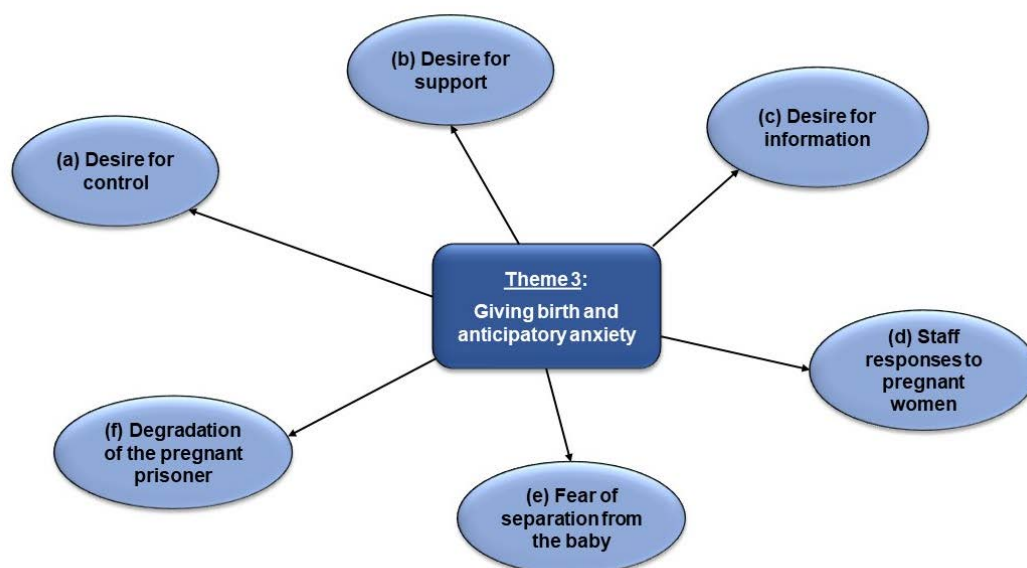
*“It's not until you look back and see, the little groups were so important in there, just being able to talk to someone, just something little, you know, just like, how will I know I am in labour? Just to be able to ask someone that question” (Frances, G1, P0).*

The Inspectorate visiting Prison A was said to have speeded up the MBU Board application for Trixie: *“since the inspectors come in a week later a board meeting was set”*. However, it was also pointed out that she should have been receiving other entitlements:

*“They (prison inspectors) said that I should be entitled to antenatal classes and stuff like that, which I haven't had, or been even offered or considered. And they just told me what I was entitled to, but I don't get anything”* (Trixie, G2, P1).

### 4.3 Giving birth and anticipatory anxiety

*“Everything's out of my control, even when I go into labour”*.



#### a) Desire for control

The sense of having *“no control”* over one’s life or pregnancy: where she would give birth; who might support her; receiving medications prescribed on the outside; and ultimately whether she would be allowed to remain with her baby beyond delivery, generated distress among all participants. Prison life demands that a woman is dictated to concerning when and what she eats, when she sleeps, what she drinks and when she accesses health care. Loss of autonomy is known to be an issue with female prisoners in general (Crewe et al., 2017); however, the pregnant woman experiences unique and multiple fears simultaneously. Women described their loss of control: *“It just feels like everything's out of my hands”*; *“every element of my life is taken*

away from me”; “there’s nothing I can do”; “you’re just stuck in your room from until they say you’re allowed out”; “sometimes the staff don’t have the keys, so you’ve got to wait for someone”. Like Trixie, Abi hoped to harness some control by opting for a surgical birth:

*“I want to be in control of my own body, I don’t want to be buzzing and buzzing people for them to get an ambulance, I just want them to book it. It’s all right anyway to get a caesarean now. It’s my right, if I ask for one”* (Abi, G3, P2).

The sense of having “no control” was distressing to most participants who: “went into panic”, because: “you’re not allowed”. Jane reflected upon her time in prison and revealed her personal restraint when wanting to “blow up” juxtaposed with fearing the removal of her daughter if she did so; she demonstrated an elevated level of restraint and resilience:

*“Having no control over the environment to having no control over your life, no control over your pregnancy. Honestly, it’s horrible...part of you wants to blow up but you can’t because if you blow up, your baby gets taken from you, you know there is always a consequence to everything.. you know everything you say, there is a consequence whether it is good or bad”* (Jane, G1, P0).

The tension felt in being controlled and having to contain emotions for fear of punishment was a common experience: “I could end up in a fight again. So, I’m not going to do it”. For Jane, the impact of her experience affected her approach to relationships after release:

*“Now I can’t stand jobs-worth people or controlling people, I can’t take it, they get to me...It’s like because you’ve had two years of your life where you have been controlled”* (Jane, G1, P0).

Caroline saw herself as being “managed” and losing control over “every aspect” of her life:

*“Everything is managed by somebody else, or decisions are made by somebody, even when I eat. Every aspect - when I sleep, when I’m locked in, when I’m allowed out, when I go to work, when I can have visits from family, when I can speak to my kids, what I can post out, what I can’t”* (Caroline, G4, P3).

Cleo discovered her pregnancy on reception to prison at 17 years of age; however, she was not able to contact her mother (her chosen birth partner) when she went into labour:



*“I was a bit pissed off because I was like, well, you could have at least let me tell me my mum or something” (Cleo, G1, P0).*

Trixie was in Prison A when she was transferred for her planned caesarean section, yet she had not been allowed to know the date or time. She was also being transferred straight from hospital to an MBU, meaning she would not be able to say goodbye to friends or pack up her room. This was particularly distressing for Trixie:

*“It’s stressful, because I just don’t feel prepared. Anyone else at home would be able to know and get ready, and to count down, but it’s just I haven’t got a clue. I don’t know what to expect, all I know is that they’re going to come to me at ten o’clock at night asking me to have a tablet, and tell me to pack my stuff” (Trixie, G2, P1).*

Some women reported that this sensation of losing control filtered to outside of the prison to family members who were deprived of participation in a life-defining event with the birth and welcome of a child:

*“She keeps asking... (about what happens when I go into labour) and I keep saying, 'Well, there's only so much I can do' and I don't think she realises the lack of control I've got here” (Caroline, G4, P3).*

## **b) Desire for support**

Having compassionate, emotional support from a doula or birth companion in labour is shown to improve outcomes for incarcerated women (Schroeder & Bell, 2005). However, several participants suggested that the choice of birth partner, support in labour and choosing who would accompany them, was disallowed further diminishing their autonomy and sense of privacy (Sykes, 1958 / 2007): *“I’m not going to have anyone”, “It wasn’t really explained”, “What’s going to happen?”; “I haven’t got a clue”*. Caroline was told she could not have support in labour:

*“I’ve been told not only can you not have a birth companion from like, a family member or a friend, you can’t even have the officer of your choice, it could just be any random person” (Caroline, G4, P3).*

The sense of disempowerment at being left unsupported in labour, fear of not being unlocked in time for birth, and the lack of privacy was distressing for all women who were spending their whole pregnancy in prison, and this sometimes influenced a woman’s choice in the mode of

delivery of her baby. The environment was perceived as so hostile to labouring spontaneously that it felt unsafe to go into labour in prison. Indeed, both Abi and Trixie attempted to regain control through requesting a medical birth:

*"I'm worried in case they try and make me have a natural birth, I told the doctor: 'I'm not having a natural birth'. I said, 'I'm not going to have it...especially the way they treat you here, I'm not going to put myself in danger. I'm certainly not going to put my baby in danger. I'd rather be in the hospital in safe hands'" (Trixie, G2, P1).*

### **c) Desire for information**

For the pregnant woman, informed decision-making was complicated (e.g. if a woman was 'overdue' she would not be told when she would be transferred to hospital for induction of labour, so she was therefore unable to make an informed decision about whether to accept or decline induction). The lack of information given extended to the process in place for when a woman goes into labour, the mother and baby unit application process and how women could meet their feeding choices if deciding to express breast milk (Abbott & Scott, 2017): *"where the baby would go after, nobody explained that process"; "they couldn't find my labour bag, and the people in the centre - whatever the centre is - don't know where this bag is"; "I'm hearing you can express but I have to buy my own bottles"*. Sometimes, after interviews, I would adopt an advocacy role; for example, I knew that pregnant women were entitled to toast yet Abi, who was losing weight, had not received this information about a food she had told me she could tolerate: *"I'm entitled to toast? In the morning and that, or at night? Toast. God, that's like a luxury"*. Women like Pamola had not been informed about what arrangements had been made for her going into labour, although she had been made aware that she was permitted to remain with her baby:

*"I sat a Board, I had arrangements, everything, it felt like a conspiracy, but they just kept me there. And I was waiting and waiting, and eventually they were like, 'Oh, we just want you to go into labour, and when you go into labour we'll take you (to the MBU)'" (Pamola, G1, P0).*

### **d) Staff responses to pregnant women**

Whilst sympathetic, staff were often powerless to help pregnant women with individual needs due to security procedures and rules. For staff, the environment appeared to be something they acclimatised to, unless they too were pregnant. One prison officer, on discovery of her own pregnancy, stated that she did not want *"prisoner contact"* anymore:

*"I'm not saying that my pregnancy was any more precious than anybody else's, but it certainly felt it. The day I found out I was pregnant, I came in and told my line manager and I just said, 'I don't want to have prisoner contact anymore'... It's not like we're getting assaulted left, right and centre, but there's people that might be smoking things on the wing that you might ingest, there's infections, there's the risk of assault, there was a whole lot of reasons" (PO A).*

It was understandable that working in a prison environment led pregnant staff to want to feel protected; however, several staff members said they also felt the prison environment was *"not a place for a pregnant woman"*. Previous prison research has uncovered the conflict staff members can feel between caring for inmates and guarding them (Price & Liebling, 1998; Liebling, 2004; Tait, 2011). In my interviews with staff, the environment was discussed in the context of their role of locking in prisoners:

*"I think women understand that when they're in prison they're going to be locked up, so it's very rare that anybody almost resents you for locking that door. The women also know if they don't toe the line, they don't follow the rules, there are consequences" (PO A).*

Most staff viewed the environment and care that pregnant women received as positive, in line with previous research undertaken (Albertson et al., 2012; Galloway et al., 2015; O'Keefe & Dixon, 2015): *"I think from a clinical point of view they're quite well looked after"*. My interviews with staff uncovered some confusion around the protected role of the midwife, exposing the most serious of 'institutional thoughtlessness', with incorrect advice being given, unfamiliarity with the midwives' role and, therefore, a lack of referrals and assessments being made. The assumption from prison staff was that a Registered Nurse was qualified to make autonomous decisions in relation to the pregnant woman under his/her care. All PO staff were unsure of the process for midwifery care: *"I don't know what happens after"; "I don't know if they attend health care"; "I don't know if a midwife does come in"; "We don't have a midwife on-site"; "if they've got any immediate concerns you straightaway get health care, which is usually one of the nurses"; "there isn't actually any of them that are midwives"*. Some staff would draw upon their own experiences of their pregnancies, comparing them to the experience of the women in prison: *"I filled my nine months just like planning. And they don't get to do that, so that must be really tough"; "you've not got your family there to share it with you"; "they can't go shopping for all the baby stuff"; "I think that it must be really hard"; "I can imagine during pregnancy that the hardest*

*thing is having to do it by yourself*". Health care staff seemed unsure about the role of the midwife in the prison:

*"And that's just the bloods and a BP, and a urine dip, isn't it? Not the stuff you get in the community, where you go and see...you go to your groups. The doctor prescribes them the Pregnacare, the folic acid and I think, to be honest, that's it" (HC A).*

Whilst only one midwife was interviewed and therefore is not representative of the profession, she gave a valuable insight into midwifery care in prison: *"they're supposed to have an extra food parcel per day, which sometimes is good, sometimes is not, but we keep on plugging"; "giving the baby up...a lot of them find that very difficult"*. The midwife could implement slight changes; however, she was detached from the prison health care team and her role did not involve carrying keys because she visited prison for only a few hours a week from her usual community role:

*"Since I've been here I've introduced that they all have a multivitamin tablet, because nutrition's not the best here. I know that if they were on the out a lot of them, the nutrition would be very poor, but while they're here and in my care, at least if they're getting the multivitamin..." (Midwife).*

Prison staff were anchored to their views on midwifery care: *"I think from a clinical point of view they're quite well looked after"; "I don't know what happens after"; "I don't know if they attend health care for a couple of days after"; "main health care would obviously keep an eye on them"; "I don't know if a midwife does come in"*. Although all staff showed understanding, there was a sense that pregnant women should not be treated differently from other prisoners. A common rhetoric from staff concerned pregnancy overriding the status of being a prisoner because of receiving extra food or nutrients: *"Just because it is a craving, it doesn't mean you can break the security rules"; "it's got foil on it, so she can't have it"*. The confusion over policy and the rights of pregnant prisoners was illustrated by staff: *"I think they do get extra milk and fruit"; "They're supposed to get extra food"*. Staff kindness towards women, recognising that they needed extra food, meant that rules would sometimes be broken. Mercy told me about how prison officers would try to negotiate extra food portions on her behalf:

*"A nice officer helped me, telling the kitchen (staff) 'she is hungry, give this pregnant lady some food'" (Mercy, G3, P1).*

Some staff would see food as potential for manipulation, with one staff member suggesting: “*I could probably have turned on the tears*”, yet other staff would sometimes show empathy.

Several staff members were unsure of entitlements with regards to pregnant women having different bedding: “*we have got some pregnancy mattresses around the jail*”; “*health care can order them (mattresses)*”. There was a lack of clarity about changes to arrangements regarding bedding as the pregnancy progressed:

*“I think the closer that they get to the end of the pregnancy they put them into a single cell, so they're on their own. Because even though the bunkbeds are bunkbeds, they're still quite difficult to get in and out of underneath, on the bottom for someone that's quite heavily pregnant” (PO A).*

Staff shared some of their experiences of women prisoners smoking in their pregnancy. They also shared concerns about colleagues who were pregnant, ensuring they were not exposed to passive smoking. One of the reasons an officer gave for women choosing to remain on a smoking wing was because of the drug ‘spice’<sup>40</sup>: “*you'd be able to tell straightaway if they were doing something (spice), because you can smell it automatically*”; “*they just don't care that there's a pregnant girl next door*”. The concerns about smoking were more often about drugs than tobacco smoke. The rules about smokers and non-smokers sharing cells were explained to me:

*“A smoker and a non-smoker can't share a cell, unless they sign a disclaimer to say that they want to stay in there. If they want to pad up with a friend they can go in there, but they'd have to sign a disclaimer to say they could never sue any of us endangering their lives” (PO B).*

The concept of prison as ‘home’ and that smoking would be allowed in a home environment, was articulated: “*people can smoke in their own homes*”; “*this is home for them, isn't it?*”; “*their cell is their living accommodation*”; “*They haven't given up whilst they're pregnant, so they're on a smoking wing*”; “*they can only smoke in their own rooms*”. Officers and health care staff in Prison A spoke about the designated non-smoking wing:

---

<sup>40</sup> Spice is a new psychoactive substance (NPS) which is a drug with similar, but often stronger, effects to marijuana.

*"We've now got a smoke-free wing, so if pregnant women wish to, they can live in a smoke-free environment; it's a lot calmer there as well. I feel better when pregnant women are there; I feel that they're safer almost"* (HC A).

The suggestion that pregnancy may create an opportunity to cease substance abuse was a common submission: *"it's something to focus on perhaps, to get them off the substance that they're abusing"*. A prison officer in Prison C spoke about one of the women stopping smoking to give her the best opportunity to remain with her baby:

*"She even stopped smoking...because she was concerned about running up a baby shop bill... she didn't buy tobacco from canteen every week, because she could then provide for her baby. She was prepared to do that"* (PO C).

A PO in Prison A described how she took care of pregnant staff, ensuring they were not working in a smoky environment:

*"The other week, they were definitely smoking spice and we'd got a pregnant nurse on the unit and I kicked her off. I dragged her out of the office and threw her off, and said, 'You're not staying on here until we can find out where it's coming from'."* (PO A).

Getting a place on an MBU was not reliant on giving up smoking, although officers told me about one of the English prisons which would not allow entry to smoking mothers:

*"We have a smoking area from outside here, but at (Y) prison...They're not allowed to smoke at all. As soon as they're put on the Mother and Baby Unit, they must stop smoking...Which I think is a fabulous idea, but I suppose you're forcing that opinion on them anyway, aren't you?"* (PO A).

In Prison B, MBU women could smoke outside: *"they're allowed to smoke in their living accommodation"*; *"this is the only place in the jail that they're allowed to smoke outside"*; *"they can't smoke in the cells because of the baby"*; *"They go out, have their last fag and then...They can't smoke until the day staff come on"*. Staff did show empathy, thinking how they might feel if they were pregnant in prison:

*"If I was in prison I wouldn't smoke, because it would be smoking in the bedroom - knowing how the prison system works, I sometimes think if I were in prison I'd give up"* (PO B).

The shock of discovering a pregnancy was witnessed by staff: *“They're usually pretty shocked, and then almost immediately ecstatic”*. Staff demonstrated empathy towards the suffering caused by unmet needs associated with the pregnant women's physiological symptoms, yet appeared unable to recognise specialist needs or to make provision, especially amongst lactating women. There was a suggestion from some staff that most pregnant women were substance abusers:

*“...the majority, are substance misusers that come in pregnant, and quite often they find out they're pregnant when they come here”* (PO A).

Leakage of breastmilk was a common theme from health and prison staff with recommendations to: *“use sanitary pads”*; *“rip a sanitary towel in half”* to soak up excess milk. Whilst normalised by staff, women described their shock at not being able to purchase breast pads or to have a supply of them in prison. Yet staff suggested that it was often women themselves who did not want to seek help:

*“When they return, and they've got no baby with them, they use sanitary pads as breast pads due to the fact that they just won't ask staff; they kind of go in on themselves a little bit because it's a reminder, really, that they've not got that baby. And I think that they do keep a lot of that to themselves, which is awful, really”* (PO B).

Being a pregnant woman in prison was recognised as being *“really tough”* and suppression of natural bodily urges was expressed through empathy, especially from staff who had been pregnant:

*“I filled my nine months just planning. They don't get to do that. I know it's ridiculous I craved ice, and I could make sure I got a nice big bag in the freezer. If I was in prison and craved ice, I wouldn't be getting ice. And that's just a simple craving, never mind if she wakes up and wants a Big Mac at three o'clock in the morning”* (PO A).

Staff were often sympathetic about the loss of control pregnant women may feel, yet felt powerless to help: *“We take away so much control, even more so when they're pregnant, I think”*; *“They don't even know when their scans are; they just get told half an hour before”*; *“A lot of the control here is taken away from them, and I think that's frustrating”*; *“They don't want to be told*

*that they're going to hospital with no notice...we can't tell them beforehand because of security risks". A prison officer reflected on her own experience of having autonomy in pregnancy:*

*"I always felt in control of my pregnancy... You've got your midwife's contact number, you know that if you're concerned I was in control of ringing them... Even if they said, 'Oh, you're all right' and then I'd sit there for an hour, and then I'd be back on the phone, because that was my prerogative. They don't have that, so it must be really tough" (PO C).*

In comparison to the overall female prison population, only a minority of women prisoners are separated from their babies immediately following childbirth each year; therefore, separations are an unusual and irregular experience for prison staff. Such limited experience, coupled with lack of training, meant that support mechanisms were often ad hoc. Reactions included a dread of being the person escorting the separating woman; "*distress*" of staff witnessing separation, and acceptance that: "*this is how it is*". All staff interviewed identified the risk to a woman's mental health in returning to the prison without her baby, and that they are "*automatically placed on an ACCT*" to ensure close monitoring to prevent self-harm by "*the distraught mother*". Staff demonstrated awareness of this risk:

*"They return, and they've got no baby, and they're on suicide watch...it's grief, really, isn't it? Dealing with that grief that they've lost their own child" (PO B).*

Additionally, staff may organise 'listeners' (prisoners who have had Samaritans training) to help women returning to prison without their baby: "*we've had two listeners in the cell with them all night, because of how bad they became*". Staff would demonstrate empathy with the women, stating: "*it must be quite difficult*"; "*it's quite painful*" and "*really emotional*". Some staff sentiments centred on missed "*opportunities to change*" and become a good parent, suggesting women should be "*given the opportunity*"; "*a lot of genuine ones that would make fantastic mums*"; "*they just need the opportunity to prove it*". Staff were also concerned for their colleagues: "*having to deal with that*"; "*distressing for the staff*".

*"The officers will go out, escort them, they give birth and they're the ones that actually see her baby taken away, and then having to bring her back to the prison" (HC A).*

Some staff accepted that this was part of the job but realised that separation is not a societal norm: "*It's where we work; we've chosen to work here, and this is how it is*"; "*they don't take kids*



*off people for fun*". Some staff expressed a lack of sympathy for the woman: *"they have lost the right"* (to be a mother) whilst others were concerned with the lack of sanctioned support for women: *"not a lot of provision for supporting them"*. Staff would also succour the woman: *"we can help them deal with it"*. However, support for staff was not explicit: *"It was awful, and we were all in tears"* (at the distress of a mother being separated from her baby). The lack of support for the women was a strong theme throughout the staff interviews:

*"There doesn't seem to be a lot of provision for supporting them. The wing staff will support them the best they can. But it's almost like a bereavement, isn't it?"* (PO A).

#### **e) Fear of separation from the baby**

Anticipating separation is a 'pain of imprisonment' (Sykes, 1958) unique to the pregnant woman. Two women (Susan and Caroline) undertook follow-up interviews throughout the study and described their experiences whilst they anticipated the planned separation from their babies and the reality that the actual separation would occur soon after birth. One woman (Lola) was having a planned separation *at* birth. Three other women were interviewed in the post-partum period following compulsory separation. Women would commonly express their worries about separating from their babies, whether this became the reality or not. Common expressions were: *"fear"*; *"stress"* and a *"need to know what is going on"*. The unpredictability around sentence status and where they would be allocated to was the main stressor for these women. Whilst instability around sentencing and prison allocation is a common prison experience generally, it was undoubtedly one of the most stressful parts of being a pregnant woman in prison: *"If he is adopted I don't know what I'll fucking do"*; *"it's the biggest fear in your mind"*; *"it's heart-breaking"*; *"I need to know"*; *"I'll go back on drugs"*; *"I've had my children taken before...it ripped me to pieces"*. On my last visit with Abi, when she was at 24 weeks' gestation, she still did not know whether she had an MBU place:

*"I'm anxious...I can't sleep at night, like I need to know now, I want to know. It's my baby. I want them to tell me if I'm allowed my baby or not"* (Abi, G3, P2).

Many women described being in a constant indeterminate state: *"it's just like a waiting game"*; *"what if they take my baby off me"*; *"not being able to go shopping for my own baby clothes and getting her stuff ready"*; *"I don't know, and I don't know when I'm going to find out, I don't know what's happening"*. Frances had conceived whilst she was a prisoner on day release and reflected on her experience of pregnancy while not knowing what would happen to her or her baby:

*"I was thinking, well, yeah, what am I going to do? What happens? I'm in prison, what's going to happen? What's going to happen to my baby?"* (Frances, G1, P0).

Jane had given birth to her daughter but reflected upon her state of limbo, whilst in hospital with her daughter, as she did not know if she would gain a place on a MBU:

*"I didn't sleep for the first five days, because I was just so fearful. I was just so scared that this might have been all I was going to get with her"* (Jane, G1, P0).

There was an expectation from women that separation would *"send me off the rails"*. Some women who were able to keep their babies imagined how it might have had been had they been separated, expressing suicidal ideation at the concept of losing their baby: *"I probably would have killed myself"*; *"I probably would have topped myself"*; *"you'd have just lost the will to live, really, wouldn't you?"*; *"I would have been absolutely distraught"*. Suicide was a reality for one woman, reported in the media in the December of my study (Parveen, 2016). The suicide of Michelle Barnes occurred in a closed prison without an MBU five days following the birth of her third baby, and several of the women in this research were aware of her death:

*"Do you know, if that was me in that position I probably wouldn't have lived, I know a girl in (another prison), she just got separated from the baby, and said there was no chance that she would ever get a place on the Mother and Baby Unit because of her behaviour, she got the baby taken away and she killed herself"* (Elsa, PP).

Women that did know they would be separated experienced different painful losses: *"Even registering his name I'm not going to be involved in"*. Some women who were unsure about whether they would get a place on the MBU displayed ambiguity when thinking about their unborn baby: *"I probably might not bond at all"*; *"What if I don't bond at all?"*. Caroline, Susan and Lola, knew they were being separated from their babies at birth, and found the conflicting feelings of love, guilt and denial of love during pregnancy especially hard to bear:

*"When they listen to his heart beat, I feel like I don't want to get too attached, like a coping mechanism and then I feel guilty like 'how can you not want to be attached to your own child?"* (Caroline, G4, P3).

The loss of control arising from the process of separation added frustration and a sense of disempowerment: *"they've had meetings and done a birth plan without me being involved"*. Susan was aware the separation was likely to be for only a brief time due to having under four weeks left to serve at the time of her due date. Lola was unsure if she would get her baby back post-release. However, Caroline was on remand and due to separate from her baby at birth and knew that if she was found guilty, she would be serving a life sentence in prison:

*"Throughout this battle, he's still here with me (strokes pregnant abdomen). But mentally I don't know how well I'll be able to cope when he's not there? I'll have no bump and no baby. I don't know what I'm going to do"* (Caroline, G4, P3).

At every interview, Caroline talked about anticipating separation from her unborn baby:

*"I can't imagine what it is going to be like...I have never had someone take a child away from me. I don't know what I am going to be like"* (Caroline, G4, P3).

Lola was able to make some plans about what her baby would wear:

*"I've got an outfit that he was coming home in, and it's like, you know 'Born in 2016'. But I'm taking his (hospital identity) bracelets off him; social services said I could"* (Lola, G2, P1).

Lola knew that separation would be difficult, and she had also seen her friend (Sinead) go through the process, returning to the prison without her baby: *"I'd be fine with my baby, but because he's getting taken it's not going to be fine"*. Lola expressed her need to run away from the situation soon after her baby is removed:

*"I don't want to stay in that room, and I want to get straight back here after he goes"* (Lola, G2, P1).

Susan underplayed her impending birth and separation as: *"a bit scary 'cos I don't want to be without her"*. Although Susan had grown comfortable in the follow-up interviews with me, it was clear that she did not want to discuss the imminent separation from her baby in too much depth:

*"I'm a bit anxious but like I said, I don't want to think about it too much as it's just too much. I cross that bridge when I come to it"* (Susan, G1, P0).

Women's' connectedness with their unborn baby appeared especially strong amongst women who were going to be separated soon after birth (Wismont, 2000; Chambers, 2009): *"I feel like he's communicating with me"; "I'm not going to know him"; "she's still a mover at night and still causing me trouble"; "I call her baby girl...I talk to her"*. It was as if this experience of mothering may be all the women would experience and the moments alone with their unborn became as real and as comforting as if the baby had been born:

*"It's funny, because I put sweets on my belly and I play games and like move him. I do tell him like that I love him and I'm sorry and all that. I wrote two pages for him saying that I'm sorry. But social services have probably put it in the bin"* (Lola, G2, P1).

Abi, who did not know if she had an MBU place, described the struggles with not knowing who would care for her baby:

*"I want it, so I know where my baby's going, If I can't have it the Dad's going to have to have it. I'm not putting pressure on my Mum. I couldn't give my Mum a new born baby"* (Abi, G3, P2).

The reality of separating from the baby was discussed in interviews with five women. Emotions were diverse and individual to each woman. Sylvia and Susan talked about being *"strong"*, whereas Caroline expressed her grief and despair: *"I just want him back"*. Sinead's response was more physical: *"I didn't eat, I didn't sleep"*, whereas Tracey said she was *"heart-broken"*: *"It was devastating leaving him, it broke my heart"*. Tracey also spoke of her anger and how she wanted to run away: *"I wanted to get the fuck out of there"*. Sylvia spoke of her need to gather strength:

*"I did cry, and I was emotional, but I just pulled myself together and just thought, well, I have to be strong and just get on with it. I don't want to be crying all the time and stuff"* (Sylvia, G5, P3).

Women who had separated from their babies described the time they had with their child in hospital. Sinead had given birth 13 days prior to interview: *"It's horrible, because I should be waking up to my daughter and I'm not, I'm waking up to a door"*. Sinead also spoke of her physical relationship with food in relation to her feelings of loss: *"Some of the food that I craved with her, I can't eat it now because, it just makes me cry"*:

*"I cried when I saw her...I thought that she wouldn't know who I was, but she was really calm on me, she was grabbing my fingers. I didn't sleep and the only time I put her down was when I went for a shower, because I didn't want to leave her. Apart from that she was never out of my arms. I wouldn't let her out of my arms"* (Sinead, G2, P1 - PP).

Susan described separation from her baby as being: *"really hard"*. However, this was interspersed with acceptance and a knowledge that she would be reunited with her daughter on release:

*"There's nothing I can do about it. I have my moments, I'm upset, but just I'd rather to try and keep myself strong, and yeah, I'm hoping that next week goes really fast, even though I think it's really going to drag"* (Susan, G1, P0 - PP).

Caroline articulated her feelings in a candid way and described intimate moments with her son *"he had his eyes open straightaway and you could see he was like studying my face"*. Caroline's emotions expressed her own grief and empathy about her son's loss of his mother:

*"It's my job to make sure that he's looked after and he's happy, and he's safe and protected, he deserves the best of everything and that's having his mum, that's having me"* (Caroline, G4, P3 - PP).

A common fear was that the baby would forget his/her mother: *"That's what worries me, that she'll forget who I am"*. Sinead spoke of her wish to avoid pregnant women on return to prison:

*"I walk away because, obviously, it hurts me. I know it sounds nasty, when she goes, 'Oh, he's moving,' and I'm like I don't really care, because that's not fair. Why have you still got your baby inside you, but I haven't mine?"* (Sinead, G2, P1- PP).

#### **f) Degradation of the pregnant prisoner**

Without exception, all participants described their embarrassment and humiliation at being seen in public as a pregnant prisoner. Hospital appointments were an essential and regular occurrence, yet most of the women spoke of being handcuffed or in chains in the maternity department, despite policy suggesting that the handcuffing of pregnant women should be

discretionary<sup>41</sup>. The requirement of handcuffs was due to the potential escape risk, although a common comment was, *“I cannot run anywhere, even if I want to”*. One woman articulated the shame of being handcuffed while pregnant as *“worse than being sentenced”*. Overwhelmingly, all pregnant women in this sample described the experience of being handcuffed as humiliating: *“just horrible”*; *“dead humiliating”*; *“such a degrading experience”*; *“so embarrassing”*; *“so demeaning”*; *“wasn't a nice feeling”*; *“it just feels degrading”*. Sammy described her experience of shame:

*“I was heavily pregnant. I'm quite big...we were cramped in the back (of the car) like sardines. It was just a protocol that nobody can sit in the front, they had to be in the back with me, and I had to be handcuffed at all times. Even through my scans. If there was a female officer, then I had to stay handcuffed to her; but if it was two male officers, then I had to be put on the chains. Just because I'm a prisoner. It was awful...It was demeaning, it really was”* (Sammy, G2, P1).

Despite being afforded no special treatment in general, women were commonly described as: *“pregnant prisoners”*, rather than either just ‘pregnant’ or just ‘a prisoner’. Caroline explained how her identity as pregnant prisoner was labelled on the front of her notes, yet during her scan she was required to expose her body in front of a male PO:

*“It's upsetting having a male officer there because I think the first man to see my baby should be the father, on my second scan I saw on the top of my notes “prisoner pregnant, female officers only” and they'd ignored that...I had to go on the monitor for half an hour and it was the same experience, they had to take my top off and sit about that far away (gestures a small distance with her hands) from me”* (Caroline, G4, P3).

Caroline talked about her experience of being handcuffed and chained to male officers at a subsequent hospital visit, when she had been transferred as an emergency in her 39<sup>th</sup> week of pregnancy; she felt it was a personal violation and especially upsetting:

*“I know they have got procedures to follow, but it wasn't even like the short handcuffs, it was the ones with long chains on which are heavy, and I was*

---

<sup>41</sup> ‘Pregnant women are not handcuffed after arrival at a hospital or clinic as published protocol. Women in active labour are not handcuffed either en-route to, or while in, hospital. Restraints are to be carried but not applied unless the woman's behaviour is refractory or there are indications that she may attempt to escape’ (PSO 4800).

*handcuffed to the man officer and he had to be asked every time they wanted to examine me to go out...But he stayed in the room the whole time”* (Caroline, G4, P3).

The stigma of being marked as a prisoner was keenly felt when, in Prison A, a new system of arm bands to identify prisoners was brought in. Women felt the frustration of being dehumanised, and being characterised exclusively as a prisoner: *“I want them to know me as a person”*. I had met Susan many times in prison for interviews and the armband made her angrier than I had ever seen her. Most of this interview was taken up by discussions about the armband (a coloured elasticated 10cm armband with a transparent aperture to hold prison identification) and the tightening of prison controls which left Susan feeling de-humanised:

*“I can't believe I'm being made to wear this armband. It's the first time I've worn it and I feel like an absolute knob. Wearing an armband, like I'm an animal. It's worse enough that you're in prison, and you have to wear an armband; it's just annoying on your arm. But I've been collared once, so I've got to take it with me now everywhere I go, because if I don't...I can get in trouble, yeah. My stupid armband”* (Susan, G1, P0).

Feeling judged in a new identity of pregnant prisoner was felt keenly when visiting hospital for appointments:

*“You've got all the Mums and the Dads, husbands and wives and sitting there holding their precious little bump, and there I am walking in and they just looked at me like I was filth. And it's like, I've just made a mistake, I was stupid; I haven't hurt anybody, I'm a good Mum”* (Sammy, G2, P1).

Most women described how they *“don't get treated like an individual”*; symbolic props which contributed to a sense of dehumanisation in the form of keys, handcuffs and chains served to further strip away their identity and self-worth. For Caroline, being chained to officers unknown to her, who were guarding her during such an intimate event, amplified her feelings of distress and heightened her sense of loneliness at being without her partner. Lola, perceived that the handcuffs gave the officers a feeling of power and control over the woman:

*“Twice a week I was travelling back to my home town, handcuffed, and I would see people that I know. The officers don't, like even try and hide that they're officers. They wear the uniform, and they wear it with pride, like I've*

*got a prisoner'. And you see people looking at you, because of the way that the officers are walking"* (Lola, G2, P1).

Considering the level of restraint and suppression that pregnant women feel, they appeared to be less likely to attempt an escape, especially if this meant jeopardising a place on the MBU. Women would scoff at the concept of their running off, especially in the later stages of pregnancy: *"look at me (gesturing to large abdomen), where am I going to run off to?"*; *"even if I wanted to run off I couldn't"*. Trixie did not understand why the handcuffs were needed, especially as she was wary of the impact any negative behaviour may have on her MBU place:

*"I'm hardly going to escape, because I want to go to the Mother and Baby Unit, and I just want to get my sentence out the way"* (Trixie, G2, P1).

Women who had attended appointments accompanied by officers and in handcuffs, would talk about how the public would look at them: *"it's other people looking at you, judging"*; *"looking at you in a bad way"*; *"for my scans I was handcuffed to an officer, so children were looking at me"*; *"everyone stares at you"*; *"they all literally looked you up and down"*; *"they looked at me like I was filth"*. Layla found the experience of being handcuffed exacerbated her shame:

*"People look at you as if to say, oh, well, she must be really bad, her, if she's got two officers escorting her in handcuffs...you can see that they're moving away from you, and they're pulling their kids away from you and they don't want to be anywhere near you...they assume that you must be some really, really evil, violent person, and you're not you're just somebody that either made a mistake, or was wrongly accused"* (Layla, G2, P1).

It was especially difficult for women when they felt 'judged' in their role as expectant mother, by other parents and children. Sammy, like most women in this study, was sentenced for a non-violent crime. Therefore, she found it hurtful and humiliating to feel judged to be the same as a violent criminal:

*"I do everything for my children, and I still am trying to be as active a mum as I can, so don't look and judge me. That was tough, especially the little children looking like as if I'd killed someone, because I was walking in with the handcuffs, so I must be a really, really bad person"* (Sammy, G2, P1).



Being handcuffed for appointments was something that some women got used to and accepted over time ('institutional shrug'<sup>42</sup>) as part of the experience of being a prisoner. Interestingly, Susan, furious at being made to wear a brightly coloured 'armband', seemed to get used to the idea of handcuffs as her time in prison progressed, as is illustrated over three separate interviews:

**Interview 1.** *"It's a bit embarrassing, being cuffed - they uncuff you when you get to maternity, because there's other pregnant people there that are all anxious. I had to sit in reception handcuffed and everyone, everyone that was coming in and out was just looking down at me."*

**Interview 2.** *"You can't do anything about it (being handcuffed). I was just happy to get an appointment to the hospital. I was told they're not supposed to handcuff you at all, but God knows, they make their own rules up here".*

**Interview 3.** *"Well, people are always going to look, aren't they? But it doesn't, it just doesn't bother me anymore, and, like I said before, people are always going to stare" (Susan, G1, P0).*

All of the women interviewed talked about feeling like: "a number"; "sub-human"; "forgotten"; "just a prisoner"; "categorised" or "marked with the same card". My fieldnotes demonstrate the dehumanising language of prison:

*"The shout of the prison officer, it being 'bang up time'. The noise, clatter, clinks and shouts of 'behind your doors ladies', making you jump no matter how many times you hear it said. Being called 'Miss' is not normal for me, I ask women to call me by my name" (Fieldnotes, December 2015).*

Women described their treatment by officers as lacking humanity; however, this contrasted with the staff view that they believed they were treating the women with care: "how can you not care?" The often used label, "the pregnant", "a pregnant" or simply "pregnants" in Prisons A and B contrasted with the sanitised label of "our pregnant residents" in Prison C, which considered the women more as guests than prisoners. The way officers treated women varied and women valued being "treated like a human being":

---

<sup>42</sup> An 'institutional shrug' defines the phenomenon of how some women may adapt their identity from the initial dismay of becoming a prisoner, into a sense of resignation and institutionalised indifference over the passage of time.

*“There were quite a lot of officers there that were really nice and could speak to you like a normal human being. They didn't look at your paperwork and see, 'Oh, well, this person's in for that, so she must be this,' they talked to you as a normal human being. Whereas other people just saw your conviction and that was that, they talk to you like crap, and they treated you like crap, they just saw you as a number; you weren't a person,”* (Pamola, G1, P0).

For most participants, thinking about the lack of privacy, especially when contemplating being in labour, or having a growing abdomen, added to their sense of degradation. Assuming strangers would be at the birth epitomised the lack of privacy, dignity and anticipatory fear that women felt:

*“There is no privacy. Nothing. Even my space, so officers can come into my room at any time. If they decide they want to unlock the door to come in for a reason to...I'm used to it; I don't like it, but I'm used to it”* (Caroline, G4, P3).

Caroline's acceptance, of being 'used to' such invasion of privacy, juxtaposed with the fear of labouring in the presence of strangers, typified the uncertainty and ambiguity which many of the pregnant women felt about their prison experience. Women would often express the most indignity and anger when asked in interview about their treatment as pregnant women. Feeling “*sub-human*” led some women to worry about labour and birth, amid fears of not being heard or cared for when relying on officers. The ambivalence expressed by Trixie, not wanting to be cared for yet feeling that it was the duty of staff to care, was expressed:

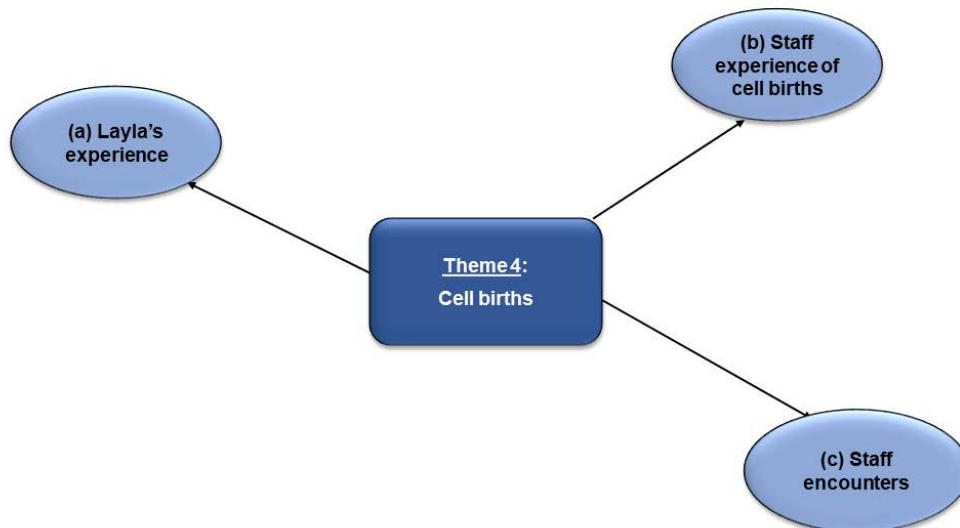
*“I don't really want them to care, but as a human being you should at least have a little bit of concern about a pregnant woman, considering it's your job, every officer has a duty of care for a prisoner”* (Trixie, G2, P1).

Ambivalence shown towards prisoners by staff was normal yet if a woman is showing signs of labour, a normal human response in the community would be to get appropriate help. In mainstream society pregnancy is respected as a 'special social category' (Balin, 1988). However, for pregnant women in prison it appeared that there was a disregard for the unique status of mother to be. When Layla went into spontaneous labour in prison she felt her status as a prisoner meant that “*nobody was listening*”. Being handcuffed and placed in chains, or being strip searched by female officers, as Cleo experienced on return from hospital - “*they*

*made me shake out my pad...and squat*” - were especially dehumanising experiences. Tammie described her experience of being sentenced to prison three weeks after having birthed her son as being treated worse than an animal: *“Even animals are treated better”*. Animal metaphors were common expressions used in relation to the prison experience; the pain of separation for Tammie elicited a response which indicated that the system considered her baby as an animal, too: *“animals get six weeks with their Mum before they are taken, my baby only got three weeks with me”*.

