

END-OF-LIFE CARE FOR FEDERALLY INCARCERATED INDIVIDUALS IN CANADA

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In this article, we review the current legislation, policies, and practices related to end-of-life care for federally incarcerated individuals as set out in statutes, guidelines, and government reports and documents that were either publicly available or obtained through Access to Information requests from the Parole Board of Canada and Correctional Service of Canada (CSC). Based on this review, we describe the status quo, identify gaps, and offer reflections and raise concerns regarding end-of-life care for federally incarcerated individuals. We conclude that there are significant information gaps about the number of people seeking end-of-life care and about how CSC is managing the provision of such care. The sparse information available is nonetheless sufficient to support the conclusion that there are good reasons to be concerned about how end-of-life care is regulated, monitored, recorded, and pro-

Dans cet article, nous passons en revue la législation, les politiques et les pratiques actuelles relatives aux soins de fin de vie des personnes incarcérées dans des établissements fédéraux, tel que définies dans les lois, les lignes directrices et les rapports et documents gouvernementaux accessibles au public ou obtenus par le biais de demandes d'accès à l'information de la Commission des libérations conditionnelles du Canada et du Service correctionnel du Canada (SCC). Sur la base de cet examen, nous décrivons le statu quo, identifions les lacunes, proposons des réflexions et soulevons des préoccupations concernant les soins de fin de vie pour les personnes incarcérées dans les prisons fédérales. Nous concluons qu'il existe des lacunes importantes en matière d'information sur le nombre de personnes qui demandent des soins de fin de vie et sur la façon dont le SCC gère la prestation de ces soins. Les rares informations disponibles

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sont néanmoins suffisantes pour étayer la conclusion selon laquelle il existe de bonnes raisons de s'inquiéter de la manière dont les soins de fin de vie sont réglementés, contrôlés, enregistrés et fournis. Des réformes importantes sont nécessaires.

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INTRODUCTION

Each year, how many federally incarcerated individuals die a natural death? What clinical options are available to them at the end of their lives? How many of them seek palliative care, refuse potentially life-sustaining care, or seek palliative sedation? How does the federal correctional system respond to their requests? Are incarcerated individuals eligible for medical assistance in dying (MAiD)? Do they seek it in significant numbers? Is the federal correctional system well-equipped to deal with MAiD? All of these questions are critical to an assessment of how well Correctional Service of Canada (CSC) serves federally incarcerated individuals at particularly vulnerable moments in their lives.

Attempting to provide such an assessment, we embarked upon a review of the current legislation, policies, and practices related to end-of-life care set out in statutes, guidelines, and government reports and documents that were available either publicly or through Access to Information requests from the Parole Board of Canada (PBC) and CSC. More specifically, we reviewed all pertinent federal legislation, directives, regulations, and guidelines, as well as the mortality reviews and reports related to death in prison from the last 10 years, from CSC and the Office of the Correctional Investigator (OCI). The OCI is the independent ombudsperson for federally sentenced individuals. It investigates individual complaints and reviews CSC policies and procedures to address systemic issues. The OCI's annual and special reports are the most important and complete sources of unbiased information available. Finally, we reviewed the few relevant medical and socio-legal articles that have emerged in the last decade. In particular, we drew extensively on findings from a study with 197 aging incarcerated individuals facing significant physical and mental illnesses. The study was conducted in seven male penitentiaries and was based on structured interviews with the participants. The study sought to identify gaps between the needs of aging persons and the health care available in prisons. The results were analyzed using both quantitative and qualitative methodologies, and confirmed the fact that there is an increasing need for specialized health care, including end-of-life care among the prison population, and that CSC is ill-equipped to address these needs in a manner that conforms with international and

national health standards and human rights.¹

Based on this review, we describe the status quo, offer reflections, and raise concerns regarding end-of-life care for federally incarcerated individuals.

