Care Complexities: Progressing Prison Palliative Care and Compassionate Release in Canada

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ABSTRACT

Prison populations continue to get older in Canada, and as aging levels increase, so do the complex health services that those held in custody require. Yet the intersection between the realities faced by older incarcerated persons and the structures for providing palliative care remains undertheorized and underdeveloped in Canadian law and policy. This article argues Canada must simultaneously (1) recognize and operationalize a right to palliative care for incarcerated older persons, including through a properly resourced embedded hospice model in federal institutions, and (2) enact a distinct, accessible, compassionate release regime tailored to the needs of aging and terminally ill prisoners. Only by designing these mechanisms together—around prisoner autonomy, choice, and dignity—can the best interests of older persons behind and beyond bars be realized. Drawing on scholarship, government reports, Correctional Service Canada (CSC) policy, and Canadian and comparative case law, we show how existing pathways to care and release are fragmented and often ill-suited to the realities of aging in custody. We conclude that the treatment of older and terminally ill prisoners is a critical test of Canada's commitments to human dignity, equality, and justice.

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KEY WORDS: *Canada*; *prison*; *palliative care*; *compassionate release*; *age*; *aging*; *older persons*; *health*.

I. INTRODUCTION[1]

Canadians continue to get older[2] and so too are prison populations.[3] According to a 2019 joint investigation conducted by the Office of the Correctional Investigator (OCI) and the Canadian Human Rights Commission (CHRC), as aging levels increase, so do the health services those held in federal custody require.[4] At the same time, Linder and Meyers suggest, "[a]lthough many in free-living society assign a low priority to providing prisoners with high-quality health care, medical ethicists, provider organizations, and the judiciary see it as an ethical imperative."[5] We too see it as an ethical imperative, and encourage others to do so. While these tensions in providing health care to prisoners remain, scant attention has been paid toward prison palliative care and compassionate release, two areas of prison health which ultimately benefit

1 We wish to thank our research assistants, Reshmin Randhawa and Dimitar Tomovski, for their hard work and assistance. We also thank Kelsey Scott for their copyediting assistance. The authors gratefully acknowledge the financial assistance provided by the Legal Research Institute of the University of Manitoba and the Manitoba Law Foundation.

2 Spencer Van Vloten, "As Canadians live longer, the realities of aging are becoming more complex", *The Province* (31 March 2025), online: <https://theprovince.com/opinion/op-ed/spencer-van-vloten-as-canadians-live-longer-the-realities-of-aging-are-becoming-more-complex> [perma.cc/3JCL-EUZ8].

3 Correctional Service Canada, *Promoting, wellness and independence of older persons in CSC custody* (Ottawa: Government of Canada, 2018); Canadian Human Rights Commission & Office of the Correctional Investigator, *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody* (Ottawa: Correctional Investigator Canada; Canadian Human Rights Commission, 2019) at 20-69 [*OCI & CHRC*].

4 *OCI & CHRC*, *supra* note 3 at 20-69.

5 John F. Linder & Frederick J. Meyers, "Palliative Care for Prison Inmates: 'Don't Let Me Die in Prison'" (2007) 298:8 JAMA 894 at 896 [Linder & Meyers 2007].

those incarcerated.[6] How do the realities incarcerated older persons[7] face connect with the complexities in receiving such care?

We contend both prison palliative care and compassionate release must progress to better serve the needs of incarcerated older persons. Our article is structured as follows to make this argument. First, we outline the responsibilities charged to Correctional Service Canada (CSC) regarding the health care and services for those incarcerated, and then tie this to the ongoing challenges of incarcerated older persons. Following this, we move to specifically examine palliative care in prisons, and we suggest prison palliative care remains a significant concern. We then move to a discussion of alternative mechanisms of care, by which we refer to the methods prisoners can receive care in the community: temporary absence; the Royal Prerogative of Mercy; and parole by exception, otherwise known as compassionate release. Yet as we will see, these methods pose more challenges than resolutions for elderly and/or terminally ill people. Such a discussion connects to our focus on the challenges faced by incarcerated older persons receiving palliative care. We then examine other jurisdictions where prison palliative care is offered to understand the overlap and distinct challenges of providing these services. Connecting the challenges of prison palliative care in Canada to the case law available will be addressed next.

We then shift our focus to a discussion of reforms which we feel are necessary to meaningfully address the care and needs of older persons internal to and external from the prison. These reforms include (i) better tracking of prisoner/patient health information, and between correctional and community care facilities; (ii) the need for a new compassionate release statutory provision; (iii) the need to formally adopt (if not substantively prioritize) the embedded hospice model of care delivery within Canadian prisons; and (iv) to argue in favour for a right to prison palliative care. Regarding (ii), this discussion was initially presented by Iftene.[8] Existing

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6 Our article focuses on palliative care in federal prisons; health care at the provincial and territorial levels remains a separate yet another area requiring further research. We therefore encourage discussion to evolve on this front.

7 Literature differs on whether to use terms like 'prisoners' versus 'inmates' versus 'offenders.' We prefer humanizing language and use 'persons' and 'people' as necessary. Of course, term usage will vary by context.

8 Adelina Iftene, "The Case for a New Compassionate Release Statutory Provision" (2017) 54:4 ALR 930 at 950 [Iftene 2017a].

work has identified the growth of the older prisoner population, the limitations of prison health services, and the obstacles that seriously or terminally ill prisoners face when seeking care or release.[9] However, responses to these issues are often fragmented. Prison palliative care programs and compassionate release mechanisms tend to be examined separately, and the choices, preferences, and autonomy of older incarcerated persons are not always placed at the centre of analysis. The result is a patchwork of policies and practices that frequently fail to meet the needs of people for whom continued incarceration has become difficult to justify on either practical or ethical grounds. We have found little conversation on compassionate release, let alone prison palliative care in Canada.[10] Our work bolsters Iftene's assertion for a new compassionate release statutory provision, but also balances this with our focus on the intersection between aging and incarceration as it connects to the complexities of care.[11]

To the reader, this might seem contradictory: how can we support a compassionate release statutory provision, when there are those suggesting the palliative care structure does not belong in prison?[12] We contend prison autonomy, choice, and dignity must play a significant factor in all decisions about and concerning prisoners themselves. Even if we bracket off the challenges of compassionate release, there is no doubt prison design could be amended to better uphold humanitarian ideals of care, so prisoners who choose to stay in custody to receive care and treatment receive it in a more meaningfully and comprehensive ways than what might be currently offered in federal custody, and that they can make this informed choice freely and willingly. Discussions surrounding prisoner palliative programs[13] highlight

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9 See *OCI & CHRC*, *supra* note 3 for discussion.

10 With exceptions, see Adelina Iftene, "Employing Older Prisoner Empirical Data to Test a Charter Claim" (2017) 40 Dalhousie L J 497 [Iftene 2017b]; Adelina Iftene & Jocelyn Downie, "End-of-Life Care for Federally Incarcerated Individuals in Canada" (2020) 14:1 McGill JL & Health 1 [Iftene & Downie 2020]; Emma Gilbert et al., "How do people in prison access palliative care? A scoping review of models of palliative care delivery for people in prison in high-income countries" (2024) 38:5 Palliative Medicine 517 at 530 [Gilbert et al. 2024].

11 Iftene 2017a, *supra* note 8.

12 *Ibid*; Iftene & Downie 2020, *supra* note 10.

13 Jessica Shaw & Peter Driftmier, "'Dying with a Smile, Just Knowing that Somebody's

the aspects and resulting benefits of an embedded hospice model, one which we contend that, while not perfect, could still uphold prisoner/patient's care, choice, autonomy, and dignity with the right conditions in place.[14] This article argues that Canada must simultaneously (1) recognize and operationalize a right to palliative care for incarcerated older persons, including through a properly resourced embedded hospice model within federal institutions, and (2) enact a distinct, accessible, compassionate release regime that is responsive to the realities of aging and serious illness in custody. We suggest a reconsideration of this model may be progressed across federal correctional facilities to help manage the current challenges incarcerated persons experience in accessing palliative care. In the event federal prisons are not able—or willing—to meaningfully address palliative care, a new compassionate release statutory provision would be implemented to ensure secure access for those persons requiring substantive terminal care and humanitarian considerations. Notwithstanding, we argue it is only when palliative care and compassionate release are brought together, as we do so here, can comprehensive, meaningful, and compassionate care for older persons behind and beyond bars be realized.

II. Connecting Health Services to the Canadian Federal Prison System

To begin, CSC is tasked with the responsibility of health care needs for incarcerated individuals.[15] This federal agency oversees the health and well-being of those sentenced to two years or more, in 43 institutions across Canada.[16] The OCI has interpreted the *Corrections and Conditional Release Act* (*CCRA*) and the *Criminal Code* as indicating a duty upon CSC to seek out alternatives to incarceration where reasonable for individuals who

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Listened to Me': End-Of-Life Care and Medical Assistance in Dying in Canadian Prisons" (2024) 88:4 OMEGA – J of Death and Dying 1290 [Shaw & Driftmier 2024].

14 Gilbert et al. 2024, *supra* note 10 at 530.

15 *Corrections and Conditional Release Act*, SC 1992, c 20 s 86(1) [*CCRA*].

16 Correctional Services Canada, "Facilities and Securities" (last modified 12 November 2025), online: <https://www.canada.ca/en/correctional-service/corporate/facilities-security/facilities-security.html>.

require palliative care and/or are terminally ill.[17] CSC, importantly and to our knowledge, has not contested said interpretation.[18]

One of the principles guiding CSC is considering "alternatives to custody in a penitentiary".[19] This is particularly relevant in the context of palliative care, where the level of care received outside a correctional facility may be higher. According to section 86 of the *CCRA*, a federally-sentenced person must have access to necessary health care and reasonable access to non-essential health care which is to be provided at "professionally accepted standards."[20] In decisions impacting the federally incarcerated person, CSC must consider their health care needs.[21] As the case law will demonstrate below, courts can take into consideration a person's health when making sentencing decisions. Furthermore, the *CCRA* states CSC shall provide incarcerated people access to patient advocacy services.[22] With access to patient advocacy services, incarcerated people can fully understand their rights to health care. Section 83(1) of the *Corrections and Conditional Release Regulations* (CCRR) states as follows:

> The Service shall, to ensure a safe and healthful penitentiary environment, ensure that all applicable federal health, safety, sanitation and fire laws are complied with in each penitentiary and that every penitentiary is inspected regularly by the persons responsible for enforcing those laws.[23]

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17 Iftene & Downie 2020, *supra* note 10 at 10.

18 *Ibid.*

19 *CCRA*, *supra* note 15 at s 4(c.1).

20 *Ibid,* s 86(1); Although no Canadian court has yet directly ruled that compassionate release is a *Charter* right, analogous jurisprudence suggests that denying a terminally ill inmate proper care or release would engage constitutional protections. For instance, in *Ewert v Canada*, the Supreme Court emphasized correctional authorities' duty to account for prisoners' unique needs and dignity (2018 SCC 30). Note also that withholding appropriate end-of-life care or release from a dying offender may contravene the principles of fundamental justice in section 7, and possibly section 12's ban on cruel and unusual punishment. See generally as an example: *Canadian Civil Liberties Assn v Canada (AG),* 2019 ONCA 243.

21 *Ibid,* s 87.

22 *Ibid,* s 89.1.

