Inmates guide inmates through peaceful deaths, and find peace with themselves

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The hospice room waits for the next inmate to come spend his final days in prison, and his final days on earth. An oceanic mural, painted years earlier by a former inmate, decorates the walls. It depicted a brunette mermaid with elegant hair, surrounded by dolphins and colorful fish; an image of a kneeling woman and child holding a bouquet of red flowers spanned above the bed.

The mural doesn’t soothe every patient. “Some people get freaked out,” said Colette Morin, a nurse here and the coordinator of the hospice program. The mural caused one feverish patient to hallucinate nurses who weren’t there, and children running around the room. “It was sad,” she said.

Typically inmates die alone in a cell or surrounded by strangers in a hospital ward. But at Osborn, some die a less lonely death, tended to by a fellow inmate. Morin and her colleagues train these inmates-turned hospice nurses.

Osborn is among an estimated eighty prisons that have hospice programs, half of which use this peer care model.

Morin, a petite woman with thinning blond hair and kind eyes, runs the volunteer nurse training program. She showed me a snapshot of herself with a class of graduated class. She stood wearing baby blue nursing scrubs next to nine carefully posed inmates clad in beige state issued jumpsuits, each with hands crossed at his waist. She smiles like a proud mother.

“A lot of our hospice volunteers are murderers,” she said.

An early assignment is for each trainee to write a letter of apology to his victim, and read it to the group.

“The transformation I feel starts there, but it carries on to the rest of their life in prison,” she said.

All told, the four prisons in Somers, Connecticut and the abutting town, Enfield, house about 5,000 inmates (just a hare under half the entire population of Somers). Not long after I exited the interstate highway and entered rural Connecticut, the farmland lining the side of the winding road—interlaced by quaint single-family homes with
pickup trucks and SUVs in the driveway—transitioned to prison land, demarcated by double-rowed barbed wire fences.

The barricaded land, spotted with Lego-like grey concrete buildings, was not entirely different from farmland; both were vast, both rolling, both had obvious utility. The farmland, though, was bare, having recently been harvested—a flock of geese sat huddled on one shorn plot, the birds taking a pit stop on their journey south—whereas the prison land was lush.

I walked across the parking lot not entirely sure that I was in the right place. One of the busiest prisons in the state of Connecticut, Osborn Correctional Institution, houses about 2,000 inmates. However, I saw nobody. The murmur of a van’s engine driving by cut through the quiet. A bird chirped. Spotlights reminiscent of high school football Friday night games pointed at an empty yard. Severe concrete buildings sat silently.

The Connecticut Department of Corrections’ communications rep had arranged an ensemble of officials to show me around. She met me at 9 a.m. sharp, and introduced me to the crew.

This prison was built in 1963, and didn’t appear to have had many updates since. “It’s elderly,” said one of my tour guides, Dr. Jennifer Benjamin.

The central medical center for the state’s prisons, Osborn’s busy hospital ward houses many sick and convalescing inmates.

A man with long, well-kept dreadlocks that reached halfway down his back pushed a cart with lunch trays past us. He wore state-issued khakis and a white-shirt, which designated his status as a Certified Nursing Assistant. “Morning, sir,” he said to Dr. Bombard, one of my guides.

“Another beautiful day,” Bombard said.

A trophy case displayed mementos of the hospice program: snapshots of graduating caretaker classes like the one Morin had shown me, program brochures propped upright, and laminated newspaper clippings posted carefully.

The ocean-themed room had only one bed. Sometimes there was more than one dying inmate at Osborn. Morin led us down the hall to a large, open room at the back of the ward where the long-term patients stay—either in hospice care or not. Very withered men occupied two of the ten beds.

The same artist who painted the mermaids and fish in the other room painted a mural in the back of this room as well. This one memorialized the deceased with a dramatic rendering of two angels—one white woman with flowing blond curls, and one black man with a glowing hallow around his head—floating above the ocean with rays of sunlight beaming from the horizon. A banner painted above the scene read, “Unforgotten Hearts.”
Two rows of rainbow-colored hearts stretched below the angels, each with the initials of a former hospice patient and the date of his death. The first, a blue heart, reads, “VC 3-9-09.” The last heart is red and blank. “We’re a little behind,” Morin said.