In Part I, we provide demographic data about those federally incarcerated individuals who may want palliative care, who may wish to refuse potentially life-sustaining care (requiring the withholding or withdrawal of such care), and who may request palliative sedation or MAiD. We explore the absolute number and proportion of incarcerated individuals over the age of 50, the prevalence of diseases amongst incarcerated individuals, as well as the number of natural deaths that occur in federal custody. Part II demonstrates that, in the future, a significant and growing number of federally incarcerated individuals may request end-of-life care.

We then review how these requests might be met by delivering such care in the community (i.e., removing the individual from correctional facilities²). This requires an explanation of how CSC utilizes its statutory authority to consider alternatives to incarceration in response to an individual's ill health (including temporary absence,³ parole by exception,⁴ and the Royal Prerogative of Mercy⁵). We expose difficulties with all of these mechanisms. Part III demonstrates that a significant and growing number of individuals who want end-of-life care experience their illness and die in correctional facilities. We offer reflections and raise concerns about the deficiencies in the mechanisms for release into community.

We also review how requests for end-of-life care are met by delivering such care in correctional facilities. First, we review the regulation and provision of palliative care inside correctional facilities. Then, because palliative

¹ For the full description of the study and its methodology, see Adelina Iftene, *Punished for Aging: Vulnerabilities, Rights, and Access to Justice in Canadian Penitentiaries* (Toronto: University of Toronto Press, 2019) at 22–32.

² “Correctional facilities” include prisons and CSC regional hospitals.

³ See *Corrections and Conditional Release Act*, SC 1992, c 20, s 115.

⁴ See *ibid*, s 121.

⁵ See *Criminal Code*, RSC 1985, c C-46, ss 748–748.1.

care cannot relieve the suffering for all patients and not everyone wants or has access to palliative care, we review the regulation and provision of the various other forms of end-of-life care. Specifically, we discuss withholding and withdrawal of potentially life-sustaining care (including potentially life-sustaining treatment as well as oral hydration and nutrition), palliative sedation, and MAiD. We offer reflections and raise concerns about the current state of end-of-life care in Canadian correctional facilities.

In the end, we conclude that there are significant information gaps about the number of people in seeking end-of-life care, and about how CSC is managing the provision of these services both in correctional facilities and in community. The sparse information available is nonetheless sufficient to support the conclusion that there are good reasons to be concerned regarding the manner in which end-of-life care is regulated, provided, recorded, and monitored. Significant reforms are needed.

I. TERMINOLOGY

Terminology in this area is contentious and hotly contested. For example, are palliative care and MAiD distinct or can MAiD be a part of palliative care? Is MAiD a form of end-of-life care (given that one does not need to be at the end of life to be eligible for MAiD in Canada)? Is voluntary stopping eating and drinking a form of suicide or withholding of care? We cannot hope to resolve these terminological debates in this paper. Fortunately, we do not need to do so as none of our arguments turn on the definitions. Therefore, we need only to stipulate definitions for the sake of clarity but we do not need to defend them.

For our purposes, it is sufficient to do two things. First, acknowledge that there is overlap between the categories of end-of-life care that we set out. Second, stipulate definitions of the key terms:

End-of-life care – a) care that is provided to individuals when they are at the end of life or facing life-limiting conditions; and b) care that ends a person’s life.

Palliative care – “an approach that improves the quality of life of patients and their families facing the problem 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.”⁶

Withdrawal of potentially life-sustaining care – ceasing care that has the potential to sustain a person’s life (this includes medical interventions including artificial nutrition and hydration as well as personal care such as providing with food and liquids).

Withholding potentially life-sustaining care – refraining from commencing care that has the potential to sustain a person’s life (this includes medical interventions including artificial nutrition and hydration as well as personal care such as providing with food and liquids).

Palliative sedation – “the intentional administration of sedative medication to reduce a patient’s level of consciousness, with the intent to alleviate suffering at the end of life. It includes both intermittent and continuous sedation, as well as both superficial and deep sedation. It may be accompanied by the withdrawal of artificial hydration and nutrition.”⁷

Medical assistance in dying – “(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their

⁶ “WHO Definition of Palliative Care” (last visited 16 February 2020), online: *World Health Organization* <www.who.int/cancer/palliative/definition/en/> [perma.cc/W2MB-ALJP].