#### 4.4 Cell births:

*“I haven't got time to get to hospital. I did say to you I was in labour”*.



Most disturbingly, Layla had given birth in her cell without midwifery care, and she described her experience while I audio-recorded. Eight staff members had anecdotes relating to births that had happened inside prison, their having been present either at a birth or shortly afterwards. Another staff member described a birth she had witnessed in a cell. No staff in Prisons A or B had specialist training in emergency births. In Prison C, there had been training for MBU staff. Layla’s testimony highlights the ‘institutional ignominy’ (see Discussion Chapter 5) and ‘institutional thoughtlessness’ (Crawley, 2005) of a woman going into labour and birthing her baby inside her prison cell. Staff portray their experiences of childbirth inside prison and my field notes support other conversations with informants. Layla’s distress as her labour progresses to the birth of her child in a prison cell at night reveals alarming and inappropriate behaviour on the part of the staff.

### a) Layla's story

I interviewed Layla in Prison C's MBU eight months after she had given birth. She told me she was 24 weeks' pregnant with her second child when she was sentenced and incarcerated in Prison B. Layla's baby had been lying in breech<sup>43</sup> position and she told me that her daughter was eventually born foot first in her prison cell at 36 weeks' gestation. The following describes her experiences, from Reception into prison to the birth of her daughter. Similar to 76% of the women in this study, Layla was incarcerated for the first time for her very first offence. Similar to most participants, she was distressed as she entered prison, was unaware of her rights and entitlements and did not know what would happen with regards to her midwifery care: *"I didn't know whether I was going to see a midwife, I didn't know anything. I was absolutely distraught"*. Layla was unaware of the process of applying for a place on an MBU: *"None of the officers spoke to me about it (MBU), I just had to go off and do it all myself"*. Layla was classed as a 'high-risk' prisoner and therefore had a single cell on her own. She found out some information from other prisoners but had received no official orientation to the prison. Layla believes the stress of the environment caused her to go into labour earlier than expected: *"She was three and a half weeks early, so I think that stress affected me quite a lot"*. Layla told me she had lost her 'mucous plug'<sup>44</sup> and was sent to health care where she saw a nurse: *"Health care were like, 'Oh, you're fine, you've got at least another seven to ten days before anything will happen"*. She was concerned as, in her previous pregnancy, losing her mucous plug signalled the start of labour: *"I was trying to explain this to health care, they were just like, 'No, don't worry about it,' and I was like, 'No, really, I know my own body"*. Layla was especially worried as she had experienced a very quick labour before and she believed she needed to go into hospital *"now"*. Expressing to staff that she knew her own body was met with indifference: *"They were like, 'Yeah, yeah, we'll sort that out when and if you go into labour"*. Layla told me that she started to have contractions at around 23.00 that night, and by midnight they were getting stronger and a nurse came to her cell:

*"I said to the nurses, I says, 'I think I am actually in labour,' and they were going, 'Mm, well, I'm not sure. Just lie down and we'll check and see if your stomach's contracting'. So, I lay down on the bed, and they're like, 'No, your*

---

<sup>43</sup> Breech position is where the baby is presenting bottom first.

<sup>44</sup> A mucous plug or 'show', formed by a small amount of cervical mucus, fills and seals the cervix during pregnancy. Losing the plug can indicate the onset of labour.

*stomach is not contracting, you're not in labour, it's Braxton Hicks<sup>45</sup>, you're in for a really, really long night”.*

Layla’s testimony suggests that the nursing staff had made assessments outside of their sphere of practice and made decisions that they were not qualified to make (NMC Code, 2015). However, being told she was not in labour, Layla accepted her position of powerless prisoner, rather than labouring woman: *“I'm telling you I am in labour,' 'No, you're not. Here's some paracetamol and a cup of tea”.* Layla said the nurses left her at 00.30, but within ten minutes she rang her bell again as her waters had broken. Layla describes the nurses as being in *“absolute panic”* saying, *“We need to get an ambulance, we need to get her to hospital! I says, 'I haven't got time to get to hospital. I did say to you I was in labour”.* Layla described how she gave birth to her daughter, who was presenting as a footling breech<sup>46</sup> and was therefore at high risk of morbidity:

*“I was laid there on my bed, in my cell with a male nurse and a female nurse, not midwifery trained at all, trying to put gas and air in my mouth and I'm like, 'I don't want anything, I need to feel awake and I need to concentrate,' and then out popped (baby) at twenty past one. Still no ambulance, still no paramedics and she came out foot first”.*

Layla was distressed during the interview and she cried through much of it. She relayed her experience and told me that she felt disempowered because: *“Nobody was listening”.* Layla expressed concern and exasperation that there were no appropriately trained personnel:

*“These (nurses) were not even trained in that field whatsoever...telling me that I wasn't in labour, so I ended up having (baby) in my cell. The male nurse wasn't allowed to be in there, so I had one nurse that was telling me what I should and shouldn't be doing”.*

Layla told me she remained confused about what had happened to her, stating: *“I just want to know what happened”.* No plans had been activated for a place on an MBU and therefore Layla was left not knowing whether or not she would be able to keep her baby: *“not knowing whether I would have to hand (baby) out or if she was coming back with me”.* This lack of knowing meant

---

<sup>45</sup> Braxton Hicks is a term used to describe the irregular tightening of the uterine muscles; it is not associated with labour contractions but can feel uncomfortable in the latter weeks of pregnancy.

<sup>46</sup> Footling breech is when one or both of baby’s feet are born first.

that Layla did not know what she should do about feeding: *“To sit there not knowing whether to breastfeed or not breastfeed? Is she staying with me, she isn't staying with me?”* The new-born baby was transferred with Layla from prison, via ambulance, to the local hospital but she had no provisions for the baby:

*“I had nothing for her, no clothes, no nappies, because I was still in the main jail, and I wasn't allowed any baby stuff in. It was September - freezing - so I had to just wrap her up in clothes, completely naked underneath my nightie. She had nothing”.*

Layla was unable to debrief with anyone about her labour experience; she was told by staff that they had been worried that both Layla and the baby may have died but without explaining why: *“He told me: 'Oh, we could have lost both of you,' but to not explain was awful, absolutely traumatic”.* Layla relayed her experience to me in some distress. Outside of the interview, I took on an advocacy role and offered to refer her to the MBU staff and health visiting team for debriefing of her birth experience, which Layla accepted.

#### **b) Staff experiences of cell births**

Corroborating Layla's story, a prison officer in Prison B spoke in interview about Layla's experience:

*“Layla, who used to be here was shoved on the biggest, noisiest wing. She was like eight months pregnant, and she was supposed to be moved up here (MBU). I think she got to about 34 weeks and she ended up going into labour, and they didn't listen to her, didn't listen when she was saying, 'I think I need to go to hospital, I think the baby's coming,' and she ended up giving birth in her cell” (PO B).*

The prison officer recognised that Layla had not been listened to and showed empathy when describing her situation: *“how uncomfortable would that have been?”*. The PO talked about the prison system's shortcomings:

*“That was a complete failing in the prison system, because she should have been moved up here (MBU) prior to that, had she have been up here, they would have phoned an ambulance and she would have got to hospital. But down there they don't listen to you; not interested” (PO B).*

We discussed health care and I asked about midwifery support in prison:

*“No, there’s no midwife. Health care, obviously, you’ve just got nurses, there’s no doctors on a night time here, it’s just nurses that are here. So, no one was trained in delivering a baby. She’s just lucky. They’re lucky, should I say, that nothing happened, they’re just really lucky” (PO B).*

Layla’s experience of labour and birth was extraordinary. However, her testament suggests that staff were working outside of their sphere of practice and experience. Although Layla was the only woman interviewed for this research who had birthed inside of prison, several members of staff had experience of women labouring and giving birth in prison: *“we don’t have mobile phones in the prison, so a mobile phone was brought down for (the nurse) to ring to be talked through delivering the baby”*; *“you’re delivering a baby and you don’t know whether that baby is going to be breathing”*; *“in hindsight, thinking back now, it’s sad, as a Mum, and she’s just given birth and she’ll never have that moment back again”*; *“We all panic, and hope it’s a good nurse that’s on”*; *“We were like: ‘We’ve got a baby in prison!’ ...and we didn’t know what to do”*. Staff decisions about the progress of a woman’s labour is further demonstrated by a prison officer’s observations of a nurse’s assessment:

*“They opened her door and gone in and she was like, ‘I’m in labour’. The nurse went, ‘You don’t look like you’re in labour,’ because apparently, she looked quite normal, she wasn’t screaming by this point with no pain relief, and she was, ‘And then the next thing I turned around and baby was nearly there’ ” (PO A).*

One member of the health team told me about a birth that had happened in Prison A, where she, a male nurse and a prison officer were present. The following describes her experience of witnessing a prison birth: *“I went across and timed her, and I think she was about every seven or eight minutes”*. They had called an ambulance; however, the baby was coming quickly:

*“She just stood up and she just took off her leggings and I looked down and she’d - is it crowned? - baby’s head was just there...we kind of knew immediately then that that baby was going to be coming, and there was still no ambulance” (HC A).*

She told me they were trying to keep the woman calm but there was some confusion about mobile phones and who to call for support and guidance. This birth in prison had caused staff anxieties leading to feelings of panic. Most of the health worker’s remarks focused on staff

feelings and the fact that they had successfully delivered the woman of her baby. She told me about when the baby was born, and the emotions felt by staff:

*“The nurse delivered, and I grabbed the baby with a towel and started rubbing his back; I twisted him over and just cleared his mouth, and he just let out this little cry. It was amazing! There were three of us in that room and we all had a tear; I think it was more adrenalin and fear, I think it was just tears of relief and, huh, we've done it! We've done it! Yeah, it was amazing”!*  
(HC A).

Prison officers described their empathy for their colleagues when births in prison occurred: *“It was a scary one walking in”*; *“touch wood, I have never actually had to be involved”*; *“that's quite scary for staff”*; *“the head was coming so there was nothing that he could do”*; *“It must have been awful for night staff”*. In Prison C, staff did receive childbirth training: *“All the mother and baby staff have childbirth training, and there should always be a trained member of mother and baby staff on duty”*. In all three prisons there appeared to be no knowledge that the nurses were acting outside of their normal spheres of practice as health staff or officers, or that a Registered Nurse is not permitted to act as if a Registered Midwife. Some of the staff talked about their lack of training: *“I suppose just your normal first aid”*; *“the ambulance service is generally on the phone with them all the time talking them through it”*; *“Apart from one birth, we've always got the ladies out”*.

When a woman in labour needs to be transferred to the hospital from a closed prison, prison protocol usually means that two members of staff will accompany her. Staff described the usual circumstances when a woman goes into labour: *“They just jack up the escort as quick as they can”*; *“hopefully they just don't have them here”*; *“We do try our hardest to get them out before they do”*. Prison protocol states that a paramedic ambulance is to be called if a woman is in established labour: *“I think our response for an emergency is meant to be seven minutes”*. I asked the midwife who ran the antenatal clinics for her opinions and experience of prison births. She described a recent birth as *“a bit of a bodge-up”*; she spoke of the unavailability of fast or precipitous<sup>47</sup> labours in prison, but expressed surprise that the nursing staff in this case had not contacted the hospital to speak to a midwife: *“And this poor baby was born before the ambulance was here, but they hadn't contacted assessment unit”*. Many study participants had spoken about their concerns about labouring in prison and getting to the hospital in time: *“there's no midwife”*; *“I don't want him born in a prison”*; *“you've just got nurses”*; *“there's no doctors on a*

---

<sup>47</sup> 'Precipitous' or 'fast labour' is defined when the baby is born in less than three hours from commencement of labour.



*night time here”; “no one was trained in delivering a baby”; “the last thing I want is this on the birth certificate”. Other prisoners spoke about the experience of babies being born in the prison: “they didn't listen to her, when she was saying, ‘I think the baby's coming,’ and she ended up giving birth in her cell”, “it was really quiet, and then we just heard this little baby's cry”. Whilst undertaking this study, a birth occurred in Prison B during the week I was meant to be undertaking fieldwork there, but where my entry to the prison had been refused. In an interview with a PO, I was told:*

*“There was a lady at (Prison B) went to the toilet the other week and had her baby” (PO C).*

### **c) Staff encounters**

Staff were often unsure about the rights and entitlements of pregnant women: *“there could be more, I'm not sure”; “I know that we'd have to do an F35 for the kitchens for the pregnant ones”; “They do get the extra milk and fruit, I think”; “Clothes are a big issue for pregnant women”; “IEPs (incentives and earned privileges) are written for men and taken on by the female estate and did not consider women, especially not pregnant women”. Prison officers and health staff in all prisons recognised that they did not always know what pregnant women were entitled to but were cognisant that the prison system made it difficult for pregnant women, too:*

*“Things like clothing are a big issue. The IEP system policy only allows so many kit changes and catalogue providers do not provide maternity wear or bras and women cannot afford to buy the expensive bras needed” (PO A).*

Maternity clothes were something that women were to buy for themselves but often the prison catalogues did not have maternity wear to purchase:

*“I think they can purchase things like that (maternity clothes and bras) for themselves, if they've got money. If they haven't got money and there really isn't any way of getting anything like that, then they're issued with prison-issue clothes anyway, so they'd just go bigger sizes. You know, the jogging bottoms and T-shirts and things like that” (PO B).*

Staff would largely display empathy towards women, especially those that they seemed to like. The pregnant women elicited empathy; however, the common expression of *“leaving it at the gatehouse, just inside the gate with my keys”* was a metaphor often used for not taking emotions home and was a way of staff coping with their own suppressed emotions. An emotional response by staff to a baby being born unexpectedly in prison was: *“we all had a tear”*. Staff were often

sympathetic towards pregnant women, new mothers and separating women: *"I think that's got to be hard for the mum, really, hasn't it?"; "I can't imagine what it must be like to come to prison pregnant or with a young baby"; "having the uncertainty of not knowing when you have that baby where it's going to go"; "you can't just go out and get in the car, get on a bus, pick a phone up, it's awful".* Staff who had been pregnant themselves would often display compassion: *"It's just sad, isn't it? It's - I think more so since I've been pregnant myself"; "I don't think I treat the women any different, I feel differently about them, I think, is probably the right way of saying it"; "I can empathise far better now".* Some prison staff were concerned that they were perceived as uncaring: *"People think that because we're prison officers, we don't care".*

*"If they've got no family, no family support and all they've got is a uniformed member of staff stood at the side of them holding their hand, I think it must be so distressing for the mum to go through that on her own, without that family support and to be with us" (PO B).*

Staff described how women blocked emotions, especially when separating from their babies in the post-natal period: *"It's grief, really, isn't it?":*

*"They do go in on themselves, and they'll speak to you, but it's more of just a general thing. I think talking about it for some people can be quite distressing. Yeah, I think that's what they try and do, to block it out so it's not happened, so then they can really just get on" (PO B).*

Staff recognised the sense of distress and frustration especially when women unexpectedly find out that they are pregnant during their initial prison health screening: *"it's a huge shock to them, and they are angry and distressed and distraught".* The women who have been in prison before occasion empathy from staff because they are in a new position:

*"It's a whole new situation to be in. They've probably been in prison before, not being pregnant, but then to come in and suddenly find that you're pregnant, that you didn't know about, it's ten times worse" (Midwife).*

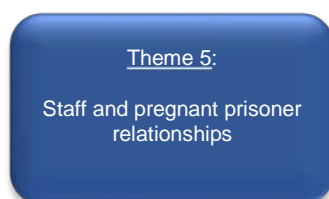
Emotional support for pregnant women in Prisons B and C was delivered via the MBU: specialist officers supported women in Prison A. The recognition that repressed emotion was a pathway to post-natal mental illness was familiar to staff; however, their role in supporting the women was ill-defined:

*“I think it might be useful to maybe look at what else can be done. Some women want officer support, some women seem to just cope with it quite well, some women have had a couple of babies taken off them already, some women it's the first time and they don't want to speak to other people about it, they just want to deal with it in their own way” (PO B).*

The emotional side of being prison staff when a woman was separating from her baby was acknowledged as being: *“incredibly hard”*, *“I don't think people realise just how emotional it is for the staff”*; *“I think they would benefit from some form of counselling”*. The understanding that staff needed emotional support when undertaking this challenging work was an important way of acknowledging the emotion work that goes into being a prison officer or member of health care staff when working with pregnant and post-natal women.

#### **4.5 Staff and pregnant prisoner relationships**

*“Everybody loves to see babies, don't they, but there's no training for it and there's no training for dealing with a separation either.”*



The relationships between pregnant women and staff mirrored findings from the criminology literature where characteristics and personalities of prison officers were intrinsic to the prison experience (Crawley, 2004; Liebling, 2011; Arnold, 2016). Most of the pregnant women would talk about specific members of staff, from describing them as *“a laugh”*; *“going the extra mile”*; to *“evil”* or a *“complete bitch”*. There were favoured members of staff and these were often the ones who were chosen to be on a rota to escort pregnant women in labour. ‘Turning a blind eye’ to some contraventions from women following birth was a common occurrence, as women were allowed an *“extra photograph”* or even a *“MacDonalds”*. Some staff would state that they would treat the *“women like I want to be treated”*; however, this often depended upon the severity of the crime that had been committed. Health staff were reported to be more judgemental, more demeaning and less sympathetic to the pregnant prisoner. I occasionally found that when I voiced sympathy towards women, I was perceived as naïve by health staff and prison officers, and I was once met with a sharp reminder: *“you would not be so sympathetic if you knew her crime”*. Staff held varying views on the pregnant women, and relationships were often dependent on how acquiescent the women were:

*“staff will go an extra mile always”; “People think that because we’re a guard, we don’t care, but how can you not care?”* However, the language used by staff contrasted with the sentiment of *“giving women opportunities”* when they labelled them as *“the pregnant”*. Labels are meant to differentiate different prisoners but also serve to further strip their personal identities. Nonetheless, it was clear that those staff interviewed were dedicated to their jobs and to the women: *“it’s a measure of how well you are, how well you treat your prisoners”*; yet the fine balance in a relationship was recognised as not going beyond a prisoner/staff relationship:

*“Because these aren’t really relationships, they aren’t people that you’ve chosen to be with. Because next week when you’re at home, these people won’t mean a thing to you; you will have forgotten all about them. It’s not like if you get upset with your best friend, because they’re being rude to you and that kind of lives with you, doesn’t it?”* (PO C).

Women reported that they could often request specific officers to accompany them in labour, suggesting a new typology of Prison Officer: *‘a maternal’*. When accompanied by a supportive officer of their choosing, women had a better experience of labour and birth, and often talked in glowing terms of their accompanying officer: *“she was lovely”; “really caring”; “he was ace”*. Staff, too, found the experience of supporting women in labour rewarding, albeit emotional: *“everybody loves to see babies”; “I’ve had my fingers squeezed”*; however, no training was in place to prepare them for the emotional support needed to be given when babies were separated from their mothers. Women’s opinions on staff varied from negative descriptions: *“a bitch”; “disrespectful”; “I’m spoken to like shit”; “do like sneaky things”; “a lot of favouritism”; “they make the rules, so it’s what they say goes”; “officers treating you like shite”; “they are just the same as us, nobodies locking these doors”*. Positive descriptors were less common and mainly came from those who had been released from prison: *“the officers and the prisoners (on the MBU) were really close”; “she was all lovely and she come (sic) and held the baby”; “the officers would listen to the prisoners”*. Most participants talked about one particular officer who would treat women poorly, as Kayleigh illustrates:

*“They don’t care! Why? Because we’re criminals. There’s one officer who I don’t like. I don’t want to sound horrible when I say this - I’m trying to find a nice word - she’s a bit much. She’s a bitch! A bit much of a bitch. It’s one of them kind of if I wasn’t a criminal and we were both on the outside, I would have beat her up”* (Kayleigh, G2, P1).

The restraint shown by women like Kayleigh when faced with staff who, in her view, were ‘disrespectful’ enhanced the strain of the prison experience. Preferentialism was also commonly experienced:

*“There is so much favouritism. The girl next door gets so much more than me. She even gets more money than me and has a fridge in her room. The other girl who is next door is also favoured by one of the officers and that is why she gets everything” (Trixie, G2, P1).*

Although women’s experiences of distinct types of staff are common in the criminology literature, for pregnant women the impact of being treated in a punitive way made them feel like *“just a prisoner”* rather than a *“pregnant prisoner”*. It was as if some officers went the other way around in not showing ‘special treatment’; that women were treated worse by them *because* of being pregnant: *“like I am beneath her”*; *“looking down their nose”*; *“they treat you like you’re a piece of dirt”*; *“you’re just a number, you’re just a name, you’re not a person”*. Nevertheless, the difference was striking in Prison C (an open prison), compared to prisons A and B (closed prisons), as women were called ‘residents’ rather than ‘prisoners’. The positive label of ‘guest’ rather than ‘prisoner’ seemed to impact on both staff and women. However, it was noted by Ellie that staff moving from closed to open prison had difficulty adjusting to this:

*“The ones that have been here a while know they just treat you as a resident, as an equal and they’re really supportive. The majority of the ones (POs) from closed prison, they’re still a little bit like, when you’re in prison you will do as you’re told, you know what I mean? Maybe being judgemental, but that in closed prison you’re doing as you’re told, and it can be a bit like that some of them” (Ellie, G4, P3).*

The choice of language used by officers and health staff whilst chatting in the coffee room or around the prison exposed both humane and dehumanising forces at work. Bias is acknowledged here as those staff agreeing to be interviewed may have been from a generally more helpful and caring group. However, their views were valuable in distinguishing the pregnancy experience between prisoners and staff. Sammy reflected upon the reasons she thought why some staff would treat women as sub-human:

*“I used to say there were certain officers there that you could tell they were bullied at school. Yeah, so now they’re in charge of other people’s lives, it’s them like sort of getting their own back. I used to say that quite a lot, you could tell they were bullied at school” (Sammy, G2, P1).*

Staff would describe how they treated prisoners in general and demonstrate empathy with their position, which reflects previous research on prison officer typology (Crewe et al., 2015; Price & Liebling, 1998):

*"I think as soon as you think they're just people, they're people, so I treat them how I would want to be treated in the same position, and I think that that can go a long way" (PO C).*

In Prison C, the open conditions appeared to encourage staff to humanise 'residents' so that they felt more like individuals: *"there is an officer on my wing called Mr X and he is really nice. He'll do anything for anybody"*:

*"We have staff working alone with residents in all kinds of different areas in this prison, so we expect all the staff to behave in a professional and appropriate way" (PO C).*

Several women spoke about requesting POs they trusted and had built a relationship with to accompany them on 'bed watch' when they went into labour: *'It depends who's on'; 'I've got preferred officers'; 'I've made a list of the officers who I would like to be there'*. Women would choose staff who they felt were the most caring:

*"You can choose an officer from here, and I've chose...I've chosen Miss B, because she's lovely" (Krystal, G1, P0).*

Whilst most women could have their choices, some did not:

*"First, they were saying I could make a list of officers that I would like to, officers that I get on with, but they can't make any guarantees, but whoever's on that shift and if they're on they could be my prison escort when I go into labour. So, I did the list, submitted it and then I got a message back saying, 'No, whoever you get you get' basically" (Caroline, G4, P3).*

Susan spoke of having continuity of care with one of the officers who had accompanied her to scans and who she wanted with her in labour:

*"She's been to all of my scans as well so it's quite nice, so she saw me like grow from like literally the first and then she saw my scan, so it would be nice as I am really relaxed with her, so it would be nice to get her. But obviously, I can't, I can't choose when" (Susan, G1, P0).*

Several participants spoke of staff with really high regard, having had a positive experience. It appeared that sometimes the PO took on a maternal role as they supported women in labour: *“The officers were brilliant, they were holding my hand and everything”*; *“Some officers actually booked time off work to arrange to be at the birth and were just amazing”*. The support shown by some officers seemed to be extraordinary and full of compassion, making women feel valued and cared for. On the other hand, some women had mixed experiences:

*“The first was a bit of an arse. I don't know whether she was detached or what, but she just wasn't nice. In the end, I had my personal officer, but he left the room when I was ready to push. He's a star, I think he's ace, me. And Miss, I'd never met her before, but she was really lovely, really kind, really supportive, held my hand, everything”* (Ellie, G4, P3).

Staff talked warmly of supporting women in labour, but admitted to not having had the training or support they needed for themselves, especially when women were separating from their babies soon after birth. Some described their relationships and role with women in labour as: *“talking and trying to keep the person calm”*; *“supporting them and encouraging them”*. Nonetheless, the role of birth supporter was carried out more through instinct, than through having a given specialist role:

*“Quite a lot of us like doing it, because you get to see a baby, or you get to see a birth. But there's quite a lot of us that won't do it now, because I think if you know that they're being separated it's not a nice thing. In fact, everybody loves to see babies, don't they, but there's no training for it and there's no training for dealing with a separation either”* (PO B).

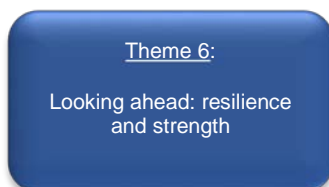
Staff would sometimes feel ‘awkward’ at being in the room with a labouring woman:

*“You also try and blend in the background a bit because you're aware that the midwives are thinking, 'Oh, the prison officers stood there,' and stuff. So, it must be traumatic enough giving birth, without the knowledge that someone, well, they might not even know”* (PO A).

Being able to choose their accompanying officers alleviated some anxieties for the women, even contributing to more positive experiences of labour. Conversely, some women felt they were treated more harshly as pregnant women *because* they were pregnant, although it is unclear whether this is due to self-perception of their own stigma and being judged.

## 4.6 Looking ahead: resilience and strength

*“Throughout my whole life I've had struggles, and I've had to survive...so this is just another thing that I've had to go through.”*



The layers of resilience required for the pregnant woman to cope with imprisonment are multifaceted. All participants were asked how they coped with their experience, which gave the women pause for thought. Answers varied with some women saying: *“I’m not”* (Lola), to others meeting the question with a shrug: *“I have no choice”*. Others coped through exercise (Karis), or religious faith (Caroline), or *“counting down the pregnancy weeks”* (Sharon). For those women who were questioned several times throughout their pregnancy, descriptions of coping changed during each interview. For women who had been released, their reflections often focused upon their own inner strength and how they coped. The findings relating to coping are not unique to the criminology literature but what is striking was the extraordinary use of restraint and resilience in order to get by. Receiving letters and reading books as forms of escape was one of the ways of coping: *“letters and photographs”*; *“I’m reading Nelson Mandela”*. Women reflected on their experience of how they coped post-release: *“There was some days where I’d go really downhill where I just felt I couldn’t carry on”*; *“For everything that we went through, or that we did, we all remembered that we are in jail”*. Karis, a ‘safe haven’ woman, had been homeless and using drugs on the outside and was determined to use her experience of being pregnant in prison to change her life and so keep her baby. Her way of coping was through the discovery of the Harry Potter books, and exercise in prison:

*“Reading and exercise are the best things ever, reading, you forget that you’re even in prison you know...I was in Harry Potter world for ages ... crying when Dumbledore died”* (Karis, G6, P3).

Several women spoke about positivity being a necessity rather than a choice for the sake of their unborn baby, whether a woman was being separated or not: *“have to make it positive because I don’t want to be stressed because it will make the baby stressed”*; *“I just need to think about my baby inside of me”*. Several women worked until the very late stages of their pregnancy; but for some, work was a way of passing time and coping, and meant that they could socialise and avoid being locked up for hours on end: *“I work, it gets me out of my cell”*; *“Luckily they have given me a job in textiles”*; *“I worked in the gym until about two weeks before I had him”*. Several women talked



about the strength they gained in knowing that their family was there for them, and that they needed to cope for the sake of their children on the outside: *"I have a phone call to my partner every day, so that makes me happy"; "once I have my last visit that's a month done"; "I cope because I still see the kids; if I didn't see the kids I don't think I'd cope"; "my mum, or my sisters and my brothers. I think without them I'd be a wreck"; "you get through it, you've got to for the kids"; "the only thing that keeps me going in here is my kids"*. Thinking of deceased family members as 'angels' were ways of coping for some pregnant women, like Trixie, to cope: *"I lost my mum so I'm sure to God I can cope with this"*. Trixie's mother had died suddenly when she was a teenager, and she would tell me about how she believed her mother was with her in a spiritual sense. At each interview, Trixie would bring a photograph of her mother to show me:

*"I feel I'm strong, because I just keep my mum close to my heart... I'm going to make her proud by getting through it... It's not about trying to like act strong, it's when you are strong you like to just not think you're that strong, and just get on with it. Because then, when I'm at a good place, and I can look back, I'll know how strong I've been"* (Trixie, G2, P1).

Some women would find ways to maintain wellness in prison as a reaction to their pregnancy: *"I'll make a fruit salad with all my fruits"*. Karis used her experience of prison to prove that she could be a mother and demonstrated her tenacity while she used the environment to her advantage to ensure her optimal health:

*"I managed to get a job in the gym, you know I was exercising even though I was pregnant. I had salad, I was known for it, salad every single day, my friends in the kitchen would, you know - bring me an extra piece of chicken to put with the salad, that's why I got a job in the gym as well, the cross trainer was my best friend"* (Karis, G6, P3).

Achieving small goals and breaking down the days and weeks of a prison sentence were ways of coping and acceptance for several participants as their pregnancies progressed: *"I found that I had to break things down and give myself little targets, and then that way, once you achieve them it's a lot more, it's a lot easier"; "just thinking and putting my mind in the right frame of mind to just get on with what I need to do"*. A way of coping for some women was looking to the future, often with thoughts of using their experience constructively: *"people need to understand you need to have yourself, you need to, because you need that strength all the way throughout life"; "I want to do counselling for young offenders, or something in that area"*. Some suggested their coping was because they were women, and were therefore innate survivors with internal strength: *"I don't know how I did it but as a woman I did"*. Being strong and finding an inner forte was commonly described

when asked how they approached coping with being pregnant in prison: *“keep myself strong”*; *“being weak is not going to help anything”*; *“I’ll just have to be strong”*; *“I’ll make the most of it and just go out even stronger”*. Pregnancy was seen by some women as a positive coping mechanism, being encapsulated in a private world that no one could penetrate, especially when alone.

The formation of pseudo families in the female prison estate is a common occurrence and is well documented (Carlen & Worrall, 2004; Wulf-Ludden, 2016). Some women found their strength was valued by other prisoners, which reinforced a feeling of self-worth as role models on the wings: *“some of the girls said I was inspirational”*; *“they don’t know how I manage to cope so well”*. Others found the support of other women helpful: *“she’s a big support (pad-mate)”*; *“we play cards and that all the time”*; *“they’re more supportive than the staff”*; *“One of them even made me a mobile for my baby; it’s not the same as having your friends at home but I am grateful”*; *“some of them are really looking out for me”*. For women like Tammie, prison was just another challenging experience in a life full of complexity. Frequently, an intangible force ‘from within’ kept her going:

*“I don’t know, it’s just within. Sometimes I feel like, oh, I can’t take any more, but I have to just keep going, innit? I feel throughout my whole life I’ve had struggles, and I’ve had to survive. I’ve been on my own since 16, and I’ve lived on my own, so I’ve seen a lot and had to go through a lot, so this is just another thing that I’ve had to go through”* (Tammie, PP).

Abi suggested that by looking at those who she perceived in a worse predicament strengthened her ability to cope:

*“I look at other people thinking how are they in that situation? She’s dying (a on her wing woman with cancer) and I’m still here, and I’m still breathing and I’m going to be going home to my kids. That’s what keeps me going as well, and I’m just putting those things in my head. It makes me stronger, instead of breaking”* (Abi, G3, P2).

Others, like Trixie, considered themselves ‘lucky’ and ‘grateful’ for not having a long sentence:

*“I just feel blessed and I just feel lucky to do this short amount of time, and it makes you feel better though in yourself thinking you’re lucky you’re not doing that sentence”* (Trixie, G2, P1).

Women nearing the end of their sentence in an open prison were allowed out on ROTLs:

*“It sounds silly now, but we used to do hair and makeup and we used to have a laugh because I had hidden in myself so long and been in a dark, dingy place and suddenly you’re going out again and you get dressed up and you are getting attention from guys and it is like it’s taken from you, and when you are there it doesn’t feel real” (Jane, G1, P0).*

Caroline was being held on remand<sup>48</sup> while awaiting trial and was facing life imprisonment. At each interview, I asked her about her coping mechanisms. Caroline had told me at the initial interview that: *“my coping mechanism is just getting on with it”*, similar to other women who were finding ways to pass the time. Caroline told me that coping was something she had to do: *“You just have to, I just acclimatise, I think”*. However, as time progressed, Caroline found coping strategies within her Christian faith. which mirrors findings of Maruna et al. (2006) *“Just keep going to chapel, keep going to work, ‘cos it’s just a distraction”*. Initially describing her religion as a distraction, by the third interview, when she was 41 weeks pregnant and anticipating the enforced separation from her baby at birth, Caroline found her spiritual faith had strengthened dramatically:

*“You ask me how I am coping, I ask myself that, I really don’t know, I am just getting through it, I am a religious person as well, so I go to chapel on a Sunday and I think that is getting me through. I don’t know. I’m just in my room; I just read the Bible, it’s just everything’s taken away from you here, everything. I just pray.”*

Caroline’s resilience ebbed and flowed throughout her pregnancy, but she often focused on *“keeping positive”*. Despite knowing she would be separated from her newborn and the anticipatory grief she expressed at each meeting, Caroline was expressing breast milk for her son and was able to draw upon winning *“little battles”* to help her cope with her loss:

*“I’ve got moved upstairs back into my old room... it’s really quiet and you don’t get any of the smoke or anything, any of the noise, it’s really peaceful... So that’s a little positive, and I just, I take the positives wherever I can. And they stopped doing my pregnancy packs, because I wasn’t pregnant anymore...so I’ve had to put like a request in to say, I’m still breastfeeding, and now I get my pregnancy packs... I’m winning the little*

---

<sup>48</sup> Being ‘on remand’ is when a person is detained in prison, often charged with a serious crime but awaiting trial, usually having pleaded ‘not guilty’.

*battles, and so I'm thinking, well, if that can happen I can win this big battle as well"* (Caroline- PP).

For Caroline, anticipating separation was also about foreseeing an inability to cope. The expectation of not coping post-birth was realised, yet Caroline was able to rationalise this by considering the possibility that her post-natal emotions may have been causing feelings of desperation: *"I just feel everything's going against me... I couldn't really imagine what it would feel like"*. Caroline reflected on how she coped with prison during her pregnancy: *"whilst I was pregnant I still had him with me, so even though I knew that I wouldn't have him with me, I still had him at that time"*, yet, blamed her feelings of not being able to cope on being post-natal: *"before I was optimistic and I was - I just thought, well, nothing else bad can happen, but I don't know maybe I'm just postnatal?"* The response from staff to her outward expression of post-partum emotions showed they were concerned she was having thoughts of possible self-harm: *"the officers keep asking me, 'You don't have any thoughts of self-harm, do you?' which I don't, I never would"*. However, Caroline stated that: *"This is the lowest I've ever felt, and I'm the most depressed I've ever felt, but I'm not suicidal"*. The reasons given for not succumbing to suicidal ideation were her children and her new-born baby: *"it's my children that get me through because I always think they need me; I can't do anything like that"*.

Also separated from her baby, Sylvia explains how she was coping with being in prison:

*"I just pulled myself together and just thought, well, I have to be strong and just get on with it. I don't want to be crying all the time and stuff, so I'm just trying to get on with it and then do what I have to do in here and when I get out of here to make a change, so that's what I want to do"* (Sylvia, G5, P3 - PP).

The resilience and strength demonstrated, even when pushed to the limit, is noteworthy and reminiscent of survivors of deep trauma (Greene, 2002; Tec, 2004). Women often came up with their own solutions regarding what should happen about the rights and entitlements of pregnant women: e.g., developing a *"booklet"* to be given on reception to prison:

*"What they're entitled to needs to be made aware and put in a booklet. Because the first day here you're not going to fucking take any notice. Not that you don't want to, it just doesn't sink in, and that booklet to be there for you to read what you are entitled to"* (Ellie, G4, P3).

Another recommendation from women was the provision of clear guidance for prison staff to avoid them giving 'conflicting advice', and ensuring that paperwork was ready to avoid unnecessary separation of mothers from babies:

*"If you are going to send mothers to prison make sure before you send them that the paperwork is in place that their babies are going (to the MBU) with them straightaway"* (Tammie - PP).

Caroline differentiated between the different types of pregnant prisoner and suggested that information about entitlements should be adapted accordingly:

*"...Rights and entitlements, and what to expect. Because there'll be two types of pregnant prisoner: there'll be women who are in prison, pregnant, who have been to prison before, or they'll be like me who's pregnant in prison and never been to prison. So, if you've been to prison before you've got a little bit of an advantage, because you know how prison works. Whereas I was just - I was coming in blind as a prisoner, and as a pregnant prisoner"* (Caroline - PP).

## **Summary of findings**

This chapter embedded narratives of the 28 women and ten members of staff interviewed, and field observations describing interactions and encounters, all revealing the experiences of the pregnant prisoner. Field observations have illustrated the prison setting, describing the sounds, smells, sights and ambiance of the institution. Capturing the atmosphere through description and reflection has given context to the women's experiences as well as presenting the routine minutiae of prison life. The experience of pregnancy is detailed through accounts of women's entry into prison, the environmental impact, their expectations and access to necessities, the deprivations on their health and how they employ strategies to cope. The reality of health care in prison, depictions of indignity, the experience of giving birth in a prison cell and staff/prisoner relationships, are all portrayed. This chapter concludes by looking to the future, with descriptions of how some women manage to cope and accumulate personal resilience.

The following Chapter 5 expands upon these discoveries to reveal four significant concepts, which will be deliberated drawing primarily upon the work of Goffman (Goffman, 1959;1961;1968), Sykes (Sykes,1958) and Laing (Laing, 1960) to contextualise the discussion:

- the concept of 'institutional thoughtlessness' (Crawley, 2005) whereby the system intensifies the pains of imprisonment due to a milieu which negates the normal physiological changes of pregnancy;
- 'institutional ignominy' where feelings of shame experienced by pregnant women in prison are brought about through regular public display;
- the strategies that women use to cope with the prison experience whilst pregnant; and
- the tiers of bureaucracy women are required to negotiate for their rights and entitlements.

---

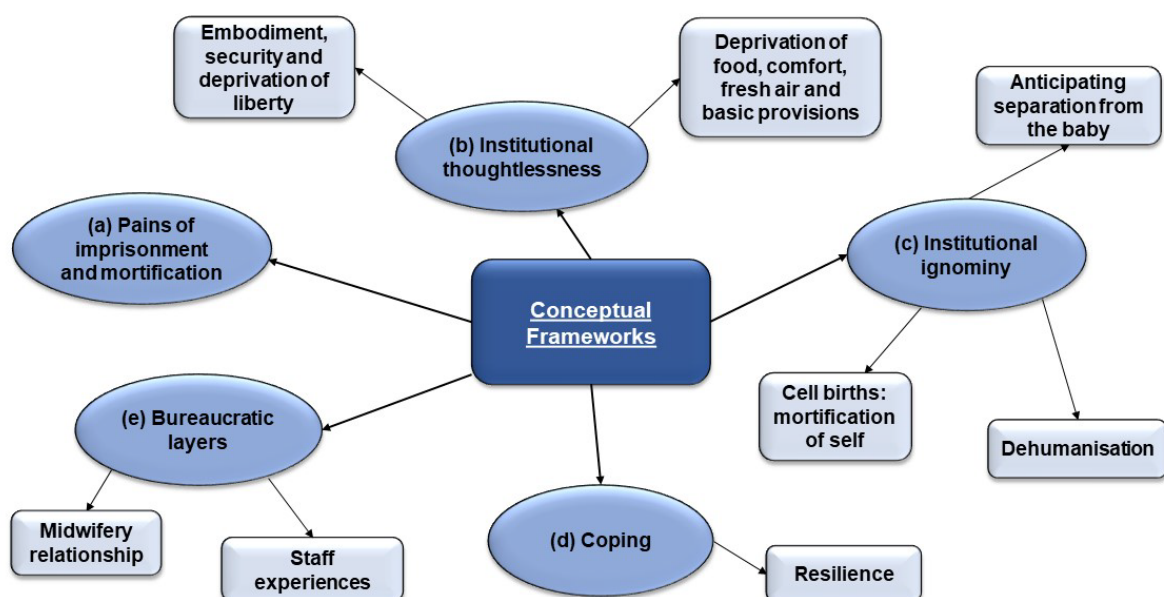
## Chapter 5: Discussion

---

### Introduction

This study has explored the experiences of 28 female prisoners in England who were pregnant, or had recently given birth whilst imprisoned, and ten members of staff; it was undertaken in three English prisons through semi-structured interviews and ethnographic research, over a period of ten months. Thematic analysis of the findings revealed four over-arching themes: echoes of Crawley's concept of 'institutional thoughtlessness' (Crawley, 2005) whereby the system amplifies the pains of imprisonment due to an environment which negates the normal physiological changes of pregnancy; 'institutional ignominy': a process where public display and the existence of institutional symbols of imprisonment bring about feelings of shame; the strategies that women use to cope with the prison experience whilst pregnant; and the 'bureaucratic layers' where women are required to negotiate abrogated rights and entitlements. This Chapter 5 expands upon those themes, analysing what makes the pregnancy experience so unique compared to any other prison encounter, and drawing principally upon the work of Goffman (Goffman, 1959;1961;1968), Sykes (Sykes,1958) and Laing (Laing, 1960) to frame the discussion.