23 *Corrections and Conditional Release* Regulations, SOR/92-602 [*Corrections Regulations*]; Statutory provisions (*CCRA*, s 3 & s 4) support the Office of the Correctional Investigator's view that CSC must seek community alternatives for palliative or

Finally, at the international level, Canada is also a signatory to the *UN Basic Principles for Treatment of Prisoners.*[24] International human rights standards also underscore certain obligations. Canada adheres to the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the "Nelson Mandela Rules"), which affirm that prisoners are entitled to health care equivalent to that available in the community, and denial of necessary medical care may thus constitute cruel, inhuman or degrading treatment, something unequivocally prohibited by these Rules.[25]

Taken together, the statutory provisions governing health care for prisoners, the regulatory duties to maintain a safe and healthful penitentiary environment, and the international standards Canada has endorsed support an understanding of prison health care—including palliative care—as a legal obligation rather than a discretionary benefit. For aging and terminally ill prisoners, the principle that people in custody should enjoy a standard of health care equivalent to that available in the community requires more than formal access to services: it demands functionally comparable opportunities for adequate symptom control, psychosocial support, and dignified dying. The persistent gaps in planning, delivery, and transparency identified by research and oversight reports, therefore, raise not only policy concerns but also questions about the under-realization of existing legal and human rights commitments.

III. Challenges Faced by Incarcerated Older Persons

We recognize how federal correctional facilities like CSC are correctional spaces brought together by and through a mixture of carceral realities and legal mechanisms. While not all facilities or experiences are alike, we also recognize how laws can limit prisoners' rights and freedoms

terminally ill inmates, whenever public safety allows: *Corrections and Conditional Release Act*, *supra* note 15, ss 3, 4.

24 *Basic Principles for the Treatment of Prisoners,* GA Res 45/111, UNGAOR, 45th Sess, Supp No 49A, UN Doc A/45/49 (1990), Principle 9.

25 *The United Nations Standards for Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules),* GA Res 70/175, UNGAOR, 70th Sess, UN Doc A/RES/70/175 (2015) at Rules 1, 24-35.

in particular ways, and depending upon the jurisdiction.[26] Rather than engage in an exhaustive list, below we highlight several challenges facing incarcerated older persons, which contextualize our twinned focus upon prison palliative care and compassionate release. To begin, the 2019 OCI/CHRC joint report published several findings from an investigation regarding the experiences incarcerated older persons had in federal custody. The findings showed the effects of incarceration for older prisoners are disproportionately much more negative than the conditions endured by their younger counterparts.[27] Linder and Meyers also note that the population in prisons is sicker than the general population.[28] While Iftene and Downie echo these concerns,[29] they also point out CSC's documents are often vague and often lack definitions for key terms, such as terminal illness.[30] This has led to the language in the document being read permissively, rather than prescriptively, and wherein some contend that they are essentially discretionary guidelines.[31]

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26 See generally Tina Maschi & Marina Richter, "Human Rights and Dignity Behind Bars: A Reflection on Death and Dying in World Prisons" (2017) 23:1 J of Correctional Healthcare 76.

27 *OCI & CHRC, supra* note 3 at 20-69.

28 Linder & Meyers 2007, *supra* note 5 at 895.

29 Iftene & Downie 2020, *supra* note 10 at 27.

30 *Ibid* at 27.

31 *Ibid* at 28; see further discussion of this in Section IV. Also, since the criminal legal system often targets and captures marginalized individuals, and since marginalized individuals tend to have worse health outcomes to begin with as a result of social and economic determinants of health, it is important to recognize and acknowledge health outcomes in prisons may in part reflect larger trends in society. See, for instance, Dennis Raphael, ed, *Social Determinants of Health: Canadian Perspectives*, 3rd ed (Toronto: Canadian Scholars, 2016); *OCI & CHRC, supra* note 3; Meghan A. Novisky et al., "Incarceration as a Fundamental Social Cause of Health Inequalities: Jails, Prisons and Vulnerability to COVID-19" (2021) 61 Brit J Crim 1630 [Novisky et al. 2021]; Rosemary Ricciardelli et al., "Correctional Services during and beyond COVID-19" (2021) 6 FACETS 490 [Ricciardelli et al. 2021]; Stephanie Grace Prost et al., "Prisons and COVID-19: A Desperate Call for Gerontological Expertise in Correctional Health Care" (2021) 61 Gerontologist 3 [Prost et al. 2021]. The fact that many individuals impacted by a lack of proper healthcare in prisons are members of equity-seeking groups, including many in an intersectional capacity, should serve to strengthen the calls for urgent reforms in this area.

Moreover, Iftene and Downie point out there are often issues with availability of medication (further discussed below).[32] Equally concerning are the challenges referenced by the OCI/CHRC joint report. For example, Finding 1 states, "Some older, long-serving offenders are being warehoused behind bars,"[33] Finding 6 states, "There is a lack of adequate and humane release options,"[34] and Finding 7 states, "Community alternatives are lacking and are not well resourced."[35] There is a particularly noticeable gap in providing older people specific medical and programming needs, as they are often not recognized as vulnerable prison populations by Parliament in the same way certain groups, such as women and Indigenous people are, and are not recognized as a population with special needs by legislation or by internal documents from CSC.[36] Other concerns for the elderly population in prisons include bullying from officers[37] and lack of nurse and emergency services available late at night.[38] Aside from medical care, older persons also have different psychosocial needs from younger inmates. The fast-paced and noisy atmosphere of a prison oftentimes is too much to cope with for the former, leading to feelings of unsafety and vulnerability to attacks from the latter.[39] Colsher also notes how older persons often require additional health care services, personal care, and modifications of their physical environment, but adds that since "relatively little is known about the health and functional status of older inmates, planning for this population is difficult."[40] Most often, prison staff are not equipped or adequately trained to provide care for older persons, since they are trained

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32 *Ibid* at 29. They note that there is a limited set of options for the management of chronic pain set out by the CSC National Drug Formulary.

33 *OCI & CHRC*, *supra* note 3 at 20.

34 *Ibid* at 59.

35 *Ibid* at 65.

36 Iftene 2017a, *supra* note 8 at 502.

37 Adelina Iftene, "Comment: The Bad, the Ugly, and the Horrible: What I Learned about Humanity by Doing Prison Research" (2020) 43 Dalhousie L J 345 at 350 [Iftene 2020].

38 *Ibid* at 351.

39 Ronald Aday, "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates" (1994) 58:2 Federal Probation 47 at 48 [Aday].

40 Patricia Colsher, "Health Status of Older Male Prisoners: A Comprehensive Survey" (June 1992) 82:6 AJPH 881 at 881 [Colsher].

"to run prisons, not old-age homes."[41] For older persons who ultimately pass away in prison, Antonowicz and Winterdyk note how regrettably, there is still no systemic national effort to collect detailed information on in-custody deaths.[42] While the Canadian Centre for Justice Statistics does collect data on deaths in correctional custody, the data are not as comprehensive as data found in the United States (USA), United Kingdom (UK), and Australia.[43]

There are ongoing logistical issues with housing older persons in prisons as well. The OCI/CHRC joint report notably found "[c]orrectional health care costs are rising as the number of aging individuals in federal custody with chronic disease increases."[44] For this issue, the joint report recommends CSC should provide better training to its staff to deal with physical, social and psychological age-related needs.[45] Luther and Mela also identified prison programs do not often align with the needs of the elderly, so incarcerated older persons will often be excluded from educational and

41 Aday, *supra* note 39 at 53.

42 Daniel Antonowicz & John Winterdyk, "A Review of Deaths in Custody in Three Canadian Provinces" (2014) 56:1 Canadian J Criminology & Crim Just 85 at 89 [Antonowicz & Winterdyk]. We also recognize a perennial problem (of many problems) found within federal prisons in Canada continues to be deaths in custody. While the issues of prison suicides (i.e., dying by unnatural causes) and aging in prison (i.e., dying by natural causes) remain significant concerns, the legalization and introduction of medical assistance in dying (MAiD) in federal corrections raises its own host of challenges (policy, operational, etc.). While beyond the scope of this article's focus, we acknowledge CSC policy now allows for a federal prisoner to end their life, contingent upon exceptional circumstances, and certainly there are greater moral, ethical and practical considerations of MAiD to discuss. While we do not explore the state and challenges of carrying out MAiD in relation to federal corrections, see generally James Gacek et al., "Morbid Matters: Medical Assistance in Dying in Federal Corrections" (2025) 47:4 Man LJ 143 [Gacek et al. 2025]. As Gacek et al. (2025) suggest, the arrival of MAiD has introduced an expansion of ideas of what constitutes fostering life and/or preparing for death, and the subsequent relationship between the conditions of life and conditions of death. For a further, associated discussion, see generally Mary J Shariff, Derek BM Ross & Trudo Lemmens, "Mental Illness, Health Care and Assisted Death: Examining Parameters for Expanding or Restricting MAID Under Canada's Charter and Federal System" [Forthcoming] at 4-7 [Shariff, Ross & Lemmens].

43 *Ibid* at 89.

44 *OCI & CHRC*, *supra* note 3 at 71.

45 *Ibid* at 71-72.

vocational programs prisons offer.[46] This leads to poor peer relationships with other inmates, contributing to unmet mental health needs.[47] Moreover, Ornduff suggests despite the fact incarcerated older persons require more special attention and care relative to their younger counterparts, most of the former do not receive any special treatment or care from prison systems.[48] This leads to negative consequences for the prisons, in part because prison hospitals primarily intended for emergencies, become nursing homes for older persons with deteriorating medical abilities.[49] Additionally, correctional physicians or medical care professionals often lack the expertise to provide necessary care.[50] As the number of individuals over 50 years old who are in custody continues to grow, the widespread presence of diseases, illnesses, and serious health conditions continues to rise in Canadian federal correctional institutions.[51] Indeed, Ruby argues sentencing judges ought to be mindful of the age of an offender when considering the relevant principles in sentencing, indicating how "[a]fter a certain point, the utilitarian and normative goals of sentencing will eventually begin to exhaust themselves once a contemplated sentence starts to surpass any reasonable estimation of the offender's remaining natural life span."[52]

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46 Glen Luther & Mansfield Mela, "The Top Ten Issues in Law and Psychiatry" (2006) 69:2 Sask L Rev 401 at 432 [Luther & Mela 2006].

47 *Ibid*; For discussion see Lisa A Lares & Susanne Montgomery, "Psychosocial needs of released long-term incarcerated older adults" (2020) 45:3 Crim J Rev at 358–377; Amanda Li, Brie Williams & Lisa C Barry, "Mental and physical health of older incarcerated persons who have aged in place in prison" (2020) 41:4 J of Applied Gerontology at 1101–1110.

48 Jason Ornduff, "Releasing the Elderly Inmate: A Solution to Prison Overcrowding" (1996) 4 Elder L J 173 at 174-175 [Ornduff 1996].

49 *Ibid* at 185.

50 We see this especially for MAiD in federal corrections; see generally Gacek et al. 2025, *supra* note 42.

51 See generally Iftene & Downie 2020, *supra* note 10.

52 Clayton Ruby, *Sentencing*, 10th ed (LexisNexis, 2020) at §5.180 [Ruby 2020].

IV. PALLIATIVE CARE CHALLENGES INTERNAL TO THE PRISON SYSTEM

Literature demonstrates the growing challenges facing incarcerated older persons—might it be time we have more comprehensive care services within overall prison health services to meet them? Before we can answer this, it is essential to define the contours of palliative care in the prison context and the corresponding obligations for its provision. The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[53] The provision of palliative care in prison populations is an important area of research because, as indicated above, not only is there a higher prevalence of disease among incarcerated individuals compared to the general public, but the former over the age of 50 is expected to remain noticeable and increase in the coming years.[54]

According to Health Canada, federal correctional facilities are not always equipped to offer the full range of palliative supports needed.[55] As Iftene explains, there is a lack of information on the scope and quality of palliative care in federal prisons.[56] Despite the limited information, it is evident those incarcerated face numerous challenges in accessing palliative care within prisons. Prisons are not designed as healthcare facilities, and so they continue to lack the resources and infrastructure to meet the complex medical and psychosocial needs of aging prisoners.[57] Additionally, public and political resistance to reforms stemming from a tough-on-crime mindset further stifles efforts to implement humane care, while ethical obligations

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53 World Health Organization, "WHO Definition of Palliative Care" (last visited 26 July 2024), online: *World Health Organization* <www.who.int/cancer/palliative/definition/en/> [perma.cc/W2MB-ALJP].