⁷ See *Carter v Canada (AG)*, 2012 BCSC 886 at para 42 [*Carter*].

own death.”⁸

II. CATALYSTS FOR REQUESTS FOR END-OF-LIFE CARE AMONG FEDERALLY INCARCERATED INDIVIDUALS

A. Age

Prison populations are aging. The absolute number of people admitted to prison over the age of 50 has increased over the last decade by 39%,⁹ despite the fact that the overall number of admissions to prison has decreased slightly.¹⁰ The proportion of individuals in Canadian federal correctional institutions aged 50 or older at admission has also increased from 10.1% in 2007–2008 to 16.4% in 2014–2015.¹¹ In 2016–2017, 24.7% of federally incarcerated individuals were aged 50 or over.¹² 46% of federally incarcerated individuals are serving life or indeterminate sentences and thus will continue to age in prison.¹³

This absolute and relative aging of the federal corrections population can be explained by a multitude of factors that include: increased use of “tough on crime” policies that have resulted in more mandatory minimum sentences, longer sentences, more people serving indeterminate sentences

⁸ *Criminal Code*, *supra* note 5, s 241.

⁹ See Public Safety Canada, *Corrections and Conditional Release Statistical Overview, 2017 Annual Report* (Ottawa: Public Safety Canada Portfolio Corrections Statistics Committee, 2018) at 43–44 [Public Safety Canada, *2017 Annual Report*].

¹⁰ See *ibid* at 37.

¹¹ See Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2014-2015* (Ottawa: OCI, 2015) at 11 [Office of the Correctional Investigator, *Annual Report 2015*].

¹² See Public Safety Canada, *2017 Annual Report*, *supra* note 9 at 47.

¹³ See Adelina Iftene, “The Pains of Incarceration: Aging, Rights and Policy in Federal Penitentiaries” (2017) 59:1 *Can J Criminol & Crim* 63 at 68 [Iftene, “Pains of Incarceration”].

under the designation of “dangerous offender”,¹⁴ and tougher criteria for release.¹⁵

It is reasonable to assume that the number of incarcerated people over 50 will remain significant and continue to grow over the coming years. It is particularly important to attend to this phenomenon given that the average age at time of natural death in custody is 60¹⁶ (in contrast to the Canadian average of the general population at 82).¹⁷

B. Prevalence of disease

The leading causes of death are: cancer (36%), cardiovascular-related (29%) and respiratory-related (11%).¹⁸ Individuals in federal prisons have higher disease prevalence than non-incarcerated individuals. There is a higher prevalence of blood-borne diseases (such as hepatitis C and HIV),

¹⁴ If an individual is found guilty of three or more violent offences in his lifetime, he or she can be given the designation of “dangerous offender” upon sentencing and receive an indeterminate sentence. That means that similar to that of those serving life sentence, even if eventually released from prison, they will continue to serve their sentence under supervision in the community, for the rest of their life. Though entitled to apply for parole at regular intervals, many people serving indeterminate sentences serve long periods of time behind bars. See *Criminal Code*, *supra* note 5, ss 752, 761(1); Public Safety Canada, 2017 *Annual Report*, *supra* note 9 at 107.

¹⁵ See e.g. the changes brought about by the passing of the *Safe Streets and Community Act*, SC 2012, c 1 cited in Adelina Ifene & Allan Manson, “Recent Crime Legislation and the Challenge for Prison Health Care” (2013) 185:1 CMAJ 886 at 887. See also *Protecting Canadians by Ending Sentence Discounts for Multiple Murders Act*, SC 2011, c 5, which allows for periods of incarceration without possibility of parole of up to 75 years.

¹⁶ See Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2017-2018* (Ottawa: OCI, 2018) at 28 [Office of the Correctional Investigator, *Annual Report 2018*].