### Conceptual frameworks:



## **Pains of imprisonment and mortification**

The predominant conceptual framework for this study derives from Sykes' (1958) 'pains of imprisonment' and Goffman's (Goffman, 1959;1961;1968) sociological examination of closed institutions, dramaturgy and 'mortification of self'. Sykes' (1958:68) oft-cited 'pains of imprisonment' exposed the deprivations associated with men in prison, encompassing: the loss of goods and services; relationships; autonomy; security and liberty of the prisoner. The present study questioned whether and how these pains were understood and experienced by pregnant prisoners. Criminologists (Crewe et al., 2017) have more recently referred to the 'gendered pains of imprisonment'. Their research on life imprisonment exposed greater implicit understanding of the gender differences among 'lifers'. It appeared that women often experienced greater suffering than men due to childhood abuse, which exacerbated the painful loss of autonomy, relationships and security (ibid).

Goffman's (1959) 'mortification of self', although not specifically related to females, creates echoes in the current study as it usefully illustrates how a pregnant prisoner is given wearable 'marks of shame' (such as handcuffs and arm bands, as well as lactation stains and ill-fitting clothes). The development of the concept of 'institutional ignominy' builds upon Goffman's premise of the process of mortification: the pregnant prisoner revisits the stages of mortification (e.g., entering the institution and being deprived of outside networks) many times as she transitions between prison and hospital during her pregnancy. Goffman's (1959) concept of theatre, with its stage and performers representing life (dramaturgy), guided my thinking of women as 'actors' metaphorically positioned both front and back stage. Women would 'perform' in front of their 'audience', shifting their identity through repression when 'front of stage', hitherto with limited 'backstage' release as rarely without spectators. Goffman's (1961) definitions of prisoners as described by staff, place value judgements on inmates, separating 'them' (prisoners) from 'us' ('normals') and help to explore concepts of dehumanisation, 'othering' and staff/prisoner relationships.

The rites of passage - from pregnant woman to new mother - are common phenomena in midwifery (McCourt, 2009; Walsh, 2011; Reed et al., 2016). However, for pregnant women in prison, these transitional upsets from liberty to imprisonment, from pregnant to non-pregnant, from mother to baby-less mother and, ultimately, from pregnant prisoner to non-pregnant prisoner, are newly found phenomena within distinct liminal phases. Laing's (1960) classical text "*The Divided Self*" has been useful when thinking about the pregnant woman's experience of prison, particularly the notion of ontological insecurity and existential crises in women's identities. The concept of liminality has been useful when considering the pregnant woman in prison whose identity may fluctuate in relation to her experiences and responses to her needs (Van Genneep,1960/2011). Liminality as one of three stages to the acclimatisation of prison life has been used to describe how young men adapt to



incarceration, with some remaining stuck in the liminal phase for considerable lengths of time (Harvey, 2007: 58). However, for the pregnant woman a further layer of complexity is added by having two concurrent liminal states: that of adaptation to prisoner status *and* of adjusting to pregnancy.

### **Institutional thoughtlessness**

*“We all panic, and hope it's a good nurse that's on”.*

The notion of ‘institutional thoughtlessness’ was devised by Crawley (2005) in her study on imprisoned elderly men. She defines it as: *‘the ways in which prison regimes simply roll on with little reference to the needs and sensibilities of the old’*. This perception is easily adapted to the observation of the pregnant woman in prison. These painful deprivations of institutional thoughtlessness impacted daily upon their physical condition, including deficiencies in accessing equivalence of health care, food and nutrition, comfort and clean air. Sykes (1958/2007:68) described the pain of ‘material impoverishment’ under a heading of loss of goods and services, with the provision of the *‘minimum level of consumption for the maintenance of health’*. Although it is a current policy requirement (Niveau, 2007; Ross, 2013; Rogan, 2017), many pregnant women in this study did not receive health care equivalent to pregnant women in the community. Ross et al. (2011) argued that health care blends into prison ‘culture’, with health care staff adopting the prison ‘climate’. This potentially impacts negatively upon the pregnant woman due to her being perceived as part of a homogenous group, rather than as a woman with unique needs. Whilst a community midwife visited the prison most weeks, a lack of planning meant there was no replacement midwife available to provide holiday cover in her absence. It could be argued that if a midwife was a permanent member of prison staff then she, too, could become part of the culture and climate of prison health care, which could impact negatively upon the pregnant woman: however, it was clear that equivalence of care could not be met without planning for alternate cover. In Prison A, three interviewees reported that they did not receive important medication that had been prescribed to them on the outside: Trixie had high blood pressure and had been taking antihypertensive drugs; Kayleigh had been receiving anti-depressants and sleeping tablets for anxiety and insomnia; and Boo needed a regular supply of inhalers to treat her asthma:

*“I've not yet had my aspirin, so I sit worrying...with my high blood pressure. They've sorted out my vitamins, but not my aspirin, like I need my aspirin, like you don't understand, I need it” (Trixie).*

Women who needed midwifery advice had to negotiate with gatekeepers, who made decisions on whether their request warranted referral. For Layla, the effect of being told by health care staff “you

*are not in labour*”, was devastating as she laboured alone in a locked cell until her baby arrived with no qualified midwife or doctor in attendance. It can be argued that an experience such as Layla’s exemplifies suffering in the purest sense in a literal (*labour*), as well as conceptual, way, surpassing all other pains of imprisonment:

*“...I was laid there...in my cell with a male nurse and a female nurse, not midwifery trained at all, trying to put gas and air in my mouth” (Layla).*

Thoughtlessness could be viewed as a protective element for staff who may not wish to really ‘see’ or ‘think about’ or acknowledge the pregnant woman. My field observations of the organisation exposed much in the form of thoughtlessness in a system where the pregnant woman does not ‘fit’ ordinary protocol and policy. Frequently, pregnant women were hungry, or wearing inappropriate clothing that was either oversized or tight-fitting due to their being unable to access maternity wear. My field diary entries, written about the wings in Prison A and B where women were housed, described how ‘the smell of tobacco lingered in the air’: fresh air was limited, and I noted personal ‘air hunger’ on stepping out of the prison wings. The need for women’s physical needs to be met in response to a normal pregnancy were commonly left wanting, especially in relation to food, basic comfort and the environment. The pregnant woman’s pains of imprisonment were heightened as the physiology of her body left her with exacerbated symptoms, limited comfort and unmet health care needs. At worst, institutional thoughtlessness, rather than simply being carelessness, led to potentially life-endangering situations, such as women not receiving vital medication or being inappropriately assessed in labour by nursing staff. Women returning to prison following birth were often unable to access provisions such as breast pads, thus visibly exposing lactation stains on their clothing - an embodied pain, especially following separation from the baby. These kinds of suffering are unimaginable and border on the breach of human rights (Van Gundy & Baumann-Grau, 2016): they suggest an institutional thoughtlessness causing suffering through indignity, unique to the pregnant woman in prison. They are compounded by the fact that ‘pregnancy’ is not even mentioned within the ‘Health Care in Prison’ section of the UK government’s own website.

Some extreme conditions of pregnancy can go unrecognised by untrained health care staff. For example, Abi was suffering from the debilitating condition ‘hyperemesis gravidarum’, which causes constant nausea and vomiting. Abi’s needs were seen as normal pregnancy discomforts by health care staff despite the fact that HG can lead to dehydration and chemical imbalance. Abi was viewed as attention-seeking and ‘manipulative’ and felt punished for her condition. Unable to eat, living on a smoking wing and being made to work or face the consequences of withdrawal of privileges were hard for her. Whilst Abi could have been signed unfit for work, this was not done as her sickness was doubted, leaving her in an impossible situation. The historical view of all female illness being

'malingering' (Ross, 2013:44) seemed to be a particular, falsely judgemental issue in Prison A. Other inmates suggested that Abi was 'putting it on' but, more surprisingly, her midwife also made a value judgement, stating in interview, "*if you (the researcher) had greater knowledge of her crime you, too, would be less 'sympathetic'*". This proposed that even a midwife who was not a member of the prison health team could be absorbed into the 'prison climate', echoing the historical notion of the malingering prisoner (Ross et al., 2011). I interviewed Abi several times and she always wanted the interviews recorded, despite her feeling so unwell, so that her voice would be heard:

*"I want to go home. [becomes upset] I hate it here! I'm not going through it anymore. And then I'm going to blame them as well when I have an abortion...they're going to make me have an abortion, because I feel ill and I can't do anything about it"* (Abi).

It was assumed that Abi's front-of-stage self was 'conveying falsehood' (Goffman, 1959) which meant her condition was judged subjectively through a criminal lens, rather than from a health perspective. Having no advocate, and with some staff suggesting that the nature of her crime meant that she deserved her pains, Abi was left considering a termination of pregnancy.

### **Deprivation of food, comfort, fresh air and basic provisions**

*"If you're not fast, you're last."*

Hunger, cravings and digestive discomfort, although normal during pregnancy, can be exacerbated by the prison environment. When Kayleigh was interviewed, she could think of nothing apart from food: this basic need overtook all other concerns. Having to eat at set times and being unable to satiate food cravings left women feeling hungry, and they often lost weight in prison as a result. The inability to access simple over-the-counter remedies for digestive complaints such as heartburn exacerbated women's physical pregnancy pains and negated any equivalence between women in prison and those in the community. Descriptions of food by using animal metaphors: "*dog food*"; "*I wouldn't feed it to a dog*", have applications beyond the pregnant prisoner. However, they had to adapt to a system which was thoughtless to their needs leaving them to lose weight and exacerbating their discomfort and hunger. Women often voiced an expectation that their pregnancy deserved a 'special status' which would guarantee access to high-quality and timely food (for example), yet this was not in their experience:

*"The food is not for pregnant people. You get the same food as other people who are not pregnant"* (Mercy).

Basic comfort and decency for the pregnant woman was a common theme often causing physical pain. Again, the literature reports on prison discomforts and material loss (Sykes, 1958; Crewe et al., 2017); however, for the pregnant women, the physical pain was often unbearable. Sammy talked of “*sleeping on the floor*” and “*begging*” staff to provide her with a mattress thick enough to stop the metal bed frame digging into her aching hips. Pregnant women were entitled to an ‘extra mattress’ but this had to be ‘prescribed’; yet despite having the signed prescription, mattresses were not always forthcoming. Several of the women would tell me they had been waiting for ‘weeks’ for their mattress. Knowing their entitlements did not guarantee they would receive what was due. Conversely, when women, like Ellie, received an entitlement, such as sleeping on the bottom bunk, inmate tensions increased.

The Prison Service Order 4800, regarding women, (see **Appendix 1.17** for truncated version) states ‘...*what is seen as special treatment given to pregnant women may be a focus for bullying...*’. This suggests that the notion of ‘special treatment’ might cause a woman to be singled out for ‘bullying’ rather than describing what the special treatment or entitlements might be. The language of the PSO is cloaked in benign paternalism. It could be argued that the system is so intent on not showing ‘special treatment’ that it inadvertently goes too far in the opposite direction, using the perceived danger of pregnant women being bullied as a reason to ‘protect’ them from it by not even providing that special treatment. The common retort from staff of ‘she’s just a prisoner’ meant that showing indifference for fear of reprisals from other inmates appeared culturally entrenched.

It is understood that 66% of pregnant women within the general prison population are smokers (Knight & Plugge, 2005a) so it was unsurprising that several pregnant women in this study smoked. Krystal had commenced smoking in prison despite being a non-smoker previously: “*because of the stress*”. However, non-smoking pregnant women often shared cells with smokers, leading to feelings of ‘*revulsion*’ (Jane) and an exacerbation of nausea (Abi). An unexpected finding was that the need for privacy in pregnant inmates was so great that some women in Prison A opted to live on a smoking wing in a single cell, rather than on a non-smoking wing in a room shared with four or five others. Paradoxically, pregnant members of staff were moved away from the wings to avoid breathing in smoke from tobacco and illegal drugs, but pregnant prisoners had limited choice, despite all the known risks of inhalation to maternal and foetal health. The complexity of balancing one woman’s choice to smoke with another’s choice of a smoke-free environment was difficult to manage; this exposes a further layer of the institutional thoughtlessness found in this study – one that is known to cause harm to the unborn.

## Embodiment, security and deprivation of liberty

*"I've got baggy tops...to hide my bump...I want it hidden, because I don't know who's who and who is in for what."*

Sykes (1968:77) stated that the prisoner '*can never feel safe... (s)he is evaluated in public view*'. The sense of embodiment for the pregnant prisoner juxtaposes pregnant women's embodiment in free society. It is normal for a pregnant woman to want to seek out privacy and retreat from public view because pregnancy can be embarrassing due to biological changes and bodily prominence (Longhurst, 2001). Many incarcerated women have suffered abuse and exploitation of their bodies and have abused their own bodies through drugs and self-harm. Crewe et al. (2017) profile women in prison as having suffered 'unrelenting' abuses in childhood and other trauma, including bereavement, evoking an 'unembodied' state (Laing, 1960:69). Self-care is said to be difficult when a woman is 'divorced or detached' from her own body (ibid). Nonetheless, for some women, such as Karis and Ellie, their pregnancies meant that their pregnant body and unborn baby represented a 'status passage' (transition) symbolising a fresh start (Glaser & Strauss, 2011). This transition came from their not knowing whether they would keep their babies to then being told they could: "*it (being able to keep the baby) was better than any drug*" (Ellie). Women like Lola had little self-worth, but pregnancy brought a desire to care for her body on behalf of her unborn baby. Several women were suddenly concerned with their diet, health and drug-taking to keep their unborn baby safe, suppressing negativity where they could, the concern embodied by the waves of kicks and movements from their unborn baby and a connectedness, bringing them from detachment of their body to embodiment: "*I call her baby girl*" (Kayleigh). These findings demonstrate that pregnancy can represent an opportunity where change in health behaviours are known to occur, if the conditions are right and appropriate care and support are facilitated. If authorities and the prison system seize pregnancy as a chance to encourage women to reform, this may benefit society as a whole, as well as the women themselves.

Bodily cravings for food, comfort and safety were often negated by the prison system. The majority of women entered prison in their second trimester and, as pregnancy became more visible, it 'marked' them with an almost 'tribal stigma' with its 'undesired differentness' from the 'normals' (Goffman: 1961:14-15). Where pregnancy is usually celebrated in free society, pregnant women in prison often sought to hide their growing bodies, disliking this visibility of difference and of belonging to a minority group. This represents a dichotomy where the dualistic elements of sacrosanct (pregnancy) collide with the profane (criminality) elements of social life. This stigma of a prisoner's pregnant body contrasted with the pregnant prison officer who had stated that her own pregnancy felt more 'precious' than the prisoner's, and who was therefore able to keep herself safe when the

prisoner could not. The pregnant prisoner's body symbolised inequality and a minority status which disembodied the woman from her unborn, suggesting that a prisoner's pregnancy attracted lower social value, an example of 'othering' from staff (Johnson et al., 2004). Leder (2016:175) suggests that the prisoner's body is viewed as a 'possession of the state'. Overwhelmingly, most women experienced bodily suffering during their pregnancy, often brought on, or exacerbated by, institutional thoughtlessness because a pregnant woman was treated the same as a 'normal' prisoner. Labelled as "*the pregnant*s" by some staff, bodily suffering for these women was often extreme: "...*they must think, oh, you're pregnant, you're going to feel sick...I promise I feel really ill*". Abi was so unwell that she could not work, so she faced loss of privileges as a direct result of a pregnancy illness: "*I got a negative the other day for not going (to work) ...*". This caused a turmoil, where Abi's refusal to work would mean loss of possessions and privileges, such as those which temporarily served to distract her from her sickness, e.g. television.

Descriptions of leaking breasts as a raw visual reminder of women separated from their babies was compared to "*bleeding all over the place*" by other prisoners, who offered empathy. The stark contrast between bleeding - which implies danger/morbidity - and the seepage of milk - which indicates newborn sustenance/growth - suggests a bleak dualism and is an example of 'binary opposite' (Derrida, 1967). Yet the thoughtlessness of the system meant the prison was neither able to provide basic supplies nor recognise the bodily functions and specialist requirements of the perinatal woman. The unavailability of breast pads meant that women were inappropriately advised to use other provisions, such as a sanitary towel, ripped in half, or toilet tissue, to soak up leaking breast milk. This demonstrates a normalising of deprivations leaving many women astonished by these suggestions: "*I've been told to just rip a pad in half and just put each side on each breast*". The lack of breast pads raises an embodied pain unlike any other a prisoner may suffer: for women like Sylvia, separated from her baby, who also did not possess a bra to hold a sanitary towel in place: "*I've asked for breast pads, but they haven't given me anything*". Sykes (1958/2007:78) suggests that the loss of liberty is not 'limited to the physical loss', but rather that this pain of imprisonment represents a 'loss of status' through the 'moral rejection of the criminal by the free community'. The prison environment is described as harsh and brutal but the question of the impact of such a difficult setting on the pregnant woman has been unanswered thus far. These findings demonstrated the women's increasing sense of fear as their pregnancies progressed to an inescapable visibility. Trixie spoke of her anxiety about other inmates when she and her unborn baby were threatened with violence, even when in her own room with limited means of escape. A sense of helplessness, claustrophobia and stress was articulated by women who were locked in, especially when in the latter stages of pregnancy and unable to work. The sense of isolation among such women, of being locked in for twenty-three hours a day, demonstrates the thoughtlessness of a system when a woman's pregnancy symptoms made her incapable of meaningful prison activity:

*"23 hours locked behind a door with nothing to look at, bars on the windows, no conversation, no goals to reach, nothing to look forward to, nothing to do. What do you do with that when you've got nothing? You can't even set yourself targets, because there are none...that's it, nothing! I felt guilty because I wasn't getting any milk... I thought I'm pregnant, how can you not just give me a little bit of extra fruit, or 11 o'clock at night when I'm starving because I couldn't eat at tea because I had heartburn... there was just no compassion, you're a prisoner, you're behind your door and that is it!"*  
(Sammy).

Neglect is further highlighted by the inappropriate assessment by health staff of a labouring pregnant woman. Whilst Layla was 'thoroughly in her body' (Laing, 1960:69), exclaiming: "*I know my body!*", staff negated her sense of embodiment: "*you are not in labour!*", causing Layla to retreat, denied her physicality, and feeling abandoned and disempowered. Such helplessness disrupted Layla's 'ontological security' in that her bodily autonomy was invalidated (Laing, 1960:44). The loss of autonomy as seen through Sykes' (1958:73) lens suggests a 'total and imposed' helplessness. Crewe et al. (2017) build on the notion of 'helplessness' where in women this represents often painful and traumatic childhoods. Sykes' depiction of the helpless prisoner being 'thrust' into past childhood pains has deeper resonance with imprisoned women whom Crewe (2017) describes as being in 'psychological limbo' and argues that the experience of prison is more painful for women than for men. Pregnancy, albeit a 'liminal' state (Van Gennep, 1960/2011), builds on Sykes' and Crewe's descriptions of pain and suffering, whereby the loss of autonomy and control equals a loss of choice for the pregnant woman in English prisons. Not knowing whether she will keep her baby offers up an exquisitely painful ambiguous state:

*"I don't know what to do...So I've got to wait and wait and wait. It's stressful! Because I am depressed as well if I'm anxious I want to know what's happening, and I don't want to wait and wait and wait. It's doing my head in"*  
(Abi).

Knowing whether a woman will be unlocked in time for transfer to hospital when in labour is a pain of imprisonment that is unique to the pregnant woman:

*"I hate being locked up, I hate it...I have never had anxiety before I came here. It's horrible cos you think if anything were to happen, would they get me out in time? cos my door's locked"* (Sharon).

Strikingly, some women chose a medicalised, surgical birth over the uncertainty of the potential complexities around spontaneous labour in prison, in order to access some agency over their autonomy. These modes of delivery were chosen by Abi and Trixie and offered a sense of control, although for Trixie, even as she approached the latter stages of pregnancy, the procedure date was still unknown. The disempowerment experienced was not exclusively associated with labour and birth: not knowing dates and times of scans and hospital appointments meant that a woman could not make an informed decision about whether she should accept these assessments. The ultimate pain - the fact that separation from one's baby was impending - was also often not disclosed until the latter stages of pregnancy:

*“There was like 12 people sat in a room, and then I poured my heart out to them saying I want another chance. And then they said, 'Oh, social services said we shouldn't give you a chance,' and then all of them said no and I just put my head in my jumper, and I wouldn't face them. It was horrible knowing that he's getting taken...”* (Lola).

Sykes (1958) argues that a purpose of prison is to take away liberty and exert control yet, in pregnancy, these pains are exacerbated and largely threefold: control over her body (lack of autonomy over timings); control over her pregnancy and birth choices; and ultimately control over whether she could be a parent to her unborn baby. This is despite Articles 3 and 8 of the Human Rights Act (Feldman, 1999; Van Gundy & Baumann-Grau, 2016; Schiller, 2016; Citizen's Advice Bureau, 2017) having a robust, legal foundation in the UK to protect against degrading treatment, defending the right to a private life and ensuring 'choice' and dignity. Layla, who gave birth in her prison cell, suffered deeply degrading treatment, having her right to privacy and dignity removed in addition to being unable to make choices over her body.

### **Institutional ignominy**

*“If there was a female officer, then I had to stay handcuffed to her; but if it was two male officers, then I had to be put on the chains. Just because I'm a prisoner.”*

Respondents in the current study suggested that an additional pregnancy pain was the lack of differentiation between them and 'normal' prisoners. Furthermore, as pregnancy became increasingly visible, women who were transferred to hospital for routine appointments felt shame and stigma, especially if placed in handcuffs. Without exception, women described their embarrassment and humiliation at being seen in public as a pregnant prisoner. Leder (2016:209) talks of the public perception of a prisoner as a '*social caricature as savage, bestial and sub-human*'. Simply being pregnant necessitated regular public 'outings', to attend recurrent hospital



appointments, a quite different experience from other prisoners. Having regular appointments and scans, often more frequently than in a normal low-risk pregnancy due to multiple health risk factors, also meant that a woman would have no warning about when she would be taken out of the prison, and therefore no time to prepare herself mentally or physically. Representative of the general prison population (Walmsley, 2013), 75% of the women in this study were imprisoned for non-violent crimes, yet the women felt as though they were perceived by the public as ‘monsters’ and ‘murderers’: in the antenatal departments, mothers pulled their children closer to them and the public stared. They experienced the ‘public spectacle of punishment’ (Foucault, 1979). I have characterised this phenomenon with the label ‘institutional ignominy’ whereby shame is brought upon the pregnant woman through the very notion of prisoner institutionalisation, and the public display of institutional symbols of imprisonment exacerbate the stigma. The handcuffing of pregnant women on the way to appointments at the hospital was described as especially painful as they felt judged as a woman, as a criminal, and also exposed as a “*bad mother*” due to the visibility of her pregnant body:

*“People look at you as if to say, oh, well, she must be really bad...you can see that they're moving away from you, and they're pulling their kids away from you... they assume that you must be some really, really evil, violent person, and you're not, you're just somebody that either made a mistake, or was wrongly accused” (Layla).*

The loss of identity is a common consequence of incarceration for either gender (Sykes, 1959; Goffman, 1963; Crewe, 2009;); however, it appears that the pregnant woman experiences loss of identity differently from the rest of the prison population. Twelve of the women interviewed were first-time mothers, which adds weight to the assertion that they would have no previous experience of adjusting to their changing identity. This could be due to pregnancy eliciting normal bodily changes which are already complicated from an embodiment perspective (Longhurst, 2001), coupled with the uncertainty of knowing whether birth will mean keeping the baby with her or facing separation. Women who already had children were facing additional losses of identity as mothers, blended with feelings of guilt at having left their existing children, and ambiguity in the love they felt and /or suppressed for their unborn. Confusion and pain co-existed with the usual dualistic status in society whereby a pregnancy is to be protected, is vulnerable and worthy of special treatment and importance; for example, priority seating on public transport, or a door held open. For pregnant women in prison it appeared that the revered status of mother-to-be was disregarded. In contrast, in prison this status is superseded by being a prisoner and, hence, a criminal (Goffman, 1968): “*I shut it out (pregnancy) because I was in prison*”.

Getting used to being a 'pregnant prisoner' and adapting to this new identity over time appears to lead to indifference for some women. Whilst the notion of stages of adaptation to prison life has been identified in previous research (Harvey, 2007), from the perspective of a pregnant woman in prison, this has been characterised into the label of an 'institutional shrug', whereby adaptation from reception into prison transitions into institutionalised inconsequentiality as a woman becomes desensitised to feelings which were initially so acute (e.g. shame). Susan depicted this inurement over several interviews as she moved from initial deep embarrassment to "*it doesn't bother me now*". In Prison A, new rules necessitated that all inmates wore a coloured armband to identify them as prisoners, with distinct colours signifying prisoner whereabouts and whether they were working, in education or visiting health care. The "*stupid*" armband symbolised a new 'mark' of shame for Susan, making her angrier than I had ever seen her, even more so than that of the impending separation from her baby. It was as if she had been dehumanised all over again: "*...wearing an armband, like I'm an animal!*". Goffman (1968:24) describes this universal pain of imprisonment as 'mortification of self' in which the first stage, the 'barrier' between prison and the outside world, equals the first 'curtailment of self'. Moving in and out of this first stage created a layer of pain unique to the pregnant woman, exceptional from the general prison population and especially due to the numerous times they would attend appointments outside of the prison.

Apart from the feelings of shame of the pregnant mothers themselves, it is important to consider the effect on their maternal feelings towards their babies. In life on the outside, seeing a scan of your baby, or finding out it is developing healthily, are usually a cause for celebration which often helps bonding between the mother and baby. The shame of being seen outside as a pregnant prisoner negates any positive effects of these antenatal appointments and is therefore, arguably, not really an equivalence of health care. The pregnant prisoner juxtaposes Goffman's view of moving through mortification in 'stages' as women revisited the first stage in a painful reawakening of shame each time they moved from behind prison walls, to public viewing, to new marks of humiliation such as the 'armbands'. In Susan's case it was as if, having transitioned through the layers of mortification of self, she perceived the armband situation more harshly because of being thrust back into a stage she had previously moved through. The second mortification exists in the prison admission process or, as Goffman (1968:24) describes, 'the welcome', where the woman enters the prison and finds out the processes and structures. Uniquely, for women unaware of their pregnancies, finding out during their reception that they were pregnant - as Cleo and Susan did - meant the 'welcome' had an additional layer of shock to it:

*"The woman come and told me I was pregnant, and I was like, 'Oh God!'...my mum had just found out I'm in jail... I sent out the visiting order for my mum and I had to tell her on the visit like, 'By the way, mum, I'm pregnant'" (Cleo).*

The 'welcome' included a ritual stripping of identity, as described by Caroline: "*Metal doors banging, girls screaming...it was noisy...it was dark, it was cold it was just the worse thing I have ever been through...*". In the third mortification, the pains of deprivation of privacy are set about: letters are read, belongings are handled, maternity clothes ordered do not arrive or are delayed. The differentiation caused by the privilege system is said to add 'acute psychological stress' (Goffman 1968:50). Such 'toxic stress' is known to affect the unborn baby (Glover & O'Connor, 2002; Sarkar et al., 2008; Glover et al., 2010; Capron et al., 2015).

## Dehumanisation

### *"The Pregnants."*

Laing (1960:46) suggests that being depersonalised is 'dangerous', causing a potential existential crisis. An autonomous identity is said to be essential in order to be 'related as one human being to another' (ibid). The process of 'othering' (Canales, 2000, Brons, 2015) came not only from staff towards prisoners but, interestingly, from pregnant women towards 'normal prisoners', too, with exclamations of: "*I'm not like them!*" and "*they are not like normal people*". The expectation of different treatment led to othering, especially when it came to food and health care, often coupled with incredulity that "*I am getting the same as normal prisoners!*". The pain of dehumanisation was common in the pregnant women: being viewed as "*just a prisoner*" and being afforded no "*special treatment*" was distressing:

*"I don't really want them to care, but as a human being you should at least have a bit of concern about a pregnant woman!"* (Trixie).

Additionally, the staff labelling them "*the pregnant*s" or "*a pregnant*" represented the sub-human, alienation of a marginalised group lacking in any special characteristics or individuality despite being pregnant. Pregnancy normally occupies a societal position of inviolability, deserving of tenderness - starkly contrasting with what the women in prison have described. The societal signals and visual codes of behaviour towards pregnant women seemed not to be applied in prison. Still, there was also a recognition by some staff that pregnancy made the experience of being in prison especially difficult for a woman: "*we take away so much control, even more so when they are pregnant*". The value placed on one pregnancy over another was apparent during an interview with a prison officer who had recently had a baby: "*I'm not saying that my pregnancy was any more precious...but it certainly felt it*". The labelling of pregnant women as "*the pregnant*s" by some prison staff personified the woman, symbolising 'othering' (Canales, 2000; Johnson et al., 2004; Brons, 2015; Dervin, 2016), whereby women were treated as inferior and different and viewed as a cohort rather than individually.

## Anticipating separation from the baby

*"It's the biggest fear in your mind...I've had my children taken, I know what it's like, it's heart breaking, it just ripped me to pieces."*

Sykes (1958:72) refers to a pain of imprisonment in the denial of a heterosexual relationship; however, the definition Sykes puts forward as: *'self-image is in danger of becoming half complete...a partial identity'* is relatable to a pregnant woman's anticipatory grief at the separation of her unborn baby. This anticipation creates an existential crisis, which Laing (1960:50) terms as 'petrification', with desperate expressions from women evoking an acute inner pain:

*"I'll have no bump and no baby. I don't know what I'm going to do...how can anyone think it's natural to just take a baby away from their mum?"* (Caroline).

Kitzinger (1997) described the enforced separation as 'emotional mutilation' for both mother and baby. Yet, it can be contended that it is not just emotional suffering; it is a very physical separation and mutilation as well. The mother must endure traumatically physical wounds of separation (e.g. breast engorgement and leaking and/or surgical wounds: e.g. caesarean scar or perineal tear/episiotomy) but without a baby to give them purpose. The experience of parting, or anticipating the separation, for imprisoned mothers has been explored before by Wismont (2000) and Chambers (2009), and bonding with the unborn was a common finding both in women who were remaining with or being separated from their baby:

*"I do tell him that I love him and I'm sorry and all that"* (Lola).

The unique pain of losing a baby in this way was commonly described by women as being "*ripped*" apart or of their newborn being "*ripped*" from them symbolising violence in the act of separation. The return to prison, usually within 24–48 hours of birth, was said to be "*devastating*" and "*heart-breaking*" yet women talked of ways to be strong and move forward with resignation on return to prison without their baby:

*"Hard, really hard, but there's nothing I can do about it...so I have my moments, I'm upset, but just I'd rather to try and keep myself strong"* (Susan).

The process of applying for an MBU place and knowing whether a place would be granted was lengthy and confusing for women, which resonates with recent research undertaken by Powell et al. (2016) and Sikand (2017): *'no one really explained to me the whole process'*. For women like Abi,

the experience of not knowing was an issue described at three of the follow-on interviews I had with her: *"I don't know what to do. [becomes upset]. So, I've got to wait and wait and wait. It's stressful!"* Crewe et al. (2017) found that the severing of relationships, especially of a mother from her children, was a struggle to cope with: *'I didn't know how to switch it off'*. The inner conflict through connectedness (Wismont, 2000) with the unborn, starkly juxtaposed the deep, painful void of separation. The temporary status of being pregnant created a rhetoric of 'I don't know how I will cope', yet women did seem to cope, moving from one liminal state (Van Genneep, 1960/2011) (expectant mother) to another (baby-less mother) to another (a 'normal' prisoner). Caroline articulated how she moved through these liminal spaces where she had entered prison at 16 weeks pregnant, had given birth to a son at 41 weeks' gestation and then returned to prison without her baby:

*"For me, it's...I feel like I've got through one stage, I've got through the pregnancy stage and I'm starting to feel more like a prisoner now. Whereas before I was a pregnant prisoner, now I'm just like everybody else, I'm just a prisoner like everybody else. So, I'm now experiencing prison life as me, not as me the pregnant woman, if that makes sense?"* (Caroline).

Although deeply anguished by the loss of her baby, Caroline rebuilt her identity and blended in to the prison population. For those anticipating separation but then surprised at being allowed to keep their baby, being given a chance at motherhood was described positively: *"I was just overcome with... I can't even describe it, it was just immense. Better than any fucking drug I've ever taken in my life"* (Ellie). This prospect often appeared to signify a change in the woman to better herself, seizing the opportunity fully where being in prison was the catalyst to change. It is uncertain whether the threat of separation from their baby in prison uniquely encourages women to maximise opportunities despite being incarcerated or whether such women would have bettered themselves on the outside. However, this catalyst to change is worthy of deeper exploration. Criminology scholars discuss various 'turning points' for prisoners being a 'catalyst for desistance'; e.g. a male prisoner's partner being pregnant, or finding religion (Maruna, 2001; Maruna et al., 2006; LeBel et al., 2008; Paternoster & Bachman, 2017). My research found that pregnancy, too, is a 'catalyst for desistance', thus adding to this body of knowledge.

Turning points are significant in terms of releasing one's potential contribution to society, with a real opportunity for reform through 'desistance' whereby a significant societal impact reduces the burden to society: a burden avoided if both mother and child bond and develop healthy relationships (Kennedy et al., 2016). For example, Karis, who had been in prison multiple times and had endured enforced removal of all of her children, admitted: *"I kinda go on a destructive, I've done it in the*

*past... the worst thing they ever did was take my kids away*". Karis used the pregnancy experience to change her behaviour in order to be given a chance to keep a baby for the first time: *"I told her (social worker) ... I'll do anything...I'll jump through hoops if you want me to... if you want me to go for a drug test every day I'll do it"*. It was acknowledged by women who were not allowed to keep their baby that keeping it could have been a catalyst for change, yet the forced separation meant that women felt despair that, sometimes, sent them into a negative spiral of self-destruction and despondency. Lola recognised that had she been given a chance to be a mother, which *could* have led to a turning point, and wanted to breastfeed her baby; however:

*"I poured my heart out to them saying I want another chance...and then all of them said no...I was going to breastfeed her, to have more bond with her while I'm in here, but, obviously, she's getting taken so there's no point"*  
(Lola).

The pain of separation for those who anticipated enforced removal co-exists with the joy of others being able to keep their baby. This divergence appeared to split the women's experiences of imprisonment into the pleasure of those given a chance to be with their baby from the unbearable suffering of those who were separating.

### **Cell births: mortification of self**

Prisoner: *"I'm in labour. I'm telling you I am in labour."*

Staff: *"No, you're not. Here's some paracetamol and a cup of tea."*

Layla's birth in a prison cell fuses the concepts of institutional thoughtlessness and institutional ignominy. The physical pain of labour alongside the emotional pain of Layla's voice going unheard was an extraordinary pain of imprisonment, symbolic of 'mortification of self' (Goffman, 1968) and 'petrification' (Laing, 1960) and breaching her human rights (Van Gundy & Baumann-Grau, 2016). Layla's labour (cf. Layla's Story, above) depicted what Sykes (1958:77) describes as a *'fight for the safety of (her) person...a tense and fearful existence'*. An unexpected and shocking ethnographic observation was that prison staff, and nurses without the necessary training or experience, were making midwifery decisions about Layla's condition and thereby breaching Article 45 of the Nursing and Midwifery Statutory Order (2001) which is harnessed in UK legislation, where: *'A person other than a Registered Midwife or a Registered Medical Practitioner shall not attend a woman in childbirth'* (Nursing & Midwifery Order, 2001). Indeed, to do so may attract a criminal penalty.

Giving birth in a prison cell without a midwife or doctor in attendance raises serious questions about a lack of available specialist care, unmet entitlements and dangerous prison practice. Assessing

whether a woman is in labour is a specialist skill requiring years of training and professional entry to the NMC Register as a Registered Midwife. The lack of recognition by health and prison staff of the limitations to their sphere of responsibility surpasses all pains of imprisonment, thoughtlessness and ignominy encountered in this research. The dehumanisation of prisoners, the lack of special treatment and having unqualified decisions made about a labouring woman were later acknowledged by eight members of staff: *'it must have been uncomfortable'*; *'no one was trained in delivering a baby'*; *'a complete failing of the system'*, demonstrating that there was a recognition that what happened to Layla was known to be unethical. Suffering was heightened for Layla in the unimaginable terror of not knowing whether she would keep the baby or not, should it survive. The loss of privacy corresponded to a loss of dignity and decency for Layla, intensifying the experience of institutional ignominy. Staff were placed in a stressful situation where they had no training or guidelines, left vulnerable by a system which has no manual to follow in such a circumstance (see concluding Chapter 6 recommendations).

## Coping

*"I had to just continue as normal, get with the regime and not really show any emotions."*

Identity in prison as a 'pregnant woman' is overridden by the status of 'prisoner'. Women reported being categorised by their crimes, losing their identity as a mother to existing children and as wife/partner if they were in a relationship prior to incarceration. Women would feel stripped of their individuality due to being grouped together as a homogenous collection of prisoners. The changing status of prisoner identity, e.g. from mother to prisoner, has signified liminality in previous research (Fludernik, 1999; Jewkes, 2005; Thomassen, 2009; Beech, 2011; Baldwin, 2017; Baldwin & Epstein, 2017). However, an added complexity to the depersonalisation of becoming a prisoner is a woman's pregnancy, where her identity shifts from 'pregnant woman' to 'prisoner' after childbirth. Sykes (1958:76) suggests that in order to overcome the pain of loss of autonomy, prisoners need to find a way of 'coping with issues'. During follow-up interviews, I revisited this coping theme with women. Staff often showed empathy and acknowledged the emotions of the women but found it challenging to support them when they were distressed and isolated.

Goffman's (1959:66) 'impression management' is a useful concept to use in considering how women may try to 'influence' themselves 'front of stage' to prison officers by restraining their anger and frustration and thus appear well-behaved. Sharon is an example of a woman who would have ordinarily "*kicked off*", demonstrated restraint by "*keeping my head down*", thus showing a new-found maturity at the shock of realising that becoming a mother was a serious matter. Yet, no matter how carefully managed, the visible pregnancy, intrinsic to her identity of 'conveying honest truth',

appeared to be ignored. Staff often found it difficult to see the identity of a pregnant woman, preferring to see her as 'just a prisoner', and this would often leave women feeling outraged because they were standardised as one homogenous group: *"They don't care! Why? Because we're criminals"*. This identity shift is a normal occurrence as a woman progresses through pregnancy (Oakley, 1979; Bailey, 1999; Earle & Letherby, 2003; Hennekam, 2016;); however, for the pregnant woman in prison, her pregnancy was either concealed to hide this identity or, when on show, was ignored by the 'audience' (prison officers). The restraint and suppression shown by prisoners, usually whilst out in public: *"not showing weakness"*; *"walking with swagger"*, contrasted dramatically with the helpless and childlike state that women reported to revert to when locked in at night:

*"When I go back to my cell I cry"* (Trixie).

Responses to the question, 'how are you coping?' elicited a variety of responses: *"one day at a time"*; *"a job"*; *"try to keep busy"*; *"try not to think about it"*; *"counting down my pregnancy weeks"*. O'Donnell (2014) states that prisoners sense time passing slowly due to monotony and rigid timetables. Pregnant women would often suppress their feelings, masking emotions when 'front of stage' (Goffman, 1959); yet when 'back stage', the mask would come off, especially at night-time, illustrating the emotional distress in psychoanalytical terms (Wright et al., 2016). Suppression and denial of emotions were expressed as coping mechanisms for women who were long-term prisoners (ibid). Women talked of *"not showing any weakness"* and therefore suppressing emotions with 'front of stage deep acting' when out on the prison wings (Goffman, 1959). Hochschild (2003:47,53) identified that 'deep acting' in 'everyday life' requires a person to 'suppress truths' to manage their wealth of emotions, especially due to the 'formal rules' imposed within institutions. Moving 'back-stage' the 'actor' (pregnant woman) would release feelings of isolation when back in their cell, where they would sometimes lapse into despair and sadness: *"When I'm in my cell on my own...I'm literally crying like a baby"*. The dichotomy of having to balance front- and back-stage management, blocking emotions, especially frustration and anger, was difficult for some women to manage. In contrast to this were pleasurable 'back stage' moments of feeling bonded to her unborn baby, perhaps as the woman fleetingly felt like a normal pregnant woman connecting with her child.

The need for control over the pregnancy led some women to choose a surgical birth, usually reserved for those with serious mental-health morbidity. The tension involved in restraining emotions for fear of the ultimate punishment of losing ones' baby through enforced separation, puts an intolerable strain and physical burden upon pregnant women. A torrent of turbulent emotions was experienced by women, from denial to despair to the isolation of crying alone in a cell when they could be alone. Prison staff acknowledged the difficult emotion work, especially when supporting women separating from their babies. The identity of the pregnant prisoner was often confused and symbolised dualisms



as the societal status of being a pregnant woman was superseded by the prisoner / criminal label. Women reported feeling stripped of their identity, and staff often found it difficult to see the pregnancy as part of her uniqueness, preferring to keep the prisoner groups as standardised. Yet, some women sought to conceal their pregnancy through fears of physical violence or of appearing different from the norm. 'Finding inner strength and resilience' were common expressions from women interviewed about their ways of coping with being pregnant in prison. The extraordinary experience of being pregnant or becoming a new mother brought about unique coping skills, different from any other human prison experience. Whilst there are commonalities with previous literature in coping with prison (religion; passing time; getting on and making good; pseudo families; visits; looking to the future), what makes the pregnant woman so different is that what she needs to be strong for is within her own body, tangible as the unborn baby kicks at night, distracting her momentarily and shifting her focus inward, these moments making the prison experience easier to cope with. The need to be strong appeared to come from the pregnancy itself. Coping with being in prison was a struggle, challenging and difficult but the unborn baby was often the focus of that survival, whether a woman was being separated or not.

## **Resilience**

*"Throughout my whole life I've had struggles, and I've had to survive... so this is just another thing that I've had to go through."*

Hiding vulnerability and weakness is a common experience for women in prison (Carlen & Worrall, 2004): *"I'm here now, and there's nothing I can do about it"*, *"If I keep it together I'll see the end of the gate"*; *"keeping myself occupied; you can't break down in here"*; *"I don't think about things"*; *"writing things down"*; *"I've got to fight for things that's what's getting me through"*. Yet, for the pregnant woman, the increasing visibility of their pregnancy, coupled with an internal voice of having to stay strong for their unborn sometimes meant internal struggles:

*"When you're around certain people you can't show, I think, weakness. I got that straightaway that if you showed weakness, you got taken advantage of. So, you had to put on this strong persona"* (Sammy).