54 Iftene & Downie 2020, *supra* note 10 at 7.

55 Health Canada, *Framework on Palliative Care in Canada,* (Ottawa: Health Canada, 2018) [*Framework* 2018].

56 Iftene & Downie 2020, *supra* note 10 at 31.

57 *OCI & CHRC*, *supra* note 3 at 20-69.

to provide adequate health care remain unmet.[58] This creates a system where older persons face substandard treatment, raising critical concerns about care, but also justice and human dignity.[59]

According to Iftene and Downie, very few prisoners receive palliative care and die outside of prison.[60] Moreover, the number of deaths due to illness or aging in Canadian federal prisons is higher than all other causes of death combined.[61] Individuals ages 50 and older make up 25% of the federal prison population.[62] While there remains some debate in the literature regarding whether the age-delineator of 50 years should be considered 'old age',[63] the statistics presented in the OCI/CHRC joint report urges research in prison palliative care, especially since a substantial and ever increasing number of incarcerated individuals (older or otherwise) may seek palliative care in their future.[64] The challenge with this area of research continues to be a general lack of information about the number of individuals who are seeking palliative care in prisons and how CSC is handling the provision of this care.[65] While CSC guidelines on palliative care exist, it is uncertain whether—and how—these guidelines are being implemented in practice.

The *Hospice Palliative Care Guidelines for Correctional Service Canada* is a CSC document available under the *Access to Information Act* "which is the only health-related CSC document that is not publicly available and must be requested via an ATIP request [...][and] endorses the Canadian Hospice Palliative Care Guidelines, but with a strong focus on security as a baseline

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58 Helen Hudson, Amélie Perron & David Wright, "Palliative Care & the Injustice of Mass Incarceration: Critical Reflection on a Harm Reduction Response to End of Life Behind Bars" (2019) 1:2 Can J of Critical Nursing Discourse 4 [Hudson, Perron & Wright 2019].

59 Iftene 2017a, *supra* note 8.

60 Iftene & Downie 2020, *supra* note 10 at 21.

61 Hudson, Perron & Wright 2019, *supra* note 58 at 6.

62 *OCI & CHRC*, *supra* note 3 at 3.

63 Helene Merkt et al., "Defining an age cut-off for older offenders: a systematic review of literature" (2020) 16: 2 Intl J of Prisoner Health 95 [Merkt et al. 2020].

64 *Ibid* at 9.

65 *Ibid* at 1.

from which patient-centered care can be offered 'whenever possible.'" [66] These guidelines were similarly requested by Iftene, who states as follows:

> The *Hospice Palliative Care Guidelines* recommend that palliative care be assessed and provided on a case-by-case basis in prison, and that ideally a team be available to address the needs and wishes of the incarcerated individual. The team potentially includes medical staff and spiritual care, and family members are to be involved "where possible". When care cannot be provided within the institution, arrangements are to be made to transfer the incarcerated individual to the CSC regional hospital or to a community hospital. However [...]the guidelines are essentially discretionary.[67]

As witnessed above, while the guidelines provide directives for palliative care, their implementation remains dependent upon on CSC discretion, which is also reaffirmed by Iftene and Downie.[68] As Hudson and colleagues then wrote, "no scholarly research has been published that specifically addresses dying or palliative care among Canadian prisoners, either at the federal or provincial level, making it difficult to know how these guidelines are actually implemented in practice."[69] While scholarship like Shaw and Driftmier's study on medical assistance in dying (MAiD) for federal prisoners seemingly begins to fill this empirical gap, they too cite Hudson et al.'s work,[70] which leaves unanswered the question of how the guidelines are implemented, the generalized principles of care embedded within them, and the guidelines' "attention to nuance".[71] Nevertheless, from what literature is publicly available in the Canadian context, we see a host of problems associated with prison palliative care, from the challenges of discretionary guidelines to the costs associated with providing palliative care, of which the latter may not allow for individualized care or the allocation of medical staff solely for the purpose of the former.[72] Yet there are other practical challenges to add. For example, older persons face long

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66 Shaw & Driftmier 2024, *supra* note 13 at 1294.

67 Iftene & Downie 2020, *supra* note 10 at 27-28.

68 *Ibid.*

69 Shaw & Driftmier 2024, *supra* note 13; Hudson, Perron & Wright 2019, *supra* note 58 at 7.

70 *Ibid.*

71 Shaw & Driftmier 2024, *supra* note 13 at 1310.

72 Iftene & Downie 2020, *supra* note 10.

wait times in prison due to a shortage of medical professionals.[73] This becomes particularly problematic in the context of palliative care, as some of these individuals may be facing rapidly progressing illnesses and may not have much time. Moreover, healthcare professionals within institutions do not have the same level of autonomy as they might have outside. For example, the rules in prisons prevent nurses from being able to access their patients as they would be able to out in the community.[74]

In addition, there are interruptions to medication provision.[75] Iftene identifies issues regarding availability of appropriate medication in the context of palliative care. As indicated above, this includes pain medication. Furthermore, physicians do not have full autonomy to determine the course of treatment in institutions.[76] For example, in prisons, certain types or doses of medication cannot be used, no matter how sick the person is, how poorly the alternative treatment works, or that the medication itself goes against proper pain management practices.[77] Most inmates must pick up their own medications by standing in line. These lines can form outside and sometimes last hours.[78] Older persons, for instance, who cannot stand in line because of their health, may not have access to their medication.[79] Inmates cannot have any item which can be dangerous; therefore, if certain medication is deemed dangerous, the inmate may not have access to it.[80] Finally, it remains uncertain from the available data if people in federal prisons who got palliative care only received pain management or if they got the full range of palliative care treatments like drugs, acupuncture, and counseling.[81] This highlights the continued need for more research into the scope of palliative care services currently offered and operating.

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73 *Ibid* at 29.

74 Iftene & Downie 2020, *supra* note 10 at 31.

75 *Ibid.*

76 *Ibid.*

77 *Ibid* at 30.

78 *Ibid.*

79 Hudson, Perron & Wright 2019, *supra* note 58 at 8.

80 *Ibid.*

81 Iftene & Downie 2020, *supra* note 10 at 31.

In explaining the scope of palliative care, Hudson et al. state the following:

> In addition to responding to physical health needs, palliative care by definition ought to also attend to the emotional, psychological and spiritual needs of those facing death, and their loved-ones[…]. Further, given the severe over-representation of racialized and Indigenous peoples in prison, 'whole person' care must also be culturally competent. All of these therapeutic aspirations, however, are severely constrained by the custodial relationship between prisoners and staff, and by the very nature of the institution[.][82]

Further challenges include "deficiencies in provision such as family support, insufficient training and obstacles to round-the-clock care."[83] A number of gaps were identified in CSC's approach to palliative care: a lack of 24-hour nursing care in the institutional environment (with the exception of regional hospitals); a lack of support and recognition for family members of inmates experiencing life-threatening illness; a lack of education, specialized training for those that provide the palliative care services; a lack of outcome measures and progress monitoring in providing palliative care services; and a lack of strong relationships with community partners.[84]

The OCI/CHRC joint report concluded the following:

> Prison is not the appropriate environment to provide end of life care. Hospice and palliative care are specialized services and should not take place in a prison setting. A community placement would more easily facilitate visits from family and friends and ensure that federally sentenced individuals have access to care that is equivalent to that offered in the community. Human rights protection requires these kinds of appropriate alternatives. Moreover, community placement would also bring a more human approach to very difficult situations.[85]

Of course, the cost and availability within the community to receive the adequate standard of palliative care to enhance their quality of life hinges on the feasibility of support—medical, social, political, and otherwise—within the community.[86] The likelihood prisoners receive a spot for medical

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82 Hudson, Perron & Wright 2019, *supra* note 58 at 8.

83 Gilbert et al. 2024, *supra* note 10 at 530.

84 *OCI & CHRC*, *supra* note 3 at 54.

85 *Ibid.*

86 See generally Gacek et al. 2025, *supra* note 42.

care is improbable due to CSC's readiness to commit to medical care outside of the carceral institution.[87] The lack of support within the community for these prisoners to receive palliative care and temporary absences is likely not permitted without proper funding and resources made available to them. One may argue this infringes upon a prisoner's fundamental right to access adequate healthcare and continues to drive the narrative of how dehumanizing federal corrections have become.[88] Notwithstanding, building strong relationships with community services could be beneficial for prison health services. Either providing palliative care in prison or ensuring older prisoners receive this care in another institution is in line with the principle of equivalence and human rights law.[89] When considering how community hospice care includes services provided by a range of individuals like health care staff, social workers, chaplains, and volunteers, the former may require significant further investment in federal corrections (as discussed below) in comparison to levels of care currently available in prisons.[90]

The current state of palliative care in Canadian federal prisons reveals profound systemic inadequacies which clash with the ethical mandate to provide humane care. Prisons lack the infrastructure investment and support systems required to deliver comprehensive care, with challenges such as long wait times, medication interruptions, and limited autonomy for healthcare professionals. These issues are particularly concerning for older, chronically ill, and terminally ill inmates who need holistic support, including psychological, emotional, and spiritual care. Moreover, the over-representation of racialized and Indigenous peoples in prisons makes the absence of culturally competent care even more problematic. The rigid custodial dynamics in prisons further hinder the delivery of proper palliative

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87 Iftene & Downie 2020, *supra* note 10 at 12.

88 See generally Marisa Ranieri, "Medical Assistance in Dying (MAiD) While Incarcerated vs Compassionate Release: A Comprehensive Analysis of "Dying with Dignity" within the Canadian Correctional System" (MHR, University of Manitoba, 2024) [unpublished] online: [perma.cc/4GXT-Q8KB] [Ranieri 2024].

89 See generally Liz Gwyther, Frank Brennan & Richard Harding, "Advancing Palliative Care as a Human Right" (2009) 38:5 J of Pain and Symptom Management 767 [Gwyther, Breenan, & Harding 2009].

90 See generally David Field et al., "Some Issues in the Provision of Adult Bereavement Support by UK Hospices" (2007) 64:2 Social Science and Medicine 428 [Field 2007].

care, and critical findings from the OCI/CHRC joint report emphasize that prisons remain inappropriate for end-of-life care.[91] Alternatives like community-based placements, which could offer a more humane approach and appeal to decarceration advocates in principle—as we explore below—face practical hurdles related to resource allocation and the readiness of correctional services to facilitate such transitions. Without significant investment in either strengthening relationships with community health services or improving the care provided within prisons, Canada will continue to fall short of fulfilling its ethical and legal obligations. The failure to provide adequate palliative care underscores a deeper issue of dehumanization within the federal corrections system, which urgently calls for reform.

In sum, the provision of palliative care for federally incarcerated individuals is governed by guidelines that are often vague and fail to meet the ethical and procedural benchmarks established by medical ethicists, professional organizations, and judicial bodies. Significant gaps and concerns persist within the system, particularly for aging incarcerated populations, who face substantial deficits in medical care and limited psychosocial support. The ethical obligation to ensure access to health care—especially adequate levels of health care—remains unfulfilled in carceral environments. Compounding this issue is the inherent unsuitability of prisons to serve as de facto nursing homes, a role for which they were never designed. However, is it time to give new meaning to correctional space, given these care complexities and carceral realities? Compounded care challenges like the ones we have addressed above would suggest perhaps the prison system has outlived its purpose. Yet, is it time for reinvestment in a prison design structure, programs, and models which repurpose and reframe comprehensive care as a priority for those incarcerated?