¹⁷ See Statistics Canada, *Archived – Life Expectancy and Other Elements of the Life Table, Canada and Provinces, Table 39-10-0007-01* (Ottawa: Statistics Canada, 2018), online: <www150.statcan.gc.ca> [perma.cc/U3JF-LE5P].

¹⁸ See Correctional Service Canada, *Annual Report on Deaths in Custody 2015/2016* (Ottawa: CSC 2017), Table 6 [Correctional Service Canada, *Annual Report 2017*].

cardiovascular disease, diabetes, asthma, and other respiratory diseases in incarcerated populations than in community populations.¹⁹

Among non-incarcerated populations, the most common underlying medical condition for individuals referred for palliative care is cancer (70–80%).²⁰ The most common underlying medical circumstances for individuals who received MAiD between 1 January and 31 October 2018 were cancer (64%), neuro-degenerative (11%), circulatory/respiratory system (16%), and other/unknown (9%).²¹

Given this data, it is reasonable to assume that requests for palliative care and MAiD will be made by some federally incarcerated individuals.

C. Mortality

Approximately 66% of all deaths in custody are “natural deaths” (defined in contrast to “non-natural deaths”, which include suicide, homicide, accident, overdose, staff intervention, and deaths from undetermined causes).²² In its latest report, the OCI noted that in 2017–2018 there were 39 natural deaths in custody (accounting for 71% of all deaths).²³

Of course, some of the natural deaths would not have been candidates for end-of-life care as, “36% of the natural cause deaths were deemed ‘unexpected’ – the result of sudden cardiac arrest, complications arising from

¹⁹ See Fiona Kouyoumdjian et al, “Health Status of Prisoners in Canada: Narrative Review” (2016) 62:3 *Can Fam Physician* 215 at 217–18.

²⁰ See Graeme Rocker, James Downar & R Sean Morrison, “Palliative Care for Chronic Illness: Driving Change” (2016) 188:17–18 *CMAJ* E493 at E493.

²¹ See Health Canada, “Fourth Interim Report on Medical Assistance in Dying” (2019) at 6, online (pdf): <www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019.html> [perma.cc/L9H3-ELE9].

²² See Correctional Service Canada, *Annual Report 2017*, *supra* note 18 at 5–6 (“death in custody” is defined as a death occurring in a federal correctional facility).

²³ See Office of the Correctional Investigator, *Annual Report 2018*, *supra* note 16 at 27.

medical procedures, or rapid disease progression.”²⁴ It is not clear what percentage of this 36% were so sudden as to render end-of-life care (e.g., withdrawal of potentially life-sustaining treatment) irrelevant. In addition, some of the non-natural deaths (accident, suicide, etc.) would have been candidates for end-of-life care as these are not all immediate deaths. Manner of death is determined by reference to whatever initiated the chain of events ending in death so considerable time can pass between the non-natural initiation (e.g. accident) and death – leaving the potential for requests for end-of-life care.

D. Summary

Based on these statistics about age, prevalence of disease, and mortality in prisons, it is reasonable to conclude that a significant and growing number of incarcerated individuals may desire end-of-life care. They may want these services in the community or, if that is not possible, within correctional facilities. We consider each in turn.

III. ACCESS TO END-OF-LIFE CARE IN COMMUNITY

The *Corrections and Conditional Release Act*²⁵ (CCRA) and the *Criminal Code*²⁶ have been interpreted by the OCI as establishing that CSC has a responsibility to seek alternatives to incarceration for “a palliative or terminally ill individual.”²⁷ This OCI statutory interpretation has not been rejected or disputed by CSC. With this responsibility in mind, we now explore how federally incarcerated individuals can be released into community for care and how well the systems for release are working for individuals who

²⁴ Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 21.

²⁵ *Supra* note 3, s 121.

²⁶ *Supra* note 5, ss 748–748.1.

²⁷ Correctional Investigator of Canada, *An Investigation of the Correctional Service’s Mortality Review Process*, by the Office of the Correctional Investigator (Ottawa: CIC, 18 December 2013) at 7 [Office of the Correctional Investigator, *Mortality Review Process*].

want end-of-life care in community.