The absence of hospice patients meant an absence of inmate caretakers on the ward at this moment. Soon, though, I would meet two men who had been doing this work for years: Brian and Billy (Osborn officials asked that their last names not be used). They awaited my visit downstairs.

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Natural death in prison is becoming more and more an American experience. Largely thanks to bloated sentences during the ‘tough-on-crime’ ‘80s and ‘90s, our country’s prisons are experiencing an unprecedented swell of elderly inmates. In 2013, about ten percent of the prison population was 55 and older (it is widely accepted that inmates age faster than the general population, 55 is often used as a benchmark for old age). By 2030, experts predict that percentage will rise to a solid one-third. In other words, one out of three prisoners will have geriatric healthcare needs, including end-of-life care.

The decade leading up to the ‘tough on crime’ era marked an unrelated transformation in American culture. In the ‘70s and ‘80s, a transformation in attitude towards death and dying brewed, one that brought death closer to home, both metaphorically and literally. A catalyst of this movement was Swiss-born psychiatrist Elisabeth Kübler-Ross’s seminal 1969 book, *On Death and Dying*. In it, she argued that patients should have the power to decide how they spend their final days.

In 1972 the U.S. Senate Special Committee on Aging held the first national hearings on the subject of death with dignity. Kübler-Ross testified. “We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose, I guess. They are reminders of our own mortality,” she said.

Kübler-Ross’s gospel fueled hospice. The core doctrine of hospice is death should be pain-free and dignified — though Kübler-Ross herself avoided the phrase “death with dignity.” She preferred “life with dignity,” including the dying process as part of life. Typically hospice patients die at home, under the care of their family with frequent visits from hospice nurses. In prison, inmate volunteers serve as both legitimate nurses and makeshift loved ones. Hospice caregivers care, they don’t cure. They don’t attempt to prolong the life of patients, but rather they administer painkilling medicine, and assist patients with the emotional and spiritual aspects of dying.

The pioneer of prison hospice in America was Fleet Maull. Maull is a senior teacher in the Shambhala Buddhist community, and has guest lectured at a number of universities including Harvard. He also served fourteen years at a federal prison in Springfield, Missouri.
“My story was a little weird,” Maull said. “I was practicing and being trained as a Buddhist teacher for ten years before going to prison, but I was one of those people growing up in the sixties with a dual major: I was always a spiritual seeker, but I was always caught up in counterculture and the drugs,” he said.

He was convicted of drug trafficking in 1985. As an inmate, he founded the first prison hospice program. (Several prison programs are rumored to be the first. I’ve heard Maull’s referenced most frequently.)

“This place was just a hell realm of suffering,” he said of his first impression of prison. He became particularly concerned with the plight of inmates with AIDS, who prison staff quarantined off to die. This concern catalyzed Maull’s study of end-of-life care.

Maull became a hospice care autodidact. He read all the material he could get his hands on from behind bars: magazines and books with articles on the AIDS epidemic, on dying and grief, and of the nascent hospice movement. And he networked. One of his professors at Naropa University, where he earned his MA in Psychology, Bob Hall, played an instrumental role by putting Maull in touch with the right people. Through a letter-writing campaign, Maull corresponded with many leaders of the hospice movement, including Kübler-Ross herself.

Maull remembers exchanging several letters with Kübler-Ross. “She was just very encouraging and very empowering,” he said. She was familiar with end-of-life care in prisons having recently visited Vacaville Prison in California. There she witnessed inmates dying from AIDS in what she described as “deplorable circumstances,” in her book *The Wheel of Life*. The ills she sought to cure in American end-of-life care were magnified and multiplied in prison.

A student of Kübler-Ross’s would later visit Maull’s program in Missouri, and use what she learned there to start a similar hospice program at Vacaville.

Maull drafted proposals to start a hospice program, which he said the Associate Warden swiftly blocked. When a new Associate Warden arrived, one who recently had a family member die in hospice care, the plan made headway. “Like most people who experience hospice, he became a believer,” Maull said.

In the fall of 1987, the first class of inmate caretakers learned the art of hospice care. In January of 1988, the first inmate hospice nurse spoon-fed a dying peer.

“We did everything,” Maull said. “Bathed them, took them out to the yard, to chapel programs, helped communicate with family — write letters, or be on the phone with family if they couldn’t speak. We became like surrogate family members,” he said.