The resilience demonstrated by most women in this study shows the unique pains of a pregnant woman adapting to, and coping with, the prison environment. It appeared that trying to keep positive could only stretch so far as a coping mechanism for a woman being separated from her baby. Being outside of normal human experience, the enforced separation of a baby - described by Kitzinger as 'emotional mutilation' (Kitzinger, 1997; Vis, 2000) - makes coping with imprisonment for the pregnant woman exceptional and outside the experience of any other person. The innate resilience and inner

strength of the woman was a common thread through all the interviews, whether reflecting on a past prison experience: *"I did it as a woman"* (Jane) or if currently pregnant:

*"It's not about trying to like act strong, it's when you are strong...when I'm at a good place, and I can look back, I'll know how strong I've been"* (Trixie).

Even the most vulnerable women who chose to be interviewed, those recently separated from their babies, found inner strength either through personal philosophy: *'I have to be strong and get on with it'* (Sylvia) or through religious faith (Koenig, 1995):

*"I go to chapel on a Sunday and I think that is getting me through...I just read the Bible, it's just everything's taken away from you here, everything. I just pray"* (Caroline).

Such a demonstration of personal resilience and strength is not unique to pregnant prisoners, yet their inimitable type of pain required a special type of survival and strength. The sensations of the movements of her baby were often helpful prompts that enabled women to harness an inner resilience whilst pregnant; that encapsulated the woman and her unborn together in a moment of pleasure and protection, cocooned in a world of their own that nobody could penetrate. It was as if the unborn brought some comfort and softness, contrasting against the ragged pain of prison, especially at night. The unborn was a focus of resilience and strength and survival, allowing the prisoner to take pleasure in the mother state, even if just transitorily.

## **Bureaucratic layers**

*"Everything is a waiting game here...you could be dying, and you would still be waiting."*

The frustrations experienced through loss of liberty were often brought about by complex bureaucratic layers. Goffman (1968:78) describes the prison system as being somewhere between providing 'humane standards' mixed with 'institutional efficiency'. Findings demonstrated that women and staff were confused about a pregnant woman's entitlements: *"loads of good things that you just don't get"*. Prison Service Order 4800 cautions that women being pregnant may be targets for bullies and acknowledges that 'special treatment' may, at worst, single out a pregnant prisoner for bullying or, at best, trigger resentment from other inmates. This was seen with Trixie, who was threatened with violence against her unborn child, and Kayleigh, who needed to defend herself because of being appropriately assigned to a bottom bunk. The 'thoughtlessness' of the institution towards the pregnant woman is generated at government level where guidance on 'maternity leave' benefit is

omitted from a UK government advice web page about the continuation of benefits for prisoners and families (such as pensions and disability benefit). Goffman (1968:81) defines the purpose of prison as the 'social control of the criminal', yet, the pregnant woman in prison needs to have her entitlements met, and staff need clarity about what guidance to follow to support their role (see concluding chapter recommendations).

## **Staff experiences**

*"Quite a lot of us like doing it, because you get to see a baby, or you get to see a birth."*

A new typology of prison officer has emerged from this study. The 'maternal' is a staff member who is considered "*lovely*", "*nice*", or a '*true carer*' (Tait, 2011) and is chosen to go on 'bed watch' with pregnant, labouring women. Goffman (1968:79) exposed the 'sympathiser' as an officer most likely to burn out; yet it appears that the 'maternal' is left feeling valued as a chosen person able to 'hold a hand' or 'hold a baby'. This role ambiguity between guard and birth supporter warrants exploration. It is clearly juxtaposed: the officer, chosen or not, is going on bed watch in her role to 'watch' and 'guard' the prisoner. However, as the findings have demonstrated, in many cases both staff and prisoners see the role of 'bed watch officer' to be like that of a birth supporter. This role confusion is interesting: the boundaries appear more fluid when an officer is outside of the institution on 'bed watch' and it often leads to rule breaking in, e.g. "*taking an extra photograph*", or turning "*a blind eye to a McDonald's*". The natural instinct to care for a pregnant woman conflicts with the duties of a guard, and this created tension for staff. The tone and language used by the PSO's suggest that the fear of demonstrating 'special treatment' could be a disincentive for staff to treat a pregnant woman any differently from any other prisoner; this in turn appeared to be enabling staff to care less instead of more. My research demonstrates a cultural acceptance with staff being complicit in normalising the pregnant woman and subsequently treating her the same as non-pregnant prisoners. Tensions were commonly expressed in my fieldwork observations. An example of this was when I asked for cold water when I was interviewing 'Abi' who was feeling nauseous: one member of staff suggested that she was malingering and passed judgement on her crime, whilst another discreetly provided me with the requested cold water for Abi. My field notes suggest that being compassionate within the prison setting meant being discrete. Staff had varying views about the impact of the environment for the pregnant prisoner. In Goffman's *Asylums* (Goffman, 1961), he made no differentiation between staff and patients, describing them both as 'inmates'. In my research, health and prison staff making midwifery decisions that they are not trained for demonstrated a lack of awareness of the risk to a woman's perinatal health. Furthermore, such breaches in statutory codes of conduct and practice could lead to criminal conviction (Nursing & Midwifery Order, 2001; Baird et al., 2015). The potential

for birth occurring in the prison was approached with emotions such as panic and insecurity by staff: *“there’s no doctors on a night time here”; “it’s just nurses that are here”; “no one was trained in delivering a baby”*. Staff talked about their lack of training in obstetric emergencies and basic midwifery care: *“I suppose just your normal first aid”; “they couldn’t get her out quick enough”; “the hospitals don’t provide anything”; “we just didn’t know what to do”; “we’ve got the emergency birthing basket”*. Bureaucratic layers for the pregnant woman in prison often render her pregnancy invisible. Many of the processes seemed to be in place to protect the prison system and staff, *“signing a disclaimer”*, rather than supporting the pregnant woman’s needs. Staff/prisoner relationship findings mirrored previous scholarly work that shows prison staff can be categorised by personality traits or types (Price & Liebling, 1998; Crewe et al., 2015). Previous research into pregnancy in prison often elucidated positive views of staff in relation to the care provided and treatment given (Albertson et al., 2012; Galloway et al., 2015; Gardiner et al., 2016). However, findings in this research describe contradictory experiences that contrast with the generally optimistic staff view of women being pregnant in prison.

### **Midwifery relationship**

*“I was meant to see the midwife today...she hasn’t been here for three weeks.”*

The experiences women had with midwifery care, and their opinions about their midwives, varied, mirroring experiences women may have with their midwives in the community (Dowswell et al., 2001). The sense of *‘being controlled’* as a pregnant prisoner starkly contrasts with best midwifery practice where current evidence suggests that empowerment, continuity of care, partnership models, promotion of normal birth, principles of the *‘Better Births’* initiative and choice of birth location should be guiding principles (Hodnett, 2004; McCourt et al., 2006; Leap et al., 2010; Mander, 2011; Oakley, 2016; Cumberledge, 2016). The main differences for pregnant women in prison were: the lack of a replacement midwife when the usual one was absent; being sent ‘home’ in early labour when home is a prison cell; the midwife being an outsider to the prison thereby making advocacy difficult; and the lack of differentiation between the role of a nurse and a midwife in caring for the pregnant woman in prison. In the community, a woman may change her midwife should she wish; however, in prison there was no choice of midwifery care provider. Therefore, women like Abi, were not able to build a trusting relationship with their midwife. Of positive note was the continuity of care offered to women in prison, who often saw the same midwife every week. However, the non-existence of a specialist prison midwife and therefore being an ‘outsider’, the visiting community midwife was unable to advocate effectively for the women in the prison setting:

*“There’s not much they can do to help the situation – they can’t say ‘oh excuse me she needs to have more fresh air’” (Karis).*

The role of the community midwife was to come in to the prison from her community location; yet, not having specialist prison training or support, the midwife had a complex caseload of pregnant prisoners as well as her patients outside in the community. The midwife was often left to liaise with several geographical areas, organising care for women who may have sentences of varied lengths of time:

*“When you’re in the prison you can’t see any records from the past at the hospitals, any social care... You’ve got that extra bit of detective work to do on it” (Midwife).*

Women were sometimes viewed as devious and the midwife affectionately called the pregnant women her ‘girlies’. It was suggested that when women were ‘nice’, they may get extra privileges:

*“As a midwife, I can get them privileges. So, the nicer they are to us... I can get them extra mattresses, I can get them extra pillows, extra food, make sure they get the medication that they need and the vitamins and things” (Midwife).*

Suggesting that receiving the entitlements they require as pregnant women is dependent on behaviour, submits a system that is discriminatory, reliant upon women being manipulative, ‘conveying falsehood’ and ‘front of stage’ (Goffman, 1959:66). The privileges described are, in fact, entitlements, yet for the most vulnerable women - who may ‘misbehave’ - it appears they are more deprived than those who show restraint. Describing the entitlements that women should receive as ‘privileges’ suggests confusion about what the women’s rights are. Further, there appeared to be a suggestion that some pregnant women in prison were ‘undeserving’, and this may explain why some women who were characteristically perceived as being belligerent may have been at risk of not receiving their entitlements and appropriate health care.

## **Summary**

The woman’s experience of being pregnant in prison suggests a deep rooted psychological pain which appears to punctuate all aspects of her incarceration. Where physical pain exists, little comfort is offered as women are left ‘begging’ for a softer mattress (Sammy) or ‘crying’ for pain relief (Kayleigh) to ease the normal discomforts of pregnancy. Ignored or negated by the system, the institutional thoughtlessness of the prison organisation defines their experience. Bodily suffering is heightened by their being unable to satiate the normal cravings or ease normal pregnancy

discomforts. The hunger that the women would feel often caused distress and suffering. For some pregnant women, however, prison is a refuge or 'safe haven' and a unique 'turning point' and catalyst for change, especially when they are given the opportunity to keep their baby. With limited autonomy or choice, the pregnant woman's emotions are suffused with frustration. Her identity is concealed, wanting to 'forget' she is pregnant (Jane) or trying to 'ignore' her pregnancy (Sammy). Suppression of emotions causes stress for the woman as she tries to act like a 'normal prisoner', often 'hiding' her abdomen under baggy clothes (Trixie). Night-time brings isolation as well as tears (Caroline) and, in contrast, also brings with it a union with her unborn baby as she takes momentary pleasure from the kicks and movements, cocooned in oneness with the life growing inside of her (Lola).

A notion of 'othering' was apparent, as rhetoric such as "*the pregnant*" confirmed, and appeared to dehumanise women. However, the use of the concept of othering was not limited to staff, as pregnant women viewed themselves as having an elevated status from the 'normal prisoner'. Most of the women interviewed were imprisoned for non-violent crimes such as theft, fraud and drug offences, yet many experienced having to be handcuffed on multiple excursions to hospital, so they believed that the public viewed them as dangerous criminals and unfit mothers. A central theme running through this research was shame causing painful humiliation for the pregnant woman. Designated as 'institutional ignominy', it captures the sense of Goffman's 'mortification of self' which is revisited as a cyclical pain for the pregnant woman as she is moved in and out of prison. The embarrassment came with the artefacts of power and control - handcuffs and chains - yet the most excruciating humiliation for women was being seen in public as a 'pregnant prisoner'. The sense that her pregnancy, guarded by prison officers and wearing handcuffs, symbolised her as 'unfit mother', 'criminal', 'judged' and a public spectacle of shame. The gaze of women, their partners and children in maternity departments left the pregnant women feeling judged and shamed in public. The ultimate shame of giving birth in a prison cell, an oft-expressed fear of many of the women in this study, was realised by one participant and described by several staff members as an unusual but not isolated phenomenon. The distress this ultimate 'institutional ignominy' caused with no recourse for Layla to debrief her experience was a definitive 'mortification of self'. In common with other research, prisoners were good at 'masking' their pains, often retreating to their cells at night time where emotions would flow. Nonetheless, the difference between pregnant prisoners and the general prison population (and pregnant women in mainstream society) was the wish for some to conceal their pregnancies. The wish to blend in to avoid being singled out for attention or, worse, threats of violence, intensified their stress. The intensity of this 'masking' concerned women about the effect of stress on their unborn baby. Being 'front of stage' as a pregnant woman yet having this ignored by some staff who viewed her as 'just a prisoner' was emotionally frustrating. However, a common finding amongst the participants was their survival instinct and burgeoning inner strength. Women

found ways of coping with this life-defining experience in various ways, from religion to keeping busy, demonstrating often extraordinary resilience.

Staff were often unaware of whose role it was to care for the pregnant woman; a common theme amongst staff and women is the limited knowledge of entitlements; this led to officers' perceptions that nursing staff were able to make midwifery decisions and, therefore, nurses were at risk of acting outside of their sphere of practice. The distressing culmination of this was depicted in an inappropriate and unqualified assessment of a woman in labour, breaching the Nursing and Midwifery Statutory Order (2001) which forbids the attendance of anyone other than a Registered Midwife or Medical Practitioner from attending a birth. Whilst emergency births can happen anywhere, Layla was in labour and this needed to be properly assessed by a qualified midwife and referred to maternity services to avoid the emergency birth that it subsequently became. A new concept of 'maternal' prison officer typology has emerged, where officers supporting labouring women have blurred boundaries between being 'prison guard' and 'caring birth supporter'. The layers of bureaucracy essential in the smooth running of a prison institution, did not consider the anomaly of pregnancy. The institutions of 'health' and 'prison' appeared to collide with confusion over the role of each culture. When entitlements were known, they were often not acted upon, or they took weeks to appear. The thoughtlessness of the system was evident in the artefacts, or lack of them, such as guidance about the care of the pregnant woman. Where such guidance was included, 'pregnancy' was hidden in files and paperwork, as demonstrated in the elusiveness of the 'F35 form' (**Appendix 1.15**), a list of entitlements for pregnant women. Staff seemed not to know what the form was, what it contained or where to find it. The dependence of women behaving 'nicely' appeared to increase the likelihood of their receiving entitlements.

The question needs to be asked why pregnant women in prison are treated in this way. Pregnant prisoners are incongruous in a patriarchal prison system. Staff as well as the women are left vulnerable: the emotional trauma of separation of mother and baby is painful for staff in attendance - they have limited training and no recourse to debriefing, and, the boundaries between care and security are loosened. The experience of being pregnant in an English prison betrays 21<sup>st</sup> century Midwifery values, which support empowerment, autonomy and choice for the mother (Sandall et al., 2013; Renfrew et al., 2014). The restraint shown by these women, in light of the potential severing of their physical and emotional bond with their unborn baby, covers a depth of pain beyond the ordinary tensions of incarceration. Extraordinary resilience and coping amongst a vulnerable population demonstrates enormous strength used in masking and hiding the physical and emotional sides of pregnancy. The pains of imprisonment for the pregnant woman are severe, theirs being a visible minority with multiple and changing layers of identity as they grow in gestation and move in and out of prison, revisiting the first stage of 'mortification of self' at frequent intervals.

The succeeding and closing chapter of this thesis will add to the deductions of this study by suggesting recommendations for the prison service, health care staff and for future research.



---

## Chapter 6: Conclusion

---

This thesis set out to reveal pregnant women's experiences within three English prisons. Set against the context of the UK prison system at an especially turbulent juncture, this study provides a distinctive understanding, examining pregnant women's experiences at a time of institutional strain. To consider what makes the pregnant woman's experience of prison unique from other experiences of incarceration or, indeed, of other pregnancy experiences, has led to the formation of an important and original contribution to knowledge which spans several academic and health disciplines. My position as a Registered Midwife occupies an exceptional stance, with my professional expertise merging with sociology and prison research. For pregnant women, as a minority group in prison, the 'pains of imprisonment' are substantial and multifaceted in their severity. Reflections on my own self-control in having to observe and not speak out while undertaking fieldwork mirrors some of the restraint and resilience of the women as they succumb to similar environmental pressures. My findings demonstrate: the complexity involved in navigating the prison system when rights and entitlements are complicated to access; the inconsistency of provision of appropriate basic requirements; the thoughtlessness within this patriarchal system when considering the pregnant woman; the uniqueness of the stigma experienced and the potential for pregnancy being a unique 'turning point' and 'catalyst for desistance' (Maruna, 2001; LeBel et al., 2008; Sharpe, 2015; Paternoster & Bachman, 2017). My interpretations examine the ways in which women cope with their experience; they add 'pregnant women' to the body of knowledge regarding prisoners' coping strategies.

### **Building on existing knowledge**

This research provides several notable additions to previous evidence, enhancing the understanding of the pregnant woman's experience. My findings build upon the current knowledge in concluding, like Wismont (2000) and Chambers (2009), that participants often experienced a deep connectedness with their unborn baby; throughout this thesis, there are examples of how loving that connection can be. The anticipation of separation and feelings of pre-emptive grief found in this study mirror some of Shroeder and Bell's (2005) research in that the anticipation of separation elicits feelings of loss. I found in my research that the emotional responses of women were often more aligned with restraint and frustration than with the hostility reported by Hutchinson et al. (2008). I believe this could be because of the methodological approach I used in that, immersing myself in the field and my not holding keys may have meant there was less suspicion of me as an outsider and therefore I elicited greater candour in responses. My research demonstrated the notion of role

uncertainty about who delivers care for pregnant women, adding to the conclusions around inconsistencies in Edge's (2006) and Price's (2005) studies, and Knight and Plugge's (2005b) review. This paralleled Albertson et al.'s (2012) discoveries, yet my findings also show that confusion around care provision often existed within the same institution. Like Walker et al. (2014), the prison system being unprepared for pregnant women was a common thread found throughout my research. The stigma women experience, especially when wearing handcuffs to antenatal appointments on the outside, was a key discovery in my research, with utterances from women emulating some of Fertz and Whiteacre's (2012) descriptions of the humiliation and dehumanisation that pregnant prisoners feel. My research resonates with Gardiner et al.'s (2016) conclusions relating to the stress of the environment experienced by pregnant women and new mothers. Additionally, the strains of navigating the bureaucratic layers when applying for MBU places, as reported by Sikand (2017), were commonly expressed. Grey literature and anecdotal evidence of women's experiences, especially in relation to babies occasionally being born inside of prison, has been supplemented in greater depth through accounts from women and staff.

## **Original contributions to knowledge:**

### **The pregnant woman as an anomaly in a patriarchal system**

The stress of the prison environment has been referred to in previous research; my study reveals what it is about the environment that specifically impacts upon the pregnant woman. I believe that by immersing myself in the same setting and conditions where a pregnant woman found herself, offered a multi-dimensional way of answering the research question. A key - albeit expected - finding was that the pregnant woman is an irregularity of the patriarchal prison system, meaning that the suffering she experiences is exceptional to any other 'pain of imprisonment' (Sykes, 1958). Nonetheless, my research offers explanations of *how* the prison system falls short in taking pregnancy into account which subsequently impacts upon the pregnant woman's normal bodily physiology, exacerbating her suffering. Throughout this study, women describe their struggles as they balance managing their pregnancy symptoms with maintaining a sense of bravado, trying to meet their physical needs whilst attempting to blend in. These tensions create an overriding sense of strain which is carried through the pregnancy, potentially impacting upon a woman's physical health and that of her unborn baby. Layla's story demonstrates a complacency within the system which primes an inappropriate response from staff and results in a potentially dangerous situation. Recent communications with the prison service and third sector charities suggest that Layla's situation is not unique, creating a sense of urgency in ensuring that the recommendations from this research are taken seriously to safeguard the physical and emotional health of women and their babies.

### **The pregnant prisoner as a public spectacle of shame**

The expression of shame was a probable expectation, given previous research and concepts of stigma as described by scholars such as Goffman (1961). Nonetheless, my findings reveal that ignominy was intensified as an institutional response to pregnancy as women felt paraded in public and branded with prisoner emblems. The inner torment this caused women was often expressed in indignance, that being a prisoner did not warrant what they perceived to be the public opinion that they were failing as a mother. The uniqueness of this finding suggests that pregnancy, and the resulting necessity of regular outings in public for health assessments, amasses supplementary suffering and shame for a woman different from any other type of prisoner experience. Contrastingly, the concept of the 'institutional shrug' describes how some women get used to such experiences, and show indifference as time goes on, although such acceptance seems not to apply to all pregnant prisoners. The notion of 'othering' was an expectation due to dehumanisation being synonymous with the prison experience, yet labelling women as '*the pregnant*s' added a new categorisation to the perception of 'othering'. Staff, although often demonstrating kindness (as illustrated in a new concept of 'the maternal' in prison officer typology), often revealed conflict in wishing to support pregnant women without showing special treatment. Women, too, would often feel confusion in being treated as the same as a 'normal prisoner' whilst feeling indignant that their pregnant status should be sacrosanct; this, juxtaposed with the tensions of not wishing to stand out, creating a sense of inner turmoil.

### **Pregnant women's layering of identity as a way of coping**

Goffman (1959) likens the masking of emotion and repression of feelings to a type of 'stage management'. Whereas stress and the pregnant prisoner have previously been linked together by researchers, the extent of the restraint they adopt and the layering of identity as a way of managing tension are unique findings of this research. This study has given voice to the manner in which pregnant women mask their emotions and cope with their experiences; from physically hiding their expanding pregnancy from other prisoners, to more subtle subterfuge in concealing their feelings. Not 'kicking off' for a pregnant woman is multi-layered, yet further exacerbates her inner anxiety and subsequent stress. The excessive restraint that a pregnant woman may adopt appears to have more to do with her unborn baby and her own survival in the mother-to-be role, than the fear of punishment for poor behaviour.

### **'Red tape' disguising the rights and entitlements for pregnant women in prison**

It was foreseeable that bureaucracy and 'red tape' would be found as ubiquitous in the prison system. Therefore, it was surprising to find that staff, as well as women, were unaware of available guidance. I also discovered, after deeper research, that guidance for pregnant women was hard to find and seemed to be as hidden as the women themselves. Commonly, women were unaware of their rights

and entitlements and this led to expressions of frustration and disempowerment with a potential for incalculable consequences for the woman; the lack of clear guidance for the treatment of pregnant women led to staff uncertainty, and feelings of insecurity in the women. At worst, this preceded misrepresentation of the midwifery role, breaching statutory regulation and rendering the pregnant woman and unborn baby vulnerable to inappropriate assessment and care. Furthermore, it appears that the language and the tone used by the PSOs enables a culture of complacency to escalate by rationalising the need for staff to take care not to show the use of 'special treatment'. This rationalisation can be combatted through the language of PSOs to facilitate a cultural shift and address the ambiguity felt by staff.

### **Unexpected findings**

The gaps in policy and guidance in an institution so steeped in rules and regulations were remarkable. However, considering the small numbers of pregnant women within the general prison population, it is easy to see how their presence has been overlooked through 'institutional thoughtlessness' or even 'institutional blindness'. The lack of midwifery input or knowledge about the midwifery role, especially in relation to assessment of pregnant women, was unanticipated, yet the dearth of research with a specific midwifery focus on pregnant women in prison could be an explanation. The ambivalence of the prison system's response to labouring women in prison was unanticipated and professionally alarming: there are no specific guidelines for emergency birth, not even basic instructions. Layla's experience troubled me, especially with her expressions of incredulity about her labour being disbelieved, and her emotional pain as she relayed her birth story in an interview. Most disturbing of all was the experience of staff, who, at worse, came across as complacent as they conveyed their accounts of their involvement in cell births when my feelings, based upon training and expert midwifery knowledge, were completely opposite, alerting me to the perils of the situation.

Bearing in mind the numbers of women in the general prison population who experience prison as a 'safe haven', it was unexpected to find that the majority of my sample did not fit this profile. Most of the women interviewed were experiencing prison for the first time, following their first offence, and were not substance misusers. This warrants further exploration, beyond the scope of this research, into why pregnant women are being incarcerated for non-violent crimes. The notion of 'institutional shrug' as a way of accepting poor conditions and predicaments (such as public handcuffing) was an unforeseen finding, yet leads to further questions about how some women can shift to a state of acquiescence, whilst others remain unaccepting of their plight. It is understood that in times of stress, people can demonstrate high levels of resilience; however, the inner strength of most of the women I interviewed, expressed either through restraint or fortitude, was an unpredicted finding. Whether

this surprised me due to my own reflections on the harshness of prison life or whether prison life itself leads to a harnessing of survivor mentality in pregnant women also remains an unanswered question.

## **Personal Growth**

My doctoral research has had an engrained impact on me on multiple levels. The closed institution of prison was a difficult world to inhabit. At times my personal resolve was tested due to my feeling haunted by the environment and the disturbing accounts from women. On reflection, the clinical psychotherapeutic supervision I accessed was indispensable in supporting my emotional wellbeing. The complexity of unravelling my own feelings to ensure interpretations of the women's voices were unbiased took determination and relentless self-critique. Writing this thesis found me considering how I might have undertaken this research differently as I struggled for the right words to depict the multiple truths. On a personal level, I have learnt to be more patient, to question deeper, to be more compassionate, to judge less and understand more. As a professional, I am learning that advocacy needs to be actionable rather than rhetorical, and that speaking out takes inordinate courage, yet is critical where women have no voice.

## **Impact**

From the outset, I was ambitious that my research would positively influence the way pregnant women in prison are perceived and hoped it would make an impact on society. I have always agreed with the sentiments of King and Wincup (2008:37) that there is '*no point in doing research unless it makes a difference*'; furthermore, research can build a substantive theory about a phenomenon. This goal led me to apply for funding awards and to raise the profile of my study from an early stage. I have been indelibly, personally, affected by the experiences of the women, and subsequently wish to campaign for better conditions. Participants would often tell me that they had 'no voice' and many women asked me to represent and share their experiences, so their voices could be heard: writing about and presenting my research has already highlighted some of the issues pregnant women in prison face, raising the voices of the women. The impact of this research has already gained some impetus and laid the foundations to ensure that the recommendations are followed up and implemented, with networks already firmly established, ensuring increasing momentum to set about making changes happen.

I have disseminated widely across midwifery, nursing, criminology, sociology and psychology disciplines (**Appendix 1.20**). This has helped to build a broad cross-academic network of interest and helped me in formulating questions and building up knowledge of disciplines outside of my own

expertise. A personal highlight was being asked to deliver a keynote speech about my research at the UNICEF *Baby Friendly Initiative* Annual Conference to an audience of over 800 delegates. Partnering with the charity *Birth Companions*, I have developed two online learning modules specifically relating to the care of pregnant women and new mothers in prison. A live ‘webinar’ for the Royal College of Midwives on the care of pregnant women in prison was delivered to an audience of midwives, students and support workers which culminated in an interactive question-and-answer session about my findings. Smaller presentations include: speaking at charity events; presenting to service users; seminar events at universities; and delivering papers at international conferences. I was invited to share my findings at Westminster with a Member of Parliament interested in my research and have met with leaders of the women’s team at the National Offender Management Service, the Prison Inspectorate and the Care Quality Commission who have expressed an interest in working together following completion of this thesis. My written work includes co-authoring the *Birth Charter* with *Birth Companions* which sets out evidence-based recommendations and guidance for the care of pregnant women and new mothers in prison (**Appendix 1.19**). Further articles and book chapters have honed my scholarly thinking and writing style whilst contributing to academic knowledge. These include two peer reviewed articles which were outside the scope of this research: findings relating to women’s breastfeeding experiences in prison, and reflections on leaving the field in prison research (**Appendix 1.16**).

### **Recommendations for future research**

This ethnographic study has uncovered several findings worthy of future examination. Investigations would be useful in evaluating the worth of supportive interventions for the pregnant woman in prison, to explore what could improve her experiences. Evaluation of the staff role on ‘bed watch’ with labouring women would help to understand more of the ‘maternal’ typology of the prison officer attending women in labour. It would be helpful to further delve into the midwife’s role in caring for the pregnant woman in prison to understand the nuances and make recommendations for best practice. Evaluating prison health care staff experience with pregnant women would uncover whether the breach of sphere of practice is a widespread phenomenon across the female prison estate. A survey of all pregnant women, or women who have recently given birth, across the whole estate could examine the concepts of institutional thoughtlessness, ignominy, coping, and bureaucratic layers in a quantitative way. Surveying women about the entitlements they receive against the entitlements they should get would add to quantitative knowledge to inform policy. Research into reception into prison needs to be undertaken to examine what advice and initial care are given to pregnant women. Detailed research into experiences of health in prison relating to food, equivalence of health care and comfort could be undertaken with greater focus to build upon the findings already gleaned. Investigating further the experiences of women separated from their babies would clarify more about

this unique group of women. I would also recommend research into the long-term health effects of those babies born to incarcerated pregnant women. The boundaries of this study meant that inquiries such as: the experience of fathers/partners; baby perspectives, and crimes committed were beyond the scope of my doctoral research and exploring those angles would add more depth to the body of knowledge.

- Quantitative and mixed method approaches should include wider-scale research where all pregnant women or women who have recently given birth across the whole estate are surveyed with questions built in around concepts of institutional thoughtlessness, ignominy, coping and bureaucratic layers. A longitudinal cohort study would be a useful method to extricate temporary and enduring experiences for perinatal women. Auditing women on the entitlements they receive against the entitlements they should get would be a useful addition to knowledge to inform prison and health policy.
- Research into reception into prison needs to be undertaken to examine what advice and initial care are given to pregnant women. Embedded case studies may be a useful way of following a woman through from reception to birth to explore the processes and the woman's experience in detail. Detailed research into experiences of physical and mental health in prison relating to nutrition, equivalence of health care and comfort could be undertaken in greater depth and focus, to build upon the findings already gleaned. Investigating further the experiences of women separated from their babies would clarify more about this unique group of women.
- Evaluation of the staff role on 'bed watch' with labouring women would help to understand more of the 'maternal' typology of the prison officer attending women in labour. It would be beneficial to look at the midwife's role in caring for the pregnant woman in prison in further depth to understand and make recommendations for best practice. Evaluating prison health care staff experience with pregnant women would uncover whether the breach of sphere of practice is a widespread phenomenon across the female prison estate.
- Future research should also include the evaluation of the roles of siblings, fathers and grandparents to examine their experiences in having a pregnant partner/mother in prison. Research could also include family members/partners deprived of participation in the birth and welcome of a new child.

## **Broad recommendations from findings of this study**

*“There'll be two types of pregnant prisoner: there'll be women who are in prison, pregnant, who have been to prison before, or they'll be like me who's pregnant in prison and never been to prison. So, if you've been to prison before you've got a little bit of an advantage, because you know how prison works. Whereas I was just coming in blind as a prisoner, and as a pregnant prisoner” (Caroline).*

A key finding of this doctoral research is that breaches of pregnant women's rights and entitlements are being experienced in some English prisons on multiple levels. Whilst the reasons for imprisonment and the suitability of prison for the pregnant woman have not been deliberated in this thesis, due consideration by the judicial system to alternatives to imprisonment, where possible, should be contemplated, as recommended by Corston (2007), and Baldwin and Epstein (2017). If there is no alternative to a custodial sentence for a pregnant woman, the development of clear, explicit and tailored guidance in the form of a PSI/PSO specific to the perinatal woman in prison is required with some urgency. To ensure that guidance is evidence-based, it is imperative that there is midwifery input. The *Birth Charter* offers appropriate and evidence-based guidance and recommendations that would be a useful foundation on which to create a PSO (Kennedy et al., 2016). This needs to be comprehensive but with clear definitions of the role of the midwife, linking to the NMC rules so as not to put nursing staff at risk of working outside of their sphere of professional practice by making decisions beyond their training. Seamless collaboration is required between the Prison Service, NHS Trusts and charities to facilitate the support of pregnant women: this is especially important with regards to obstetric emergencies but also concerns care in early labour, the potential for precipitous birth and the timely debriefing of women should they endure a cell birth. Women should not be giving birth in prison cells and if, on a rare occasion, an unexpected birth occurs, the minimum she should expect is to have an appropriately-trained professional to support her and her baby. Training needs to be robust, multidisciplinary and appropriately delivered by experts. This training and guidance should include legal perspectives of childbirth so that staff are aware of the statutory Nursing and Midwifery Order (2001) and that breaches are considered a criminal offence.

## **Recommendations for the Ministry of Justice and implications for policy**

- Accurate numbers of pregnant women must be collected and included by the MoJ in the monthly published prison population statistics. Maternal morbidity and neonatal outcomes, including stillbirth, premature labour and miscarriage, need to be recorded (by the Department



of Health in conjunction with the MoJ) as well as the incidence of pregnancy conditions such as pre-eclampsia.

- A Prison Service Order should be devised specifically relating to the perinatal woman.
- Appropriate plans should be made for pregnant women who are locked in at night, and they should be prioritised if calling for help.
- All pregnant women should be made aware of their entitlements on entry to prison. Staff should be trained to know pregnant women's entitlements. Written information should be given to women and, for those who have language barriers or who are unable to read, ways to ensure information is given should be adopted by the Prison Service. Entitlements should always be a matter of the woman's rights and not a privilege dependent on prisoner behaviour.
- A telephone should be available on each wing, modelled upon the 'Samaritans' phone' provision, for every pregnant woman to contact maternity services should she require expert advice.
- Pregnancy groups (facilitated by organisations and charities such as *Birth Companions* and *The Born Inside* project) where women can discuss hopes and fears and have access to information and guidance appropriate to their situation should be facilitated in every prison that holds pregnant women, and count as part of 'meaningful prison activity'.
- Female staff should accompany pregnant women to hospital appointments. NHS staff should be made aware of this. Staff should leave the room for scans or any examination which may expose a woman's body unless she expresses the wish to have prison staff present. Appropriate training and support should be given to prison officers who attend women on 'bed watch', with debriefing available when this has been especially emotional.
- At present the PSO 4800 (2008) states: '*Pregnant women are not handcuffed after arrival at a hospital or clinic. Women in labour are not handcuffed either en route to, or while in hospital. Restraints are carried but not applied unless necessary*' Policy should be explicit to ensure this guidance is followed. The use of handcuffs and / or chains should be the exception rather than the rule for perinatal women and guidance should be updated to reflect this. If handcuffs/chains are considered essential due to flight risk, written permission should be sought from the managing Governor.
- Basic provisions should be provided for lactating women. Breast pads should be available in every prison, on every prison wing where pregnant women or new mothers are held.
- Clothing brochures provided to prisoners should include a choice of maternity wear and women should be provided with appropriate maternity bras or be able to purchase these.

- Support for women recently separated from their babies should be offered and individual plans of care designed, in partnership with maternity teams and the woman, and prior to hospital discharge back to prison.
- Maternity leave must be meaningfully and properly planned in partnership with the women and not on an *ad hoc* basis. Women should receive maternity pay commensurate to that which she would receive if in employment or education in the community.
- Government online guidance should be updated to include maternity leave when giving instruction on benefit entitlements.
- When women are on maternity leave, they should be able to attend appropriate antenatal classes and be 'unlocked' during the daytime.

### **Recommendations for the prison inspectorate**

- Where pregnant women are held, it is essential to have an appropriately specialised midwife representative on the health inspectorate and the Care Quality Commission teams, to ensure appropriate assessment, evaluation and measurement of maternal wellbeing and conditions.
- Inspections should be conducted bi-annually across the prison estate until benchmarks have been set, training given, and guidance is firmly in place.

### **Recommendations for health care, midwives and maternity services**

- If confirmation of pregnancy is made on reception, referral to maternity services should be made within 24 hours and care plans developed. Ideally, a small team of specialist midwives should be involved with the care of pregnant women in prison, rather than reliance on one external staff member, to ensure appropriate cover and team support.
- Medication should be continued seamlessly on entry to prison to prevent exposure to risk of exacerbations of pre-existing conditions such as pre-eclampsia and mental illness. This is in line with current recommendations from MBRRACE-UK (2017) in relation to '*not stopping medication without consulting a specialist*'. If a woman is suspected to be in labour, is experiencing abdominal pain, bleeding, headaches or visual disturbances, she must always be assessed immediately by a midwife or obstetrician in the first instance.
- Appropriate multi-disciplinary training delivered by midwives should include emergency births and initial actions to be taken in case of an obstetric emergency whilst waiting for hospital transfer (such as post-partum haemorrhage).

- Pregnant women need 24-hour phone access to a Registered Midwife if they are to meet the minimum equivalence of health care standards afforded to women in the community. Conversations with a midwife should be held in private to maintain confidentiality.
- A hospital care pathway needs to be developed for pregnant prisoners attending antenatal departments and labour wards, to respond compassionately to her unique needs, e.g. the implication of discharging a woman in early labour 'home' to a prison cell needs to be understood.
- Development of the role of specialist midwife with additional training and experience in prison maternal health.

It is not surprising to find prison to be a place of tension, stress, loss of autonomy and basic provisions. Indeed, punishment and the prison environment has been the focus for scholars, researchers and humanist activists for centuries. Pregnant women appear incongruous to the patriarchal prison system. Staff as well as women are left vulnerable with the emotional trauma of separation of a baby from his/her mother with staff attending labours having no recourse to debriefing or specific training, loosening boundaries between care and security. Pregnant women in prison are in a minority but this should not render them invisible. This thesis has in some way attempted to strengthen their voice and has the potential to springboard future research and reformation, which will impact positively upon the health of the woman and her unborn baby on publication. New understandings of women at the margins of society have been exposed, making this thesis of noteworthy social interest. My thesis has dispelled some of the myths associated with the dualistic sacred/profane status of pregnant women in prison to question how women in prison should be cared for in a location which is necessarily stripped of the comforts generally accessible to women who are pregnant. Providing a societal documentary, I have reported on how the happenings, conversations, sounds, sights and milieu of prison life juxtapose the experiences of the pregnant women. The English prison has a hidden and minority population of pregnant women confined within. This research has illuminated some of their voices and clarified their experiences, from the indignity and fear of birthing in a cell, the shame of feeling paraded in public, to the missed opportunities for change and the turning points in behaviour for some; this study has revealed those encounters, contextualising women's voices. The scope for impact is substantial. My hopes for the future are that we can reform the landscape for pregnant women in prison so that negative experiences detailed within my work are not replicated and the opportunities for change are realised to their full potential.

---

## References

---

- Abbott, L. (2015). *A Pregnant Pause: Expecting in the Prison Estate*. In L. Baldwin (Ed.), *Mothering Justice: Working with Mothers in Criminal and Social Justice Settings* (1st ed.). England: Waterside Press.
- Abbott, L. and Scott, T. (2017). Women's Experiences of Breastfeeding in Prison. *MIDIRS Midwifery Digest*, 27(2).
- Abbott, L. and Scott, T. (2018). Reflections on Researcher Departure: Closure of Prison Relationships in Ethnographic Research. *Nursing Ethics*. February 2018. Sage.
- Albertson, K., O'Keefe, C., Lessing-Turner, G., Burke, C., and Renfrew, M. J. (2012). *Tackling Health Inequalities Through Developing Evidence-Based Policy and Practice with Childbearing Women in Prison: A Consultation*. The Hallam Centre for Community Justice, Sheffield Hallam University and The Mother and Infant Research Unit, University of York.
- Albertson, K., O'Keefe, C., Burke, C., Lessing-Turner, G. and Renfrew, M. (2014). Addressing Health Inequalities for Mothers and Babies in Prison. *Health and Inequality: Applying Public Health Research to Policy and Practice*, 39.
- Almack, K. (2008). Women Parenting Together: A Reflexive Account of the Ways in Which the Researcher's Identity and Experiences May Impact on the Processes of Doing Research. *Sociological Research Online*, 13(1), 4.
- Alvesson, M., and Sköldböck, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research*. Sage.
- Antonovsky, A. (1996). The Salutogenic Model as a Theory to Guide Health Promotion. *Health Promotion International*, 11(1), pp. 11-18.
- Antonovsky, A. (1987). The Salutogenic Perspective: Toward a New View of Health and Illness. *Advances, Institute for Advancement of Health*, 4 (1), 47-55
- Arnold, H. (2016). The Prison Officer. *Handbook on Prisons*, 265.
- Bakker, A. B., and Heuven, E. (2006). Emotional Dissonance, Burnout, and in-role Performance Among Nurses and Police Officers. *International Journal of Stress Management*, 13(4), 423.

- Baird, B., Murray, R., Seale, B., Foot, C. and Perry, C. (2015). Midwifery Regulation in the United Kingdom. *Report Commissioned by the Nursing and Midwifery Council, The King's Fund, London.*
- Balin, J. (1988). The Sacred Dimensions of Pregnancy and Birth, *Qualitative Sociology*, 11(4), pp. 275-301.
- Baldwin, L., O'Malley, S. and Galway, K. (2015). Mothers Addicted: Working with Complexity. Chapter 10: 239-262 in Baldwin, L. (2015). *Mothering Justice: Working with Mothers in Social and Criminal Justice Settings.*
- Baldwin, L. and Epstein, R. (2017). *Short but not Sweet: A Study of the Imposition of Short Custodial Sentences on Women, and in Particular, on Mothers.* De Montfort University.
- Baldwin, L. (2017). Motherhood Disrupted: Reflections of Post-Prison Mothers. *Emotion, Space and Society*. March 2017.
- Bailey, L. (1999). Refracted Selves? A Study of Changes in Self-Identity in the Transition to Motherhood. *Sociology*, 33(2), 335-352.
- Barbour, R. (2013). *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research:* Sage Publications Ltd.
- Bard, E., Knight, M., and Plugge, E. (2016). Perinatal Health Care Services for Imprisoned Pregnant Women and Associated Outcomes: A Systematic Review. *BMC Pregnancy and Childbirth*, 16(1), 285.
- Bartholomew, C.M. (2017). *Nausea and Vomiting in Pregnancy.* Chapter 52: 888-894 in *Mayes Midwifery: 15<sup>th</sup> Edition.* Eds. MacDonald, S. and Johnson, G. Elsevier. London.
- Beck, A. T., Steer, R. A., and Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* San Antonio, TX: Psychological Corporation.
- Beech, N. (2011). Liminality and the Practices of Identity Reconstruction. *Human Relations*, 64(2), 285-302.
- Bjørnholt, S. M., Leite, M., Albieri, V., Kjaer, S. K. and Jensen, A. (2016). Maternal Smoking During Pregnancy and Risk of Stillbirth: Results from a Nationwide Danish Register-Based Cohort Study. *Acta Obstetrica et Gynecologica Scandinavica*, 95(11), pp. 1305-1312.
- Body, C. and Christie, J. A. (2016). Gastrointestinal Diseases in Pregnancy: Nausea, Vomiting, Hyperemesis Gravidarum, Gastroesophageal Reflux Disease, Constipation, and Diarrhea. *Gastroenterology Clinics of North America*, 45(2), pp. 267-283.