A. In theory

In theory, there are three potential pathways to receive care in community rather than in prison for individuals who are not eligible for regular parole: temporary absence, parole by exception, and the Royal Prerogative of Mercy. We consider each in turn.

1. Temporary absence

Under the Commissioner's Directive 710-3 (in turn under the authority of the *CCRA*²⁸, the *Corrections and Conditional Release Regulations*²⁹, and the *Criminal Code*³⁰), "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..."³¹ They can, in theory, be for an unlimited time. There are two types of temporary absences: escorted and unescorted. All incarcerated individuals are eligible for *escorted* temporary absences for medical purposes no matter the length of their sentence or how much time they have served. Subject to two exceptions,³² incarcerated individuals are eligible for *unescorted* absences for medical purposes when they have served a sufficient portion of their

²⁸ *Supra* note 3, ss 17, 115.

²⁹ SOR/92-620, ss 9, 155 [*Corrections Regulations*].

³⁰ *Supra* note 5, s 746.1(2).

³¹ Correctional Service Canada, "Temporary Absences" (1 June 2016), Commissioner's Directive No 710-3, s 6 (Ottawa: CSC, 1 June 2016) [*Commissioner's Directive 710-3*].

³² See *ibid*, s 9. The exceptions identified in *Commissioner's Directive 710-3*, *supra* note 31 are, a) cases in which indeterminate sentences are imposed for offences that occurred prior to 1 August 1997; b) cases in which life and indeterminate sentences are followed by determinate sentences. *An individual falling within one of these categories is not eligible for an unescorted absence.*

sentence.³³ The criteria for temporary absences are the following:

- 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.³⁴

The assessment of an application for a temporary absence includes the following steps:

- a. review the application against the objectives of the Correctional Plan
- b. interview the inmate to 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 and the need for the imposition of conditions pursuant to subsection 17(2) of the *CCRA*, in the case of an ETA, or subsection 161(2) of the *CCRR*, in the case of a UTA, in order to manage the risk
- d. request, if applicable, a Community Assessment or a Community Strategy. In cases of UTAs of more than 72 hours, a Community

³³ See *Commissioner's Directive 710-3*, *supra* note 31, s 8. A "sufficient portion of the sentence" means, "a) in the case of a life sentence, other than a person who was under the age of eighteen at the time of commission of the offence of murder, the portion of the sentence to be served to reach the inmate's full parole eligibility date less three years; b) in the case of a sentence of incarceration for an indeterminate period, the portion of the sentence to be served to reach the inmate's full parole eligibility date less three years; c) in all other cases, one-half of the period required to be served before the inmate's full parole eligibility date, or six months, whichever is the greater."

³⁴ *Ibid*, s 21.

Strategy must be requested.

- e. review victim information as well as any victim statement(s) provided pursuant to subsection 133(3.1) of the *CCRA*.³⁵

A maximum of 30–60 days is allowed for the parole or correctional officer who receives the request for temporary absence to complete an “assessment for decision.” Then up to ten days is allowed for the “institutional head decision,” and an unspecified length of time for review and appeal. Thus, a decision on a request for a temporary absence could be made quickly or it could take up to 70 days and more if there is an appeal.³⁶

The feasibility of temporary absences hinges on the costs (especially costs associated with the need for an escort) as well as the willingness and ability of CSC to secure health care services and a bed in the community. As sole providers, CSC is responsible for the health care of federally incarcerated individuals, no matter where that care is being delivered. As a practical matter, therefore, the possibility and length of any kind of medical temporary absence will depend in part on whether CSC can and will make arrangements for health care provision in the community. Unsurprisingly, temporary absences may be impossible or unlikely for CSC to grant due to the unavailability of health care services and beds. In addition, escorts can be prohibitively expensive. Individuals seeking end-of-life care however, are likely to be physically weak, require assistance with daily activities and

³⁵ *Ibid*, s 22. It is important to note here that the potential impact of the release of the incarcerated individual on the victim is not a factor considered in the determination of whether the individual should be released. Rather, the *CCRA* simply establishes the authority to impose conditions on the release that are considered reasonable and necessary to protect the victim. We do not, in this article, engage in the debate about whether the impact on the victim should have any role in the decision whether to release an individual for the purpose of accessing end-of-life care. That would require a lengthy exploration of a controversial issue of general application – an important issue which is outside the scope of this article.