Gilbert et al. conducted a study[92] aimed at identifying and categorizing the different palliative and end-of-life care mechanisms for inmates across high-income countries. They identified a typology of three models of care delivery

> for people in prison in high-income countries: (1) [e]mbedded hospice model, typified by an interdisciplinary team and volunteer caregivers providing care on-site; (2) [o]utsourcing [c]are model, in which end-of-life care is provided outside the

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91 See generally *OCI & CHRC*, *supra* note 3.

92 Gilbert et al. 2024 *supra* note 10 at 530.

> prison; (3) [c]ollaborative community model, which involves prisons engagement with other healthcare facilities or practitioners.[93]

The study concluded that the USA mainly uses the "embedded hospice" model, which is "typified by an interdisciplinary team and volunteer caregivers providing care on-site."[94] The authors state there is evidence that the embedded hospice model is associated with "high-quality care, cost reduction and potentially transformative experiences for caregivers."[95]

While the embedded hospice model has been mentioned[96] or alluded to in the literature,[97] it still remains unclear whether this model has been formally adopted in the Canadian federal prison system, or some hybrid version of it, which includes aspects of the other two models of care. Presuming the embedded hospice model has been hypothetically adopted, it also remains unclear whether there are concrete plans towards standardizing and expanding this model across Canada's federal correctional facilities.[98] In Shaw and Driftmier's study, they highlighted the 'Pal Program,' which is as follows:

> Most of the participants had limited experience with EOLC [end-of-life care] prior to becoming involved with the prison palliative care program. Some were involved as patients, while others were enrolled in a peer caregiver program referred to as "the Pal Program." Pal caregivers perform certain forms of hygiene, social care, and even administering medications in coordination with professional healthcare staff. Upon entering our research project, we had not known of the program, but learned about it through our interviews. Pal is a play on words, between palliative care and 'pal,' as in friend. The men who were Pal workers described the work as involving significant degrees of hands-on care, which illuminates how the peer program both enables and erects barriers to quality care.[99]

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93 *Ibid.*

94 *Ibid.*

95 *Ibid.*

96 Gilbert et al. 2024, *supra* note 10 at 530.

97 Shaw & Driftmier 2024, *supra* note 13.

98 *Ibid.*

99 Shaw & Driftmier 2024, *supra* note 13 at 1301.

Yet, Shaw and Driftmier admit they only became aware of the 'Pal Program' through respondents themselves talking about it.[100] While perceived as an interest from CSC staff at the Pacific Institution/Regional Treatment Centre (PI/RTC)—a "federal penitentiary and prison hospital" in Abbotsford, British Columbia[101]—regarding the model of care they provide, the authors faced limitations:

> Since the interviews did not focus on the "Pal Program," we did not elicit details about the program specifically, such as what training prisoners may or may not have received prior to becoming a peer caregiver. In the interviews that were scheduled with CSC staff members (but were canceled due to COVID-19), there was an expressed desire from staff who wanted to elaborate on the PI/RTC model of peer support care. There may be tensions around whether the program ought to be considered an exemplary standard of in-prison peer support, or whether it is inappropriate for care to be provided by peers. Further interviews with all: prisoners, CSC healthcare and non-healthcare staff, and CSC decision-makers are necessary in order to better understand the nuances of the peer-support program[.][102]

To date, there remains no public knowledge we could find on the model of care CSC provides. Per Shaw and Driftmier, "PI/RTC [...] has an established palliative care program within a prison, where health and social service teams support incarcerated people at end-of-life, and where healthy prisoners are involved in the daily care of sick and/or elderly prisoners."[103] Yet, there is also no public information we could find available to affirm whether the embedded hospice model is implemented in this facility, nor if there are plans to expand the PAL Program and its associated care model to other facilities. It remains crucial to understand how care is guided and delivered to incarcerated older persons, especially if progressing prison palliative care in Canada rests upon the potential introduction, if not

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100 *Ibid.* However, it is important to note this program is detailed in the OCI/CHRC joint report; see *OCI & CHRC supra* note 3 at 47-48, and 50-52.

101 *Ibid* at 1293.

102 *Ibid* at 1309.

103 *Ibid* at 1293; it is notable in the OCI/CHRC joint report that Bowden Institution does have an Assisted Living Unit (ALU), which acts in a similar fashion to the PAL program; see *OCI & CHRC supra* note 3 at 47-48, and 50-52 for further discussion.

expansion of peer-support programs like the one Shaw and Driftmier describes.[104]

V. The Challenges of Receiving (Palliative) Care in the Community

This section is divided into two parts. The first part will cover the three mechanisms in place to allow federal inmates to receive care outside of prison,[105] while the second part will focus on the challenges community care services are facing in providing (palliative) care for older persons. We do this to underscore the current pathways of accessing outside care, while also demonstrating the mounting challenges those incarcerated continuously face in care access and delivery.

In Canada, there are three ways federal inmates can receive community care: temporary absence, parole by exception, and the Royal Prerogative of Mercy.[106] First, temporary absences are the most common way to receive palliative care in the community.[107] Iftene and Downie refer to the

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104 *Ibid.* A similar recommendation is found in the OCI/CHRC joint report, captured in Recommendation 10: "We recommend that CSC introduces standardized peer assistance and peer support programs across all institutions. These programs should be modeled along the lines of the caregiver program at Pacific Regional Treatment Centre, including a comprehensive manual, recurring training and ongoing support to peer caregivers." See *OCI & CHRC supra* note 3 at 52.

105 Aspects of this discussion regarding legal mechanisms can also be found in James Gacek & Emily Molloy, "Natural Death in Canadian Federal Corrections" (2026) Mortality, OnlineFirst 1-17 [Gacek and Molloy 2026]. Gacek and Molloy draw upon the legal mechanisms to reconsider and potentially resolve the challenges facing natural death in federal corrections, but their reconsideration is limited in considering a conversation of (prison) palliative care models and compassionate release, especially as neither prison palliative care nor compassionate release was the sole focus of the thematic analysis in their conducted study. Discussions of either topic were limited to the reporting found in government and policy reports. The current article, however, adds deeper socio-legal and doctrinal analytical reasoning, scholarship, and supplementary caselaw to underscore the important contexts embedded within the twinned focus of prison palliative care and compassionate release as mutually beneficial care complexities.

106 Correctional Service Canada, "Commissioner's Directive 710-03: Temporary Absences" (last modified 7 June 2025), online: <https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/710-3.html#s1a> [Commissioner's Directive 710-3].

107 Iftene & Downie 2020, *supra* note 10 at 19.

Commissioner's Directive 710-3, which states the following: "temporary absences may be granted for the following purposes: medical reasons, to allow the inmate to undergo medical examination or treatment that is not provided in the penitentiary[.]"[108] Temporary absences can be for an unlimited time, and may be escorted or unescorted.[109] However, whether a temporary absence is practical remains depends on the expenses and CSC's again readiness to facilitate health care services and find space within the community, both of which continues to prove quite difficult to execute.[110] Escorted temporary absences can be expensive; however, incarcerated people seeking end-of-life care may not require an escort because they are physically weak.[111] As a result, an unescorted temporary absence can be arranged, leading to a reduction in the associated costs. It is clear that the costs associated with temporary absences require further empirical scrutiny.

Temporary absences are granted based on the following criteria:

a. an inmate will not, by reoffending, present an undue risk to society during the absence
b. it is desirable for the inmate to be absent from the institution for one of the reasons for which temporary absences may be granted
c. the inmate's behaviour while under sentence does not preclude authorizing the absence
d. a structured plan for the absence, has been prepared.[112]

The following are some of the steps used to assess the application for a temporary absence:

a. review the application against the objectives of the Correctional Plan
b. interview the inmate to the discuss the proposed temporary absence
c. review the inmate's progress against the Correctional Plan, assess the level of risk involved in the proposed absence [...]

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108 *Ibid.*

109 Iftene & Downie 2020, *supra* note 10 at 11.

110 *Ibid* at 12.

111 *Ibid* at 13.

112 Commissioner's Directive 710-3, *supra* note 106 at s 21.

> d. request, if applicable, a Community Assessment or a Community Strategy.[113]
> [...]

As indicated by the criteria above, the application process for a temporary absence can be time-consuming. In addition, one of the steps in assessing the application requires interviewing the incarcerated person. Depending on the prisoner-applicant's health, this step may pose an unnecessary burden. Indeed, Iftene and Downie state more evidence is required in this regard.[114]

The OCI/CHRC joint report suggests CSC collaborate with the Parole Board of Canada (PBC) to ensure terminally ill persons can apply for parole by exception and spend more time in the community with their families, permitting the person is not a risk to themselves or society.[115] Section 121 of the *CCRA* permits incarcerated individuals to apply for parole by exception.[116] Those granted parole serve the remainder of their sentence in the community or within rehabilitation institutions or associated rehabilitative services. Parole by exception may apply to terminally ill inmates; inmates whose physical and mental health is likely to suffer serious damage if they remain in jail; those for whom continued confinement would result in excessive hardship not reasonably foreseeable at the time they were sentenced; or those subject to an order of surrender under the *Extradition Act*.[117] Those serving life or indeterminate sentences can only apply for parole by exception if they are terminally ill.[118] Parole by exception is granted using the same criteria as regular parole, which means a prisoner-applicant can be denied release to receive palliative care on grounds unrelated to health.[119] Moreover, it is not always possible for prisoner-applicants to fulfill the requirements of parole because they are sick.[120]

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113 *Ibid*, s 22.

114 Iftene & Downie 2020, *supra* note 10 at 22.

115 *OCI & CHRC*, *supra* note 3 at 35.

116 *CCRA*, *supra* note 15 at s 121.

117 Iftene & Downie 2020, *supra* note 10 at 16.

118 *Ibid*.

119 *Ibid*.

120 *Ibid* at 16-17.

Another issue is that there is currently no expedited process for parole by exception.[121] Those whose illness progresses rapidly may not have the time they need to go through the parole by exception application process.

The Royal Prerogative of Mercy is available under section 748 of the *Criminal Code*, which states: "748 (1) Her [sic] Majesty may extend the royal mercy to a person who is sentenced to imprisonment under the authority of an Act of Parliament, even if the person is imprisoned for failure to pay money to another person."[122]

Under the Royal Prerogative of Mercy, the prisoner-applicant may "spend the remainder of their sentences under supervision in the community."[123] Some of the principles identified by the PBC that guide the granting of the Royal Prerogative of Mercy are:

1. The Royal Prerogative of Mercy should be exercised in exceptional circumstances.
2. There should be evidence of substantial injustice, or undue hardship.
3. The exercise of the Royal Prerogative of Mercy should be determined based solely on the applicant's case.[124]

Once the other two mechanisms (temporary absence and parole by exception, the latter of which is discussed below) are exhausted, the prisoner-applicant may apply for the Royal Prerogative of Mercy.

A critical avenue for accessing community care is parole by exception, more commonly referred to as compassionate release. This mechanism provides a pathway for incarcerated individuals, especially those facing terminal illness or significant health risks, wherein and should they be successful they could serve the remainder of their sentences outside prison. Parole by exception is designed for individuals who meet specific criteria that consider their health and the potential undue hardship of continued confinement. According to section 121 of the *CCRA*, this:

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121 *Ibid* at 17.

122 *Criminal Code,* RSC 1985, c C-46, s 748 [CC].