- Bohannon, J. (2009). The Theory? Diet Causes Violence. The Lab? Prison. *Science*, 325(5948), pp.1614-1616.
- Booker, A., and Dearnley, H. (2016). Faith and Identity in Prison. In *Religion, Faith and Crime* (pp. 347-373): Springer.
- Bosworth, M. (2000). Conforming Femininity: A History of Gender, Power and Imprisonment. *Theoretical Criminology*. Vol. (3) 265 -284
- Bosworth, M. (1996). Resistance and Compliance in Women's Prisons: Towards a Critique of Legitimacy. *Critical Criminology*, 7(2), 5-19.
- Bowling, A. (2014). *Research Methods in Health: Investigating Health and Health Services*: McGraw-Hill Education (UK).
- Bottoms, A. E. (1999). Interpersonal Violence and Social Order in Prisons. *Crime and Justice*, 26, 205-281.
- Bradley, R. G., and Davino, K. M. (2002). Women's Perceptions of the Prison Environment: When Prison is "The Safest Place I've Ever Been". *Psychology of Women Quarterly*, 26(4), 351-359.
- Braun, V., Clarke, V. and Terry, G. (2012). Thematic analysis. *APA handbook of research methods in psychology*, 2, 57-71.
- Brayton, J. (1997). What Makes Feminist Research Feminist? The Structure of Feminist Research Within the Social Sciences. <http://www2.unb.ca/parl> [Accessed 19.06.16].
- Brinkmann, S., and Kvale, S. (2005). Confronting the Ethics of Qualitative Research. *Journal of Constructivist Psychology*, 18(2), 157-181.
- Brisman, A. (2008). Fair Fare: Food as Contested Terrain in US Prisons and Jails. *Georgetown Journal on Poverty Law and Policy*, 15, p. 49.
- Britain, G. (2013). *Women Offenders: After the Corston Report, Second Report of Session 2013-14, Vol. 1: Report, Together with Formal Minutes, Oral and Written Evidence*: Stationery Office.
- Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., and Kershaw, S. (2015). Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England. *British Journal of Social Work*, Volume 45, Issue 8, 1 December 2015, pp. 2241–2260.
- Brons, L. L. (2015). Othering, an Analysis. *Transcience*. Vol. 6, Issue 1.

- Brown, D. (2016). Finding Diamonds in the Rough and Helping Them Shine: Prospects for Penal Reform in the UK. *Alternative Law Journal*, 41(3), 155.
- Brown, J. E. and Toma, R. B. (1986). Taste Changes During Pregnancy, *The American Journal of Clinical Nutrition*, 43(3), pp. 414-418.
- Bryar, R., and Sinclair, M. (2011) *Signposting Future Developments in Midwifery Theory, Practice and Research*: In: Bryar, R., and Sinclair, M. (Eds.). *Theory for Midwifery Practice (second edition)*. Palgrave MacMillan: Basingstoke.
- Bryman, A., and Cassell, C. (2006). The Researcher Interview: A Reflexive Perspective. *Qualitative Research in Organizations and Management: An International Journal*, 1(1), 41-55.
- Bryman, A. (2015). *Social Research Methods*: Oxford University Press.
- Buckley, S. J. (2015). Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care, *Washington: Childbirth*.
- Bulman, M. (2017). 'Serious Failings' by Prison Staff Led to Suicide of 'Deeply Caring' Mother, Jury Finds. *The Independent*. Friday 26 May 2017. <http://www.independent.co.uk/news/uk/home-news/prison-staff-suicide-failings-caroline-ann-hunt-suicide-hmp-foston-hall-mother-cell-death-hanging-a7757941.html> [accessed 27.5.17].
- Burns, E., Fenwick, J., Schmied, V., and Sheehan, A. (2012). Reflexivity in Midwifery Research: The Insider/Outsider Debate. *Midwifery*, 28(1), 52-60.
- Caddle, D., and Crisp, D. (1997). *Home Office Research Study 162: Imprisoned Women and Mothers*. London: Home Office.
- Callahan, K. (2013). Women Who Kill: An Analysis of Cases in Late Eighteenth and Early Nineteenth Century London. *Journal of Social History*. Vol. 46, No.4: 1013-1038. Oxford University Press.
- Campbell, M. (1998). Institutional Ethnography and Experience as Data, *Qualitative Sociology*. March 1998, Volume 21, Issue 1, pp 55–73.
- Campbell, M. and Gregor, F. (2002). *Mapping Social Relations: A Primer in Doing Institutional Ethnography*. University of Toronto Press.
- Campbell, M., DeVault, M. L., Diamond, T., Eastwood, L., Griffith, A., McCoy, L., and Turner, S. (2006). *Institutional Ethnography as Practice*: Rowman & Littlefield Publishers.
- Campbell, M. (2003). Dorothy Smith and knowing the world we live in. *Journal of Sociology & Social Welfare*, 30, 3.

- Canales, M. K. (2000). Othering: Toward an Understanding of Difference, *Advances in Nursing Science*, 22(4), pp. 16-31.
- Canvin, K. L. (2000). *The Kick Inside: An Account of the Experience of Pregnancy in Prison*. [electronic resource, accessed 26.01.13].
- Cantora, A., Mellow, J., and Schlager, M. D. (2016). Social Relationships and Group Dynamics Inside a Community Correction Facility for Women. *International Journal of Offender Therapy and Comparative Criminology*, 60(9), 1016-1035.
- Capron, L., Glover, V., and Ramchandani, P. (2015). Does Maternal Antenatal Depression Alter Infant Hypothalamic-Pituitary-Adrenal (HPA) Axis Functioning in the Offspring at Four Months Postpartum? *Psychoneuroendocrinology*, 61, 33.
- Carlen, P., and Worrall, A. (2004). *Analysing Women's Imprisonment*. Taylor & Francis.
- Carrington, K. (2014). *Feminism and Global Justice*. Routledge. New York.
- Chambers, A. N. (2009). Impact of Forced Separation Policy on Incarcerated Postpartum Mothers. *Policy, Politics, & Nursing Practice*, 10(3), 204-211.
- Chamberlen, A. (2015). Embodying Prison Pain: Women's Experiences of Self-Injury in Prison and the Emotions of Punishment. *Theoretical Criminology*. Vol. 20, no. 2, 205-219.
- Christopher, P. P., Candilis, P. J., Rich, J. D., and Lidz, C. W. (2011). An Empirical Ethics Agenda for Psychiatric Research Involving Prisoners. *AJOB primary research*, 2(4), 18-25.
- Citizens Advice Bureau, (2017). <https://www.citizensadvice.org.uk/law-and-courts/civil-rights/human-rights/what-rights-are-protected-under-the-human-rights-act/your-right-not-to-be-tortured-or-treated-in-an-inhuman-way/> [accessed 26.09.17].
- Clarke, J. G., and Adashi, E. Y. (2011). Perinatal Care for Incarcerated Patients: a 25-year-old Woman Pregnant in Jail. *JAMA*, 305(9), 923-929.
- Clough, P., and Strycharczyk, D. (2012). *Developing Mental Toughness: Improving Performance, Wellbeing and Positive Behaviour in Others*: Kogan Page Publishers.
- Cooke, A., Smith, D., and Booth, A. (2012). Beyond PICO the SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, 22(10), 1435-1443.
- Corston, J. (2007). *The Corston Report: A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System: The Need for a Distinct, Radically*



*Different, Visibly-led, Strategic, Proportionate, Holistic, Woman-centred, Integrated approach.* Home Office.

Council of Europe. Committee of Ministers. (2006). *European Prison Rules*. Council of Europe. Recommendation Rec. 2 of the Committee of Ministers to member states on the European Prison Rules.

Craig, S. C. (2009). An Historical Review of Mother and Child Programs for Incarcerated Women. *The Prison Journal*. Vol. 89. No.1. Sage Publishers.

Crawley, E. M. (2004). Emotion and Performance: Prison Officers and the Presentation of Self in Prisons. *Punishment & Society*, 6(4), 411-427.

Crawley, E. (2005). Institutional Thoughtlessness in Prisons and its Impacts on the Day-to-Day Prison Lives of Elderly Men. *Journal of Contemporary Criminal Justice*, 21(4), 350-363.

Creswell, J.W. (2016). *30 Essential Skills for the Qualitative Researcher*. Sage Publications.

Creswell, J.W. and Poth, C.N. (2017). *Qualitative Inquiry and Research Design*, Thousand Oaks: Sage.

Crewe, B. (2009). *The Prisoner Society: Power, Adaptation and Social Life in an English Prison*: Oxford University Press.

Crewe, B., Liebling, A., and Hulley, S. (2015). Staff-Prisoner Relationships, Staff Professionalism, and the Use of Authority in Public- and Private-Sector Prisons. *Law & Social Inquiry*, 40(2), 309-344.

Crewe, B., Hulley, S., and Wright, S. (2017). The Gendered Pains of Life Imprisonment. *British Journal of Criminology*, 20.

Cumberledge, J. (2016). National Maternity Review. Better Births: Improving Outcomes for Maternity Services in England: A Five Year Forward View for Maternity Care. London: NHS. <https://www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf> [accessed 22.12.17].

Curtin, S. C., and Matthews, T. J. (2016). 'Smoking Prevalence and Cessation Before and During Pregnancy: Data from the Birth Certificate, 2014', *National Vital Statistics Reports: From the Centres for Disease Control and Prevention, National Centre for Health Statistics, National Vital Statistics System*, 65(1), pp. 1-14.

Darlington, Y., and Scott, D. (2003). *Qualitative Research in Practice: Stories from the Field*: Taylor & Francis.

- Davidson, J. (2001). Pregnant Pauses: Agoraphobic Embodiment and the Limits of (Im)pregnability. *Gender, Place and Culture: A Journal of Feminist Geography*, 8(3), 283-297.
- Denscombe, M. (2014). *The Good Research Guide: for Small-Scale Social Research Projects*: McGraw-Hill Education (UK).
- Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services*, Standard 11: Maternity Services. London: DH.
- Derrida, J. (1967). *Of Grammatology*. Baltimore, MD: Johns Hopkins University Press.
- Derrida, J. (1982). *Margins of Philosophy*. Chicago, IL: University of Chicago Press.
- Dervin, F. (2016). Discourses of Othering, in *Interculturality in Education*. Palgrave Pivot. Springer, pp. 43-55.
- Dewa, L. H., Hassan, L., Shaw, J. J., and Senior, J. (2017). Trouble Sleeping Inside: A Cross-Sectional Study of the Prevalence and Associated Risk Factors of Insomnia in Adult Prison Populations in England. *Sleep Medicine*, 32, 129-136.
- Dickson-Swift, V., James, E. L., Kippen, S., and Liamputtong, P. (2009). Researching Sensitive Topics: Qualitative Research as Emotion Work. *Qualitative Research*, 9(1), 61-79.
- Dolan, R. M., Birmingham, L., Mullee, M., and Gregoire, A. (2013). The Mental Health of Imprisoned Mothers of Young Children: A Follow-up Study. *Journal of Forensic Psychiatry & Psychology*, 24(4), 421-439.
- Dolan, R. M. (2016). Pregnant Women, Mothers, Mother and Baby Units and Mental Health in Prisons. *Psychology Postgraduate Affairs Group* (100), 32-36.
- Doward, J. (2016). New Crisis in Prisons as Suicides Hit Record Levels. *The Guardian*: 29 October 2016. <https://www.theguardian.com/society/2016/oct/29/prison-suicides-record-levels-scandal> [accessed 05.10.16].
- Downe, S. (2010). Towards Salutogenic Birth in the 21st Century. *Essential Midwifery Practice: Intrapartum Care*. Oxford: Wiley-Blackwell.
- Downe, S., and Dykes, F. (2009). Counting Time in Pregnancy and Labour. *Childbirth, Midwifery and Concepts of Time*, 61-83.
- Dowswell, T., Renfrew, M. J., Gregson, B., and Hewison, J. (2001). A Review of the Literature on Women's Views on their Maternity Care in the Community in the UK. *Midwifery*, 17(3), 194-202.
- Earle, S., and Letherby, G. (2003). *Gender, Identity and Reproduction*. Springer.

- Earthy, S., and Cronin, A. (2008). *Narrative Analysis*. Chapter 21. Pp 420 – 439 In Gilbert, N., (2008). *Researching Social Life*: Sage.
- Edge, D. (2006). Perinatal Health care in Prison: A Scoping Review of Policy and Provision. *The Prison Health Research Network, Manchester*.
- Enkin, M. W., and Jadad, A. R. (1998). Using Anecdotal Information in Evidence-Based Health Care: Heresy or Necessity? *Annals of Oncology*, 9(9), 963-966.
- Feldman, D. (1999). The Human Rights Act 1998 and Constitutional Principles', *Legal Studies*, 19(2), pp.165-206.
- Ferszt, G. G. (2011). Who will Speak for Me? Advocating for Pregnant Women in Prison. *Policy, Politics, & Nursing Practice*, 12(4), 254-256.
- Ferszt, G. G., and Clarke, J. G. (2012). Health Care of Pregnant Women in US State Prisons. *Journal of Health Care for the Poor and Underserved*, 23(2), 557-569.
- Fiander, S. (2016). Pregnancy, Birth, and Mothering Behind Bars: A Case Study of One Woman's Journey Through the Ontario Criminal Justice and Jail Systems. Wilfrid Laurier University. Theses and Dissertations.
- Fielding, J. (2008). *Coding and Managing Data*. Chapter 17. Pp.323 – 352. In Gilbert, N., (2008). *Researching Social Life*: Sage.
- Fielding, N., and Thomas, H. (2008). Qualitative Interviewing. Chapter 13. Pp.245 – 265 In Gilbert, N., (2008). *Researching Social Life*: Sage.
- Fitzgibbon, W., and Stengel, C. M. (2017). Women's Voices Made Visible: Photovoice in Visual Criminology. *Punishment & Society*, March, 2017.
- Fludernik, M. (1999). Carceral Topography: Spatiality, Liminality and Corporality in the Literary Prison. *Textual Practice*, 13(1), 43-77.
- Fontes, L. A. (2004). Ethics in Violence Against Women Research: The sensitive, the dangerous, and the overlooked. *Ethics & Behavior*, 14(2), 141-174.
- Forey, B., Hamling, J., Hamling, J., Thornton, A., and Lee, P. (2016). *International Smoking Statistics*: A Collection of Worldwide Historical data. Wolfson Institute of Preventive Medicine.
- Foucault, M. (1979). *Discipline and Punishment. The Birth of the Prison*. Vintage Books.

- Fullerton, C. A., Kim, M., Thomas, C. P., Lyman, D. R., Montejano, L. B., Dougherty, R. H., and Daniels, A. S., (2014). Medication-Assisted Treatment with Methadone: Assessing the Evidence, *Psychiatric Services*, 65(2), pp.146-157.
- Fritz, S., and Whiteacre, K. (2016). Prison Nurseries: Experiences of Incarcerated Women During Pregnancy. *Journal of Offender Rehabilitation*, 55(1), 1-20.
- Galloway, S., Haynes, A., and Cuthbert, C. (2015). All Babies Count – An Unfair Sentence: Spotlight on the Criminal Justice System. *In*: London: NSPCC.
- Gardiner, A., Daniel, B., Burgess, C., and Nolan, L. (2016). The Rose Project: Best for Babies - Determining and Supporting the Best Interests and Wellbeing of Babies of Imprisoned Mothers in Scotland. University of Stirling.
- Garland, D. (1985). *Punishment and Welfare: A History of Penal Strategies*: Gower. Aldershot.
- Gelsthorpe, L., and Morris, A. (1990). *Feminist Perspectives in Criminology*. Milton Keynes: Open University Press.
- Gerrish, K., and Lacey, A. (2010). *The Research Process in Nursing*: John Wiley & Sons.
- Gerry, F., and Harris, L. (2016). Women in Prison: is the Justice System Fit for Purpose? Halsbury Law Exchange. <http://blogs.lexisnexis.co.uk/halsburyslalexchange/wp-content/uploads/sites/25/2016/11/SA-1016-077-Women-in-Prison-Paper-ONLINE-FINAL.pdf> [Accessed 21.09.17].
- Gibbs, J. J. (1982). 'Disruption and Distress: Going From the Street to Jail', *Coping with Imprisonment*, pp.29-44.
- Gilbert, M. J. (1997). The Illusion of Structure: A Critique of the Classical Model of Organization and the Discretionary Power of Correctional Officers. *Criminal Justice Review*, 22(1), 49-64.
- Gilbert, N., and Stoneman, P. (2015). *Researching Social Life*: Sage.
- Giorgi, A. (1997). The Theory, Practice, and Evaluation of the Phenomenological Method as a Qualitative Research Procedure. *Journal of Phenomenological Psychology*, 28, 235-260.
- Given, L. M. (2008). *The Sage Encyclopedia of Qualitative Research Methods*. Sage Publications.
- Glaser, B. G., and Strauss, A. L. (1969/2011). *Status Passage*: Transaction Publishers.
- Glatte, E., and Bjerkedal, T. (1983). The 24-Hour Rhythmicity of Birth. *Acta Obstetricia et Gynecologica Scandinavica*, 62(1), 31-36.

- Glover, V., and O'Connor, T. G. (2002). Effects of Antenatal Stress and Anxiety. *The British Journal of Psychiatry*, 180(5), pp.389-391.
- Glover, V., O'Connor, T., and O'Donnell, K. (2010). Prenatal Stress and the Programming of the HPA Axis. *Neuroscience & Biobehavioral Reviews*, 35(1), pp.17-22.
- Godderis, R. (2006a). Dining in: The Symbolic Power of Food in Prison. *The Howard Journal of Criminal Justice*, 45(3), pp. 255-267.
- Godderis, R. (2006b). Food for Thought: An Analysis of Power and Identity in Prison Food Narratives. *Berkeley Journal of Sociology*, Vol.50. pp. 61-75.
- Goffman, E. (1959). *The Presentation of Self in Everyday Life*. In: Garden City, NY: Doubleday Anchor.
- Goffman, E. (1961). *On the Characteristics of Total Institutions*. Paper presented at the Symposium on Preventive and Social Psychiatry.
- Goffman, E. (1963). *Stigma; Notes on the Management of Spoiled Identity*. Penguin.
- Goffman, E. (1968). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*: Aldine Transaction.
- Gomm, R. (2008). *Social Research Methodology: A Critical Introduction*: Palgrave MacMillan.
- Graham, H. and Hunt, S. (1994). Women's Smoking and Measures of Women's Socio-Economic Status in the United Kingdom. *Health Promotion International*, 9(2), pp.81-88.
- Gravett, S. (2003). *Coping with Prison: A Guide to Practitioner on the Realities of Imprisonment*. SAGE.
- Greene, R. R. (2002). Holocaust Survivors: A study in Resilience. *Journal of Gerontological Social Work*, 37(1), 3-18.
- Guba, E. G., and Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. *Handbook of Qualitative Research*, 2(163-194), 105.
- Gulick, R. (2003). *Approaches to Field Research*. in Burgess, R. G. (2003). *Field research: A sourcebook and field manual*: Chapter 1. P15. Routledge.
- Gullberg, S. (2013). State of the Estate - Women in Prison's Report on the Women's Custodial Estate 2011-12. *London: Women in Prison*.

- Halliday, A., Miller, C., and Peterson, J. (2017). "What are Women's Prisons for?" Gendered States of Incarceration and History as an Agent for Social Change. *Museums & Social Issues*, 1-11.
- Hammersley, M. (2013). *What's Wrong with Ethnography?* Routledge.
- Hammersley, M., and Atkinson, P. (2007). *Ethnography: Principles in Practice*: Routledge.
- Haney, C., Banks, W. C., and Zimbardo, P. G. (1973). A Study of Prisoners and Guards in a Simulated Prison. *Naval Research Reviews*, 9 (1-17).
- Hart, C. (2007). *Doing a Literature Review: Releasing the Social Science Research Imagination*: Sage. 5<sup>th</sup> Edition.
- Harvey, J. (2007). *Young Men in Prison: Surviving and Adapting to Life Inside*. Routledge.
- Harvey, J. (2008). *An Embedded Multimethod Approach to Prison Research*. In King, R., and Wincup, E. (2008). *Doing Research on Crime and Justice*: Part V: Chapter 18: pp.487-500. Oxford University Press.
- Harvey, J. (2015). *The Ethnographic Practitioner*. In: *The Palgrave Handbook of Prison Ethnography*. Part III: Chapter 20: pp.390-402. Springer.
- Hennekam, S. (2016). Identity Transition During Pregnancy: The Importance of Role Models. *Human Relations*, Volume: 69, issue: 9, 1765-1790.
- HM Chief Inspector of Prisons (2016). *Report on an Unannounced Prison Inspection of HMP and X*. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/10/HMP-YOI-Web-2016-1.pdf> [Accessed 14.12.16].
- Ho, A., Flynn, A. C., and Pasupathy, D. (2016). Nutrition in Pregnancy. *Obstetrics, Gynaecology & Reproductive Medicine*, 26(9), pp. 259-264.
- Hochschild, A. R. (2003). *The Managed Heart: Commercialization of Human Feeling*: University of California Press
- Hodnett, E. (2004). Continuity of Caregivers for Care During Pregnancy and Childbirth (Cochrane Review), *Cochrane Database of Systematic Reviews*, Issue 4.
- Hotham, E. D., Ali, R. L., White, J. M., and Robinson, J. S. (2016). Ethical Considerations When Researching with Pregnant Substance Users and Implications for Practice. *Addictive Behaviors*, 60, 242-243.

- Horrigan-Kelly, M., Millar, M., and Dowling, M. (2016). Understanding the Key Tenets of Heidegger's Philosophy for Interpretive Phenomenological Research. *International Journal of Qualitative Methods*, 15(1), January-December: 1–8.
- Hotelling, B. A. (2008). Perinatal Needs of Pregnant, Incarcerated Women. *The Journal of Perinatal Education*, 17(2), 37-44.
- Howson, A. (2013). *The Body in Society: An Introduction*. John Wiley & Sons.
- Hunt, S. C., and Symonds, A. (1995). *The Social Meaning of Midwifery*. MacMillan. London.
- Hutchinson, K. C., Moore, G. A., Propper, C. B., and Mariaskin, A. (2008). Incarcerated Women's Psychological Functioning During Pregnancy. *Psychology of Women Quarterly*, 32(4), 440-453.
- Jayes, L. R., Ratschen, E., Murray, R. L., Dymond-White, S. and Britton, J. (2016). Second-Hand Smoke in Four English Prisons: An Air Quality Monitoring Study. *BMC public health*, 16(1), p. 119.
- Jefferson, A. M. (2015). Performing Ethnography: Infiltrating Prison Spaces. *The Palgrave Handbook of Prison Ethnography*, 169.
- Jewell, K. (2017). *Nutrition*. Chapter 17: 262-273. in *Mayes Midwifery: 15<sup>th</sup> Edition*. Eds., MacDonald, S., and Johnson, G. Elsevier. London.
- Jewkes, Y. (2005). Loss, Liminality and the Life Sentence: Managing Identity Through a Disrupted Lifecourse. *The Effects of Imprisonment*, 366-388.
- Jewkes, Y. (2012). Autoethnography and Emotion as Intellectual Resources Doing Prison Research Differently. *Qualitative Inquiry*, 18(1), 63-75.
- Jewkes, Y., Crewe, B., and Bennett, J. (2016). *Handbook on Prisons*: Routledge.
- Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., and Clarke, H. (2004). Othering and Being Othered in the Context of Health Care Services. *Health Communication*, 16(2), pp.255-271.
- Jones, R. S., and Schmid (2000). *Doing Time: Prison Experience and Identity Among First-Time Inmates*. Emerald Group Publishing Limited.
- Kennedy, A., Marshall, D., Parkinson, D., Delap, N., and Abbott, L. (2016). *Birth Charter for Women in Prison in England and Wales*. London. Birth Companions.
- King, N., and Horrocks, C. (2010). *Interviews in Qualitative Research*: Sage.
- King, R., and Wincup, E. (2008). *Doing Research on Crime and Justice*: Oxford University Press.

- King, R., and Liebling, A. (2008). *Doing Research in Prisons*. Chapter 15. Pp.431-455. In: *Doing Research on Crime and Justice*. Ed: King, R., and Wincup, E. (2008). Oxford University Press.
- Kirsch, G. (1999). *Ethical Dilemmas in Feminist Research: The Politics of Location, Interpretation, and Publication*: SUNY Press.
- Kitzinger, S. (1997). 'Sheila Kitzinger's Letter from Europe: How can we Help Pregnant Women and Mothers in Prison?', *Birth*, 24(3), pp.197-8.
- Kleinman, S. (2007). *Feminist Fieldwork Analysis*: Sage.
- Knox, S., and Burkard, A. W. (2009). Qualitative Research Interviews. *Psychotherapy Research*, 19(4-5), 566-575.
- Knight, M., and Plugge, E. (2005a). Risk Factors for Adverse Perinatal Outcomes in Imprisoned Pregnant Women: A Systematic Review. *BMC Public Health*, 5(1), p.111.
- Knight, M., and Plugge, E. (2005b). The Outcomes of Pregnancy Among Imprisoned Women: A Systematic Review. *British Journal of Obstetrics and Gynaecology: An International Journal of Obstetrics & Gynaecology*, 112(11), pp. 1467-1474.
- Knight, C. (2012). *Soft Skills for Hard Work: An Exploration of the Efficacy of the Emotional Literacy of Practitioners Working Within the National Offender Management Service (NOMS) with high risk offenders*. Doctoral theses: De Montford University.
- Knight, C., Phillips, J., and Chapman, T. (2016). Bringing the Feelings Back: Returning Emotions to Criminal Justice Practice. *British Journal of Community Justice*, 14(1), 45.
- Knight, V. (2014). *Researching Complexity: Social Domains and Emotion in Prison Research*. Paper presented at De Montford University, Leicester.
- Koenig, H. G. (1995). Religion and Older Men in Prison. *International Journal of Geriatric Psychiatry*, 10(3), pp. 219-230.
- Kristiansson, P., Svärdsudd, K. and von Schoultz, B. (1996). Serum Relaxin, Symphyseal Pain, and Back Pain During Pregnancy. *American Journal of Obstetrics and Gynaecology*, 175(5), pp. 1342-1347.
- Kvale, S. (2006). Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, 12(3), 480-500.
- Kvale, S. (2008). *Doing Interviews*: Sage.
- Laing, R. (1960). *The Divided Self: An Existential Study in Sanity and Madness* (Vol. 731) Penguin UK.



- Lawson, A., and Marsh. E. (2017). Hearing the Silenced Voices of Underserved Women. *Obstetrics and Gynaecology Clinics*. Elsevier, 44 (1), pp.109-120.
- Leap, N., Sandall, J., Buckland, S., and Huber, U. (2010). Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care. *Journal of Midwifery & Women's Health*, 55(3), pp. 234-242.
- LeBel, T. P., Burnett, R., Maruna, S., and Bushway, S. (2008). The Chicken and Egg of Subjective and Social Factors in Desistance from Crime. *European Journal of Criminology*, 5(2), 131-159.
- Leder, D. (2016). *The Distressed Body: Rethinking Illness, Imprisonment, and Healing*: University of Chicago Press.
- Lee-Treweek, G., and Linkogle, S. (2000). *Danger in the Field: Risk and Ethics in Social Research*: Psychology Press.
- Leifer, D. (2003). The Keys to Care: A Team of Community Midwives is Giving Some of the Most Disadvantaged Women in Society a High-Quality Maternity Service. *Nursing Standard*, 18(13), 14-16.
- Letherby, G. (2002). Claims and Disclaimers: Knowledge, Reflexivity and Representation in Feminist Research. *Sociological Research Online*, 6(4).
- Levac, D., Colquhoun, H., and O'Brien, K. K. (2010). Scoping Studies: Advancing the Methodology. *Implementation Science*, 5(1), 69.
- Liebling, A. (1999). Doing Research in Prison: Breaking the Silence? *Theoretical Criminology*, 3(2), 147-173.
- Liebling, A. (2004). *Prisons and Their Moral Performance: A Study of Values, Quality, and Prison Life*. Oxford University Press.
- Liebling, A., and Maruna, S. (2013). *The Effects of Imprisonment*. Routledge.
- Liebling, A. (2011). Moral performance, Inhuman and Degrading Treatment and Prison Pain. *Punishment & Society*, 13(5), 530-550.
- Liebling, A., Price, D., and Shefer, G. (2010). *The Prison Officer*. Routledge.
- Longhurst, R. (2001). Breaking Corporeal Boundaries: Pregnant Bodies in Public Places. *Contested Bodies*, pp. 81-94.
- Lofland, J., and Lofland, L. H. (2006). *Analyzing Social Settings*: Wadsworth Publishing Company Belmont, CA

- McNabb, M. (2017). *Maternal Neurohormonal and Systematic Adaptions to Feto-Maternal Development*. Chapter 31: 484-502. in *Mayes Midwifery: 15<sup>th</sup> Edition*. Eds., MacDonald S., and Johnson, G. Elsevier. London.
- Mander, R. (2011). The Partnership Model. Chapter 14: 304- 317 in Bryar, R., and Sinclair, M. (Eds.). *Theory for Midwifery Practice* (second edition). Palgrave MacMillan: Basingstoke
- Marmot, M. G. (2010). *Fair Society, Healthy Lives: The Marmot Review. Executive Summary*. Strategic Review of Health Inequalities in England Post-2010.
- Marshall, D. (2010). Birth Companions: Working with Women in Prison Giving Birth. *British Journal of Midwifery*, 18(4), 255.
- Maruna, S., Wilson, L., and Curran, K. (2006). Why God is often Found Behind Bars: Prison Conversions and the Crisis of Self-Narrative. *Research in Human Development*, 3(2-3), 161-184.
- Maruna, S. (2001). *Making Good: How ex-Convicts Reform and Rebuild their Lives*: American Psychological Association.
- Maruna, S., McNeill, F., Farrall, S., and Lightowler, C. (2012). Desistance Research and Probation Practice: Knowledge Exchange and Co-Producing Evidence-Based Practice Models. *Irish Probation Journal*. Volume 9, October 2012.
- Mason, J. (2002). Qualitative Interviewing: Asking, Listening and Interpreting. *Qualitative Research in Action*, 225-241.
- Mason, M. (2010). *Sample Size and Saturation in PhD Studies Using Qualitative Interviews*. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.
- Mayhew, H., and Binny, J. (2011). *The Criminal Prisons of London: And Scenes of Prison Life*: Cambridge University Press.
- McCourt, C. (2009). How Long Have I Got? Time in Labour: Themes from Women's Birth Stories. *Childbirth, Midwifery and Concepts of Time*. New York, NY: Berghahn Books, pp. 184-201.
- McCourt, C. (2013). *Childbirth, Midwifery and Concepts of Time*. Berghahn Books.
- McCourt, C., Stevens, T., Sandall, J., and Brodie, P. (2006). Working with Women: Developing Continuity of Care in Practice. *The New Midwifery: Science and Sensitivity in Practice*, pp.141-165.
- McKenna, H., Hasson, F., and Keeney, S. (2010). Surveys. Chapter 18, pp. 216 – 236, In Gerrish, K., and Lacey, A. (2010). *The Research Process in Nursing*: John Wiley & Sons.

- Michalski, J. H. (2017). An Integrated Theory of Lethal Punishment: Social Geometry, Status Relationships, and the Dehumanization Process. *Comparative Sociology*, 16(2), 248-283.
- Miller, J. (2008). "Otherness". *The SAGE Encyclopedia of Qualitative Research Methods*. Thousand Oaks, CA: SAGE Publications, Inc., 588–91.
- Ministry of Justice. (2017). *Population and Capacity Briefing for Friday 22nd December*. London: Ministry of Justice.
- Moher, D., Stewart, L., and Shekelle, P. (2015). All in the Family: Systematic Reviews, Rapid Reviews, Scoping Reviews, Realist Reviews, and More. *Systematic Reviews*, 4(1), 183.
- Moore, L., Scraton, P., and Wahidin, A. (2017). *Women's Imprisonment and the Case for Abolition: Critical Reflections on Corston Ten Years On*. Routledge.
- Morse, J. M. (2000). Determining Sample Size. *Qualitative Health Research*, 10(1), 3-5.
- Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK). (2017). National Perinatal Epidemiology Unit. Oxford.  
<https://www.npeu.ox.ac.uk/mbrrace-uk> [accessed on 20.12.17].
- Mullings, B. (1999). Insider or Outsider, Both or Neither: Some Dilemmas of Interviewing in a Cross-Cultural Setting. *Geoforum*, 30(4), 337-350.
- Naples, N. A. (2003). *Feminism and Method: Ethnography, Discourse Analysis, and Activist Research*. Psychology Press.
- Naples, N. A. (2014). Deconstructing and Locating Survivor Discourse: Dynamics of Narrative, Empowerment, and Resistance for Survivors of Childhood Sexual Abuse. *Signs*, 40(1).
- National Institute for Health and Clinical Excellence (NICE, 2010). *Pregnancy and Complex Social Factors: A Model for Service Provision for Pregnant Women with Complex Social Factors*. NICE.  
<http://www.nice.org.uk/guidance/cg110> [accessed on 13.09.17].
- National Institute for Health and Clinical Excellence (NICE, 2014). *Pregnancy and Complex Social Factors Overview*. NICE. <http://pathways.nice.org.uk/pathways/pregnancy-and-complexsocialfactors> [accessed on 13.09.17].
- National Offender Management Services. (2014). *Mother and Baby Units Prison Service Instruction (PSI) 49/2014 PI 63/2014*. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2014/psi-49-2014-mother-and-baby-units.pdf> [accessed on 10.08.15].

- Newcomen, N. (2016). *Independent Investigation into the Death of Ms M B a Prisoner at HMP L on 16 December 2015*. Probation Ombudsman Independent Investigations: A Report by the Prisons and Probation Ombudsman.
- Niebyl, J. R. (2010). Nausea and Vomiting in Pregnancy. *New England Journal of Medicine*, 363(16), pp. 1544-1550.
- Niveau, G. (2007). Relevance and Limits of the Principle of “Equivalence of Care” in Prison Medicine. *Journal of Medical Ethics*, 33(10), 610-613.
- North, J., Chase, L., and Alliance, M. (2006). *Getting it Right: Services for Pregnant Women, New Mothers, and Babies in Prison*: Lankelly Chase.
- Nursing and Midwifery Council (2015). *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.
- Nursing and Midwifery Order, 45 Statutory. (2001). Department of Health. [http://www.legislation.gov.uk/ukxi/2002/253/pdfs/ukxi\\_20020253\\_en.pdf](http://www.legislation.gov.uk/ukxi/2002/253/pdfs/ukxi_20020253_en.pdf) [accessed 10.02.17].
- Nyange, C., and Cphi, D. (2017). Common Discomforts of Pregnancy. *Childbirth Education*, 25.
- Oakley, A., and Roberts, H. (1981). Interviewing Women: A Contradiction in Terms. *Doing Feminist Research*, 30(6), 1.
- Oakley, A. (1979). A Case of Maternity: Paradigms of Women as Maternity Cases. *Signs*, 4(4), 607-631.
- Oakley, A. (2016). The Sociology of Childbirth: An Autobiographical Journey Through Four Decades of Research. *Sociology of Health & Illness*. Volume 38, Issue 5. Pp.685–836.
- O'Donnell, I. (2014). *Prisoners, Solitude, and Time*. Oxford University Press.
- Olcese, J., Lozier, S., and Paradise, C. (2013). Melatonin and the Circadian Timing of Human Parturition. *Reproductive Sciences*, 20(2), 168-174.
- O'Keefe, C., and Dixon, L. (2015). *Enhancing Care for Childbearing Women and their Babies in Prison*, [http://www.birthcompanions.org.uk/media/Public/Resources/Extpublications/FINAL\\_MBU\\_report\\_8th\\_December\\_2016.pdf](http://www.birthcompanions.org.uk/media/Public/Resources/Extpublications/FINAL_MBU_report_8th_December_2016.pdf) [accessed on 14.03.16].
- Orwell, G. (1949). *Nineteen Eight Four*. Penguin modern classics.

- Parveen, N (2016). Prisons ombudsman investigates death of new mother taken off suicide watch. *The Guardian*, [https://www.theguardian.com/society/2016/feb/09/new-mother-killed-herself-prison-shortly-after-taken-off-suicide-watch?CMP=share\\_btn\\_gp](https://www.theguardian.com/society/2016/feb/09/new-mother-killed-herself-prison-shortly-after-taken-off-suicide-watch?CMP=share_btn_gp) [accessed on 02.01.17].
- Paternoster, R., and Bachman, R. (2017). The Missing Element in Theories of Desistance. *The Routledge International Handbook of Life-Course Criminology*, 29.
- Peterson, J., Pearce, P. F., Ferguson, L. A., and Langford, C. A. (2017). Understanding Scoping Reviews: Definition, Purpose, and Process. *Journal of the American Association of Nurse Practitioners*, 29(1), 12-16.
- Piché, J., Gaucher, B., and Walby, K. (2014). Facilitating Prisoner Ethnography: An Alternative Approach to “Doing Prison Research Differently”. *Qualitative Inquiry*, 20(4), 449-460.
- Player, E. (2007). Remanding Women in Custody: Concerns for Human Rights. *The Modern Law Review*, 70(3), pp. 402-426.
- Plimmer, G. (2016). Care UK Becomes Biggest Prison Health Care Provider. *Financial Times*. 9<sup>th</sup> May 2016.
- Plummer, K. (2001). The Call of Life Stories in Ethnographic Research. *Handbook of Ethnography*, 395-406.
- Polit, D., and Hungler, B. (2001). *Essentials of Nursing Research: Methods, Appraisal, and Utilization*. Philadelphia: Lippincott.
- Powell, C., Marzano, L., and Ciclitira, K. (2016). 'Mother–Infant Separations in Prison. A Systematic Attachment-Focused Policy Review', *The Journal of Forensic Psychiatry & Psychology*, Taylor and Francis. pp.1-16.
- Price, S. (2005). Maternity Services for Women in Prison: A Descriptive Study. *British Journal of Midwifery*, 13(6), 362-368.
- Price, D., and Liebling, A. (1998). *Staff-Prisoner Relationships: A Review of the Literature*. Report submitted to The Home Office. London.
- Prison Reform Trust, (2017). *Bromley Briefings, Prison: The Facts*. Summer 2017. Prison Reform Trust, London.  
<http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Summer%202017%20factfile.pdf> [accessed on 10.08.17].

- Rafiq, N. B. (2017). Normal Pregnancy, Labor, and Delivery. *Family Medicine: Principles and Practice*, 141-152.
- Reed, R., Barnes, M., and Rowe, J. (2016). Women's Experience of Birth: Childbirth as a Rite of Passage. *International Journal of Childbirth*, 6(1), 46-56.
- Reinharz, S. (1993). Neglected Voices and Excessive Demands in Feminist Research. *Qualitative Sociology*, 16(1), 69-76.
- Reiter, R. (2012). *Toward an Anthropology of Women*. New York Monthly Review Press.
- Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., and Malata, A. (2014). Midwifery and Quality Care: Findings from a New Evidence-Informed Framework for Maternal and Newborn Care. *The Lancet*, 384(9948), 1129-1145.
- Ribbens, J., and Edwards, R. (1997). *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*: Sage.
- Ritchie, J., Lewis, J., Nicholls, C. M., and Ormston, R. (2013). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*: Sage.
- Rogan, M. (2017). 'Human Rights and Correctional Health Policy: A View from Europe', *International Journal of Prisoner Health*, 13(1).
- Ross, M. W. (2013). *Health and Health Promotion in Prisons*: Routledge.
- 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(3), 262-274.
- Rowe, A. (2014). Situating the Self in Prison Research: Power, Identity, and Epistemology. *Qualitative Inquiry*, 20(4), 404-416.
- Rowe, A. (2015). 'Tactics', Agency and Power in Women's Prisons. *British Journal of Criminology*, Volume 56, Issue 2, 1 March 2016, Pp.332–349.
- Royal College of Midwives. (2016). *Caring for Childbearing Prisoners: A Position Paper*. Position Statement for Women in Custody. London.
- Sandall, J. (1995). 'Choice, Continuity and Control: Changing Midwifery, Towards a Sociological Perspective', *Midwifery*, 11(4), pp. 201-209.