³⁶ See *ibid*. See Adelina Iftene, “The Case for a New Compassionate Release Provision” (2017) 54:4 Alb L Rev 929 [Iftene, “Case for a New Compassionate Release Provision”] (However, as of 2017, “the Federal Court has only heard two judicial reviews of negative PBC decisions. Neither were based on a request for release due to medical issues, but were rather grounded in section 121(d): release while awaiting deportation” at 936. Thus appeals of parole board decisions are rare).

therefore less likely to require an escort to keep them from escaping.

2. Parole by exception

Parole is a process through which service of a sentence is shifted from prison to community. In Canada there is no sentence without possibility of parole. All offenders will eventually become eligible to apply for parole. However, obtaining parole is not guaranteed even where an individual is eligible. Indeed, some offenders spend most or all of their sentence in prison.

If an offender is serving a determinate sentence (i.e., not a life sentence), they are *eligible to apply* for parole after serving one-third of their sentence.³⁷ Barring exceptional circumstances they are *entitled to “statutory release”* after serving two-thirds of their sentence. Incarcerated individuals can nonetheless be denied statutory release because it has been established that they are “likely to commit, before the expiry of his/her sentence, an offence causing death or serious harm, a serious drug offence or a sex offence involving a child”³⁸ and be required to serve their entire sentence or die in custody. If an offender is serving an indeterminate sentence³⁹ or some form of life sentence,⁴⁰ they are *eligible to apply* for parole after serving seven years. If they are serving a life sentence for second or third degree murder, they can apply for parole after 10–25 years for second degree murder⁴¹ and 25 years for first degree murder.⁴² There is no statutory release for life sentences. An incarcerated individual is eligible to apply for day parole six months before his or her full parole eligibility date.⁴³ Day parole is a pre-

³⁷ See *Corrections and Conditional Release Act*, *supra* note 3, s 120(1).

³⁸ *Ibid*, *supra* note 3, s 129(2).

³⁹ See *Criminal Code*, *supra* note 5, s 761(1).

⁴⁰ See *Corrections and Conditional Release Act*, *supra* note 3, s 120(2).

⁴¹ See *Criminal Code*, *supra* note 5, s 745(c).

⁴² See *ibid*, s 745(a).

⁴³ See *Corrections and Conditional Release Act*, *supra* note 3, s 119(c).

condition of full parole.

The overarching principles of parole are set out in section 102 of the *CCRA*:

- a. the offender will not, by reoffending, present an undue risk to society before the expiration according to law of the sentence the offender is serving; and
- b. the release of the offender will contribute to the protection of society by facilitating the reintegration of the offender into society as a law-abiding citizen.⁴⁴

The main eligibility criteria for both day parole (when the individual may go into community during certain day hours and return to prison in the evening) and full parole (where the individual lives fully in the community, under supervision) are set out in the *CCRA* and the *Criminal Code*.

Once the eligibility criteria are met, the individual may apply to the Parole Board of Canada (PBC) for early release. The criteria that the PBC will consider before making their decision are fleshed out in the Decision-Making Policy Manual for Board Members (“Policy Manual”) under As-

⁴⁴ *Ibid*, s 102.

assessment for Pre-Release Decisions under the following categories:⁴⁵

- Actuarial measures of the risk to re-offend;
- Criminal, social and conditional release history;
- Factors affecting self-control;
- Responsivity to programming and interventions;
- Institutional and community behaviour;
- Offender change;
- Release plan and community supervision strategies.