In some ways, Maull found relief in his work. “You’re focused on someone's needs at that moment, which are so much greater than your own, even though you’re in prison,” he said. “This is deep work. And it changes you. It changes you.”

Less than a decade later, another dogmatic guru founded the most well-known prison hospice program. In the late ‘90s Warden Burl Cain brought hospice to the prison
he was charged with overseeing: the Louisiana State Penitentiary at Angola, the largest maximum-security prison in America. About 95 percent of the over 6,000 inmates at Angola will spend the rest of their days here, without the possibility of parole. So for Angola inmates, dying on prison grounds is much more likely than not. (The prison has another program where inmates build wooden coffins for on-site burials.)

Before hospice was introduced at Angola, “The way in which folks were dying was pretty remarkable,” said Jamie Boudreaux, Executive Director for the Louisiana and Mississippi Hospice and Palliative Care Organization (LMHPCO). “Usually they would be put in a closet or a room. People would just make sure that they had stopped moving.”

Warden Cain read about a hospice program in the nearby city Baton Rouge, was intrigued by what he read, so he paid a visit. By 1997 he had the hospice program up and running with forty handpicked inmate caregivers. The program’s launch left a slew of fired or transferred medical workers in its wake. The staff members who he fired opposed the idea, and tried to sabotage his efforts. “They thought hospice was a luxury that inmates didn’t deserve,” said Boudreaux.

In the field of corrections, Warden Cain earned national fame for reforms he brought to Angola, long known as the bloodiest prison in America. In 1992 there were 1,346 assaults at Angola, both inmate-on-inmate and inmate-on-staff. In 2014, that number dropped four-fold to 343. The core of his doctrine was “moral rehabilitation.” He did this through iron-fisted Christian evangelizing, and he did this through hospice.

Boudreaux attributes much of the change in culture at Angola to hospice. He first heard of Cain’s program when he came to his current position at LMHPCO in 1998. Members of his board of directors were concerned about rumors they had heard of the warden claiming to run a hospice program at Angola—hospice was still a relatively new concept in America, and taking its name in vain was an offense they wished to stop.

“I saw what they were doing,” said Boudreaux of his first visit to Angola, “They were providing a level of care that we were trying to provide in the free world.”

Boudreaux invited the board of directors to come see for themselves. Rather than shut the program down, LMHPCO helped start similar programs in five other Louisiana prisons and one in Mississippi.

In 1998, the Open Society Foundation made a short documentary, *Angola Prison Hospice: Opening the Door*, as part of its Project on Death in America. The film took viewers through the emotional as well as practical aspects of prison hospice. Many scenes depicted inmates caretakers at work: lifting a wilted patient from a wheelchair, and tucking him into bed; spooning mushed food from a Styrofoam cup into a patient’s mouth; and simply sitting at a patient’s bedside passing the time with him.

One of the patients, William Light, tells the camera why he prefers to be taken care of by his fellow inmates. “You’re uncomfortable in prison. You’re uncomfortable with the number of years you’ve been down, the separation from your family,” he said.
“The other inmates in Angola become your family. You become closer to the other prisoners in here than to your brothers and sisters in the streets.”

The film also showed the work of staff members. In one scene a group including social workers, nurses, a doctor, and a Chaplain sit in a circle discussing a patient who is in his final days. He lived longer than expected. “Some people might get mighty tired if we run vigil three, four, five days,” said the Hospice Medical Director, Dr. Robert Barnes,

“Don’t worry about that, security does allow them to be released from their other jobs when they’re on vigil,” said a nurse, Tanya Tillman.

Scenes such as this, though somewhat mundane, proved to be useful. The film served as an instruction manual in prisons across the country running their own program. The care it depicted, inmates taking care of other inmates, is often referred to as the “Angola model.” Boudreaux said he knows of about eighty prisons across the country that use hospice care, about half of which use the Angola model—including Osborn.

The first class of inmate volunteers in a Connecticut prison started work in the spring of 2001.

Billy’s parents, Belva and Billy Sr., look forward to their oldest son’s return. In 2003, Billy pled guilty to four counts of first-degree robbery, for which he is serving eighteen years. This is his fourth bid, and his parents believe his last. “Unless he fooled me, he’s done a three hundred and sixty degree turnaround,” said Billy Sr.