- Sandall, J., Soltani, H., Gates, S., Shennan, A., and Devane, D. (2013). Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women. *Cochrane Database Systematic Rev*, 8(8).
- Sandelowski, M. (1995). Sample Size in Qualitative Research. *Research in Nursing and Health*, 18(2), 179-183.
- Sarkar, P., Bergman, K., O'Connor, T. G., and Glover, V. (2008). Maternal Antenatal Anxiety and Amniotic Fluid Cortisol and Testosterone: Possible Implications for Foetal Programming. *Journal of Neuroendocrinology*, 20(4), pp. 489-496.
- Scarnati, J. T. (2000). Beyond Technical Competence: Developing Mental Toughness. *Career Development International*, 5(3), 171-176.
- Schiller, R. (2016). *Why Human Rights in Childbirth Matter*. Pinter and Martin.
- Schroeder, C., and Bell, J. (2005). Doula Birth Support for Incarcerated Pregnant Women. *Public Health Nursing*, 22(1), 53-58.
- Scott, D. (2008). Creating Ghosts in the Penal Machine: Prison Officer Occupational Morality and the Techniques of Denial. *Understanding Prison Staff*, 168-186.
- Sharpe, G., Gelsthorpe, L., and Worrall, A. (2009). Looking for Trouble: A Recent History of Girls, Young Women and Youth Justice. *Youth Justice*, 9(3), 209-223.
- Sharpe, G. (2015). Precarious Identities: 'Young' Motherhood, Desistance and Stigma. *Criminology and Criminal Justice*, 15 (4), 407-422.
- Shannon, S. K., and Page, J. (2014). Bureaucrats on the Cell Block: Prison Officers' Perceptions of Work Environment and Attitudes toward Prisoners. *Social Service Review*, 88(4), 630-657.
- Shaw, J., Downe, S., and Kingdon, C. (2015). Systematic Mixed-Methods Review of Interventions, Outcomes and Experiences for Imprisoned Pregnant Women. *Journal of Advanced Nursing*. Volume 71, Issue 7. Pp.1451–1463.
- Shilling, C. (1997). Emotions, Embodiment and the Sensation of Society. *The Sociological Review*, 45(2), 195-219.
- Shlafer, R. J., Gerrity, E., and Duwe, G. (2015). Pregnancy and Parenting Support for Incarcerated Women: Lessons Learned. *Progress in Community Health Partnerships: Research, Education, and Action*, 9(3), 371-378.

- Shlafer, R. J., Stang, J., Dallaire, D., Forestell, C. A., and Hellerstedt, W. (2017). Best Practices for Nutrition Care of Pregnant Women in Prison. *Journal of Correctional Health Care*. Vol. 23(3) 297-304.
- Shobeiri, F., Masoumi, S. Z., and Jenabi, E. (2016). The Association Between Maternal Smoking and Placenta Abruption: A Meta-Analysis. *The Journal of Maternal-Fetal & Neonatal Medicine*, pp.1-5.
- Sikand, M. (2017). *Lost Spaces: Is the Current Provision for Women Prisoners to Gain a Place in a Prison Mother and Baby Unit Fair and Accessible?* The Griffins Society University of Cambridge Institute of Criminology.
- Silverman, D. (2013). *Doing Qualitative Research: A Practical Handbook*. SAGE Publications Limited.
- Simons, L., and Lathlean, J. (2010). *Mixed Methods*. Chapter 27, pp 331 – 342, In Gerrish, K., and Lacey, A. (2010). *The Research Process in Nursing*: John Wiley & Sons.
- Sinclair, M. (2007). A Guide to Understanding Theoretical and Conceptual Frameworks. *Evidence Based Midwifery*, 5, 39.
- Sinclair, M., and Stockdale, J. (2011). Achieving Optimal Birth using Salutogenesis in Routine Antenatal Education. *Evidence Based Midwifery*, 9(3), 75.
- Smith, C. (2002). Punishment and Pleasure: Women, Food and the Imprisoned Body. *The Sociological Review*, 50(2), pp. 197-214.
- Smith, D. E. (2005). *Institutional Ethnography: A Sociology for People*: Rowman Altamira.
- Smoyer, A. B. (2015a). Feeding Relationships: Foodways and Social Networks in a Women's Prison. *Affilia*, 30(1), pp. 26-39.
- Smoyer, A. B. (2015b). Making Fatty Girl Cakes Food and Resistance in a Women's Prison. *The Prison Journal*. Volume: 96:2: 191-209.
- Smoyer, A. B., and Lopes, G. (2016). Hungry on the Inside: Prison Food as Concrete and Symbolic Punishment in a Women's Prison. *Punishment & Society*, Vol: 19. No: 2: 240-255.
- Standing, K. (1998). *Writing the Voices of the Less Powerful: Research on Lone Mothers*, in, J. Ribbens and R. Edwards (eds) *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*. London: Sage.



- Stanley, L., and Wise, S. (1993). *Breaking out Again: Feminist Epistemology and Ontology*. London: Routledge.
- Stauffer, J. (2015). *Ethical Loneliness: The Injustice of Not Being Heard*. Columbia University Press.
- Sykes, G. M. (1958 /2007). *The Society of Captives: A Study of a Maximum-Security Prison*. Princeton University Press.
- Szatkowski, L., Fahy, S. J., Coleman, T., Taylor, J., Twigg, L., Moon, G., and Leonardi-Bee, J. (2015). Small Area Synthetic Estimates of Smoking Prevalence During Pregnancy in England. *Population Health Metrics*, 13(1), p. 34.
- Tait, S. (2011). A Typology of Prison Officer Approaches to Care. *European Journal of Criminology*, 8(6), 440-454.
- Tec, N. (2004). *Resilience and Courage: Women, Men, and the Holocaust*. Yale University Press.
- Thomassen, B. (2009). The Uses and Meanings of Liminality. *International Political Anthropology*, 2(1), 5-27.
- Tisdell, E. (2008). *Feminist Epistemology*. Pp 331-335. in Given, L. M. (2008). *The Sage Encyclopedia of Qualitative Research Methods*. Sage Publications.
- Todres, L., and Holloway, I. (2010). *Phenomenological Research*. Chapter 15, pp 177- 187, in Gerrish, K., and Lacey, A. (2010). *The Research Process in Nursing*. John Wiley & Sons.
- Tong, V. T., England, L. J., Rockhill, K. M., and D'Angelo, D. V. (2017). Risks of Preterm Delivery and Small for Gestational Age Infants: Effects of Nondaily and Low-Intensity Daily Smoking During Pregnancy. *Paediatric and Perinatal Epidemiology*.
- UN General Assembly (1948). *The Universal Declaration of Human Rights*. Resolution adopted by the General Assembly 10/12. New York: United Nations.
- United Nations (2013). 'The Bangkok Rules'. <http://www.penalreform.org/priorities/women-in-the-criminal-justice-system/bangkok-rules-2/>. [accessed 21.5.15].
- Van Gennep, A. (1960/2011). *The Rites of Passage*. University of Chicago Press. Routledge.
- Van Gundy, A., and Baumann-Grau, A. (2016). *Women, Incarceration, and Human Rights Violations: Feminist Criminology and Corrections*. Routledge.
- Van Hoven, B., and Sibley, D. (2008). 'Just Duck': The Role of Vision in the Production of Prison Spaces. *Environment and Planning: Society and Space*, 26(6), 1001-1017.

- Van Teijlingen, E., and Hundley, V. (2002). The Importance of Pilot Studies. *Nursing Standard*, 16(40), 33-36.
- Van Maanen, J. (2011). *Tales of the Field: On Writing Ethnography*. University of Chicago Press.
- Verberg, M. F. G., Gillott, D. J., Al-Fardan, N., and Grudzinskas, J. G. (2005). Hyperemesis Gravidarum, a Literature Review. *Human Reproduction Update*, 11(5), 527-539.
- Vermani, E., Mittal, R., and Weeks, A. (2010). Pelvic Girdle Pain and Low Back Pain in Pregnancy: A Review. *Pain Practice*, 10(1), pp. 60-71.
- Wahidin, A. (2006). Time and the Prison Experience. *Sociological Research Online*, 11(1).
- Walby, K. (2007). On the Social Relations of Research, A Critical Assessment of Institutional Ethnography. *Qualitative Inquiry*, 13(7), 1008-1030.
- Waldram, J. (1998). Anthropology in Prison: Negotiating Consent and Accountability with a "Captured" Population. *Human Organization*, 57(2), 238-244.
- Walklate, S. (2004). *Gender, Crime and Criminal Justice*. 2nd edn. London: Willan Publishing.
- Walmsley, R. (2013). World Prison Population List. World Prison Brief. *Institute for Criminal Policy Research, International Centre for Prison Studies, Birkbeck, University of London*.
- Walker, J. R., Hilder, L., Levy, M. H., and Sullivan, E. A. (2014). Pregnancy, Prison and Perinatal Outcomes in New South Wales, Australia: A Retrospective Cohort Study Using Linked Health Data. *Bio Med Central: Pregnancy and Childbirth*, 14(1), 1.
- Walker, T. (2009). 'Seeing Beyond the Battled Body' – An Insight into Selfhood and Identity from Women's Accounts Who Self-Harm with a Diagnosis of Borderline Personality Disorder. *Counselling and Psychotherapy Research*, 9(2), 122-128.
- Walker, T., Shaw, J., Hamilton, L., Turpin, C., and Reid, C. (2016). Supporting Imprisoned Women Who Self-harm: Exploring Prison Staff Strategies. *Journal of Criminal Psychology*, 6(4), 173-186.
- Walsh, D., and Downe, S. (2005). Meta-synthesis Method for Qualitative Research: A Literature Review. *Journal of Advanced Nursing*, 50(2), 204-211.
- Walsh, D., and Downe, S. (2006). Appraising the Quality of Qualitative Research. *Midwifery*, 22(2), 108-119.
- Walsh, D. J. (2010). Childbirth Embodiment: Problematic Aspects of Current Understandings. *Sociology of Health & Illness*, 32(3), 486-501.

- Walsh, D. (2011). *Nesting and Matrescence*. Chapter 8: 178-187. In: Bryar, R., and Sinclair, M. (Eds.). *Theory for Midwifery Practice (second edition)*. Palgrave MacMillan: Basingstoke.
- Ward, B. A. (2017). *Pregnancy-Related Sleep Disturbances and Sleep Disorders*. in Attarian, H.P., and Schuman, C (Eds.). *Clinical Handbook of Insomnia*. Springer, pp. 159-180.
- Watkins, C. (2017). Industrialized Bodies: Women, Food, and Environmental Justice in the Criminal Justice System. In: *Addressing Environmental and Food Justice Toward Dismantling the School-to-Prison Pipeline* (pp. 137-160): Springer.
- Welford, C., Murphy, K., and Casey, D. (2012). Demystifying Nursing Research Terminology: Part 2. *Nurse Researcher*, 19(2), 29.
- Whitehead, D. (2006). The Health Promoting Prison (HPP) and its Imperative for Nursing. *International Journal of Nursing Studies*, 43(1), 123-131.
- Windham-Stewart, P. W. (2016a). The Born Inside Project. *Psychoanalytic Psychotherapy*, 30, 152-163.
- Windham-Stewart, P. (2016b). Creating Mother and Baby Therapy Groups in Prison: Emotional Valuation. *Psychoanalytic Psychotherapy*, 30(2), 152-163.
- Wood, A. (2016). *Challenging Occupational Norms: An Ethnographic Study of Female Prison Officers in a Women's Prison*. PhD Thesis, The University of Salford.
- Wright, S., Crewe, B., and Hulley, S. (2016). Suppression, Denial, Sublimation: Defending Against the Initial Pains of Very Long-life Sentences. *Theoretical Criminology*, Volume: 21, issue: 2, pp: 225-246.
- Wismont, J. M. (2000). The Lived Pregnancy Experience of Women in Prison. *Journal of Midwifery and Women's Health*, 45(4), 292-300.
- Wulf-Ludden, T. (2016). Pseudo families, Misconduct, and the Utility of General Strain Theory in a Women's Prison. *Women and Criminal Justice*, 26(4), 233-259.
- Young, I. M. (1984). Pregnant Embodiment: Subjectivity and Alienation. *Journal of Medicine and Philosophy*, 9(1), 45-62.
- Zamble, E., and Porporino, F. J. (2013). *Coping, Behavior, and Adaptation in Prison Inmates*: Springer Science and Business Media.

Zedner, L. (1998). *Wayward Sisters: The Prison for Women* (Chapter 11, pp295-324) in: *The Oxford History of the Prison: The Practice of Punishment in Western Society*. Edited by Morris N., and Rothman D.J. Oxford University Press.

Zimbardo, P. (2016). Revisiting the Stanford Prison Experiment: A Lesson in the Power of Situation. *Perspectives on Contemporary Issues*, 309.

Zimbardo, P. G., Maslach, C., and Haney, C. (2000). Reflections on the Stanford Prison Experiment: Genesis, Transformations, Consequences. *Obedience to Authority: Current Perspectives on the Milgram Paradigm*, 193-237.

---

# APPENDICES

---

## Appendix 1.1: Ethics approval – National Offender Management Service



National Offender  
Management Service

Mrs Laura Abbott  
Room F305  
The Wright Building  
College Lane  
Hatfield  
AL10 6AB  
[l.abbott@herts.ac.uk](mailto:l.abbott@herts.ac.uk)

**National Offender Management Service**  
*National Research Committee*  
Email: [National.Research@noms.gsi.gov.uk](mailto:National.Research@noms.gsi.gov.uk)

25<sup>th</sup> September 2015

### **APPROVED SUBJECT TO MODIFICATIONS – NOMS RESEARCH**

**Ref:** 2015-209

**Title:** The incarcerated pregnancy

Dear Mrs. Abbott,

Further to your application to undertake research across NOMS, the National Research Committee (NRC) is pleased to grant approval in principle for your research. The Committee has requested the following modifications:

- Response/participation rates should be monitored and plans established to address low response rates where necessary.
- Further consideration should be given to the need for stratification when sampling to ensure that a sufficient range of views is obtained (e.g. placement in an MBU or not; giving birth pre- or post-release etc)
- The following should be included in all participation information sheets/consent forms:
  - Participants should consent to any follow-up contact and the method of this contact.
  - Participants should be informed how their data will be used and for how long it will be held.

- The following should also be included in the participation information sheets/consent forms for offenders:
  - Access to any NOMS records for the participants should be explicitly covered.
  - The respondent should be asked to direct any requests for information, complaints and queries through their prison establishment/community provider. Direct contact details should not be provided.
- Under the Prison Act (as amended by the Offender Management Act 2007), mobile phones, cameras and sound recording devices are classified as list B items, requiring authorisation from Governing Governors / Directors of Contracted Prisons (or nominated persons) to take them into and use them in prison (PSI 10/2012 Conveyance and Possession of Prohibited Items and Other Related Offences).
- When using recording devices, the recordings should be treated as potentially disclosive and it is recommended that devices with encryption technology are used. Recordings should be wiped once they have been transcribed and anonymised unless there are clear grounds for keeping them any longer.
- The availability and appropriateness of key training remains at the discretion of individual establishments.
- In the final research reports, any limitations should be clearly set out (e.g. the use of snowball sampling might have introduced a degree of sampling bias; the findings may not be representative of all women's prisons)

Before the research can commence you must agree formally by email to the NRC ([National.Research@noms.gsi.gov.uk](mailto:National.Research@noms.gsi.gov.uk)), confirming that you accept the modifications set out above and will comply with the terms and conditions outlined below and the expectations set out in the NOMS Research Instruction

(<https://www.gov.uk/government/organisations/national-offender-management-service/about/research>).

Please note that unless the project is commissioned by MoJ/NOMS and signed off by Ministers, the decision to grant access to prison establishments, National Probation Service (NPS) divisions or Community Rehabilitation Company (CRC) areas (and the offenders and practitioners within these establishments/divisions/areas) ultimately lies with the Governing Governor/Director of the establishment or the Deputy Director/Chief Executive of the NPS division/CRC area concerned. If establishments/NPS divisions/CRC areas are to be approached as part of the research, a copy of this letter must be attached to the request to prove that the NRC has approved the study in principle. The decision to grant access to existing data lies with the Information Asset Owners (IAOs) for each data source and the researchers should abide by the data sharing conditions stipulated by each IAO.

Please quote your NRC reference number in all future correspondence.

Yours sincerely,  
National Research Committee

## National Research Committee - Terms and Conditions

### All research

- **Changes to study** - Informing and updating the NRC promptly of any changes made to the planned methodology. *This includes changes to the start and end date of the research.*
- **Dissemination of research** - The researcher will receive a research summary template and project review form template attached to the research approval email from NOMS. These two forms are for completion once the research project has ended (ideally within one month after the end date). The researcher should complete the research summary document for NOMS (approximately three pages; maximum of five pages) which (i) summaries the research aims and approach, (ii) highlights the key findings, and (iii) sets out the implications for NOMS decision-makers. The research summary should use language that an educated, but not research-trained person, would understand. It should be concise, well organised and self-contained. The conclusions should be impartial and adequately supported by the research findings. It should be submitted to the [NRC](#) alongside the completed project review form (which covers lessons learnt and asks for ratings on key questions). Provision of the research summary and project review form is essential if the research is to be of real use to NOMS.
- **Publications** - The NRC ([National.Research@noms.gsi.gov.uk](mailto:National.Research@noms.gsi.gov.uk)) receiving an electronic copy of any papers submitted for publication based on this research at the time of submission and at least one month in advance of the publication.
- **Data protection** - Researchers must comply with the requirements of the Data Protection Act 1998 and any other applicable legislation. Data protection guidance can be found on the Information Commissioner's Office website: <http://ico.org.uk>. Researchers should store all data securely and ensure that information is coded in a way that maintains the confidentiality and anonymity of research participants. The researchers should abide by any data sharing conditions stipulated by the relevant data controllers.
- **Research participants** - Consent must be given freely. It will be made clear to participants verbally and in writing that they may withdraw from the research at any point and that this will not have adverse impact on them. If research is undertaken with vulnerable people – such as young offenders, offenders with learning difficulties or those who are vulnerable due to psychological, mental disorder or medical circumstances - then researchers should put special precautions in place to ensure that the participants understand the scope of their research and the role that they are being asked to undertake. Consent will usually be required from a parent or other responsible adult for children to take part in the research.
- **Termination** - NOMS reserves the right to halt research at any time. It will not always be possible to provide an explanation, but NOMS will undertake where possible to provide the research institution/sponsor with a covering statement to clarify that the decision to stop the research does not reflect on their capability or behaviour.

### Research requiring access to prison establishments, NPS divisions and/or CRCs

- **Access** – Approval from the Governing Governor/Director of the establishment or the Deputy Director/Chief Executive of the NPS division/CRC area you wish to research in. (Please note that NRC approval does not guarantee access to establishments, NPS divisions or CRC areas; access is at the discretion of the Governing Governor/Director or Deputy Director/Chief Executive and subject to local operational factors and pressures). This is subject to clearance of vetting procedures for each establishment/NPS division/CRC area.
- **Security** – Compliance with all security requirements.
- **Disclosure** – Researchers are under a duty to disclose certain information to prison establishments/probation provider. This includes behaviour that is against prison rules and can be adjudicated against, undisclosed illegal acts, and behaviour that is potentially harmful to the research

participant (e.g. intention to self-harm or complete suicide) or others. Researchers should make research participants aware of this requirement. The Prison Rules can be accessed here and should be reviewed:

[http://www.justice.gov.uk/downloads/offenders/psipso/ps0/PSO\\_0100\\_the\\_prison\\_rules\\_1999.doc](http://www.justice.gov.uk/downloads/offenders/psipso/ps0/PSO_0100_the_prison_rules_1999.doc)



## Appendix 1.2 : Ethics approval – University of Hertfordshire



UNIVERSITY OF HERTFORDSHIRE  
HEALTH & HUMAN SCIENCES

### ETHICS APPROVAL NOTIFICATION

**TO** Laura Abbott  
**CC** Professor Fiona Brooks  
**FROM** Dr Richard Southern, Health and Human Sciences ECDA Chairman  
**DATE** 08/05/15

---

Protocol number: **HSK/PG/UH/00384**

Title of study: The incarcerated Pregnancy: What is the experience of being pregnant in an English prison

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 01/10/15

To: 30/08/16

Please note:

**Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.**

**Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.**

**Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.**

**Students must include this Approval Notification with their submission.**

## Appendix 1.3 : Application to bring a prohibited article into prison



**Ministry of  
JUSTICE**  
National Offender  
Management Service



### Application to bring a prohibited article into the Prison

This application form is in conjunction with PSI 2012/10 - Conveyance Prohibited Items and other related offences.

Prohibited articles are now graded according to their seriousness and perceived threat to security and safety within a prison, and are classified as List A, list B or List C articles, as set out below:

List A Articles – drugs, explosives, firearms or ammunition and any other offensive weapon.

List B Articles – alcohol, mobile telephones, cameras, sound recording devices (or constituent part of the latter three articles)

List C Articles – tobacco, money, clothing, food, drink, letters, paper, books, tools or information technology equipment.

This application is particularly for the articles above underlined.

The establishment reserves the right to refuse access to any item.

This form is to be completed in the main by the host of the visitor to site

#### Details of visitor / staff / department

Surname	Abbott	Forename	Laura	Company	University of Hertfordshire	Date of Visits	8/12/15 17/12/15 8/1/16 15/1/16 2/2/16 16/2/16
---------	--------	----------	-------	---------	-----------------------------	----------------	---

Plus further dates until summer 2016 which will be arranged in advance (approx. twice a month)

Article (s) to be brought in	Serial Number (any number to easily identify the article)	Product name
Dictaphone	203144898	Olympus Linear PCM Recorder LS-14.
Note that an SD card will not be NOT used within this device in the Prison. The recording will be written up shortly after the interview, and the data will be deleted from the Dictaphone.		

Reasons for request
Laura has gained NOMS approval to research the pregnancy pathways and experiences of women in prisons.
Laura will spend time performing one to one interviews with pregnant women (those who agree to be part of the research programme – consent forms have been included and would be completed), meeting with key partners, spending time within the establishment with discipline staff in order to understand the regime and rules/regulations.
The one to one interviews would be recorded on a Dictaphone. Laura is aware of the need for this to be encrypted and that approval is required from the establishment.

## **Appendix 1.4 : Information sheet**

### **The Experience of Being Pregnant in Prison**

Participant information sheet

Protocol number: HSK/PG/UH/00384

## **What is the experience of being pregnant in an English Prison?**

**Laura Abbott, University of Hertfordshire**

### **Who am I?**

I am lecturer in midwifery and undertaking a research doctorate at The University of Hertfordshire. I do not work for the Prison Service, and my study is independent of the prison service

### **Why am I doing this study?**

I am interested in finding out more about the experiences of prisoners and ex-prisoners who are pregnant or who have been pregnant whilst in prison. I am particularly interested in how you cope(d) with being pregnant whilst in prison and what relationships you (have) formed with other prisoners and with staff. I think that my study will help the Prison Service, and other researchers, understand more about what it is like to be in your position

### **What will participation involve?**

Participation will involve one interview. I will ask you to tell me about your time in prison so far and your feelings about yourself being pregnant and your sentence. I will want to hear your story.

### **Do I have to take part in the study?**

Your participation is completely voluntary. If you do not want to take part, you do not have to, and this will not disadvantage you in any way.

### **Are there any risks involved in taking part?**

During the interview you will be asked to discuss your background and your experiences. Some questions might also ask you to think about things you have not previously thought about, or choose not to think about. Depending on your circumstances, this might trigger some unhappy or upsetting thoughts. However, you do not have to answer any questions you do not wish to, and time will be given at the end of the interview to discuss anything you may have found difficult. If you find the interview distressing, you can stop at any time, and I can advise you on whom, in the prison, or outside of the prison, you could talk to about your feelings.

**Are there any benefits in taking part?**

I cannot pay you for taking part in the study, but if you agree to take part and are interviewed when you would normally be working or in education, you will not lose any pay. Taking part in the study will not affect your privilege level or any decision about your parole or release.

You may, however, feel that talking about your experiences of prison is useful or helpful to you. People who have been interviewed in the past have often welcomed the chance to speak to someone neutral, who is willing to listen to them. You will also be contributing to our understanding of prison life for pregnant women.

**Will what I say be kept confidential?**

The information you share in the interview will normally be kept completely confidential. However, if you are currently in prisons, the researcher will be obliged to pass on to a member of prison staff any information regarding:

- A breach of prison security
- Any further offences you admit to that you have not yet been convicted for
- Any breach of prison rules that occurs during the interview
- Anything you say that implies a threat to yourself or to others

In all other circumstances, everything you say will remain confidential. The information you provide will be stored securely, for an indefinite period.

**Will my contribution remain anonymous?**

If you agree to the using of quotes from the interviews, this will be done in such a way that you cannot be identified. I will give you a different name and will change any details about your life which would 'give away' who you are.

**How do I agree to take part in the study?**

If you agree to take part, you will be asked to complete a consent form, confirming that you understand what the study involves and have had a chance to discuss any questions with the researcher. You will also be asked to state whether you are happy for the interview to be recorded.

**What if I want to withdraw from the study?**

You are free to stop an interview or refuse to take part in any further interviews at any stage during the research process, without having to explain why you want to stop. You can also insist that the content of your interviews so far is excluded from the study, without having to explain why. Making this decision will not be held against you or disadvantage you in any way.

**Where can I go for support should participation in the research cause me anxiety?**

If, once you have finished the interview, you feel that some of the things that you have talked about have made you to feel anxious or distressed, there are a number of ways that you can access support:

- You can speak to a member of staff or ask Laura to contact a member of staff who you would like to talk to.
- You can contact a peer support worker, such as a Listener or another prisoner in your establishment to let them know that you would like their support.
- You can contact the Samaritans, whose number will be printed on posters on your wing.

**What will happen to the results of the study?**

Your interview may contribute to various publications that I will write about the issues I am interested in. These will mainly be academic articles and books. The findings may also be discussed in other academic publications written by the researchers, and in discussions or presentations with members of the Prison Service or the National Offender Management Service (NOMS), as well as other university researchers. Again, this would be done in such a way that you could not be personally identified.

**What if I want more information about the study, or want to complain about some aspect of it?**

The study has been reviewed by the Ethics Committee of The University of Hertfordshire. If you would like more information or have any questions or complaints about the research please feel free to speak to me directly.

**Thank you for your time in reading this information. If you have any further questions at any stage of the research, please do not hesitate to ask me.**

**Laura Abbott**

## Appendix 1.5 : Consent form

Protocol number: HSK/PG/UH/00384

NOMS protocol number: **Ref:** 2015-209

**Project title:** What is the experience of being pregnant in an English prison?

**Researcher:** Laura Abbott, University of Hertfordshire

---

Please tick the boxes if you agree with the following three statements.

- |   | YES                      |
|---|--------------------------|
| 1. I have read and understood the Participant Information Sheet for the study (or have had it read out to me and have understood it), and have had chance to ask questions.                                 | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary, that I do not have to answer any of the researcher's questions if I do not wish to, <b>and that I can withdraw at any time, without giving reasons.</b> | <input type="checkbox"/> |
| 3. I agree to take part in the study, which means being interviewed by the researcher.  | <input type="checkbox"/> |

Please answer **YES** or **NO** to the following two statements by ticking the appropriate box.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 4. I agree to our interviews being recorded.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I agree to let the researcher use quotes from our interviews and conversations, as long as this is done in such a way that I cannot be identified. | <input type="checkbox"/> | <input type="checkbox"/> |

Name of participant:

---

Date:

---

Signature:

---

Name of researcher:

---

Date:

---

Signature:

---

## Appendix 1.6 : Timeline of accessing prisons

TIMELINE OF ACCESS TO PRISON SETTING: THE INCARCERATED PREGNANCY - PHASE 1 OF RESEARCH PROCESS		
TRAINING AND NETWORKING TIMELINE PRIOR TO RESEARCH	DATE	RATIONALE
CONTACT MADE WITH PRISON MIDWIFE	24.10.2012	To explore options for shadowing
CONTACT MADE WITH BARONESS (AUTHOR OF CORSTON REPORT)	09.4.2013	To find links to prison volunteering, signposted to Birth Companions charity and introductions made.
VISIT TO ROYAL COLLEGE OF NURSING CRIMINAL JUSTICE NURSES LEAD	15.7.2013	To establish new links and latest evidence base
BORN INSIDE PROJECT INTERVIEW WITH FORENSIC PSYCHOTHERAPIST	15.07.2013	To see viability of observe facilitated groups
PRISON 1 VISIT: SHADOWING MIDWIFE*	17.07.2013	To observe environment and understand issues of pregnant women in prison
BIRTH COMPANIONS INTERVIEW	28.10.13	For training application
BIRTH COMPANION TRAINING	15.11.2013 TO 01.07.2014	Monthly training on Saturdays over nine months to prepare for group facilitation and one to one support of pregnant and recently birthed women in prison
BORN INSIDE PRISON VISIT WITH PSYCHOTHERAPIST*	10.01.2014	Observing group and getting to know women in prison setting
HIBISCUS CHARITY TRAINING	28.01.2014	In order to volunteer with the support of women recently released from prison
BIRTH COMPANION PRISON VISITING, FACILIATING PREGNANCY GROUPS, ONE TO ONE SUPPORT AND EARLY YEARS GROUPS ON MBU	01.08.2014 ONGOING	Monthly prison visits offering one to one support and facilitating pregnancy groups inside prison
PRISON 2 VISIT*	22.09.2014	Observation and familiarisation of setting and establishing networks
PRISON 3 VISIT*	6.5.2015	Observation and familiarisation of setting and establishing networks
PERSONAL PROTECTION TRAINING	28.9.2015	To reassure Ethical Committee of personal safety

\* For each prison visit, enhanced clearance and Disclosure and Barring Service (DBS) is required; finger printing and profiling needed. Prisons visited in the above access phase were unable to grant approval for my research.



## **Appendix 1.7 : Interview schedule - woman**

INTERVIEW SCHEDULE (woman)  
Laura Abbott: interviewer

Name (pseudonym)  
Age  
Gestation of pregnancy / Weeks post birth

### **Introduction**

Thankyou for agreeing to talk with me today. My name is Laura Abbott and I am a lecturer in midwifery and undertaking a research doctorate at The University of Hertfordshire. I do not work for the Prison Service, and my study is independent of the prison service

I am particularly interested in how you coped / are coping with being pregnant whilst in prison and what relationships you (have) formed with other prisoners and with staff. I think that my study will help the Prison Service, and other researchers, understand more about what it is like to be in your position

### **Prison History**

Is this the first time you have been in prison?

Please tell me about your 1<sup>st</sup> week in prison?

### **Prison life and culture**

Can you tell me about the prison routine?

### **Social relations**

Where do you get your emotional support from in prison?

### **Pregnancy**

Please tell me about your pregnancy?

Prompt: How are you feeling about being pregnant in prison?

Do you have a plan for your birth?

Prompt: How are you feeling about going into labour?

Prompt: Who will be with you when you give birth?

### **Food**

Please tell me about what you are eating in prison?

---

## Appendix 1.8 : Participants' demographics in table format

PSEUDONYM	AGE	SENTENCE	DRUG	CRIME	PARITY	PRIS	LANG	NO. TIMES IN	SEPERATING OR K	PREGNANT WHEN INCARCER	GESTATION AT TIME OF IN	ETHNI	Gesta
1 : ELLIE	30-39	4 - 10 YEARS	A	NV	M	C	ENG	MULTIPLE	WITH BABY ON MBU	PREGNANT	OVER 1 MONTH PN	WBr	12
2 : LAYLA	30-39	4 - 10 YEARS	NA	S	M	C	ENG	1ST TIME	WITH BABY ON MBU	PREGNANT	OVER 1 MONTH PN	WBr	24
3 : LINDA	30-39	4 - 10 YEARS	NA	JE	M	C	ENG	1ST TIME	WITH BABY ON MBU	WITHIN 4 WEEKS OF BIRTH	OVER 1 MONTH PN	WBr	
4 : SAMMY	30-39	4 - 10 YEARS	NA	NV	M	C	ENG	1ST TIME	WITH BABY ON MBU	PREGNANT	OVER 1 MONTH PN	WBr	30
5 : TAMMIE	30-39	1 - 3 YEARS	NA	NV	M	C	ENG	1ST TIME	WITH BABY ON MBU	WITHIN 4 WEEKS OF BIRTH	OVER 1 MONTH PN	MRBr	
6 : ABI	30-39	4 - 10 YEARS	NA	NV	M	A	ENG	1ST TIME	NOT KNOWN	PREGNANT	1ST & 2ND TRI	MRBr	6
7 : ANGEL	40-50	<6 MONTHS	A	NV	P	A	ENG	MULTIPLE	NOT KNOWN	PREGNANT	2ND TRI	WBr	16
8 : BOO	22-29	<6 MONTHS	A	NV	M	A	ENG	MULTIPLE	NOT KNOWN	PREGNANT	2ND TRI	WBr	15
9 : CAROLINE	30-39	REMAND	NA	V	M	A	ENG	1ST TIME	PLANNED SEPERATIO	PREGNANT	1ST,2ND,3RD TRI & PN	BBr	16
10 : DANIELA	17-21	<6 MONTHS	NA	NV	M	A	NE	1ST TIME	LEAVING PRISON BB	PREGNANT	3RD TRI	Weur	18
11 : JOLENE	30-39	<6 MONTHS	A	NV	M	A	ENG	1ST TIME	LEAVING PRISON BB	PREGNANT	2ND TRI	WBr	16
12 : KAYLEIGH	30-39	REMAND	A	NV	M	A	ENG	MULTIPLE	NOT KNOWN	PREGNANT	3RD TRI	WBr	28
13 : SHARON	22-29	6-12 MONTHS	NA	V	P	A	ENG	1ST TIME	NOT KNOWN	PREGNANT	2ND TRI	WBr	12
14 : SUSAN	22-29	6-12 MONTHS	NA	NV	P	A	ENG	1ST TIME	PLANNED SEPERATIO	PREGNANT	1ST,2ND,3RD TRI & PN	MRBr	6
15 : SYLVIA	22-29	<6 MONTHS	NA	NV	M	A	ENG	1ST TIME	WITHOUT BABY IN PF	PREGNANT	1ST WEEK PN	WBr	41
16 : TRACEY	22-29	<6 MONTHS	A	NV	P	A	ENG	MULTIPLE	WITHOUT BABY IN PF	PREGNANT	1ST WEEK PN	WBr	
17 : TRIXIE	17-21	<6 MONTHS	NA	NV	M	A	ENG	1ST TIME	NOT KNOWN	PREGNANT	2ND TRI	MRBr	14
18 : DEBBIE	22-29	1 - 3 YEARS	NA	NV	P	B	ENG	1ST TIME	WITH BABY ON MBU	WITHIN 4 WEEKS OF BIRTH	OVER 1 MONTH PN	WBr	
19 : ELSA	22-29	1 - 3 YEARS	NA	NV	P	B	ENG	1ST TIME	WITH BABY ON MBU	WITHIN 4 WEEKS OF BIRTH	OVER 1 MONTH PN	WBr	
20 : KRYSTAL	22-29	1 - 3 YEARS	NA	JE	P	B	ENG	1ST TIME	NOT KNOWN	PREGNANT	2ND TRI	WBr	12
21 : LOLA	17-21	6-12 MONTHS	NA	V	M	B	ENG	1ST TIME	PLANNED SEPERATIO	PREGNANT	3RD TRI	WBr	30
22 : SINEAD	17-21	1 - 3 YEARS	NA	NV	M	B	ENG	1ST TIME	WITHOUT BABY IN PF	PREGNANT	OVER 1 MONTH PN	WBr	35
NV= NON-VIOLENT		A = ADDICT	M = MULTIGRAVIDA			ENG=ENGLISH			BB= BEFORE BIRTH				
JE=JOINT ENTERPRISE		NA = NON AD P= PRIMIGRAVIDA			NE=NON ENGLIS			WB			18.5 weeks average no. of weeks when incarcerated		
S=SEXUAL CRIME		EA= EX ADDICT			TRI=TRIMESTER								
V=VIOLENT													
ETHNICITY					Language								
WBr	White British				ENG	English							
BBr	Black British				NE	Non English							
MRBr	Mixed Race British												
Weur	White European												
BFN	Black Foreign National												



## Appendix 1.9 : Iolanthe Midwifery Trust Award details

### Jean Davies Award



The 2015 Jean Davies Award will be available for midwives working to address the impact of social inequalities on the well-being of pregnant women, new mothers and their babies. The award is made in honour of Jean Davies who served for many years as a Trustee of the Iolanthe Midwifery Trust, stepping down in 2012, and in various roles for the RCM during her career. Jean's focus in her work as a practising midwife and researcher was to help those families experiencing social and economic disadvantage, mainly in her home region, the north-east of England.

### About The Jean Davies Awards

- Awarded annually
- Worth up to £5,000 per year
- Projects can be research, care and service improvement work, or a mixture of both.
- For midwives and student midwives or teams led by a midwife. The lead midwife/student midwife must be in RCM membership.
- Inter-professional teams are encouraged to apply.

### Activities the award will fund

The Jean Davis award is intended to fund individuals or teams working specifically with women or families who may be in circumstances such as (but not only): single mothers, young mothers, families of low socio-economic position, families in geographical areas of high deprivation, asylum seekers and refugees, mothers who experience difficulty in accessing care, homeless families and women suffering abuse. There must be a stated aim to reduce or to investigate inequalities.

The first joint Iolanthe/RCM Jean Davies award for addressing health inequalities was awarded to Laura Abbott, lecturer at the University of Hertfordshire in 2014. Laura is pursuing a Doctorate in Health Research on the experiences of pregnant women in prison. Laura's funding will help not only her studies but her voluntary work in prisons and her awareness-raising activities about the issues for these families.

## **Appendix 1.10 : Staff interview schedule**

INTERVIEW SCHEDULE (STAFF MEMBER)  
Laura Abbott: interviewer

Name (pseudonym)  
Gender  
Age  
How long worked in the prison service

### **Introduction**

Thankyou for agreeing to talk with me today. My name is Laura Abbott and I am a lecturer in midwifery and undertaking a research doctorate at The University of Hertfordshire. I do not work for the Prison Service, and my study is independent of the prison service.

I am particularly interested in the experience you may have with pregnant women you may have a responsibility for. I think that my study will help the Prison Service, and other researchers, understand more about what it is like to be in your position. I value your input in helping to find out more about pregnant women in prison.

### **Prison Career**

How long have you worked for the prison service?

What is your experience of working in a woman's prison?

### **Prison life and culture**

Can you tell me about what it is like working in a prison?

### **Pregnant women in prison**

Please tell me about your observation of the needs of pregnant women in prison?

How do you feel pregnant women cope in prison?

Have you ever experienced a woman in labour?

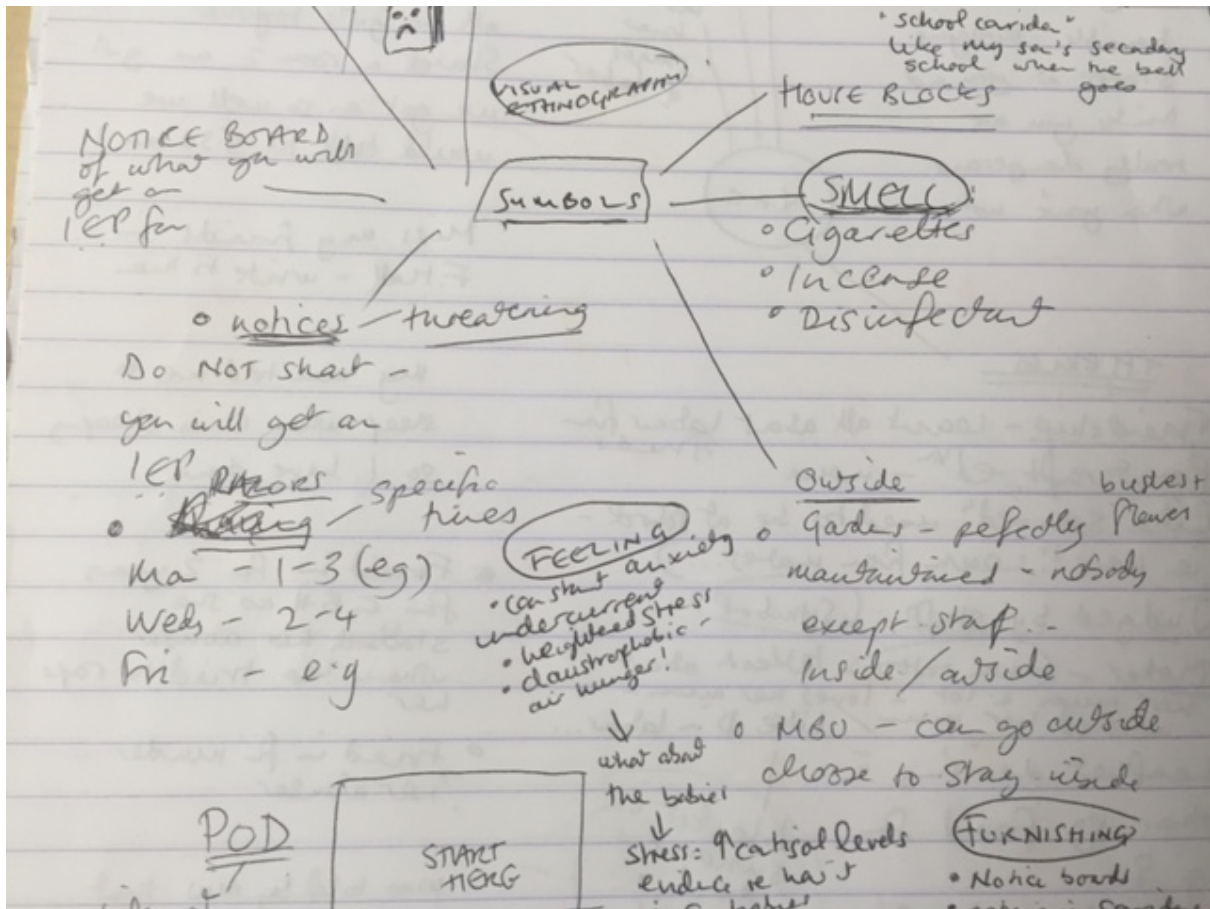
Prompt: How much support do you get in understanding the needs of a pregnant woman in prison?

Are there any policies which guide you in supporting a woman who is pregnant or in labour?

### **Labour and birth**

Have you had any experiences of women going into labour in prison?