Often, incarcerated individuals are not released when they become eligible to apply for parole. In 2016–2017, 64.4% of all releases from federal prisons were statutory releases (almost 60% for non-Indigenous people and 78% for Indigenous people).⁴⁶ The average time served before early release was 45.3% of the sentence for non-Indigenous people and 49% for Indigenous people.⁴⁷ Finally, in 2016–2017, 131 individuals were serving their entire sentence in prison under detention.⁴⁸ These numbers do not account for the individuals serving a life sentence who may wait decades before early release or who die in custody.

Under section 121 of the *CCRA*,⁴⁹ some federally incarcerated individuals are eligible to apply for parole before they reach their parole application and statutory release eligibility dates mentioned above, through what is commonly known as “parole by exception” (shifting service of the sentence

⁴⁵ See Parole Board of Canada, “Decision-Making Policy Manual for Board Members”, 2nd ed (Ottawa: PBC, 2019), s 2.1, online: <www.canada.ca/en/parole-board/corporate/publications-and-forms/decision-making-policy-manual-for-board-members.html> [perma.cc/R36J-FXGU] [Parole Board of Canada, “Policy Manual”].

⁴⁶ See Public Safety Canada, *2017 Annual Report*, *supra* note 9 at 79.

⁴⁷ See *ibid* at 89–92.

⁴⁸ See *ibid* at 104.

⁴⁹ See *Corrections and Conditional Release Act*, *supra* note 3, s 121.

from prison to the community in exceptional circumstances). This eligibility extends to an individual:

- a. Who is terminally ill;⁵⁰
- 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 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.⁵¹

It must be noted that sections 121(b)–(d) do not apply to individuals:

- a. serving a life sentence imposed as a minimum punishment or commuted from a sentence of death; or
- b. serving, in a penitentiary, a sentence for an indeterminate period.⁵²

Therefore, individuals serving life or indeterminate sentences are eligible to apply for parole by exception only if they are terminally ill.⁵³ Such individuals can only apply for temporary absence as explained above or for an exercise of the Royal Prerogative of Mercy as explained below.

It should be noted here that incarcerated individuals seeking release into community for end-of-life care will be eligible to be considered for parole

⁵⁰ “Terminally ill” is not defined in legislation or policy documents. See Parole Board of Canada, “Policy Manual”, *supra* note 45 (“a prognosis as to the length of time an offender has left to live is not required” at Policy 4.3 at 2). See e.g. *R v Woods*, 2003 BCCA 539 at paras 1, 11. See also *R v Fleming*, [2001] 203 Nfld & PEIR 309 at 52, 610 APR 309. In practice, however, based on the materials sent by the PBC in response to an Access to Information Request and how the PBC has dealt with applicants under s 121, it can be concluded that the PBC is taking “terminal illness” to mean death is expected within 6 months.

⁵¹ *Corrections and Conditional Release Act*, *supra* note 3, s 121(1) a–c.

⁵² *Ibid*, s 121(2).

⁵³ See *ibid*.

by exception because of their health conditions – sometimes (a) but often (b) and (c) in the eligibility list above. Whether they will be granted parole however, will depend on the same criteria for granting parole as set out in the Policy Manual.⁵⁴ These criteria appear to have little to do with the health conditions of the individual. There is therefore, at least on paper, the potential for an individual to be denied release into the community to receive palliative care on the grounds that, for example, he was considered non-responsive to programming because he did not complete elements of his correctional plan. In other words, an incarcerated individual who is eligible to apply for parole by exception because of ill health could be denied parole because of factors entirely unrelated to health. In addition, individuals who seek parole by exception are often very sick, and they may have been so for many months or years prior. Thus, sometimes it may be physically impossible for these individuals to fulfill the regular requirements for parole (e.g., taking a program or making a plan for release); in such situations incarcerated individuals are denied parole for reasons that are directly a result of the very poor health that leads them to apply for this exceptional form of release in the first place.