123 Iftene & Downie 2020, *supra* note 10 at 17.

124 Parole Board of Canada, *Royal Prerogative of Mercy Ministerial Guidelines,* (Ottawa: PBC, 2014) at 3.

> [i]s an exceptional provision that allows an offender who has not yet reached their day and full parole eligibility dates to be considered for parole. Pursuant to section 121 of the CCRA, parole by exception may be granted to an offender:
> (a) who is terminally ill;
> (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
> (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or
> (d) who is the subject of an order of surrender under the Extradition Act and who is to be detained until surrendered.[125]

Unfortunately, section 121 of the *CCRA* provides minimal guidance regarding parole by exception. Moreover, there is a shortage of information regarding the possibility of petitioning for it, and a person cannot apply for parole by exception without CSC's assistance.[126] Further, potentially meritorious requests may not presented to the parole board reviewing the case of the prisoner-applicant; for a request for consideration of compassionate release to be granted, the prison doctor must demonstrate that the prisoner-applicant's continued incarceration would be an undue hardship, or the prisoner-applicant's health would likely suffer substantial harm.[127] Therefore, although there are alternatives to incarceration available for individuals requiring palliative care, the fast progression of illness may not leave enough time to consider them.[128] Certainly, this highlights the need for patient advocacy services.

While section 121 of the *CCRA* outlines a process for parole by exception, the lack of detailed guidance and the procedural hurdles involved significantly complicate access to this form of compassionate release. With the additional barriers posed by the shortage of information available, as well as the necessity of CSC involvement in advancing such requests, many potentially eligible prisoner-applicants may find their applications for release stalled or even neglected. The requirement for a prison doctor to demonstrate undue hardship or potential harm to the incarcerated person's health further delays the process, with the lengthiness

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125 *CCRA*, *supra* note 15, s 121(1)(a)-(d); See generally Parole Board of Canada, "Policy 4.1.1. Decision Making Policy Manual for Board Members" (2 January 2024) online: <publications.gc.ca> [perma.cc/5G4E-5WB3].

126 See Iftene & Downie 2020, *supra* note 10 regarding further ongoing challenges.

127 Iftene & Downie 2020, *supra* note 10 at 23.

128 *Ibid.*

of these procedures often outpacing the progression of terminal illnesses.[129] As a result, some of those incarcerated may not live long enough to benefit from these mechanisms of release. Again, this underscores the urgent need for patient advocacy services to ensure timely access to alternative care pathways. Beyond these legal and procedural obstacles, incarcerated individuals—specifically older persons—continue to face chronic challenges in accessing appropriate palliative care within prison settings.

Should incarcerated older persons be released for treatment in the community, especially those seeking palliative care, there are delivery models of care available to them: the outsourcing care model and collaborative community model. The outsourcing care model involves "delivering good end of life care [...] [by] addressing the needs of their older and end-of-life population, and staff managing to influence routine practice. Prisons showed some flexibility regarding release policies to meet individual needs."[130] In so doing, incarcerated older persons and/or health care practitioners can seek release mechanisms to better secure more flexible care and treatment in community services as required. On the other hand, the collaborative community model entails the meaningful engagement of prisons involving practitioners or health care facilities in the community to assist patients. Examples of this model include:

> environmental adaptations, like creating an older prisoner's wing and implementing the use of 'buddies' [...] Collaboration with nearby community palliative care services facilitated training and knowledge exchange. Hospices actively seeking family members to facilitate visits also [utilized] this model. Successful hospice care for prisoner patients or those released from prison requires staff to be ready, trained and aware of potential risks associated with the individuals' criminal backgrounds.[131]

However, outsourcing care to the community continues to face uphill challenges. Per Gilbert and colleagues, the "fragmented [o]utsourcing [c]are model risks missing timely diagnosis, effective pain management and family communication for those in prison. Evidence regarding psychosocial needs and bereavement support were generally lacking, and hospital clinicians' lack of information regarding prison protocols had a negative impact on

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129 See generally Iftene & Downie 2020, *supra* note 10 at 23.

130 Gilbert et al. 2024, *supra* note 10 at 528.

131 *Ibid at* 529.

holistic care."[132] These challenges may be resolved through the community collaboration model, in which "[c]entral to this model is the idea that individuals in prison with serious illnesses should ideally receive care within or close to their 'home' institution, ensuring comfort and familiarity for the person in prison coping with serious illness."[133] When successful, the range and diversity of care provided beyond the carceral setting is noteworthy, involving collaborative community models of care where the incarcerated older person receives care delivered by interdisciplinary teams of health specialists and practitioners dedicated to providing comprehensive health care. Although collaboration between correctional facilities and community facilities offering palliative care is key to this model, it is the collaboration itself which may pose challenging. Relationship building between the pair, coupled with permanent staffing, staff training, meaningful communication, and effective oversight, does not happen overnight; these relationships take time, and "the barriers to the success of this model can be both systematic and environmental."[134]

VI. Comparative Analysis

Systems in other jurisdictions have also been forced to confront the realities of aging and dying in custody. Comparative experience shows that end-of-life care for prisoners can be organized and regulated in very different ways, through combinations of prison-based palliative programs, medical or geriatric release regimes, and collaborative models that link correctional institutions with community services.[135] Looking at how other countries have approached prison palliative care and compassionate or medical release exposes both the limits of the current Canadian framework and the range of possible responses that are available when aging, health care, and penal policy collide.

As Canada's population of incarcerated older persons continues to grow, it becomes increasingly urgent to address the inadequacies of its

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132 *Ibid* at 530.

133 *Ibid* at 528.

134 *Ibid* at 529.

135 See generally Gilbert et al. 2024, *supra* note 10.

palliative care framework by drawing lessons from global best practices.[136] Next, we consider examples of countries managing the intersection of palliative care and incarceration, as comparing approaches across jurisdictions can elucidate some common themes which can form lessons to learn in the Canadian context. Below, we review select approaches across several international jurisdictions.

In the USA, geriatric and medical release programs are quite common and can be found in states such as Alabama, Colorado, Connecticut, and so forth.[137] In California, a medical release known as Chapter 405 is available.[138] This is available where individuals "who are unable to permanently perform activities of daily living will be released."[139] This program has allowed California to save about $200 million per year "by releasing incapacitated individuals while still continuing to supervise and support them."[140]

France modified its *Code of Criminal Procedure*[141] so a "prison sentence may be suspended for prisoners whose life expectancy is threatened or whose health is incompatible with detention (with the exception of inmates held in special psychiatric units)."[142] In France, individuals may be temporarily transferred to a hospital but return if they recover, while in the US, compassionate release allows prisoners to seek early release due to severe health conditions, including those related to aging, with medical parole being the main method used across states.[143]

Studies from Scotland and England reported the collaborative community model, "which involves prisons' engagement with other healthcare facilities or practitioners to assist patients."[144] For example, in this model, wherein staff from community palliative services offer to provide care to inmates, prison teams collaborate with local palliative care

136 Gilbert et al. 2024, *supra* note 10.

137 Iftene 2017a, *supra* note 8 at 930.

138 *Ibid* at 949.

139 *Ibid.*

140 *Ibid.*

141 *Code penal* (Fr), art 720-1-1 C (as of 2020).

142 Iftene 2017a, *supra* note 8 at 949.

143 Gilbert et al. 2024, *supra* note 10 at 518.

144 *Ibid* at 528.

specialists, and some prisons have their own end-of-life care programs.[145] The other mechanism for end-of-life care identified in the study is the outsourcing care approach. For example, in Portugal, 14 out of the 55 prisons do not offer prison healthcare units.[146]

In examining approaches comparatively while acknowledge jurisdictional differences, several common themes emerge. Firstly, the availability of alternatives to incarceration is significant. Whether offering temporary or intermittent release programs, incarcerated older persons may potentially receive a higher degree of care in the community beyond what their correctional institutional can provide—but, as demonstrated above, this is not a guarantee, given the ongoing challenges within community care services,[147] including bed shortages; doctor and nurse shortages; those without any meaningful connection to family or friends in the community to help access services; as well as the associated costs and finances required to pay for services.[148] Indeed, the economic 'benefits' for incarcerated older persons themselves or the jurisdictions in which they live could supplement arguments to reconsider temporary release measures and correctional policy specifically addressing older persons' needs and challenges—these must be studied in greater detail. Finally, while each jurisdiction mentioned above employs unique strategies, a shared commitment to human rights underscores a global consensus on the multifaceted approach required to address the complex challenges posed by prison palliative care in the modern world. However, further empirical research on palliative care in prisons worldwide is warranted.

A comparative analysis of palliative care models across international jurisdictions reveals critical insights which highlight the limitations of Canada's current approach. In countries like the US, France, and the

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145 *Ibid.*

146 *Ibid* at 527.

147 Gilbert et al. 2024, *supra* note 10; Laura L Poulin et al., "Lost in transition? Community residential facility staff and stakeholder perspectives on previously incarcerated older adults' transitions into long-term care" (2023) 23:1 BMC Geriatrics 180 [Poulin et al. 2023]; Amber Colibaba et al., "Community Reintegration of Previously Incarcerated Older Adults: Exploratory Insights from a Canadian Community Residential Facility Program" (2023) 35:4 J of Aging & Social Policy 521[Colibaba et al. 2023].

148 Meridith C. Burles, Cindy A. Peternelj-Taylor & Lorraine Holtslander, "A 'good death' for all?: examining issues for palliative care in correctional settings" (2016) 21:2 Mortality 93 [Burles, Peternelj-Taylor & Holtslander 2016].

United Kingdom (UK), more structured and innovative mechanisms, such as geriatric and medical release programs or embedded hospice models, provide incarcerated individuals with better access to end-of-life care. These models are not only more humane but also demonstrate significant cost savings, as seen in California's Chapter 405, which has reduced the financial burden of keeping incapacitated prisoners incarcerated.[149] The collaborative community models in England and Scotland further emphasize the benefits of integrating prison healthcare with external palliative care services.[150] These international examples underscore the economic, ethical, and practical advantages of alternatives to incarceration, particularly for elderly and terminally ill prisoners. Canada, by comparison, appears to lag in providing these alternatives on a systematic scale. The lack of concrete steps toward formally adopting a care model such as embedded hospice care, or establishing it as a priority model which includes innovative features of outsourcing care or collaborative community, suggests a missed opportunity to align correctional health services with human rights principles and correctional health services with meaningful community care practices (a discussion we return to below). Moreover, the economic arguments supporting these alternatives provide a strong case for reconsidering current policies.

While the comparative analysis highlights the need for Canada to enhance its palliative care framework, understanding the specific challenges within Canadian federal prisons is essential. This necessitates a closer examination of case law, which can provide insight into the legal landscape surrounding palliative care in correctional settings. To illustrate the complexities faced, we have selected four case studies exemplifying these challenges. In conducting keyword searches across legal databases such as Lexis+, we identified relevant cases focusing on issues of old age and palliative care in carceral environments. Although Canadian case law in this area is limited, a comprehensive examination of both Canadian and American jurisprudence will supplement our discussion of what potential reform is required within and beyond Canadian prisons.

Across these examples, several themes emerge that are instructive for Canada. Where compassionate or medical release regimes are clearly

149 Iftene 2017a, *supra* note 8 at 949.

150 Gilbert et al. 2024, *supra* note 10 at 518.

defined, procedurally accessible, and grounded in medical assessment, they can function as meaningful alternatives to incarceration for people nearing the end of life rather than as purely symbolic gestures. Embedded hospice and collaborative community models show that it is possible to deliver higher-quality palliative care in or around carceral settings when institutional leadership, external partnerships and adequate resources are present. Economic considerations often reinforce, rather than undermine, the case for reform. At the same time, comparative experience cautions that the mere existence of hospice programs or compassionate release provisions does not guarantee their use. Without attention to eligibility criteria, gatekeeping practices and deeper cultural attitudes toward aging and punishment, such mechanisms may remain underutilized. For Canada, the lesson is not to import a single model, but to recognize that more integrated approaches to prison palliative care and compassionate release are both feasible and normatively necessary.