The couple lives in Waterbury, an industrial town in southern Connecticut about an hour and forty-five minutes from Osborn, where they visit every few months. Billy Sr. is a Vietnam veteran and a retired school aide. Belva worked on the production floor at a local factory making small screws. Of their three sons and one foster daughter, Billy is the only one who has been incarcerated. In their cozy living room, among the photographs of family, are angel figurines and framed Bible quotes. When Billy was a child, his mother said, he was an alter boy. He still wears a gold cross around his neck.

“He has always been a real caring person,” Billy Sr. said of his son. “He fell into the wrong crowd.”

Billy has cycled in and out of prison since he was eighteen. He described his drug addiction in linear fashion: marijuana and alcohol turned to snorting cocaine, to smoking dust, to smoking crack cocaine. His addictions fueled lying and robbing, he said. During the spree of robberies that landed him this sentence, he waved a gun in the face of a gas station attendant on two separate occasions, and robbed two cab drivers at knifepoint. Luckily, he said, he never physically injured his victims.
“My intentions, even when I was out there running the streets, it was never to hurt nobody. I am so glad that nobody did get hurt,” he said. “But when I was out there trying to get high, it was basically by any means necessary.”

His parents said that they have witnessed the way that hospice has changed Billy. He’s more open, and more articulate with his feelings now. He has always been honest—his father said that Billy never called him for bail money, and was immediately remorseful when he was arrested for whatever drug-related crime. But now, his father said, their conversations are deeper.

“He talks more openly about his mistakes,” Billy Sr. said. “He would walk a mile for that program.”

I first met Billy in the “professional visit” room at Osborn. I sat at an orange linoleum-topped table, waiting for them to be brought through the door designated for inmates. (I’m still not sure if they walked down the same hallway I did to get here, or if there was an entirely different walkway system to their lock-key waiting room.)

The clanging of correctional officers’ keys rang from the hallway. Several couples sat at long tables in the room behind me. Their murmuring reverberated in the cavernous room, past the rows of payphones, separated by glass wall for non-contact visits, and into the room where I sat.

Billy, 45, has smooth black skin, short wavy hair, a neat beard, and droopy brown eyes. A dark dot on his left nostril marks where it was once pierced.

Death was on his mind. A patient of his died two days earlier from a terminal illness. The patient was young, just 36 years old. He didn’t go easy, prison staff and hospice volunteers agree. He was full of anger until the end, and would curse out staff and volunteers alike.

“He was very particular,” said Billy. Of the twelve inmate hospice volunteers here, Billy was one of three who this patient would allow to care for him. He said that the patient took to his style of care: one-on-one, and not intrusive. Billy learns about his patients through careful observation and avoids prodding questions. He learns to anticipate his patients’ needs.

“He grew to trust me,” he said of the patient. Billy spoke softly, and often took a pause to think about his response to a question. The death of this patient upset Billy more than most of the others he had seen pass over the past five years, perhaps because the bonding took more work than usual, perhaps because he was younger than Billy (his parents suspected the later). “When you get to know an individual you really feel for a person. You really do,” he said.

Billy left the patient at 11pm that Friday, expecting to see the patient again the next day. Even when it’s clear that the end is near, he prays that his patients will keep fighting. Though, he’s comforted by his faith that they’re going to a better place. “I deal with a God that’s forgiving,” he said.
Before his Saturday shift was supposed to start, he heard the news. He went to pay his respects, but he couldn’t bring himself to prepare the body for the undertakers. This one was too personal. “I couldn’t take it. I just went to get some air and be by myself,” he said, “Sometimes you get close and it’s like… that bond.”

He’s not always so sensitive. Just two months earlier he cared for a patient who he had known in the ‘outside’ world. The man had owned a clothing store in Billy’s hometown, Waterbury, and remembered Billy coming in with his mother as a child to get school clothes. Though he and this man had a personal connection outside of prison, his death didn’t hit Billy as hard. He dealt with it like a professional hospice worker.

Billy feels that hospice has enabled him to connect with a side of himself he always knew was there, but that had been hidden. He feels like it has taken him closer to the person his parents wanted him to be.

Transformation is a common theme in literature on inmate hospice volunteers. Morin, the nurse who oversees the hospice program at Osborn, described a process of guarded men breaking out of hardened shells, metamorphosing into caretakers who are in tune with both their own emotions and their patients’. Witnessing the change, Morin said, gave her goose bumps.