Appendix 1.11 : Early jottings from fieldnotes



## Appendix 1.12 :

### Prison routine (Prison A)

<b>Week Day Routine PRISON A</b>	
07:30 to 07:45	Patrol, start of patrol.
07:45 to 08:00	Staff briefing and unlock.
08:00 to 08:15	Domestics.
08:15 to 08:30	Movement to activities.
08:30 to 11:45	Activities, e.g. workshops, education, visits.
11:40 to 12:00	Movement to wings.
12:00 to 12:30	Served meals.
12:30 to 01:30	Lock-up and patrol.
01:30 to 01:45	Movements and activities.
01:45 to 04:15	Activities commence, e.g. workshops, education, visits, and movement.
04:15 to 04:30	Movement to wings.
04:30 to 05:00	Domestics.
05:00 to 05:30	Served meal.
05:30 to 07:15	Domestics and activities, e.g. phone calls, gym, PE.
07:17 to 07:30	Lock-up and final roll call.
07:30 to 08:45	Patrol.
08:45 to 09:00	Handover, off-duty.
<b>Weekend Routine</b> (The times are slightly different)	
07:30 to 08:30	Patrol.
08:30 to 08:45	Staff briefing and unlock.
08:45 to 11:45	Activities, e.g. PE, chapel.
11:45 to 12:15	Served meal.
12:15 to 12:30	Roll check, off-duty.
12:30 to 01:30	Patrol.
01:30 to 05:15	Activities, e.g. PE, chapel.
05:15 to 05:45	Served meal.
05:45 to 06:00	Roll check, staff off-duty.
06:00 to 08:45	Patrol.
08:45 to 09:00	Handover, off-duty.

## Appendix 1.13: Confidentiality agreement with transcriber

### Transcriber Confidentiality Agreement

An examination of the Incarcerated Pregnancy: the experience of being a pregnant woman in prison. The University of Hertfordshire

This research is being undertaken by Laura Abbott, DHRes candidate at The University of Hertfordshire. The purpose of the research is to examine the experience of being a pregnant woman in prison.

As a transcriber of this research, I understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honour this confidentiality agreement.

I agree not to share any information on these recordings, about any party, with anyone except the Researcher of this project. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

I, \_\_\_\_\_ agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format (e.g. WAV files, CDs, transcripts) with anyone other than the Researcher.
2. Keep all research information in any form or format (e.g. WAV files, CDs, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g. WAV files, CDs, transcripts) to the Researcher when I have completed the transcription tasks.
4. After consulting with the Researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher (e.g. CDs, information stored on my computer hard drive).

Transcriber:

\_\_\_\_\_

(print name) (signature) (date)

Researcher:

\_\_\_\_\_

(print name) (signature) (date)

This study has been reviewed and ethically approved by the The University of Hertfordshire and National Offender Management Service (NOMS).



## Appendix 1.14 : Early coding in NVivo


The screenshot displays the NVivo Pro software interface. The main window is titled "The Incarcerated Pregnancy.nvp 1.nvp - NVivo Pro". The interface is divided into several sections:

- Top Ribbon:** Contains tabs for FILE, HOME, CREATE, DATA, ANALYZE, QUERY, EXPLORE, LAYOUT, and VIEW. Below these are various tool icons for workspace, item, clipboard, format, paragraph, styles, editing, and proofing.
- Nodes Panel (Left):** A tree view showing the project structure, including "Nodes", "DATA N", "FIELDW", "Cases", "Relationship", and "Node Matrix".
- Nodes List (Center):** A table listing nodes with their names, source counts, and reference counts. The node "ANECDOTES FROM WOMEN" is highlighted.
- Source Preview (Right):** A preview of a source document titled "TRIXIE INT 2 34 WEEKS". The text in the preview includes:
 

Confirm that you are happy  
 That's fine  
 If you want to stop at any time  
 That's fine  
 I might jot down some notes as we chat if that is ok  
 That's fine  
 Toys emptying  
 L You started to talk just before about being in pris  
 L How many weeks were you?  
 I was about 5 months pregnant and I wasn't expect  
 sentenced I said just take my baby as even then I di  
 then it wasn't until my barrister, he didn't know lor  
 could have my baby with me for 18 months and he
- Bottom Status Bar:** Shows the user "LJA" with 391 items, and the system tray with the date "22/09/2016" and time "16:53".

# Appendix 1.15 : F35 form

1 of 1



HM PRISON SERVICE  
Public Sector Prisons

Date: 26 Feb 2016

To: Kitchen \_\_\_\_\_ Wing \_\_\_\_\_

RE: **F35 Request to Kitchen relating to Pregnancy**

Name: Minnie Mouse-TestPatient Date of Birth 01 Feb 1996

Number:

The above lady is pregnant please provide her with the following **daily** requirements:

- 2 x extra fruit
- 1 pint milk (minimum)
- healthy snacks
- Use of the toaster at mealtimes (copy to wing staff for information)

Reason for recommendation(if appropriate to share, ensure patients consent):

As per health guidelines for pregnant women  
Please note that this should continue for four weeks post birth to support a positive physical recovery.


Estimated date of delivery (from midwife consultation):

F35 to be removed 4 weeks post delivery

Authorised by: \_\_\_\_\_ Signed in Absence: \_\_\_\_\_

Date: 26 February 2016

Healthcare Department



## Appendix 1.16 : Published articles in MIDIRS and Nursing Ethics

### Infant Nutrition

## Women's experiences of breastfeeding in prison

Laura Abbott, Tricia Scott

#### ORIGINAL

The benefits of breastfeeding for the long-term health and well-being of mother and baby are abundant. The effects on bonding between mother and baby are significant and physiological immunity is paramount in protecting the child in later life. Women are free to decide whether or not they wish to breastfeed; however, perinatal women in prison are less able to make this choice due to systems of power and control, enforced within the prison estate, which too frequently render these new mothers powerless in the decision to breastfeed. This paper forms part of wider research to explore women's perinatal experiences whilst in prison and aims to consider how women learn about breastfeeding, and the postnatal experience of breastfeeding, lactation and expressing milk for separated babies in prison. During 2015–2016 audio-recorded semi-structured interviews sought to discover the experiences of 28 pregnant women and new mothers in prison in England. Women were either pregnant at the time of interview, residing with their babies on a Mother and Baby Unit (MBU) within a prison, separated postnatally from their babies, or interviewed post-release. NVivo analysis enabled the deconstruction of events and interactions associated with their experience of breastfeeding. Extracts from interview transcripts highlight the women's voices regarding their breastfeeding experiences coupled with the interwoven reflections of the midwife as researcher. There is a clear need to more fully consider the benefits of breastfeeding for these women and how this essential human function may be maximised within the prison setting.



**Introduction**

The evidence on the benefits of short- and long-term breastfeeding for the long-term health and well-being of mother and baby is abundant (Entwistle *et al* 2007, Pound & Unger 2012, Horta & Victora 2013, Victora *et al* 2016). However, women from disadvantaged and low-income groups have a lower rate of breastfeeding initiation and continuation than women from other groups (Pugh *et al* 2001, Entwistle *et al* 2007, Brown *et al* 2010). Evidence from the charity ‘Birth Companions’, who work with perinatal women in prison, demonstrates that with unconditional support, women from disadvantaged groups are more likely to initiate breastfeeding and sustain this choice for longer (Kennedy *et al* 2016). Recent qualitative research about pregnant women in United Kingdom (UK) prisons, ‘the incarcerated pregnancy’ (TIP) (Abbott 2016), facilitated women’s voices to be heard with regard to aspects of their pregnancy experience. Specifically, this paper will address their postnatal experience of breastfeeding, lactation and expressing milk for separated babies in prison. Pseudonyms are used to protect women’s identities.

**Feeding choices**

Where women are supported to breastfeed and are able to attend pregnancy groups in prison, the outcomes can be positive (Kennedy *et al* 2016). The prison where the majority of TIP research took place had limited agency for women regarding their decision to breastfeed, no MBUs and no pregnancy groups. Stacey talked to me about there being ‘no point’ in breastfeeding or expressing breastmilk for her newborn as she would be separated from him at birth:

*‘I was going to breastfeed him, to have more bond with him while I’m in here, but, obviously, he’s getting taken so there’s no point.’ (Stacey)*

**‘Have you been told of your options about breastfeeding, or expressing breastmilk?’ (Researcher)**

*‘No, but I’d rather not because he’s not with me. But I was going to do it while I was in here to bond with him and that, but there’s no point now.’ (Stacey)*

**‘You just feel there’s no point to it?’ (Researcher)**

*‘Yeah, there’s no point; no point in doing it, because then that’s going to change his milk [switching from breastmilk to formula].’ (Stacey)*

Stacey believed that she may do her baby more harm by confusing her newborn with different milk as she was going to be separated from her baby whilst she finished her sentence. Stacey was entitled to visits with her baby but felt that there was little point in breastfeeding because that may create a greater bond, and therefore greater pain for her as she separated from her child.

Conversely, Jenna reflected on her experience of feeding her baby, having had the support of a

pregnancy and early parenting group in prison. In contrast to Stacey, Jenna was able to remain with her baby on a MBU. When asked about whether she was able to breastfeed her baby she said:

*‘Yeah, and that was obviously with the help of the Birth Companions.’ (Jenna)*

**‘Was it something you’d thought about prior to the pregnancy groups?’ (Researcher)**

*‘Well, obviously, you read and breastfeeding is best, blab, blab, I thought breastfeeding, yeah, that’s great until I actually tried it. And maybe if I was anybody else I would have just given up, because it pained like hell. But they taught you not to give up and try, and it’ll get better.’ (Jenna)*

**‘How long did you feed her for?’ (Researcher)**

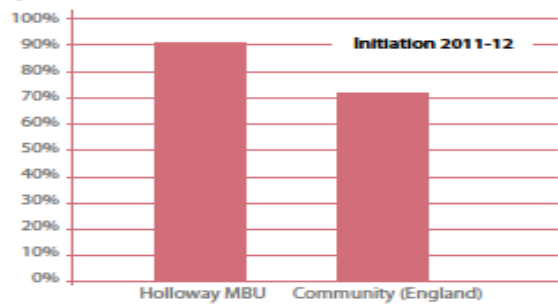
*‘Until she was I think about eight months.’ (Jenna)*

**‘Why do you think you were able to breastfeed?’ (Researcher)**

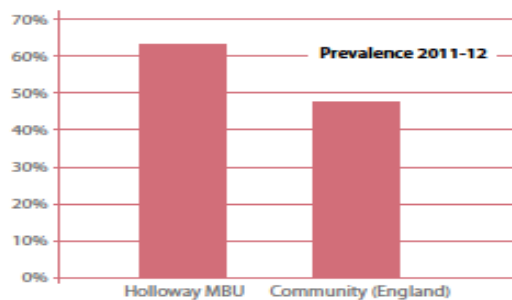
*‘Because of the support we got. Because me and [other woman in prison MBU] were still young, and she breastfed. I don’t think there was actually anybody that didn’t. Because we even expressed... So they [the babies] would go for the weekend, but then what we’d do is we’d express, put it in the freezer, and then they had the freezer stuff.’ (Jenna)*

The charity Birth Companions, who advised Jenna in weekly pregnancy support groups and early parenting groups audited the results of breastfeeding initiation and continuation when they were supporting women in HMP Holloway before the closure of the prison in 2016. Jenna highlighted the tenacity that was instilled in her, through unconditional support, coupled with her own determination to succeed in breastfeeding. Figures from 2011–2012 obtained from Birth Companions demonstrate an increased prevalence in the initiation and prevalence of breastfeeding.

**Table 1. Initiation of breastfeeding by prisoners at Holloway prison between 2011–2012.**



Birth Companions, 2012.

**Table 2. Prevalence of breastfeeding by prisoners at Holloway Prison between 2011–2012.**

Birth Companions, 2012.

### Pregnancy and early parenting groups supporting feeding choices

Some of the women interviewed had attended pregnancy groups where feeding choices were discussed and early parenting groups where they were supported in their feeding choices. Research undertaken by Thomson & Balaam (2016) demonstrated that vulnerable women who received support in the form of pregnancy groups felt better prepared for birth and were more likely to breastfeed than vulnerable women who did not receive the same support (Thomson & Balaam 2016). Jenna talked to me about the support groups she attended:

*'I'll always remember the breastfeeding groups and they were so nice, it was a bit of escapism, you can just talk about your worries and concerns... from those groups I was determined to breastfeed.'*

The determination expressed by Jenna was enhanced by the supportive, non-judgmental ethos of the pregnancy groups. The findings from Thomson & Balaam (2016) warrant replication. Further, the Department of Health (DH) should consider the findings and increase economic input to maximise the provision of bespoke pregnancy groups.

### Breastfeeding and bonding in prison

There are 12 female prisons in the UK and six MBUs (Ministry of Justice *et al* 2016). Approximately 50% of women will gain a place with their baby on a MBU (Kennedy *et al* 2016) with the remaining 50% being separated from their babies shortly after birth. Becky gained a place on a MBU. Incarcerated for a non-violent crime, Becky's story appeared in the *Practising Midwife* in October 2016 (Abbott 2016) where she described her inner struggles. On the one hand she did not want to bring her baby into a prison setting but equally, once she breastfed, Becky knew that she could not let her baby go. Becky had

gained a place on a MBU and therefore was able to remain with her daughter until she was released from prison.

*'When I first went in I said to my partner I don't want her in here, I didn't want her in this environment... But as soon as I had her and I put her on my breast, I fed, she was staying with me. I thought: "it's not nice in here for her, it's not good for her in here" but as soon as I fed it's different isn't it.'* (Becky)

Kylie was 17 when she had her first baby as a prisoner. She gained a place on a MBU and was able to breastfeed, like Jenna, with the support of Birth Companions. Kylie talked about how she bonded with her daughter and reflected that if she had been on the outside, she would not have had the intense one-to-one time and may not have breastfed:

*'At night when the door shuts, I'd go and fill up one of those baby baths and have it on my floor and just give the baby a bath by herself. Or I'd get the oil out and, I mean, you've got so much time to just sit there and look at this kid...'* (Kylie)

Becky described how she had bonded with her daughter, and how breastfeeding had cemented the bond:

*'Because I have never had a child and that bond with a child.... I didn't really know how strong the bond would be and when you have that and you are breastfeeding you can't break that bond and nothing can come close to it...'*

There are currently 75 places for mothers and babies in the female prison estate and it is estimated that there are presently less than 50 women and babies residing in MBUs (Ministry of Justice *et al* 2016). However, recent studies (Albertson *et al* 2012, Thomson & Balaam 2016) demonstrate the benefits to mother and child bonding when places are granted. The contrast I found in the TIP study demonstrated how women who were given the opportunity to bond and care for their babies on a MBU, continued to have close and loving relationships with their children. Opportunity for behavioural change is significant when a woman is pregnant, and compounded by their capacity to breastfeed, due to their willingness to invest in their child (Caddle & Crisp 1997). A number of women, upon release from prison and a MBU, who were also in loving relationships, left their criminal lifestyle in the past and gained future employment.

### Initiating breastfeeding whilst under prison officer guard

Female prisoners in England are usually accompanied to all hospital visits and during transfers with prison officers (Abbott 2015). Initiating breastfeeding highlighted a number of issues. Women spoke of their embarrassment and awkwardness. The embarrassment

Lori felt at being watched whilst trying to breastfeed exacerbated her distress:

*'He [prison officer] was sitting in front of me so if I wanted to breastfeed that was awkward.... I'm thinking oh my God, she's crying, I've got to feed her!'*

Thelma told me that she had to have two officers present at all times and they were often men which was especially uncomfortable for her.

*'It was awful. Awful, especially - because I'm quite body conscious, and to have to sit in a room with a male officer there.... when you're body conscious like that, it's not nice. I was trying to breastfeed and felt dead uncomfortable and really awkward.'*

It is known that the female prison population consists of women who have suffered trauma in childhood such as sexual abuse, neglect and physical violence (Carlen & Worrall 2004). Survivors of sexual abuse risk exacerbated shame and distress when placed in situations that replicate their feelings of exposure and vulnerability. Therefore to be required to breastfeed in front of male prison officers risks triggering reenactment of past abuse (Covington 2008), which may lessen the likelihood of successful breastfeeding.

#### Women withdrawing from methadone

Current research validates the view that breastfeeding and expressing breastmilk whilst taking controlled and prescribed methadone can be safe (Philipp *et al* 2003, Jansson *et al* 2004, Jansson *et al* 2008). Ellie had been able to keep her baby with her on a MBU whilst taking prescribed methadone and although she had three children already, her fourth child, whom she gave birth to whilst in prison, was the first baby she had breastfed:

*'I was only on 40 ml of methadone when Georgia was born. It had no effect whatsoever, because I was on just 40 ml of methadone.'* (Ellie)

Ellie was quite typical of some of the women I met who I identified in TIP as 'safe haven women' (Abbott 2016). These women found the support of the prison environment one step away from the chaos of outside, where homelessness, drug addiction and abuse are commonplace. Ellie told me that had she been in the community, her lifestyle may have led to her continuing to take street drugs:

*'If you're in the community, I'd have been mixing it with heroin and she would have withdrew.'*

Ellie, who had children removed from her care by social services in the past, believed that prison had saved her, but acknowledged that being given a chance to be a mother to her baby was the impetus she needed to change and stop using class A street drugs. Ellie was clear that had she not been given the opportunity, she would have spiraled back into a self-destructive cycle of self-abuse.

#### Breastfeeding and anticipating separation

Women who had been told that they will be separated from their babies would often express their anxieties about not being able to breastfeed. Stacey (a primigravida) felt confused about what she could do, especially as she was due for release shortly after her estimated date of birth:

*'I am planning on breastfeeding but it will, depend on what happens. I mean if I have to, if I am away from her for 2 or 3 days I will be able to stop breastfeeding and start again when I come out. I am hoping that if I have got 2 or 3 days that the hospital will just keep me in knowing that I do want to breastfeed.'*

Stacey felt hopeful that the hospital staff would keep her on the maternity unit, however, she was returned to the prison without her baby. In spite of this she was able to spend the time she did have with her daughter bonding and breastfeeding.

*'I didn't know whether I was keeping her or not keeping her, but I thought, no, I need to give what's best for her. So I went straight to breastfeeding, and I thought, if she does have to go home, then that's just something that I'll have to deal with.'*

#### Expressing breastmilk post-separation

There is scarce research into the area of women expressing breastmilk post-separation from their babies. However, during the course of my TIP research, two women who consented to follow-up interviews were expressing breastmilk for their babies who were being cared for in the community. The complexities of Lena and Stacey's emotions as separated mothers reflected the ambiguity they both felt; wanting to give their babies 'the best', whilst being apart, validating how they wished to enhance bonding and promote connectedness with their newborns.

Of note, despite Lena's long sentence she continued to express breastmilk for her newborn son to be collected by foster carers:

*'... I know I always go on about breastmilk, but I just think it's amazing because your body makes what your child needs, because it's customised, isn't it, for your child? I just don't want him to miss out on anything.'*

Women who wished to express would talk to me about the difficulties they were having in prison with the logistics of the system. Stacey spoke to me about the complications she was having at night when there was nobody to collect her expressed breast milk (EBM):

*'As soon as my door's locked and I'm doing one [EBM] about between nine and ten, and then one again about three or four in the morning; and they're not collecting it. Last night I did one and they gave me ice packs, but the ice packs aren't cold enough to be able to freeze the milk.'*

Women were unable to access the correct equipment to express, as Lena told me:

*'I haven't even seen this pump yet, and I want my – what I'm trying to stress to them is, I don't want my son to have to have formula at all. So I need to get this ball rolling.'*

The numbers of pregnant women in prison each year is estimated to be around 6% of the prison population (Albertson *et al* 2014). Therefore, numbers of women who may be expressing milk for babies who have been separated from them is very small. However, the Birth Charter sets out standards for women who may wish to EBM, including having adequate facilities (fridges in their rooms and pumps) which would standardise care across the prison estate (Kennedy *et al* 2016).

#### Lactation sensations in mothers who are separating

The emotional suffering of women being separated from their babies and returning to prison in the postnatal period was something that was shared during interviews. There is little evidence about the experience of separation from the woman's perspective. However we know that women separating from their babies are at high risk of mental health problems as the recent suicide of one separated woman demonstrated (Parveen 2016). The anguish of feeling the sensations of lactation following separation of her baby was something that Lena put into words:

*'You know that feeling, us mum's know, with my others, my baby only had to cry and I'd start leaking milk, because you just know. You get that tingling sensation when you're due a feed. A foster carer is not going to feel like that when my baby cries, and that's the hardest thing.'*

Klara described similar feelings to Lena of being recently separated from her baby whom she had been breastfeeding in hospital prior to transfer back to the prison:

*'It is horrible, I know it sounds weird, but when my boobs were like..., oh, is this the time that she's meant to have her feed, if you know what I mean? I do just feel like I've had a baby and I've passed her over, and now I've got nothing left, so it's not nice.'*

MMBRACE-UK's *Saving lives* report states that separating women are especially at risk of self-harm and suicidal ideation (Knight *et al* 2016) and the Birth Charter recommends that women recently separated from their babies should be given extra support (Kennedy *et al* 2016). Lena and Stacey were supported in their choices to express milk for their babies, however, neither woman had the opportunity to attend support groups nor did they receive specialist provision whilst they adapted to motherhood without their babies. Klara was not expressing milk for her baby and had not been given the opportunity. The separation she felt, expressed in her words 'now I've got nothing left', was particularly poignant as Klara's

demeanor suggested a numbness that being empty of milk symbolised a void in her, as she faced the loss of her baby.

#### Feeding a newborn baby on weekly visits

Unlike Klara, both Lena and Stacey were permitted weekly visits with their babies and were able to breastfeed. Lena spoke about how her son would seem to feed the whole visit in order to get as much from his Mum as possible:

*'I'll feed him, wind him and then he'll go to sleep, but then he'll wake up again and want me to feed him again. It's like he wants to spend the whole two hours feeding, because I think he must know that I've only got two hours, I need to get as much as I can. Yeah, but, oh, it's so lovely.'*

Lena talked of the ambiguity when saying goodbye following a visit:

*'When I have to say goodbye to him I feel like it's like the worst thing in the world! I wish I could just have a visit every day, see him every day, or just... I really miss him.'*

Some women, due to long sentences or for child protection reasons, may not gain a place on a MBU with their baby (Abbott 2016). However, it is encouraging that the prison enables some of these women to have regular visits with their baby, although this may also depend on the willingness of the babies' carer to travel to the prison.

#### Being sent to prison as a new mother

One woman who consented to interview had been separated from her three-week-old baby following being sentenced to prison for 18 months for a non-violent crime. Pat was a single mother and had been breastfeeding her baby.

*'They sent me to prison knowing that I had a three-week-old baby. I was breastfeeding, so I feel very upset that they took the right away from me that I couldn't continue to breastfeed; because I went to [prison A] and then I was separated for two months from him, so I saw him twice within those two months on a visit for an hour.'*

Pat felt angry at how she had been treated by the courts. Kennedy *et al* (2016) espouse that breastfeeding mothers should have an opportunity to be able to have their babies with them on a MBU much sooner than is current practice. Pat waited for two months to have her baby reunited with her due to the paperwork and permissions required. She told me of her distress:

*'I feel very upset about that, because I feel like even animals are treated better because they don't get separated from their mum until six weeks. I'm a human and he'd got three weeks from me, so I feel it needs to be looked at in terms of, if you are going to*

*send mothers to prison make sure before you send them that the paperwork is in place that their babies are going with them straightaway.'*

Pat was reunited with her baby on a MBU after two months but was unable to reestablish breastfeeding and had not been able to express breastmilk in prison. The difficulties were compounded due to the prison being a long journey from her home.

### Conclusion

To conclude, thorough analysis of women's experiences of breastfeeding, bonding and expressing breastmilk whilst in prison have revealed the following sub-themes: feeding choices when anticipating separation; lactation sensations when separating; withdrawal from methadone; breastfeeding on visits; expressing breastmilk; initiating breastfeeding when under prison guard; and being sent to prison as a breastfeeding mother. Women such as Lena and Stacey voiced their sense of frustration in getting the correct equipment and having milk collected at night whilst Pat expressed her anger at having been separated from her three-week-old baby whom she felt she had no choice but to cease breastfeeding. Women such as Becky, Kylie and Jenna spoke of the supportive environment of a MBU, coupled with the sustenance of pregnancy and early parenting groups which increased their determination to breastfeed their babies. Ellie spoke of her withdrawal from methadone and how being given a chance to be a mother on a MBU also meant that she was able to breastfeed and to change her once self-destructive behaviour. Conversely, women such as Klara, who was separated from her baby and therefore not given an opportunity to express, led her to experience feelings of numbness as her milk dried up. The incarcerated pregnancy research focused upon women who were pregnant or who had given birth as prisoners, however, the experiences of women breastfeeding, wishing to breastfeed and those who were denied the choice became an important part of the narrative as women shared their stories and experiences.

### Acknowledgements

Thank you to the women who agreed to be interviewed as part of TIP research. Your voices are being heard. Thank you to my research supervisors Dr Tricia Scott (co-author) and Dr Kathy Weston for their unwavering support. With thanks to Abbi Ayers, breastfeeding support and prison coordinator for the charity Birth Companions for the Holloway statistics.

*Laura Abbott, Senior Lecturer at the University of Hertfordshire.*

*Dr Tricia Scott, Principal Lecturer, Centre for Research in Primary and Community Care at the University of Hertfordshire.*

### References

- Abbott L (2015). A pregnant pause: expecting in the prison estate. In: Baldwin L. ed. *Mothering justice: working with mothers in criminal and social justice settings*. 1<sup>st</sup> ed. Hampshire: Waterside Press:185-210.
- Abbott L (2016). Becoming a mother in prison. *Practising Midwife* 19(9):8-11.
- Albertson K, O'Keeffe C, Lessing-Turner G et al (2012). *Tackling health inequalities through developing evidence-based policy and practice with childbearing women in prison: a consultation*. Project Report. Sheffield, Sheffield Hallam University. <http://shura.shu.ac.uk/7048/> [Accessed 14 February 2017].
- Albertson K, O'Keeffe C, Burke C et al (2014). Addressing health inequalities for mothers and babies in prison: findings from a consultation exercise. In: Tod AM, Hirst J eds. *Health and inequality: applying public health research to policy and practice*. Oxon: Routledge:39-47.
- Brown AE, Raynor P, Benton D et al (2010). Indices of Multiple Deprivation predict breastfeeding duration in England and Wales. *European Journal of Public Health* 20(2):231-35.
- Caddle D, Crisp D (1997). *Imprisoned women and mothers: Home Office Research Study 162*. London: Home Office.
- Carlen P, Worrall A (2004). *Analysing women's imprisonment*. Callompton, Devon: Willan Publishing.
- Covington SS (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs* 40(suppl 5):377-85.
- Entwistle F, Kendall S, Mead M (2007). The promotion of breastfeeding among low-income women: midwives' knowledge and attitudes following a WHO/UNICEF breastfeeding management course. *Evidence-Based Midwifery* 5(1):29-34.
- Horta BL, Victora CG (2013). *Long-term effects of breastfeeding: a systematic review*. London: World Health Organization. [http://apps.who.int/iris/bitstream/10665/79198/1/9789241505307\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/79198/1/9789241505307_eng.pdf) [Accessed 14 February 2017].
- Jansson LM, Velez M, Harrow C (2004). Methadone maintenance and lactation: a review of the literature and current management guidelines. *Journal of Human Lactation* 20(1):62-71.
- Jansson LM, Choo R, Velez ML et al (2008). Methadone maintenance and long-term lactation. *Breastfeeding Medicine* 3(1):34-7.
- Kennedy A, Marshall D, Parkinson D et al (2016). *Birth charter for women in prisons in England and Wales*. London: Birth Companions. [http://www.birthcompanions.org.uk/media/Public/Resourses/Ourpublications/Birth\\_Charter\\_Online\\_copy.pdf](http://www.birthcompanions.org.uk/media/Public/Resourses/Ourpublications/Birth_Charter_Online_copy.pdf) [Accessed 14 February 2017].
- Knight M, Nair M, Tuffnell D et al on behalf of MBRACE-UK (2016). *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14*. Oxford: National Perinatal Epidemiology Unit, University of Oxford.
- Ministry of Justice, National Offender Management Service, HM Prison Service (2016). *Prison population figures: 2016*. <https://www.gov.uk/government/statistics/prison-population-figures-2016> [Accessed 14 February 2017].
- Parveen N (2016). Prisons ombudsman investigates death of new mother taken off suicide watch. *Guardian*, 9<sup>th</sup> February, [https://www.theguardian.com/society/2016/feb/09/new-mother-killed-herself-prison-shortly-after-taken-off-suicide-watch?CMP=share\\_btn\\_gp](https://www.theguardian.com/society/2016/feb/09/new-mother-killed-herself-prison-shortly-after-taken-off-suicide-watch?CMP=share_btn_gp). [Accessed 14 February 2017].



- Philipp BL, Merewood A, O'Brien S (2003). Methadone and breastfeeding: new horizons. *Pediatrics* 111(6 Pt 1):1429-30.
- Pound CM, Unger SL (2012). The Baby-Friendly Initiative: protecting, promoting and supporting breastfeeding. *Paediatrics and Child Health* 17(6):317-21.
- Pugh LC, Milligan RA, Brown LP (2001). The breastfeeding support team for low-income, predominantly-minority women: a pilot intervention study. *Health Care for Women International* 22(5):501-15.
- Thomson G, Balaam MC (2016). *Birth Companions research project: experiences and birth outcomes of vulnerable women*.

- University of Central Lancashire, The Whittington Hospital and Birth Companions collaboration. [http://www.birthcompanions.org.uk/media/Public/Resources/Ourpublications/1486636153Birth\\_Companions\\_Research\\_Project\\_UCLan.pdf](http://www.birthcompanions.org.uk/media/Public/Resources/Ourpublications/1486636153Birth_Companions_Research_Project_UCLan.pdf) [Accessed 1 March 2017].
- Victora CG, Bahl R, Barros AJD *et al* (2016). Breastfeeding in the 21<sup>st</sup> century: epidemiology, mechanisms, and lifelong effect. *The Lancet* 387(10017):475-90.
- 
- Abbott L, Scott T. MIDIRS Midwifery Digest, vol 27, no 2, June 2017, pp 217-223.  
Original article. © MIDIRS 2017.
-



## Reflections on researcher departure: Closure of prison relationships in ethnographic research

Laura Abbott  and Tricia Scott  
University of Hertfordshire, Hatfield, UK

Nursing Ethics  
1–18  
© The Author(s) 2017  
Reprints and permission:  
sagepub.co.uk/journalsPermissions.nav  
10.1177/0969733017747959  
journals.sagepub.com/home/nj

 SAGE



### Abstract

**Background:** The United Kingdom has the highest incarceration rate in Western Europe. It is known that women in prison are a vulnerable female population who are at risk of mental ill-health due to disadvantaged and chaotic life experiences. Accurate numbers of pregnant women held in UK prisons are not recorded, yet it is estimated that 6%–7% of the female prison population are at varying stages of pregnancy and around 100 babies are born to incarcerated women each year. There are limited published papers that document the departure of the researcher following closure of fieldwork with pregnant women in prison. This article identifies the dilemmas and challenges associated with the closure of prison fieldwork through the interwoven reflections of the researcher. Departure scenarios are presented which illuminate moments of closure talk with five women, supported by participant reflections regarding abandonment and loss, making pledges for the future, self-affirmation, incidental add-ons at the end of an interview and red flags, alerting the researcher to potential participant harm through ill health or self-injury.

**Objectives:** The primary intention of the study was to observe the pregnant woman's experience with the English prison system through interviews with pregnant women and field observations of the environment.

**Research design:** Ethnographic design enabled the researcher, a practising midwife, to engage with the prisoners' pregnancy experiences in three English prisons, which took place over 10 months during 2015–2016. Data collection involved semi-structured, audio-recorded interviews with 28 female prisoners in England who were pregnant or had recently given birth while imprisoned, 10 members of staff and a period of non-participant observation. Follow-up interviews with 5 women were undertaken as their pregnancies progressed. Computerised qualitative data analysis software was used to generate and analyse pregnancy-related themes.

**Ethical considerations:** Favourable ethical opinion was granted by National Offender Management Services through the Health Research Authority Integrated Research Application System and permission to proceed was granted by the University of Hertfordshire, UK.

**Findings:** Thematic analysis enabled the identification of themes associated with the experience of prison pregnancy illuminating how prison life continues with little consideration for their unique physical needs, coping tactics adopted and the way women negotiate entitlements. On researcher departure from the field, the complex feelings of loss and sadness were experienced by both participants and researcher.

**Discussion:** To leave the participant with a sense of abandonment following closure of fieldwork, due to the very nature of the closed environment, risks re-enactment of previous emotional pain of separation. Although not an ethical requirement, the researcher sought out psychotherapeutic supervision during the fieldwork phase with 'Janet', a forensic psychotherapist, which helped to highlight the need for careful

**Corresponding author:** Laura Abbott, University of Hertfordshire, Hatfield AL10 9AB, UK.  
Email: l.abbott@herts.ac.uk

## Appendix 1.17 : Prison Service Order - Women Prisoners



## Women Prisoners

<b>Date of Initial Issue</b>	<b>28/04/08</b>
<b>Issue No.</b>	<b>297</b>
PSI Amendments should be read in conjunction with this PSO	
<b>Date of Further Amendments</b>	

## EXECUTIVE SUMMARY

STATEMENT OF PURPOSE	
To provide regimes and conditions for women prisoners that meet their needs	
DESIRED OUTCOME	
Women prisoners are held in conditions and within regimes that meet their gender specific needs and which facilitate their successful resettlement.	
MANDATORY ACTIONS	
<p><i>Governors of establishments, and Area Managers and ROMS in respect of Contracted prisons, must ensure that women's prisons under their jurisdiction put in place by October 2008 plans to implement this PSO and the accompanying gender specific standards.</i></p> <p>References in this PSO to Governors also apply to Directors of contracted prisons/YOIs.</p>	
RESOURCE IMPLICATIONS	
Most of these standards are "best practice" already in many establishments but it is recognised that it will not be possible to implement all standards immediately because of resource pressures.	
IMPLEMENTATION DATE:	22 May 2008
(signed)	
<b>Chief Operating Officer</b>	Area/Operational Manager

Further advice or information on this PSO or the systems contained within it can be sought from: in the Women and Young Peoples' Group: 0207

## **PSO 4800 Women Prisoners**

### **1. Introduction**

- 1.1 There has until now been no Prison Service Standard or Prison Service Orders written specifically about how the Prison Service should manage women prisoners to meet their different needs, except in the case of women located in Mother and Baby units.
- 1.2 It is important to establish appropriate consistent standards for the treatment of women prisoners, for implementation across the estate.
- 1.3 This PSO is written against the background of the new Gender Equality Duty (GED) which took effect in April 2007. The GED places a statutory General Duty on all public authorities
  - to eliminate unlawful discrimination
  - to eliminate harassment
  - to promote equality of opportunity between men and women
- 1.4 Criminal justice agencies need to produce evidence and outcomes to show all three strands have been considered. The Act allows provision of services to one sex in certain circumstances, such as establishments providing special care or supervision to one sex to meet general needs.
- 1.5 A Gender Specific Standard is being introduced to ensure the different needs of women are consistently addressed across the estate as well as the generic standards which are also applicable in male prisons. Women's establishments will be audited against this from April 2009. The Standard will be kept under review with the aim that it will, in due course become a comprehensive Standard for women's prisons, replacing a number of the current generic Standards.
- 1.6 It is important to note that although some aspects of how imprisonment affects a woman is clearly gender specific and will only apply to her and not a male prisoner (an example would be facilities for pregnant women), other elements of imprisonment are likely to impact women differently or to a significantly different degree and therefore it is appropriate to set a different standard.
- 1.7 Annex A sets out guidance notes on the gender specific baselines and how establishments might meet them. The development of the Standard and why there is a gender specific element is also explained.

### **2. Some Statistical and Research Information about Women Prisoners**

- 2.1 There was a 196% increase in the number of women remanded into custody between 1992 and 2002 compared to a 52% increase for men. Since that date the population appears to have stabilized at around 4,500.

- 2.2 Women more frequently than men are the main carers of children. They are often single parents. Two-thirds of women prisoners are mothers. Only one quarter of children of women prisoners live with their biological or current fathers. Only 5% of children stay in their own homes after mother's imprisonment.
- 2.3 Women in prison bring with them a considerable amount of vulnerability: one in 10 will have attempted suicide, half say they have experienced domestic violence and a third sexual assault. Now half of all incidents of self-harm in prisons will be committed by a woman even though women represent only 6% of the total prison population.
- 2.4 Around one-third of women prisoners' report having experienced sexual abuse in childhood. A survey for HMCIP in 1997 found 49% of young women said that they had experienced sexual abuse, compared with 17% of young men interviewed.
- 2.5 Two-thirds will be drug dependent or with hazardous levels of drinking
- 2.6 15% have been so seriously mentally ill that they have previously been in a psychiatric hospital and 80% have had diagnosable mental health problems.
- 2.7 60% of women remanded into custody do not receive a custodial sentence.
- 2.8 Many women will be entering custody from positions of poverty and with very little social contact.
- 2.9 The gender specific requirements contained within this document take into account the particular nature of the women's prisoner population which is disproportionately likely to have suffered domestic and sexual abuse, mental health problems and self-harm which both impacts upon on their offending behaviour and their ability to cope within custody and after release.

#### Mandatory Action

- 3.1 Governors and Directors of women's establishments must ensure that women's prisons under their jurisdiction must put in place by October 2008 plans to implement this PSO and the accompanying gender specific standards by April 2009.
- 4. Development of the Gender Specific Standards
- 4.1 The standards have been produced following widespread consultation with managers, staff and prisoners in establishments, HMPS and NOMS groups, and outside groups with special interest in women prisoners.
- 5. Role of HMPS Women and Young People's Group  
It will be part of the core work of the W&YPG to support women's establishments as they work to implement and maintain gender specific standards.
- 6. Monitoring and audit arrangements  
Standards defined as critical standards will be audited by SAU. Others will be monitored through internal auditing and monitored by W&YPG.

**ANNEX A TO PSO 4800 WOMEN PRISONERS**

**GUIDANCE NOTES ON**  
**GENDER SPECIFIC**  
**STANDARDS**  
**WOMEN PRISONERS**

**Table of Contents:**

This document is divided into 19 sections:

- A**     [Pre-custody](#)
- B**     [Reception and First Night Procedures](#)
- C**     [Induction, Resolving Urgent Issues](#)
- D**     [Health: Physical Health, Mental Health, Substance Misuse](#)
- E**     [Offender Management, Offender Supervision, Personal Officer Schemes, Allocation Decisions and Through the Gate Support](#)
- F**     [Supporting Women at Risk of Self-harm](#)
- G**     [Day-to-Day living:](#)
  - 1. [Incentives and Earned Privileges](#)
  - 2. [PE](#)
  - 3. [Property and Clothing](#)
  - 4. [Hygiene](#)
  - 5. [Environment](#)
  - 6. [Diet](#)
  - 7. [Association Activities](#)
  - 8. [Religion and Faith](#)
  - 9. [Prison Shop](#)
  - 10. [Complaints](#)
- H**     [Managing Order in Women’s Prisons: Promoting Pro-Social Behaviour, Adjudications and Segregation](#)
- I**     [The Pathways to Resettlement - Reducing Re-offending National Action Plan July 2004](#)
  - 1. [Accommodation](#)
  - 2. [Education, training and employment](#)
  - 3. [Health and Detoxification](#)
  - 4. [Drugs and alcohol](#)
  - 5. [Finance, benefit and debt](#)
  - 6. [Children and families](#)
  - 7. [Attitudes, thinking and behaviour](#)
  - 8. [Supporting women who have been abused, raped or who have experienced domestic violence](#)
  - 9. [Supporting women who have been involved in prostitution](#)



- J [Young Women Prisoners](#)
- K [Older Women Prisoners](#)
- L [Women from Black and Minority Ethnic Groups](#)
- M [Women Foreign Nationals](#)
- N [Women Prisoners with Disabilities](#)
- O [Indeterminate/ Life Sentence Women Prisoners](#)
- P [Mother and Baby Units](#)
- Q [Management Issues](#)
- R [Training of Staff and Volunteers](#)
- S [Security in Women's Prisons](#)

<b>Issue: S</b> <b>SECURITY IN WOMEN'S PRISONS</b>	<b>REFERENCE</b>	<b>GENDER SPECIFIC GUIDANCE</b>	<b>REQUIRED OUTCOMES</b>
<p>Security in women's prisons is based on the same principles/practices/procedures as in men's prisons although some security procedures are different. Two examples are the system of security categorisation and allocation to "semi-open" prisons.</p> <p>There are fewer serious incidents such as hostage taking, escapes and serious assaults in women's prisons compared to male prisons although these do occur. When women participate in acts of concerted indiscipline the incidents tend to be passive, spontaneous and small in number.</p> <p>There are a few high-risk women in prison and more who are associates of high-risk men.</p> <p>Serious acts of self-harm are much more frequent in women's prisons. Some serious incidents other than self-harm do occur – particularly around drugs. Forced removal by other prisoners of secreted drugs occurs. Arson is also fairly common particularly in locals.</p> <p>There has been historically widespread (but inconsistent) full searching of women prisoners using the same basic model as that applied to male prisoners. This is a practice that distresses many women, particularly those with mental health problems and/or who have been sexually abused, and is unpleasant for staff to carry out. It can be particularly embarrassing when women are menstruating. The traditional full search has not</p>	<p>HMPS Standard 54: Security</p> <p>HMPS Standard 53: Violence Reduction</p> <p>HMPS Standard 61: Use of Force</p> <p>National Security Framework</p> <p>Corston Report March 2007</p> <p>The 1989 UN Convention on the Rights of the Child</p>	<p>The new Women's Full Search for women prisoners will involve the removal of as much clothing as necessary on the grounds of risk, "reasonable suspicion", and intelligence collated. A woman will not be required to remove her underwear unless necessary on these grounds. <b>(SUBJECT TO OUTCOME OF CURRENT PILOT)</b></p> <p><u>Note:</u> The National Security Framework allows staff to require male prisoners, but not women prisoners, to squat.</p> <p>Searching that is to take place should always be clearly explained to women in advance.</p> <p>Staff should be trained how to maintain appropriate relationships with women and how to avoid conditioning (see section R Training).</p> <p><b>Staff should be absolutely clear about the security requirements of escorting pregnant women, women in labour and women who have recently given birth. [Audit baselines 47. &amp; 48.]</b></p> <p>MDT testing should be carried out with particular sensitivity.</p> <p>Women should not be handcuffed between the escort vans and reception if there is more than one physical barrier between reception and the outside of the prison, (i.e. a sterile area exists) unless there are other indications that this should be done because of the prisoner's behaviour or security intelligence, or if there is intelligence that the prisoner is likely to be involved in an "at height" incident.</p>	<p>There are some different security issues in women's prisons.</p> <p><b>KEY AUDIT BASELINES</b></p> <p>52. Full searching for women prisoners requires the removal of as much clothing as necessary on the grounds of risk, "reasonable suspicion", or intelligence received. Women are not required to remove underwear or external sanitary wear, unless necessary on these grounds. <b>(SUBJECT TO OUTCOME OF CURRENT PILOT)</b></p> <p><b>[For audit baselines concerning the escorting of pregnant women, women in labour and women who have recently</b></p>

<p>been particularly effective however. Because of the nature of their anatomy women find it very easy to conceal items for a long time internally, if they want to.</p> <p>MDT testing is never a pleasant experience for staff or prisoners. Women are not accustomed to urinating in the presence of others. Women can find it particularly embarrassing when menstruating.</p> <p>Sometimes prisons reduce the amount of physical contact generally being allowed between visitors to try to reduce the amount of drugs that are smuggled in. Preventing physical contact between mothers and their young children can be psychologically damaging to young children.</p>		<p>Unless women have been placed on closed visits because they have breached security rules, they must be allowed to embrace their children on open visits and be allowed to hold small children on their laps. There should be no blanket rules forbidding close physical contact between young children and their mothers and importantly prisoners must be left in no doubt that they can hold their small children. [Audit baseline 35.]</p> <p>Closed visits between women and their children should only be authorised if necessary. A single indication by a passive drugs dog without any additional intelligence that a child is likely to be used to smuggle in illicit articles, should not be considered enough to justify closed visits between a woman and her child.</p> <p>Women in active labour are not handcuffed either en route to, or while in, hospital. Restraints are to be carried but not applied unless the woman's behaviour is refractory or there are indications that she may attempt to escape.</p>	<p>given birth see baselines 46. and 47.]</p> <p>[For audit baseline concerning the contact between small children and their mothers on visits see audit baseline 34.]</p>
---	--	--	--

## Appendix 1.18 : Prison Service Instruction - Mother and Baby Units



## SECTION 1

### Executive Summary

#### Strategic Context

<b>Mother &amp; Baby Units</b>		
<b>This instruction applies to:-</b>		<b>Reference:</b>
Prisons		<b>PSI 54/2011</b>
<b>Issue date</b>	<b>Effective Date</b>	<b>Expiry Date</b>
26 September 2011	1 October 2011	1 October 2015
<b>Issued on the authority of</b>	NOMS Agency Board	
<b>For action by</b>	Prisons	
<b>For information</b>	Deputy Directors of Custody	
<b>Contact</b>	Head of NOMS Women's Team	
<b>Associated documents</b>	Mother & Baby Unit Specification PSO 4800 Women Prisoners Ofsted Standards	
Replaces the following document which is now cancelled: PSO 4801 The Management of Mother and Baby Units.		
Audit/monitoring:  Those responsible for contract management will monitor compliance with the mandatory actions set out in this PSI.		