VII. Case Law

Judicial decisions provide only a partial window into the relationship between aging, illness and incarceration, but they nonetheless reveal important patterns. Courts most often confront end-of-life issues indirectly—at sentencing, in applications to vary parole ineligibility or conditions, or in challenges to the implementation of custodial sentences—rather than through direct claims to palliative care as such. Age, infirmity and terminal illness tend to appear as mitigating or contextual factors, weighed against offence seriousness, risk and traditional sentencing objectives, rather than as triggers for a structured legal response to end-of-life needs. Surveying Canadian appellate decisions alongside selected foreign cases helps to show both what courts are prepared to do for aging and ill prisoners, and what they are not, and underscores why legislative and policy reform remain necessary.

To gain a broad illustration of palliative care challenges in Canadian federal prisons, five case studies have been selected. To select these cases, we collected potentially relevant cases by conducting a series of keyword searches in legal databases (for example, Lexis+, etc.). These searches were used to locate available caselaw with topics pertaining to old age and palliative care in carceral and/or penitentiary settings. It is important to note Canadian case law related to the scope of palliative care in prisons is

limited. However, examining Canadian jurisprudence alongside American case law on this subject can be informative (i.e., three American case studies were also chosen based upon the same topics mentioned above). We examine Canadian case law before turning to the subsequent and specific American case law.

In *R v Auckland*,[151] a case from the British Columbia Court of Appeal, the appellant's health was taken into consideration during the sentencing stage. The appellant had pleaded guilty to manslaughter, and then appealed a sentence of two years' incarceration. Following release from pre-trial custody, the appellant's health had severely deteriorated to the point that she required palliative care at a complex care facility. Once her condition had improved, the trial went forward and the matter proceeded to sentencing. The issue on appeal was whether the sentencing judge committed an error in principle that impacted the sentence or imposed a demonstrably unfit sentence. During the sentencing hearing, the issue was whether Ms. Auckland should serve any period of incarceration or should, particularly considering deterioration in her health, be sentenced in a way to avoid incarceration. After hearing evidence of facilities available at the federal and provincial institutions, the sentencing judge concluded the federal institution was better equipped to handle the appellant's complex needs. The appellant argued the sentencing judge increased the sentence that would have been imposed otherwise so that the appellant can serve it in a federal institution. However, the Court of Appeal held that the reasons of the sentencing judge did not support this argument, and the appeal was dismissed. Firstly, this case demonstrates an inmate's health is a consideration at the sentencing stage. Secondly, it can be inferred from the decision of the sentencing judge that, at the time, federal institutions were better equipped to handle complex health needs compared to the provincial institutions.

In *R v Andrews*,[152] a case from the Manitoba Court of Appeal, the accused had previously been sentenced to four years' incarceration. At the time of sentencing, the accused had existing health issues, including diabetes, kidney disease, eye disease, and pancreatic disease. A year after sentencing, the accused's health further deteriorated; he was diagnosed with

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151 *R v Auckland,* 2018 BCCA 171.

152 *R v Andrews (J.W.L.),* 2004 MBCA 60.

colon cancer and his physician stated that it was not curable. The accused sought a reduction in his sentence. The Manitoba Court of Appeal held:

> We should not disregard the accused's most recent illness, and his poor prognosis. These factors can open the door for reconsideration, if on humanitarian grounds alone. We are prepared to accept in the circumstances of this case that the accused's latest diagnosis of cancer is an infirmity that should be considered on sentencing. Moreover, it could well have influenced the sentencing judge, had the present situation then existed. On the present known facts, we must conclude that what was fit one year ago might now seem to be quite harsh.[153]

The Court of Appeal ordered the sentence be served conditionally. This case demonstrates how appellate courts may consider post-sentence circumstances to assess the appropriateness of a sentence. In this situation, the change in circumstances was the deteriorating health of the inmate.

Consider *R v Salehi*,[154] wherein the accused, who has Parkinson's disease, was convicted of two counts of second-degree murder. The accused appealed, submitting in part that his sentence was demonstrably unfit because the trial judge failed to consider the extent of his medical condition as a mitigating factor. The Court of Appeal said it is an error not to consider the effect of an offender's proven ill health where the offender is suffering from a medical condition that is likely to result in hardship exceeding the normal consequences of a conviction and sentence.[155] The sentence imposed was substituted for a sentence of life imprisonment with no possibility of parole for 15 years. This case demonstrates how courts can use discretion to address an offender's health care needs.

In *R v Woods*,[156] the British Columbia Court of Appeal determined that minimum parole eligibility requirement should be reduced from 15 years to 10 years due to a diagnosis of Lou Gehrig's disease arose after sentencing. Like *Salehi*, we see in this case how once again, courts can implement discretion to reduce minimum parole eligibility requirements to address the health care needs of an inmate.

Additionally, in *R v R(A),* Twaddle JA, writing for the Manitoba Court of Appeal, stated:

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153 *Ibid* at paras 29-30.

154 *R. v. Salehi*, 2022 BCCA 1.

155 *Ibid.*

156 *R v Woods,* 2003 BCCA 539.

> An accused's infirmity, always a factor to be considered, may warrant a reduction in the sentence that would otherwise have been imposed or a different kind of sentence. It all depends on the nature and effect of the infirmity and the nature and seriousness of the crime. Compassion must neither be stifled nor allowed to take control.
>
> [...]
>
> The accused has suffered the stigma of a conviction for a repugnant offence. Ordinarily that would not be enough. But he already suffers in his old age, through the force of destiny, from a debilitating illness. Prison for this man would be a far worse punishment than for others. And, from a public point of view, one may well ask whether there is any purpose to be served in paying for him to be hospitalized for the duration of his sentence.[157]

These cases illustrate that Canadian courts take health into account when assessing the appropriateness of a sentence. However, these cases do not directly consider palliative care in the correctional setting. The American jurisprudence is better developed in this area of the law. The following are a few examples of cases in which palliative care was a key issue.

In *United States v Berham*,[158] the defendant was serving a 235-month sentence for carjacking and brandishing a firearm during a crime of violence. The defendant brought a motion for compassionate release because he was in the final stages of terminal oropharyngeal squamous cell carcinoma. The government agreed the defendant's health constituted an extraordinary and compelling reason for compassionate release. The court determined the defendant should be transported to the family residence and continue to receive palliative care at the family home.

In *Commonwealth v Box*,[159] the court denied the defendant's emergency petition for release. The defendant was convicted of second-degree murder and robbery. The defendant had stage 4 cancer, and was placed in palliative care. He resided in a special isolation room, and was prescribed long-acting morphine two to three times daily. One of the factors the court considered was whether the licensed hospice provider could provide the inmate with more appropriate care. The court determined that the care would be comparable to that received in the infirmary. Furthermore, the court was concerned with the burden that the inmate's medical condition would place

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157 *R v R(A),* 1994 CanLII 4524 (MBCA) at paras 37, 46.

158 *United States v. Breham*, No. 21-cr-20165, 2024 U.S. Dist. LEXIS 15258 (E.D. Mich. Jan. 29, 2024).

159 *Commonwealth v. Box*, No. CP-22, 2021 Pa Dist & Cnty Dec LEXIS 1775 (CP Apr 16, 2021).

on his family. The court decided the prison was in a better position to respond to the inmate's medical needs. This case provides an example of what palliative care in the prison context may involve. It also suggests how sometimes, the care received within the prison may be comparable or even better suited to the needs of the inmate than care received outside in the community.

In *United States v Madoff*,[160] the court denied Madoff's motion for reduction in sentence and compassionate release. The defendant was diagnosed with Stage 5 kidney disease. Madoff had pleaded guilty to 11 counts of securities fraud and related crimes. The court determined the nature, circumstances, and seriousness of Madoff's crimes weighed heavily against compassionate release. This case is illustrative of how compassionate release can be denied because of reasons unrelated to health.

In sum, the exploration of how old age, terminal illness, and incarceration intersect in cases in Canada—alongside specific American cases—underscores the vital role of legal cases as repositories of comprehensive analyses and socio-contextual insights. Taken together, the complex narratives shed light on pivotal themes that resonate within the broader societal and legal frameworks. Key themes emerging from these cases include the significance of legal interventions in understanding and addressing the challenges of offering and operating palliative care services, and the nuanced approaches to sentencing and rehabilitation. Ultimately, these cases underscore the dynamic interplay between legal processes, societal concerns and values, and rehabilitative strategies in grappling with the complexities of aging and terminal illness in prison. Moving forward, continued exploration and analysis of such cases are essential for informing effective policies and interventions aimed at reforming prison health care services and governance while upholding principles of justice and rehabilitation.

The examination of case law concerning palliative care in Canadian federal prisons reveals a critical intersection of health, justice, and human dignity. The selected cases illustrate a legal landscape acknowledging the health conditions of incarcerated individuals, yet they also highlight the limitations of Canadian jurisprudence in fully addressing the complexities of palliative care within correctional settings. Unlike the more developed

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160 *United States v Madoff*, 465 F Supp (3d) 343 (SDNY 2020).

American case law, Canadian courts have yet to establish a robust framework for compassionate release or tailored sentencing that prioritizes humane treatment for terminally ill inmates. We recognize cases where age is a mitigating factor in someone's sentence, but also cases where age is not the sole consideration among the details of the case itself. We also recognize how complicated decision making can be when it involves age as a factor— in certain instances, and should the prisoner-applicant no longer be a threat to society (especially when old age is involved), then it may be best to release them; yet in other instances, the threat of society— the diminishing care towards older persons available by provincial health care systems, for instance—may mean their best interests (and care) are better served within federal custody. Such is the complexities of care we are dealing with.

This gap in understanding the complexities of aging and care signifies a pressing need for legal reforms which align more closely with the principles of compassion and rehabilitation, ensuring the aging and terminally ill populations receive adequate care without compromising their dignity or well-being. As Canada grapples with the implications of an increasingly elderly prison population, it is imperative that policymakers and legal professionals draw lessons from both domestic and international practices to foster a more just and humane correctional system which respects human rights and prioritizes effective palliative care.

The cases considered in this section chart a narrow path. Courts have recognized that serious illness, infirmity and advanced age can justify conditional sentences, reductions in parole ineligibility or other forms of mitigation, especially in cases where individuals pose little ongoing risk to public safety. Yet these decisions fall short of recognizing a positive right to palliative care in custody or a presumptive entitlement to release at or near the end of life. In many instances, health-related claims compete with punitive and symbolic considerations, and relief is highly individualized and discretionary. The jurisprudence thus confirms that judicial discretion, while sometimes responsive to the realities of aging and illness, cannot substitute for a coherent framework governing palliative care and compassionate release. That gap sets the stage for the reforms proposed in the final part of the article.

VIII. Reform

The analysis to this point has shown that prison health-care obligations, empirical realities of aging in custody, community-based release mechanisms, comparative experience, and case law all point in the same direction: the current approach to end-of-life care for prisoners in Canada is fragmented and inadequate. The intersection of aging, illness and incarceration exposes structural weaknesses in both prison health care and release mechanisms that cannot be addressed by minor adjustments alone.

In this section, we advance a set of mutually reinforcing reforms that together operationalize the article's central claim: that Canada must provide incarcerated older persons with meaningful access both to high-quality palliative care and to a distinct, accessible compassionate release regime, and must do so in ways that centre autonomy and choice. We focus on four areas. First, improving data and information-tracking about aging, health status and care trajectories inside and outside federal institutions. Second, enacting a new statutory compassionate release mechanism tailored to the needs of terminally ill and severely debilitated prisoners. Third, formally adopting and resourcing an embedded hospice model within federal institutions, which recognizes that many people will remain in custody yet are entitled to dignified, patient-centred care. Fourth, recognizing and implementing a right to prison palliative care grounded in Canada's domestic and international legal commitments.