In 2013 researchers sought to understand the motivations of inmate caretakers, so surveyed volunteers at five Louisiana prisons. Volunteers, they found, were foremost inspired by what the work did to themselves. One respondent said that to provide service to the dying was “to be alive. Truly alive.”

Kristin Cloyes, a professor of nursing at the University of Utah, co-authored this study as well as a series of studies on the hospice program at Angola.

“Here they can express caring and affection for other people that they may not be able to in other areas,” she said. And eventually, her studies found, inmates would carry that identity with them to other parts of their prison life.

“What we thought was interesting was that it went beyond personal transformation,” she said. “It's a transformation that is not just about the self — that's super important and that might have to be the first step — but it becomes about more than that. It becomes about transforming your relationship with yourself first, and then you transform your relationship with other people. And then you transform your relationship to the world, your orientation to the world.”

In the social sciences, cultural change is one of the hardest things to measure because there is little to quantify. But the fact that Cloyes hears descriptions of Angola “pre-hospice” and “post-hospice” again and again in her interviews is telling.
The drop in violence is also telling. “One of the things that we feel like we hear a lot is the idea that having the hospice has transformed the culture even for people who aren't directly participating in it. The existence of it has changed things,” she said. “People are just more willing to take care of each other in general. That's changed.”

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Brian has eight years left on his twenty-eight year sentence. No matter what happens, he believes, his hospice experiences will remain formative.

“There's no other option,” he said, “It really helped move me into who I am today.” He couldn’t shake the empathy he learned through care taking even if he tried. Brian is an attractive and charismatic 45-year-old Hispanic man with large hands and a strong jaw line. For five years he was a member of the Solidos gang, whose symbol, a comedy and tragedy mask, is marked on his forearm by a fading tattoo.

This bid is for a string of armed robberies in 1997. He wrapped a pipe in a black cloth and robbed a variety of businesses: fast food chains, gas stations, and convenience stores. In one case, the police said, he ordered twenty Kentucky Fried Chicken customers to lie on the ground while he stole money from the register. The papers attribute ten robberies to him. Brian remembers eighteen. These all took place within six months. (Like Billy, Brian didn’t physically harm any of his victims.)

“I would commit a robbery,” Brian said. “From there, I would leave, I would go to McDonald’s, I would buy like fifty, sixty dollars’ worth of food, I would bring it to my kids. I would wait for a store to open, I would go to the store, I would buy them all kinds of clothes and sneakers,” said. “Then I’d go get high.”

Brian had been addicted to cocaine since he was twelve; a habit he picked up from his mother, who used to bring him along when she scored. In this prison, somewhere is Brian’s oldest son who is incarcerated for carjacking. This time around, Brian is trying to lead by example.

He remembers his three kids on visiting day “going crazy” when they saw him, jumping up for a hug. “One day I had an epiphany,” he said. “Why do these kids love me when I have done absolutely nothing for them?” He described his initial reasons for wanting to do hospice as selfish, he wanted to create a legacy for his children to remember him by other than what got him in here.

He’s got plans for his life as a free man: he wants to be a mentor for at-risk youth, he wants to be an advocate for prison healthcare, he wants to reconnect with his children in a meaningful way. But it’s easy to dream, and he tries to not obsess about the future—doing that too much makes it more difficult to deal with the present.
“The thing with incarcerated people is we tend to focus too much on yesterday and or tomorrow. And the most valuable time for us is today, and what we're doing with today,” he said.

This bid has been a long haul, but not life. As a relatively healthy forty-five year old, death inside prison is unlikely—but not impossible. His mortality is very much on his mind. “If I was to go, I want to know that I did everything that I could with today. That's helpful for me,” he said.

When he is with a patient, changing his diaper, feeding him food, or just passing the time, Brian tries not to think of himself in the patient’s position. But sometimes it’s too hard to avoid. He’s particularly susceptible when he’s already feeling down or depressed, it’s then that a vision of himself spending his final days in the ocean-themed room creeps into his mind.

“I try to dismiss it quick,” he said. “There were times when I would dwell there in my head. Now I just toss it out pretty quick,” he said.

Billy, on the other hand, has these thoughts often. “All the time,” he said, “all the time.” For him, the possibility fuels his motivation to play it straight both as an inmate and when he is a free man in three years, so that he won’t come back here to die.

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