- 1.1 To reflect society's normal assumption that the best place for a young child is with his or her parent, the English and Welsh prison service has allowed mothers to care for their babies in prison. To allow this to happen, a Mother and Baby Unit is designated living accommodation within a women's or mixed gender prison, which enables mothers, where appropriate, to have their children with them whilst in prison. Currently there are seven units across the prison estate.
- 1.2 The Prison Rules, The Children's Act 2004 and International Conventions provide the legal foundations and principles for the operation of MBUs. The two international conventions are:
- The United Nations Convention on the Rights of the Child 1989, Article 3, para1. This states:  
*"in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be the primary consideration"*

- The European Convention on Human Rights 1950, Article 8. This provides the right to family life.

1.3 The implementation and regulation of the processes for MBUs is governed by other legislation. All legislation is referenced in this PSI.

1.4 MBUs cater for mothers with babies up to either 9 or 18 months. Timescales are a guideline only and separations should be influenced by the best interests of the child concerned. Mothers may be remands or sentenced prisoners and may be British or Foreign Nationals. A mother is only admitted to an MBU following an admission board chaired by an Independent Chair who is a certified Social Worker. The decision to admit a mother and her child takes into account:

- a) Whether it is in the best interests of their child
- b) The necessity to maintain good order and discipline within the MBU
- c) The health and safety of other babies and mothers within the unit

2.2.4 *Where the mother (applicant) cannot attend in person, a video link should be used wherever possible. If video link facilities are to be used, the mother must give her consent in writing to being present via video link before the Board sits. If it is not possible to use the video link facility, the reasons must be recorded in the minutes of the Board meeting.*

2.2.5 *Where it is not possible for the applicant to attend, for example, because of a medical condition or being located in an establishment without a video link facility, the mother must be invited to make a full written submission to the Board. She must be assisted to do so by the Mother and Baby Liaison Officer of the prison from which she is applying.*

Before an Admission Board agrees admission, it must be satisfied that the following criteria are met;

- It is in the best interest of the child/children to be placed in a Mother and Baby Unit
- The applicant is able to demonstrate behaviours and attitudes which are not detrimental to the safety and well-being of other residents.
- The applicant has provided a urine sample which tests negative for illicit substances
- The applicant is willing to refrain from substance misuse.
- The applicant is prepared to sign a standard compact, which may be tailored to her identified individual needs.
- The applicant's ability and eligibility to care for her child is not impaired by poor health, or for legal reasons such as the child being in care or on the Child Protection Register as a result of the applicant's treatment of that child, or other children being in care.

2.2.6 *A woman offender on a prescribed Methadone or Buprenorphine (subutex) withdrawal or maintenance programme must not be excluded from a place on a Unit solely for that reason.*

2.2.6 *The Board's deliberations must be accurately recorded.*

2.2.7 *The Chair of the Board must ensure that the relevant information in the reports or from attendees is made known to the Board and accurately recorded.*

2.2.8 *Where there is a need for discussion in the absence of the offender this must be explained and the reason for it recorded.*

2.2.9 *The Chair of the Board must clearly record the reasons for arriving at the decision and whether or not the decision was unanimous.*

2.2.10 *The recommendation, together with copies of the reports submitted to the Board and any additional notes sent by the Chair, must go to the Governor/Director of the MBU Prison for a decision on admittance/non-admittance to be made.*

*If a second application from a woman who has had a conditional refusal is turned down or an initial application from a prisoner has been absolutely refused, then the following procedure must be followed;*

- *If the prisoner applying for a place was not present at the Admission Board or not a participant in the Admissions Board via video link, she may request that a Board be reconvened in her presence.*
- *If the prisoner was present at the Admission Board, or a participant in it by video link, she has the right to appeal through the request and complaints procedure to the Head of Women's Team.*
- *No impediment should be placed in the way of a prisoner who wishes to express her grievance outside the system, for example, by taking legal advice.*

2.2.11 *Where known, the length of sentence to be served by the mother must be taken into account in the admission process. In the majority of cases the length of sentence actually served in prison will allow the mother and child to leave the prison together, but long sentences may not permit that to happen because all children are expected to leave at around the age of 18 months which may be before the mother's time in prison has been completed.*

2.2.12 *Despite a long sentence it may be considered to be in the child's best interest to allow admission for a short period. Such issues as allowing the mother to form some relationship with the child for the future; allowing breast feeding (expressing may be an alternative); and giving time for alternative care arrangements to be made, may be relevant. The decision is for the Admission Board to make as part of its recommendation to the Governor/Director*

*In reaching its decision, the Board should be aware that there are several types of admission and refusal and should choose the appropriate one for the case.*

- **Temporary Admission**
- **Emergency Temporary Admission**
- **Full Admission**
- **Conditional Refusal**
- **Full Refusal**

### **Temporary Admission**

This is granted when a woman is considered suitable for an MBU but is on remand, waiting trial or is convicted but un-sentenced. It should be explained to the woman that she is being temporarily admitted and that she will be re-boarded for full admission when her sentence is known. A clear record that she has been informed must be made.

When her sentence is known the Board will reconvene to make a final decision on the case. The implications of her sentence will be considered. It may be that she can continue to reside on the MBU until her release or separation plans may be required for her and her child particularly if the sentence is over 18 months. Where a period without a sentence turns out to be prolonged, staff should discuss the case with the Independent Chair to determine whether the Board should be reconvened to assess the case again in light of the latest position.

### **Emergency Temporary Admission**

Emergency Temporary Admission to a Mother and Baby Unit may be granted by the Governor/Director without a full board for unpredictable cases in circumstances where it is thought desirable for the baby to be with the mother while her application is being processed. *Those involved in such a decision must take all possible measures to identify and assess any risks to the child/mother and any other mothers and children on the unit. Social Services must be informed immediately so that they can provide the prison with advice on dealing with the case.*

Examples of cases when emergency temporary admission may be necessary are;

- Where the baby is in the care of the local authority as a result of the mother being arrested at a port or airport, particularly if the mother is a British non-resident, and it appears that there is no immediate suitable living accommodation for the child in this country.
- Where the baby is in the unplanned care of others owing to the sudden detention of the mother in custody
- Where the pregnancy is in an advanced state and the baby is due imminently.

*In all such cases a full emergency Board must be convened as quickly as possible. Every effort must be made to ensure that all necessary people can attend with the required information. As much information as practicable must be collected within the few days available; some input from the appropriate Social Services Authority is essential. This may be in the form of a telephone conversation noted in writing by the member of staff from the prison but must be followed up by a written report from the relevant Social Service by email or fax. If the woman is not known to Social Services, a risk assessment must be completed by the Board based on the woman's current and previous offences.*

### **Full Admission**

This is granted when the mother is sentenced, all the necessary documentation is available to the Admissions Board members and the Board is satisfied that it is the best interest of the child to be admitted and there are no identified risks to others on the Unit. Any special conditions of admission must be added to the compact.

### **Conditional Refusal**

A conditional refusal is offered when the Board would be prepared to recommend full admission if the applicant/mother could successfully address certain identified issues. *Where*



*an applicant has been given a conditional refusal, the reasons must be clearly explained to her and accurately recorded. A realistic time frame must be set to allow her to address any issues identified by the Board. Staff must provide appropriate support and assistance to the applicant. A further application may be made at the end of the period.*

## **Refusal**

The applicant should be refused a place on a Mother and Baby Unit if her case fails to meet any of the admission criteria.

### **2.3 The decisions of Admission Boards are communicated to relevant stakeholders**

*2.3.1 The Board's Chair must clearly record the reasons for arriving at a recommendation and whether or not the decision was unanimous.*

*2.3.2 The recommendation, together with copies of the reports submitted to the Board and any additional notes sent by the Board Chair, must go to the Governor/Director of the MBU prison for a decision on admittance/non-admittance to be made.*

*2.3.3 The Chair of the Board must communicate the recommendation to the Governor/Director of the prison with the MBU within 24 hours of the conclusion of the Board. It is the responsibility of the Governor/Director at that prison to reach the final decision and to inform the applicant within 2 working days of the Board unless there are exceptional circumstances.*

*2.3.4 Where the applicant is located in another establishment the admissions decision must be forwarded by email or fax to the Governor/Director of the holding prison, who must ensure that the prisoner is given the written response and reply form within 2 working days of the Board's decision, unless there are exceptional circumstances.*

*2.3.5 The minutes of the Admission Board must be circulated to all attendees, including the applicant, within fourteen days of the meeting.*

*2.3.6 The applicant must sign to confirm that she has received the letter of recommendation. She will retain one dated copy and a second dated copy must be placed in the woman's application dossier. The result of the woman's application must also be recorded on P-Nomis.*

*2.3.7 The written replies giving the outcome of the Admissions Board should be in the form of the sample letters set out in Annex C.*

**3.2.7 After the birth of the baby the mother is entitled to be off work and classes for a period of six weeks. When medically fit, mothers are required to work and participate in Offending Behaviour Programmes.**

**3.2.8 To assist Governors/Directors in this specialist area, the Women's Team in co-operation with Training Services provides a course entitled "Management of Pregnant Women and Mothers with Babies in Prison"**

**This course is desirable for all staff working in a female establishment. Training should be completed prior to working on a Mother and Baby Unit. It is highly recommended that all staff working in female establishments undertake this training, and most specifically, those due to work on/already working on a MBU. The course covers key legislation and activities.**

## OUTPUT - SECTION 4; MANAGEMENT AND WELFARE OF WOMEN PRISONERS

### TO BE READ IN CONJUNCTION WITH RESIDENTIAL SERVICES SPECIFICATION AND PSO 4800 WOMEN PRISONERS

- 4.1 **Mothers (including expectant mothers) are supported and their daily needs are met.**
- 4.1.1 All basic items, for example cots, are provided. Mother and Baby Units do have stocks of some articles but it is expected that mothers will provide their own personal equipment using their Child Benefit payment. Child Benefit should be used to purchase items that will be of benefit to the child/children. Where Child Benefit is not paid, e.g. in the case of foreign national prisoners, some financial assistance may be provided by the establishment. Some Unit items may be loaned to mothers for the duration of their stay.
- 4.1.2 Each Mother and Baby Unit will have its own local list published on the Unit but generally any article within reason and age appropriate should be allowed.
- 4.1.3 It is expected that food for babies will be purchased by the mother.
- 4.1.4 **Food for mothers (including expectant mothers) will be provided by the Prison Catering Department.**
- 4.1.5 U.K Citizens are entitled to claim Child Benefit. The entitlements are the same as those provided in the community. The money should be used to purchase items that will benefit the baby. Foreign National mothers will be assisted financially by the prison to purchase basic items that will benefit their babies.
- 4.1.6 *The Governor/Director must ensure that procedures are in place to ask women on reception or at the earliest opportunity whether they are pregnant or have children under the age of 18 months. They must be provided with the prisoners' information booklet "All About Mother and Baby Units"*
- 4.1.7 *Governors/Directors in all women's prisons must appoint a named MBU Liaison Officer, who will be responsible for assisting the woman to complete the application form; child care plan; ensuring all forms are correctly completed. The Mother and Baby Liaison Officer must have at least one Deputy to cover for absences.*
- 5.1.3 **All Mother and Baby Units must have a written policy on Child Nutrition, including breastfeeding, based on Department of Health guidelines.**
- 5.1.5 *In recognition of the restrictions of living on a Unit, the Governor/Director must seek ways to provide the babies with a variety of different experiences. These should include contact with other family members and the outside world. Recognition should also be given to the child's cultural identity wherever practicable. For example, by contact with appropriate outside organisations or groups for advice and guidance on a particular case, for access to facilities, where feasible, for an identified need. Agencies which may be involved could be Social Services, the Health Authority, Health care staff, General Practitioners, nurses, midwives, health visitors, paediatricians, allied health professionals, mental health services, psychologists, educationalists, day care services, Sure Start housing and Probation Services.*

**MOTHER AND BABY UNIT APPLICATION FORM**

**Name/Number of Applicant:**

**Date of Application:**

**Section 1: Child Details**

**Section 1a: For pregnant mothers applying for a place for their unborn child**

**When is the baby due?**

Who was your Doctor prior to custody?

Doctor's address

**Section 1b: For mothers applying to have their child living with them in prison**

Child's date of birth

Sex

Religion

Birth weight

Surname

Forename(s)

Name of child's Doctor

Child's current address



## NEW & EXPECTANT MOTHERS AT WORK HEALTH & SAFETY POLICY

1. The Governor of HMP ----- acknowledges the General Duties placed upon her/him as the employer. This procedure is to assess the risk to all employees, and to new and expectant mothers, to reduce the risk to their health, safety, and welfare, so far as is reasonably practicable.

2. The Management of Health & Safety at Work Regulations 1999 (MHSW99), regulation 16, is more specific in respect of new & expectant mothers, and states that an employer is required to carry out a risk assessment for new & expectant mothers.

The definition of a "new and expectant mother" is a woman who:

- Is pregnant.
- Has given birth or suffered a miscarriage after 24 weeks of pregnancy within the last 6 months.
- Is breastfeeding.

3. Where the duties/work/activity of a new & expectant mother are such that they could involve risk, by reason of her condition, to her individual health, safety & welfare, or to that of her baby, certain considerations must be taken into account, including her working environment (physical, biological or chemical).

4. The framework guidelines to be followed for this risk assessment are set out in Instruction to Governors 35/1995 entitled 'Pregnant Workers'. This instruction tells line managers which hazards should be considered, how to carry out the risk assessment, and who is responsible for completing it.

5. The risk assessment **MUST** be carried out with the new & expectant mother, taking into account her needs and wishes as far as is practicable. It should cover what is expected of her whilst she is pregnant, including the areas she is expected to work in.

6. The risk assessment should: -
- Identify possible hazards.
  - Consider the likelihood that the hazard will result in a risk to the health, safety & welfare of both the mother and unborn child, taking into account existing control measures.
  - Identify possible consequences should this occur.
  - Record the results of the assessment.

7. After the initial risk assessment (Recorded on form in Annex A of IG 102/1995) has been carried out, the assessment must be reviewed on a monthly basis and any changes agreed between the line manager and the new & expectant mother. This should continue during the three trimesters of the pregnancy, or until such time that the new & expectant mother commences her maternity leave.

8. Night working:

There are no restrictions on night working for new & expectant mothers. In some cases, it may be more beneficial for the individual to continue on a normal shift pattern. However, it must be taken into account after mutual consultation, that under certain circumstances night working may constitute a risk.

If it is decided that there is a risk, it may result in the new and expectant mother being transferred to suitable daytime work.

9. By law, the Governor of HMP -\*\*\*\*- has a Duty of Care placed upon her/him as the employer through the Health & Safety at Work Act 1974 and its associated regulations. S/he is required to take reasonably practicable steps to ensure the health, safety and welfare of the expectant mother and that of the unborn child. The obligation placed on the new and expectant mother, as an employee, is to inform the Governor in **'WRITING'**, as soon as possible that she is pregnant; has given birth within 6 months and/or is breastfeeding (MHSW 99 Regulation 18).

The Governor  
HMP  
Date



## **HMP/YOI**

### **NATIONAL MOTHER AND BABY CO-ORDINATOR**

1. Be continuously available to provide operational and policy advice to Governors and Mother and Baby Unit staff.
2. Draft, revise and amend policy documents relating to Mother and Baby issues in the light of any policy changes or legal challenge.
3. Complete periodic visits to all Mother and Baby Units, reporting through Line Management to the Head of the Women's Team.
4. Attend establishment meetings concerning Mother and Baby issues, on request.
5. Attend the bi-annual Mother and Baby Policy Group meeting.
6. Attend the quarterly Independent Chairs and Mother and Baby Unit Managers' meetings.
7. Arrange with Training Services and assist in, where required, the Mother and Baby Unit training course.  
Advise Training Services on updates and amendments to that course in the light of policy changes. Assist Training Services in the continuous validation process of the course.
8. Assist Mother and Baby Unit personnel in pre-audit preparation.
9. Inspect incoming data from Mother and Baby Units in order to predict and manage national trends and furnish an overview on Mother and Baby issues.
10. Answer Parliamentary questions and provide briefings and other information to Ministers as required.
11. Assist in the case management of individual mother and babies, in particular in contentious areas.

12. Assist in the management of Judicial Reviews.
13. Work as part of a multi-disciplinary team.
14. Work in an anti-discriminatory, non-confrontational way with all parents and children, challenging discriminatory practice where necessary

## MOTHER AND BABY LIAISON OFFICER

1. To have a working knowledge of, and be familiar with the Prison Service Instruction/Mother and Baby Handbook on the Management of Mother and Baby Units and the Application Process and the prisoner handbook, "All about Mother and Baby Units".
2. To advise women applying for a place on a Mother and Baby Unit about the application procedure and the appropriateness of each location for the individual case.
3. To assist women to consider all childcare options available to them.
4. To act as a source of information on Mother and Baby Units for prisoners and staff.
5. To ensure that all eligible women are advised of the Mother and Baby Units during induction and, where appropriate, receive the prisoner handbook "All about Mother and Baby Units".
6. To assist those women who wish to make applications to complete the application form, taking account of any language, learning or other needs.
7. To initiate relevant reports in accordance with the procedures laid out in the Prison Service Instruction/Handbook on the **Management of Mother and Baby Units and the Application Process**.
8. To liaise with the identified Mother and Baby Unit, having considered the woman's status (remand/sentenced/security category), the age of her child and her home area.
9. To co-ordinate all actions necessary with this application, including inviting and assisting the woman to make a written submission where she is not able to attend the Board either in person or via Video Link.
10. To complete the application dossier and send it to the appropriate Mother and Baby Unit. *In cases of mothers separated from their babies and women in the late stages of pregnancy, every attempt must be made to expedite this process.*
11. To update the woman on the progress of her application, the date of the Admission Board and make arrangements for her attendance when appropriate.
12. To assist the woman to prepare for the Admission Board.
13. To advise the applicant on the appeal process including re-boarding, where applicable.
14. Where the woman is serving a long sentence (that is, where the child will be older than 18 months prior to his/her mother's earliest possible release date), bring to the Governor's attention the need for a separation plan.
15. To maintain an accurate record of all applications made, their date, Board date and subsequent outcome of the application.
16. To maintain regular contact with the Mother and Baby Units, the national Mother and Baby Co-ordinator and the Women's Team. This must include the following information on the first working day of each month: -
  - The number of applications made to Mother and Baby Units.
  - The number of acceptances to Mother and Baby Units and their location.



- The number of pregnant women in the establishment.
  - The number of refusals to Mother and Baby Units and the reasons they have been refused.
  - Any other information which may be requested by the national Mother and Baby Co-Ordinator from time to time.
17. To work in an anti-discriminatory, non-confrontational way with all children and parents and challenge discriminatory practice where necessary.

## Appendix 1.19 : Birth Charter for women in prisons in England and Wales

[http://www.birthcompanions.org.uk/media/Public/Resources/Ourpublications/BirthCharterOnline\\_copy.pdf](http://www.birthcompanions.org.uk/media/Public/Resources/Ourpublications/BirthCharterOnline_copy.pdf)



Birth Charter for women in prisons in England and Wales



#### Acknowledgements

The Birth Charter was written by Annabel Kennedy, Denise Marshall, Diana Parkinson, Naomi Delap, Laura Abbott, and a group of women; all of whom have been pregnant, and some of whom have had babies in HMP Holloway. Many thanks for input, advice and support from Abbi Ayers, Viv Gray, Claire Powell, Claire Cain, Katharine Hodgson, Francesca Entwistle, Jacque Gerrard, Gabrielle Bourke, Janet Fyle, Brian Benson and Peek Creative.



E-mail: [info@birthcompanions.org.uk](mailto:info@birthcompanions.org.uk)  
Website: [www.birthcompanions.org.uk](http://www.birthcompanions.org.uk)

Design: [www.haveapeekatthis.com](http://www.haveapeekatthis.com)  
Registered Charity Number: 1120934  
Birth Companions is also a company limited by guarantee (company number:6269047),  
registered in England and Wales with a registered office address at:  
Dalton House, 60 Windsor Avenue, London SW19 2RR

## Appendix 1.20 : Impact: Papers, presentations and funding awards related to DHRes research

### Written Publications

- Abbott L and Scott T (2018). Reflections on Researcher Departure: Closure of Prison Relationships in Ethnographic Research. *Nursing Ethics*. Sage.
- Abbott L and Scott T (2017). Women's Experiences of Breastfeeding in Prison. *MIDIRS Midwifery Digest*, vol 27, no 2, June 2017, pp 217-223.
- Abbott L and Delap N (2016). Holding the baby: responsibility for addressing the needs of offending pregnant women and new mothers should be shared across the system. *The Howard League for Penal Reform Early Career Academics Network Bulletin*. 31, p. 34-40 6 p.
- Abbott L (2016). Becoming a Mother in Prison. *The Practising Midwife*. No.19, Vol.9. (Article of the month with attached webinar).
- Kennedy A, Marshall D, Parkinson D, Delap N & Abbott L (2016) *Birth Charter for Women in Prisons in England and Wales*. Birth Companions.
- Abbott L (2015). *A Pregnant Pause: Expecting in the Prison Estate* in *Mothering Justice: Working with Mothers in the Criminal Justice System*. Edited by Baldwin L. Waterside Press
- Abbott L (2014). The Pregnant Woman in Prison. *Howard League for Penal Reform. ECAN bulletin* issue 23, June 2014

### Oral Papers and Poster Presentations

- **Invited talk** at Bush House, Kings College University, for Iolanthe Midwifery Award ceremony. 28<sup>th</sup> September 18.00, Listening to women: experiences of pregnancy in prison.
- **Invited talk** at Victory House, Prison Inspectorate and Care Quality Commission. The Incarcerated Pregnancy findings. 28<sup>th</sup> September, 14.00.
- **Invited talk** at Birkbeck Department of Psychosocial Studies, for MaMSIE Research Network Mapping Maternal Subjectivities, Identities and Ethics Maternal, The Devaluing of the Maternal: Motherhood in UK Prisons on June 8<sup>th</sup>, 2017.
- **Keynote invited talk** for New Insights into the care of vulnerable woman conference chaired by Birth Rights at The Royal Society of Medicine, London on 1<sup>st</sup> February 2017
- **Paper presentation** European Midwives Association Conference 2016: 2 Dec 2016. The pregnant woman in prison: preliminary findings of an ethnographic study.
- **Keynote invited talk** for UNICEF Baby friendly national conference, November 3<sup>rd</sup>, 2016 Having a baby in prison: A mother's need to love, care and feed her baby.
- **Paper presentation, invited talk:** The Incarcerated Pregnancy: pregnancy in Prison. Cambridge University, Institute of Prison Research.
- **Paper presentation:** Human Reproduction Study Group Annual Conference, DMU. Did I tell you that already? The value of follow-up interviews with pregnant women in prison. 10 Jun 2016.
- **Paper presentation:** The Incarcerated Pregnancy: Prison Health Symposium: Glasgow 18<sup>th</sup> May 2016.
- **Paper presentation:** Soroptimists International St Albans and District "Pregnancy in Prison: The Harsh Truth", 23 May 2016.
- **Paper presentation:** The Incarcerated Pregnancy: Prison Research Network Conference. Leeds Beckett University. 15<sup>th</sup> April 2016.

- **Paper presentation:** Pregnant pause: Expecting in the Prison Estate. Keble College, Oxford University. International Howard League for Penal Reform Criminal Justice Conference. 17<sup>th</sup> March 2016.
- **Paper presentation:** The pregnant woman's journey through the criminal justice system. Royal College of Midwives. 8<sup>th</sup> March 2016.
- **Paper presentation:** Exploring Incarcerated Emotions in relation to Women Who Give Birth Whilst Serving a Sentence. Emotion and Criminology National Conference. De Montford University. 18<sup>th</sup> Feb 2016.
- **Paper presentation:** The pregnant woman in prison: Access and Negotiation. Health and wellbeing in the prison population. School of Law. The Royal Holloway University of London. 23<sup>rd</sup> September 2015.
- **Paper presentation:** Locked Out: Accessing the Inaccessible: British Sociological Association Annual Conference. The Open University. 23<sup>rd</sup> July 2015.
- **Paper presentation:** The childbearing woman in prison: A Masterclass: Collaboration for Leadership in Applied Health Research and Care, east of England National Institute for Health research, University of Hertfordshire, 17<sup>th</sup> July 2015.
- **Paper presentation:** Access: the pregnant woman in prison. Health Research Conference, University of Hertfordshire, 9<sup>th</sup> July 2015.
- **Paper presentation:** The pregnant woman in prison. Inaugural Public Engagement Conference, University of Hertfordshire, 23<sup>rd</sup> June 2015.
- **Poster presentation:** The Incarcerated Pregnancy. Research Students Annual Conference 2014. University of Hertfordshire.
- **Poster presentation:** The Incarcerated Pregnancy: A Qualitative Study Research Proposal. TCD 15<sup>th</sup> Health care Interdisciplinary Research Conference, Trinity College, Dublin.
- **Poster presentation:** The Pregnant woman in prison: midwifery care. Royal College of Midwives national conference. 2014.

### Photograph taken at UNICEF Babyfriendly conference



## Funding Awards

- Awarded £1500 Midwifery award from The Iolanthe Midwifery Trust, May 2017 to part fund reduction in working hours to write thesis.
- Awarded £4876 AHPM funding to be spent in 2016.
- Awarded £1250 Research Impact Grant 2016.
- Awarded £5000: The Jean Davies award for proposed research into the experience of pregnant women in prison by The Iolanthe Midwifery Trust and RCM 2014.

## Appendix 1.21 : Article of the month published by *The Practising Midwife*

### GIVING BIRTH IN PRISON

#### ARTICLE OF THE MONTH

Lead article each month, taking you from the journal to the website for a module on the subject.

This month:  
Becoming a mother in prison by Laura Abbott

Go to the module at  
[www.practisingmidwife.co.uk](http://www.practisingmidwife.co.uk)



**Laura Abbott**

Senior Lecturer in Midwifery at University of Hertfordshire

## Becoming a mother in prison

There are around 600 pregnant women incarcerated in one of the 12 prisons in England and Wales each year and approximately 100-150 babies are born while their mothers are in prison. It is understood that a significant proportion of these women have complex physical, social and psychological needs. I have carried out qualitative research studying the experience of being pregnant in prison. This article will consider the narrative of one of my research participants, Becky, and is dedicated to her.

#### BACKGROUND

There are currently around 4,000 women in prison and it is estimated that 6-7 per cent of them are pregnant (Albertson et al 2014; Ministry of Justice 2015; North et al 2006). A significant proportion of women discover that they are pregnant when first received into prison and having initial health checks. There are currently 12 female prisons in England and Wales and six of these estates have mother and baby units (MBUs) attached to them. It is estimated that of the 100-150 women who give birth while in prison, 50 per cent will gain a place on a MBU with their baby (Abbott 2014). The remainder will return to prison following birth, without their baby.

It is estimated that of the 100-150 women who give birth while in prison, 50 per cent will gain a place on a MBU with their baby

The profile of a woman offender is usually someone who comes from extreme disadvantage (Carlen 2013). She may have been a looked-after child or homeless. Fifty per cent are victims of domestic violence and 30-40 per cent are survivors of childhood sexual abuse (Abbott 2014; Albertson et al 2012; Knight and Plugge 2005). Around 70 per cent of women are addicted to illegal drugs or

alcohol and 80 per cent suffer from some form of mental health condition (Abbott 2014; Knight and Plugge 2005). The majority of women in prison are in for non-violent crimes, such as drug offences, theft and fraud (Carlen 2013; Marshall 2010). Considering these facts and figures it is important to be aware that the female offender has numerous complex social and health needs.

#### EXPERIENCING PREGNANCY IN PRISON

My qualitative doctorate research has involved interviewing pregnant women and new mothers in prison and post release, and prison staff (as well as observing the environment), to get a rounded picture of the experience. Following favourable ethical review from The National Offender Management Service and University of Hertfordshire, this year-long ethnography has involved more than 35 in-depth semi-structured interviews and multiple observations of prison life.

#### BECKY

Becky was 21 years old and 20 weeks pregnant when she was sentenced to four years in prison. Like the majority of women in prison (Carlen and Worrall 2004) Becky's crime was non-violent. She had not been in trouble before and told me that she had fallen in with the wrong crowd. She describes how she felt on entering prison:

*It was a shock, and I was thinking 'I have got a baby inside me and I am not going to*

>>>>

*be free until my baby is walking next to me.' When you are faced with that at 21 and you have not been through anything bad really in life, it's a lot to take on.*

## Many describe the experience of being both a prisoner and a mother-to-be in public as humiliating

The environment that Becky went into was described by her as 'horrible'. The stress she felt under was exacerbated by feelings of fear. Becky spoke of being scared to eat the food and concerned that the environment would affect her unborn baby. Evidence suggests that stress during pregnancy can have a negative impact on the fetus (Capron et al 2015; Glover and O'Connor 2002; Van den Bergh et al 2005). Becky accepted the consequences of her crime; however what was difficult was the potential impact on her 'innocent baby'. Becky described the anxiety of being around some of the other women, and feeling vulnerable. There are no hiding places in prison and, when pregnant, a woman may be more visible than others. This feeling of anxiety exacerbated the feelings of guilt that Becky had:

*The guilt that [my baby] had to go through it with me, and having no control over the environment...your life or your pregnancy.*

The perception of stigma is common for women to experience when attending hospital for scans and appointments (Abbott 2015). Usually women are accompanied by two prison officers, and many describe the experience of being both a prisoner and a mother-to-be in public as humiliating (Marshall 2010). The feeling of embarrassment at being in hospital accompanied by officers was a common theme brought up by many of the women I interviewed. Becky described a situation where she was in her third trimester and needing transfer to hospital for a late scan:

*I carry big babies and was ready to drop; I was in handcuffs, the most degraded I have ever felt, and that was even worse than being sentenced.*

### LABOUR AND BIRTH

During labour, Becky was accompanied by prison officers. Women are often able to choose officers whom they get on with and many talk of the kindness they have received. However, this is not the

same as having a birth partner of choice and, as prisons are often far away from family members, this means that many women do not have the support of their choosing. There is pressure for all women to be able to have the birthing partner of their choice (Kennedy et al 2016).

Becky describes her experience of labour: *I felt like I was being watched. I wanted to use what was there, but at the time, I didn't want to turn around and say to the officers 'Can I get off my bed and go on a birthing ball?'*

Becky underwent an emergency caesarean section after getting 'stuck' at 8cms. She reflected during the interview that it was perhaps the stress of feeling 'under guard' while in labour that meant that she could not achieve the normal birth she had wanted.

### BONDING, ATTACHMENT AND BREASTFEEDING

Becky had wanted to breastfeed her baby but during pregnancy was considering handing the baby out to be looked after by her partner. This was because she was concerned about bringing the baby back into an environment that she felt might be detrimental to her child. Approximately 50 per cent of women do gain a place on a MBU, but many women are separated from their babies. Becky did gain a place

#### Practice points

Women in prison may have experienced drug and alcohol addiction, mental illness, domestic abuse and childhood sexual abuse

Midwives have a key role in providing non-judgemental, compassionate care for imprisoned women

Midwives can support women in prison to make informed choices and devise a birth plan, specific to their circumstances (Kennedy et al 2016)

Midwives can advocate for a woman to ensure that prison officers who do not need to be present during examinations or labour are asked to wait outside, if that is her choice (Abbott 2015; Kennedy et al 2016)

The eLearn modules (at [practisingmidwife.co.uk](http://practisingmidwife.co.uk) and the RCM) are a useful resource for midwives



and described the moment she first breastfed her baby as feeling a bond that was intense – and she knew that she needed her baby to remain with her.

*As soon as I had her and I put her on my breast, I fed; she was staying with me... as soon as I fed it's different isn't it?*

### PREGNANCY GROUPS

A birth charity provided support for Becky while she was in prison. Pregnancy groups are currently run in two prisons by the charity. These groups are tailored specifically to women who are having babies in prison and cover topics each week, such as infant feeding, physiology of labour and birth and relaxation. They have been described by women as providing a safe space to feel like a 'normal pregnant woman'. Kennedy et al (2016) suggest that such groups should be delivered throughout the female prison estate for women who choose to access them. Becky had received tailored information and support for breastfeeding, which helped her in her decision to breastfeed her baby. She described the groups as a 'life line', because they help women to focus solely on their pregnancy and offer 'a bit of escapism'.

Becky spent 15 months in prison with her daughter. The three MBUs Becky lived in during her sentence helped to facilitate her bonding and breastfeeding, and the support she received from midwives, the birth charity and MBU staff helped her through a difficult time in her life. Becky was able to breastfeed her daughter for two years. Becky now has another child. When she was pregnant with her second child, outside prison, Becky told me she had flashbacks to the trauma she had felt while pregnant in prison (Knox and Burkard 2009). Becky is now relieved to be in a stable relationship and having started her own business. She told me that one day she will tell her daughter about her sentence.

### CONCLUSION

The background of many of the women who are in prison is often one that involves traumatic life events in childhood, addiction, mental illness and disadvantage. The focus for this article has been on one narrative: Becky's experience of being a perinatal woman in prison describes a number of emotions, from the embarrassment of being handcuffed, the stress of the environment to the bond she had with her baby. Women in the perinatal period are often open to change in health behaviours, and midwives play a pivotal role in providing compassionate care for those who may be imprisoned. [\[pm\]](#)

### FURTHER RESOURCES

The Birth Charter (Kennedy et al 2016) can act as a

useful tool in providing evidence based care for this small group of women. <http://tinyurl.com/jhvmzuc>

### REFERENCES

- Abbott L (2014). 'The pregnant woman in prison'. Howard League for Penal Reform ECAN bulletin, 23.
- Abbott L (2015). 'A pregnant pause: expecting in the prison estate'. In: Baldwin L (ed). *Mothering justice: working with mothers in criminal and social justice settings*, 1st edition. England: Waterside Press.
- Albertson K, O'Keeffe C, Lessing-Turner G et al (2012). *Tackling health inequalities through developing evidence-based policy and practice with childbearing women in prison: a consultation*, Sheffield: Sheffield Hallam University.
- Albertson K, O'Keeffe C, Burke C et al (2014). 'Addressing health inequalities for mothers and babies in prison'. In: Tod AM and Hurst J (eds): *Health and inequality: applying public health research to policy and practice*, Oxon: Routledge.
- Capron I, Ramchandani P and Glover V (2015). 'Does maternal antenatal depression or anxiety predict gene expression of the placental glucocorticoid receptor (NR3C1)?' *Psychoneuroendocrinology*, 61:15-16.
- Carlen P (2013). *Women and punishment*, Oxon: Routledge.
- Carlen P and Worrall A (2004). *Analysing women's imprisonment*, Devon: Willan Publishing.
- Glover V and O'Connor TG (2002). 'Effects of antenatal stress and anxiety'. *The British Journal of Psychiatry*, 180(5): 389-391.
- Kennedy A, Marshall D, Parkinson D et al (2016). *Birth charter for women in prison in England and Wales*, London: Birth Companions.
- Knight M and Plugge E (2005). 'Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review'. *BMC Public Health*, 5(1): 111.
- Knox S and Burkard AW (2009). 'Qualitative research interviews'. *Psychotherapy Research*, 19(4-5): 566-575.
- Marshall D (2010). 'Birth companions: working with women in prison giving birth'. *British Journal of Midwifery*, 18(4): 255.
- Ministry of Justice (2010). *Statistics on women and the criminal justice system: a Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991*, London: Crown. <http://tinyurl.com/h9n9z8v>
- North J (2006). *Getting it right? Services for pregnant women, new mothers, and babies in prison*, Didcot: Lankelly Chase.
- Van den Bergh BR, Mulder EJ, Mennes M et al (2005). 'Antenatal maternal anxiety and stress and the neurobehavioural development of the fetus and child: links and possible mechanisms. A review'. *Neuroscience and Biobehavioral Reviews*, 29(2): 237-258.

**NOW TAKE THE TEST >>>>**

**THIS MONTH'S MODULE:  
BECOMING A MOTHER IN PRISON**

Go to our website at [www.practisingmidwife.co.uk](http://www.practisingmidwife.co.uk) where you will find this module devised for you by Laura Abbott. Try answering the questions below and then take the assessment within the module to gain a certificate for your revalidation portfolio.

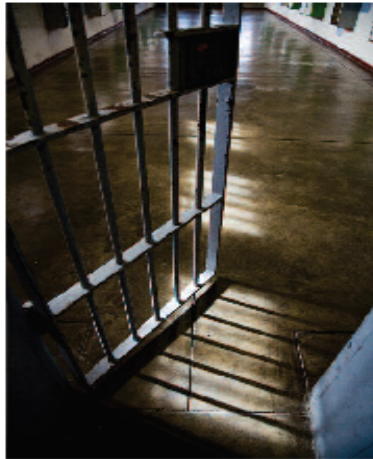
**QUESTIONS**

Tracey was remanded into custody for a shoplifting offence. Following initial health checks, it was discovered that she was pregnant. A scan was organised for her at the local hospital by the midwife. Tracey asked her midwife when the scan would be but the midwife could not tell her the date.

1. What percentage of women are incarcerated for a non-violent crime?
2. Tracey was not told the date of her scan. What reason might there be for that?

Tracey attended her scan where she was found to be 20 weeks pregnant. She attended with two prison officers and was handcuffed until she got the antenatal department. Tracey felt she was being stared at and found this humiliating.

3. Why might Tracey have been handcuffed?
4. Why would Tracey feel humiliated?



Tracey applied for a place on a mother and baby unit (MBU), but was unsuccessful due to her drug addiction.

5. Can women who are substance abusers gain a place on a MBU?
6. There are six MBUs in England and Wales and it has been reported that babies and women may have better health outcomes in terms of breastfeeding, attachment and bonding, than a similar population on the outside. Why is this?

Tracey birthed in her local unit with a prison officer as her supporter. She did want her sister with her and this had been in her birth plan.

7. Why did Tracey give birth without a labour supporter?
8. Is it a legal requirement for a prison officer to remain in the room as Tracey birthed?

Tracey transferred to the postnatal ward with her baby son whom she wanted to breastfeed. She was able to have skin-to-skin at birth and he latched on and fed beautifully. Tracey was to be separated from her baby but wished to express breastmilk.

9. Would Tracey be able to express breastmilk for her son when she went back to prison?

Tracey was transferred back to prison after having her son removed following her signing a voluntary care order. Tracey was down and depressed following her transfer back to the wing but did not want to talk to anyone about her feelings.

10. What points of referral are available for Tracey on return to prison post separation?

Now go the website at

[www.practisingmidwife.co.uk](http://www.practisingmidwife.co.uk)

and take this assessment; once you have answered all the questions correctly, download your certificate to keep in your revalidation folder.

**Appendix 1.22 : Handmade thank you card**