Taking into consideration international comparisons and case law, critical questions remain regarding the efficacy and availability of a compassionate release mechanism for elderly prisoners in Canada, as well as the potential recognition of a right to palliative care within prisons. Indeed, the lived realities and never-ending cycle of prisoners-as-patients-as-prisoners in correctional settings are critical to complicating the simplicity of a one-size-fits-all approach to correctional reform.[161] As the connection between aging and incarceration evolves, and what serves the best interests of those incarcerated? We see an apparent tension forming here, between seeking to rehabilitate the person (i.e., providing care) while locking away the offender. Whether one views the latter as providing punishment, or withholding comprehensive care—or something in-between—the tension has

[161] See generally Gacek et al. 2025, *supra* note 42.

not been resolved within the current Canadian correctional landscape. So where do we go from here? We outline our thoughts below. We note our items are not mutually exclusive, given how intersected aging, care, and incarceration have become.

A. *Better Record Keeping and Information Tracking*

Regardless of whether one is in favour of progressing palliative care, or a new compassionate release statutory provision (or both, or neither), there is an overall lack of available information on these subject matters. Moreover, what does exist focuses on federal institutions, notably Iftene's respective works. Yet there is no connecting discussion to the provincial and territorial jails, which are part of Canada's correctional landscape, and Iftene's conclusions are seemingly based on their account of palliative care in correctional facilities from CSC data on deaths in custody. Going forward, it is vital that accurate records be made and preserved to allow researchers to track the long-term prevalence of palliative care both in federal corrections and connect it to the health care services offered across provincial and territorial counterparts. Health care may be a provincial and territorial responsibility, but the complexity of caring for people is a universal phenomenon, one which must be tracked with greater rigour.

Furthermore, Iftene and Downie highlight the need for reform in the regulation, monitoring, documentation, and provision of end-of-life care.[162] Iftene and Downie made the following suggestions in their article:

1. an improved monitoring and record-keeping system;
2. approaches to finding alternatives to incarceration for those receiving end-of-life care;
3. release into the community for palliative care should not be contingent on factors beyond the individual's control or unrelated to community safety; and
4. policy and practice should be reorganized to improve palliative care in prisons for individuals who received care within the prison setting.[163]

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162 Iftene & Downie 2020, *supra* note 10 at 1.

163 *Ibid* at 33.

Currently, there are deficiencies in the courts taking into consideration a person's health when making sentencing decisions back into the community.[164] One recommendation is the criteria and process for temporary absences and parole by exception should be simplified and requests expedited for those who require palliative care.

Finally, better tracking of aging trajectories of current and formerly incarcerated older persons would be beneficial to measure the scope and breadth of care older persons received while incarcerated and upon release. Doing so would supplement efforts to see where existing gaps in comprehensive care arise, such as in geriatric-informed health and targeted release policies specific to older persons.[165] For example, in one study by Testa and colleagues,[166] they investigated how incarceration across the life course relates to cognitive impairment in older adults, with a focus on older Black individuals. By comparing cognitive scores between those with and without incarceration histories, Testa and colleagues[167] demonstrate how formerly incarcerated older adults, especially non-Hispanic Black individuals, show lower cognitive performance than never-incarcerated peers, with disparities not observed in other racial groups. In fact, for formerly incarcerated Black adults, the cognitive scores were markedly lower, which suggests a cumulative disadvantage and the role of incarceration as a social determinant of cognitive aging.[168] Testa et al. thus stress a need for research, screening, and policy attention focused on geriatric health, specifically dementia risk in formerly incarcerated older adults.[169] In another study, Testa and colleagues' examine whether older

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164 *Ibid* at 4.

165 Alexander Testa et al., "Links of previous incarceration with geriatric syndromes and chronic health conditions among older adults in the United States" (2024) 79:8 The Journals of Gerontology – Series A: Biological Sciences and Medical Sciences 1 [Testa et al. 2024].

166 Alexander Testa et al, "Mass incarceration and cognitive impairment in older adults" (2023) 71:8 J of the Am Geriatrics Society 2680 [Testa et al. 2023].

167 Alexander Testa, Luis Mijares & Dylan B Jackson, "The Impact of Prior Incarceration on Cognitive Trajectories Among Older Adults: Evidence from the Health and Retirement Study" (2025) 80:2 The Journals of Gerontology – Series B: Psychological Sciences and Social Sciences 1 [Testa Mijares & Jackson 2025].

168 Testa et al. 2023, *supra* note 166.

169 *Ibid*.

persons with a history of incarceration show different cognitive aging trajectories than those never incarcerated.[170] Using group-based trajectory modeling and multinomial logistic regression, Testa and colleagues analyzed data from 5,663 adults aged 55+ in the *Health and Retirement Study (2012–2020).*[171] Their findings suggest educational disadvantage may help us understand the complex relation between incarceration, human aging and cognition, highlighting the need to examine broader structural mechanisms and systems shaping trajectories of cognitive aging.[172]

B. *A New Compassionate Release Statutory Provision*

Some academics have attributed the increasingly aging prison demographic in part to longer custodial sentences, limits on parole eligibility, and "tough-on-crime" politics that reduce opportunities for early release, even when elderly prisoners no longer pose a substantial risk to the public.[173] Tough-on-crime politics pose significant challenges for aging prisoners in need of palliative care by prioritizing punitive measures over rehabilitation or compassion. These policies often result in rigid sentencing, limiting opportunities for compassionate release, even when elderly prisoners no longer pose a threat. These trends help to explain why, despite the growth of an older prisoner population, late-life release mechanisms are used relatively rarely.

Iftene notes that, although more incarcerated individuals are now growing old in prison, relatively few are treated as people for whom continued incarceration has become difficult to justify.[174] Iftene emphasizes how late-life imprisonment can appear particularly harsh for those who have spent decades in custody and now live with significant functional impairments. From a position of fairness, Iftene and others argue that policy should take seriously the distinctive situation of elderly prisoners.[175]

Briefly, Iftene's argument contains four parts: (i) the general parole system is flawed; (ii) the current parole by exception is not an efficient

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170 Testa Mijares & Jackson 2025, *supra* note 167.

171 *Ibid.*

172 See also Testa et al. 2024, *supra* note 166.

173 Hudson, Perron, & Wright 2019, *supra* note 58 at 3.

174 Iftene 2017a, *supra* note 8 at 929.

175 *Ibid.*

provision for compassionate release; (iii) a proper and distinct compassionate release mechanism should exist; and, finally, (iv) there are identifiable, concrete steps that ought to be taken to realize a compassionate release mechanism.[176] This is especially important for inmates with life-threating illnesses, such as HIV and Hepatitis C. Betteridge notes "CSC has a legislative obligation to provide every inmate with essential health care that conforms to professionally accepted standards. Practically, this legislative obligation has been interpreted by CSC to mean that inmates should have access to the same level of health care service available in the community."[177] DiTomas et al. argue in favour of more early medical release or parole for the elderly, frail or terminally ill. They note "[h]ealthcare facilities within most prisons are often unable to provide the needed level of care, and patients are typically transported to outside facilities."[178] Ornduff argues in favour of early release for elderly prisoners from a position of fairness. As Orduff indicates,

> [E]arly release of elderly inmates is an approach that can apply to both prisoners who enter prison at an older age and those who have spent a lifetime incarcerated. Using age as a mitigating factor in sentencing would still leave in prison those elderly inmates who were young when sentenced for their crimes, but who are no longer a threat to society.[179]

Early release of elderly inmates is therefore presented as an approach that can apply to individuals who have been punished for their crimes, but who are no longer a meaningful threat to society. Despite these arguments in favour of compassionate release, Love cautions against an uncritical embrace of what has been described as "positive ageism": the assumption that older offenders are automatically more deserving of leniency simply because of their age.[180] In this view, age may be relevant to decisions about

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176 I*bid* at 931.

177 Jonathan Glenn Betteridge, "Inquest into the Death of a Prisoner Co-Infected with HIV and Hepatitis C: How Many More Will There Be?" (2001) 6:1 Can HIV/AIDS P & L Rev 1 at para 17.

178 Michele DiTomas et al., *Growing Older: Challenges of Prison and Reentry for the Aging Population in Robert B. Greifinger,* ed, Public Health Behind Bars: From Prisons to Communities (New York: Springer, 2022).

179 Ornduff 1996, *supra* note 46 at 197-8.

180 Helene Love et al., "Age and Agism in Sentencing Practices: Outcomes from a Case Law Review" (2013) 17 Can Crim L Rev 253 at 261.

sentencing and release—especially when combined with illness, frailty, or disability—but age alone should not determine outcomes. Instead, and put simply, they argue old age should only be a mitigating circumstance when it is combined with illness, but age should not be a sole consideration for sentencing.[181]

Iftene consequently emphasizes the need for a new compassionate release system that addresses the specific situation of aging and terminally ill prisoners.[182] In their analysis, a genuine compassionate release mechanism does not currently exist in Canada; the available tools are piecemeal, discretionary, and poorly adapted to the realities of serious illness and end-of-life care.[183] Iftene states:

> A type of compassionate release, "parole by exception," is included in the legislation among other types of parole. While section 121 of the *CCRA* established parole by exception for people suffering from serious health conditions, the way this section is framed, regulated, and applied shows that this provision has very little to do with compassion or release on humanitarian grounds. [184]

Iftene makes the following arguments for a new compassionate release statutory provision:

1. Aging prisoners have high needs but present low risk to society.
2. Sentencing judges consider health issues when making their decision. Thus, it seems that if the accused is sick at the time of sentencing, they have a better chance of receiving a compassionate sentence than if the circumstances change after sentencing. Iftene argues that this double standard is unjustified.
3. Impending death negates the need for continued imprisonment.
4. Legal challenges may arise from inadequate medical care in prisons.
5. There is a high cost of incarcerating and caring for sick prisoners.

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181 *Ibid* at 262.

182 Iftene 2017a, *supra* note 8 at 930.

183 *Ibid.*

184 *Ibid.*

6. There are successful compassionate release systems in other countries.[185]

Hudson et al. discuss the following barriers to compassionate release: limited legal mechanisms; lack of political will and public support; lack of community beds; and absence of community connections. [186] According to Hudson et al., "broader policy or legislative changes should allow for the release of older or chronically ill prisoners."[187]

In sum, we see the necessity to reconsider compassionate release for terminally ill prisoners, especially as prisoners are not only staying longer in prison, but living longer as well, while custodial space remains stagnant.[188] While debates about compassionate release continue, we believe it necessary to reenergize momentum for comprehensive and consistent palliative care for aging prisoners and prisoners who have little life left, coupled with clear palliative guidelines that are open to the public to view.[189] Included in this discussion should be a re-evaluation of community end-of-life care specifically for terminally ill prisoners post-release. Moreover, we encourage the PBC to reconsider compassionate release for this specific prisoner population, given how section 121 of the *CCRA* remains a significant tool in the PBC's toolkit.[190] A reconsideration of a new comprehensive compassionate release statutory provision provides a unique opportunity to develop and advance proper pathways focused on the provision of necessary care.

C. *The Importance of Prisoner Choice, Autonomy, and Dignity: Expanding the Embedded Hospice Model*

As Gilbert et al. contend, one finding from there scoping review of models of palliative care delivery demonstrates how "[a]dvocacy for compassionate release is in tension with a prevailing punitive approach that

185 *Ibid* at 938-939.

186 Hudson, Perron, & Wright 2019, *supra* note 58 at 9.

187 *Ibid.*

188 See generally Gacek et al. 2025, *supra* note 42.

189 *Ibid.*

190 See generally Gacek and Molloy 2026, *supra* note 105.

limits access to end-of-life care. This, combined with a lack of comprehensive reporting and appeals process, has hindered evidence-based reforms."[191] We note here, however, that we do not see the creation of a new compassionate release statutory provision as the antithesis of meaningfully reforming prison palliative care; doing so presents an illusory binary between what care internal to the prison can or ought to be achieved (i.e. viewed as restrictive and failing), versus how hypothetically better external care must be (i.e., viewed as expansive and freeing). The state of health care after the COVID-19 pandemic continues to see substantive challenges inside prison and out in the community, and systems-level challenges in community care services are visible yet remain unresolved.[192] Regardless of where palliative care operates, the care older persons are receiving must improve. Both prison palliative care and compassionate release must be progressed, to ensure the best interests and needs of (older) persons internal to- and external from incarceration are addressed.

We suggest it is necessary for CSC to formally adopt the embedded hospice model into their correctional facilities, and encourage CSC to meaningfully incorporate aspects of the other two models of care into the formal adoption. We make this suggestion neither as carceral apologists nor abolitionists, but as concerned scholars recognizing the realities and complexities of care connecting correctional and community care facilities. We contend prisoner choice, autonomy, and dignity, especially when it comes to decisions involving their health, must remain a priority.[193] Given the current challenges we observe in the federal prison system and the compassionate release provision, we must acknowledge the prison could do more to care for those incarcerated, at least until momentum for a new compassionate release provision sees social and political traction. We cannot forget how for some incarcerated, prison is where basic needs are

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191 Gilbert et al. 2024, *supra* note 10 at 518.

192 Colibaba et al. 2023, *supra* note 147; Poulin et al. 2023, *supra* note 147.

193 Burles, Peternelj-Taylor & Holtslander 2016, *supra* note 148. Of course, we recognize how personal choice intersects with the complicated realities of incarceration; as the OCI/CHRC joint report suggests, correctional spaces are not places where personal choice is "ever a 'real' choice" (*OCI & CHRC, supra* note 3 at 54). While the complexities of choice are beyond the scope of our article, we underscore the importance of time, meaningful support networks, and contextual factors in custody which allow incarcerated older persons the dignity they require to make choices necessary and in the best interests of their own health and health care.

met which remain inaccessible in the community.[194] This paradox of "secure environments [becoming] a 'refuge' of sorts for an increasing-number of at-risk individuals" certainly reflects systemic failures[195] especially as more of these people seemingly "find themselves seeking health care under the auspices of the criminal justice system".[196] Yet it also speaks to the challenges outsourcing care to the community, and to collaborating with community partners and stakeholders; resources strained in the community may not be so easily provided (willingly or not) to those who have broken the law.

As discussed above, the embedded care model per Gilbert et al., "demonstrates promising evidence for enhancing the care experience for recipients and caregivers."[197] By attempting to "humanize the prisoner" the model strives to refocus person-centred approached to care regardless of the persons serving lengthy sentences.[198] However, one challenge raised by Gilbert and colleagues is "the stability of the institution [...] with palliative care programmes identified as vulnerable during periods of infrastructural unrest."[199] We broaden such unrest to include social and political, as carceral investment in the Canadian context continues to be contentious.[200] This model is not perfect, but changing the Canadian social and political culture will take more time than those of whom are incarcerated, older, and/or terminally ill have at present. Progressing this model means standardizing palliative care guidelines across correctional facilities, while also stabilizing internal palliative care programs, peer support and caregiving programs, and the institutional cultures required to keep these programs operating in a meaningful way. We arrive at this argument with a reminder

194 Sandrea Bucerius, Kevin D Haggerty & David D Dunford, "Prison as temporary refuge: amplifying the voices of women detained in prison" (2021) 61:2 Brit J Crim 519.

195 Burles, Peternelj-Taylor & Holtslander 2016, *supra* note 148 at 98.

196 *Ibid*; See also Cindy Peternelj-Taylor, *Care of Persons Under Forensic Purview*, 3rd ed (Philadelphia: Wolters Kluwer, 2015) at 891-905.

197 Gilbert et al. 2024, *supra* note 10 at 518.

198 *Ibid* at 527.

199 *Ibid.*

200 For discussion, see Jennifer Turner, Rosemary Ricciardelli & James Gacek, "The "Pains of Employment"? Connecting Air and Sound Quality to Correctional Officer Experiences of Health and Wellness in Prison Space" (2023) 103:5 The Prison J 610.

that the work of progressing both palliative care and compassionate release is unfinished—an ever-evolving conversation.[201]

From this discussion, we see the need to appreciate the value a comprehensive care system has within a prison environment. This is not an easy discussion to have, and nor do we have all the answers to resolve the seeming irreconcilability between care internal to- versus care external to the prison; what we are suggesting here is to reconsider our thinking about best serving the needs of those incarcerated older persons; we must meet the moment, their choices, autonomy, and dignity with the most comprehensive care we can offer them.

D. *The Right to Prison Palliative Care?*

As we advocate for a more robust approach to palliative care and compassionate release for terminally ill prisoners, it is crucial to recognize how the broader discourse on the right to palliative care in Canada also merits serious consideration. How could equitable access to palliative care be framed as a human right, particularly in light of the inequalities faced by those with life-limiting illnesses? While people in prison "deserve equivalent access to healthcare as the general population, [...] barriers to care delivery

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201 It challenges us to reflect critically on the tensions between reformist interventions and the potential for a broader abolitionist imagination. Can we hold space for both possibilities, while meeting incarcerated older persons where they are at in their lives and their associated levels of care? Certainly, activating decarceral logics should proceed in stages, because the act of unpacking oppression, while crucial, takes time to help reveal the purpose of correctional space itself. If no purpose exists at the end of reform, abolition could then merit discussion. Nevertheless, and rather than choosing sides, we recognize the value of critiquing institutions from within and disruption from without, as we aim to foster dialogue between necessary incremental improvements and perceivably radical reimaginings. The stakes, we assert, remain high: care within and beyond correctional systems remains complex, regulating lives, choices, and the social, medical, and legal possibilities along the way. If care is to be meaningful for those older persons entangled in these systems, we must resist reducing conversations to zero-sum games of bureaucratic management or utopian abstraction. Instead, prison palliative care and compassionate release must become responsive, reflexive, and attuned to the lived complexities of marginalized communities. By embracing this complexity, we move beyond an illusory binary debate, and urge a more expansive, intersectional, and pragmatic approach to care, justice, and change.

can be considered a human rights issue."[202] The argument for a right to palliative care in Canada is laid out by Henteleff and colleagues in "Palliative Care: An Enforceable Canadian Human Right?" Their article examines two *Charter* challenges. The first is an s 15 *Charter* challenge, which argues that, "since palliative care is provided unevenly to those who require it, the equality provisions of the *Charter* could compel equitable provision of palliative care to Canadians with life limiting illness."[203] The second is a s 7 *Charter* challenge, which argues that, "failure to provide palliative care may impose an unacceptable level of psychological stress on those at the end of life."[204] The authors conclude "[c]are, compassion, and the alleviation of pain, and psychosocial and existential suffering, are all needed by those approaching the end of life, regardless of the underlying condition that necessitates palliative care."[205] John Linder and Frederick Meyers arrive at similar conclusions, noting:

> Correctional hospice challenges physicians to use all of their communications and palliative care skills. Collaboration between local correctional and community-based palliative care service providers through joint trainings, site visit exchanges, and funding initiatives that support continuity of care for released inmates who are terminally ill will transform prison end-of-life care and perhaps serve as a model for inmate health care overall. [...] More rigorous research into the efficacy of specific palliative interventions would further refine the care standards.[206]

Taken together, the right to prison palliative care becomes an ethical imperative, given the ongoing challenges we see in federal corrections for older persons. Especially when intolerable pain and suffering are demonstrated by elderly prisoners, providing the opportunity for prisoners-as-patients with what little time they have left may foster more meaningful end-of-life care in the process.[207] We support this call for the recognition of a right to palliative care, and, going forward, we suggest that future empirical efforts should explore law and federal correctional policy reform to recognize and establish this right for elderly prisoners.

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202 Gilbert et al. 2024, *supra* note 10 at 518.

203 Yude M. Henteleff et al., "Palliative Care: An Enforceable Canadian Human Right?" (2011) 5:1 MJLH 107 at 107.

204 *Ibid* at 107.

205 *Ibid.* at 157.

206 Linder & Meyers 2007, *supra* note 5 at 900.

207 Gacek et al. 2025, *supra* note 42.

However, debate over the right to prison palliative care might also question "prisoners' access in light of the limited access of some members of society in general."[208] As Burles et al. contend:

> Specifically, animosity might arise in communities in which some members have limited access to health care services due to the [organization] of the health care system (i.e. financial costs of health care/lack of health insurance, poor geographic distribution of services and other social barriers to access). This issue is particularly significant in the USA, where there is a high number of uninsured individuals, which contributes to growing resistance to any improvements to prison health services.[209]

Nevertheless, the call for a right to palliative care within Canadian prisons is not only a reflection of ethical responsibility but also a vital component of a just and humane correctional system. There remains a pressing need for equitable access to palliative care for the terminally ill, reinforcing the notion that compassion and dignity should extend to all individuals, regardless of their circumstances, incarcerated or otherwise. As the literature suggests, failure to address the unique needs of aging prisoners can result in profound psychological distress and suffering, underscoring the urgency of implementing comprehensive palliative care frameworks. Moreover, fostering collaboration between correctional facilities and community-based palliative care providers offers a pathway toward improving care standards and ensuring continuity for older persons post-release. Moving forward, it is imperative that policymakers, legal advocates, and correctional administrators prioritize the establishment of this right, not only to enhance the quality of end-of-life care but also to affirm the fundamental human rights of some of society's most vulnerable members. Recognizing palliative care as an enforceable right within federal corrections would mark a significant step toward a more compassionate and equitable justice system that truly values human dignity in all forms.

IX. CONCLUSION

The aging of Canada's prison population has brought to the surface tensions that have long been present in the correctional system. Institutions

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208 Burles, Peternelj-Taylor & Holtslander 2016, *supra* note 148 at 102.

209 *Ibid.*

designed around security and control now house growing numbers of older people with chronic illnesses, frailty and limited life expectancy. Existing mechanisms for providing palliative and end-of-life care—both inside federal institutions and through community-based release—are fragmented, difficult to access, and often insensitive to the lived realities of aging in custody. Many incarcerated older persons therefore approach the end of life in environments ill-equipped to support their dignity, autonomy or clinical needs.

This article has argued that prison palliative care and compassionate release should be treated as interconnected rather than competing mechanisms, and that both must be structured around the autonomy and choices of incarcerated older persons. A rights-informed response to aging and dying in custody requires, at minimum, better data and monitoring, a distinct and accessible compassionate release provision, and the formal adoption of an embedded hospice model within federal institutions. It also requires recognition of a right to appropriate palliative care for people in prison, grounded in existing statutory obligations, constitutional protections and international human-rights standards.

How Canada chooses to address the needs of aging and terminally ill prisoners will say much about the kind of society it aspires to be. A correctional system that allows older people to die in conditions of neglect or inadequate care sits uneasily with commitments to human dignity, equality and justice. A system that offers meaningful opportunities for compassionate release, provides high-quality palliative care within institutions for those who remain, and respects the choices and preferences of incarcerated older persons can begin to align correctional practice with those values. Attending to the complexities of care behind and beyond bars is therefore not a peripheral issue, but a central test of Canada's willingness to take seriously the humanity of all those in its custody.