Finally, neither the legislation nor the Policy Manual provides for an expedited process for parole by exception and both are silent regarding any timelines specific to this form of release. Absent any other guidance, the parole-by-exception process is subject to the same timelines as regular parole: the legislation provides that the PBC should review a regular parole application within six months of receiving it. This period can be extended for an additional two months where the Board deems necessary.⁵⁵

3. Royal Prerogative of Mercy

Under section 748 of the *Criminal Code*, individuals (even those serving life sentences and even if not terminally ill) may have their sentences commuted. They may spend the remainder of their sentences under supervision in the community through the Royal Prerogative of Mercy.⁵⁶ The Royal Prerogative of Mercy is intended to respond to only “very exceptional

⁵⁴ See Parole Board of Canada, “Policy Manual”, *supra* note 45.

⁵⁵ See *Corrections Regulations*, *supra* note 29, s 158.

⁵⁶ See *Criminal Code*, *supra* note 5, s 748.

and truly deserving of cases.”⁵⁷ A number of principles have been set out to guide the exercise of the prerogative. The PBC identified the following principles, among others:

[U]ndue hardship, which includes suffering of a mental, physical and/or financial nature, must be out of proportion to the nature and the seriousness of the offense and the resulting consequences, and must be more severe than for other individuals in similar situations.

In general terms, the notions of injustice and hardship imply that the suffering which is being experienced could not be foreseen at the time the sentence was imposed. In addition, there must be clear evidence that the injustice and/or the hardship exceed the normal consequences of a conviction and sentence.⁵⁸

And lastly,

CSC is responsible for the care and custody of inmates as stipulated in section 5(a) of the *CCRA* and that responsibility includes caring for the medical problems of all offenders, irrespective of their seriousness. Whereas illness or deteriorating health may cause hardship, it does not, in itself, constitute a sufficient reason to grant a conditional pardon in advance of eligibility for conditional release under the *CCRA*. For this exceptional measure to be invoked, serious medical problems would be considered as one of many factors.⁵⁹

The Royal Prerogative of Mercy is only available when all other potential mechanisms (i.e., parole by exception, temporary absences etc.) for release have been unsuccessfully exhausted. Therefore, the process for release based on a Royal Prerogative is particularly lengthy. Moreover, the Royal Prerogative is a fully discretionary mechanism and there are no timelines

⁵⁷ Parole Board of Canada, *Royal Prerogative of Mercy Ministerial Guidelines*, (Ottawa: PBC, 2014) at 3.

⁵⁸ *Ibid* at 3.

⁵⁹ *Ibid* at 6.

within which such decisions must be made.

B. In practice

Very few federally incarcerated individuals are released through parole by exception or an exercise of the Royal Prerogative of Mercy, and only a minority of natural deaths occur through temporary absences spent in community hospitals.⁶⁰

1. Temporary absence

The most common mechanism for receiving end-of-life care in community appears to be temporary absence. The OCI's Annual Report 2015 revealed that, "nearly 60 [of 94 reviewed in lookback] of the natural cause deaths involved individuals who were receiving palliative care (including end-of-life) services. Of those palliative cases, 60% died in a CSC regional hospital, 31% died in a community hospital, and 9% succumbed in a CSC institution."⁶¹ One can deduce from the data that 25% of the natural death cases in which individuals were receiving palliative care involved temporary absences and 6% involved parole by exception.⁶²

There is no data available about how long these individuals were in the regional or community hospitals (i.e., whether were they transferred there to

⁶⁰ See Iftene, "Case for a New Compassionate Release Provision", *supra* note 36 at 936. See also Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2013–2014*, (Ottawa: OCI, 2014) at 31.

⁶¹ Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 21; see also Correctional Service Canada, *Annual Report 2017*, *supra* note 18 at 5 (this data is given under the heading "Natural Cause Deaths in Custody" yet CSC defined "death in custody" as a death occurring in a federal correctional facility and community hospitals are not correctional facilities. We are therefore assuming that these statistics refer to federally incarcerated individuals still in custody as well as those given parole by exception for health reasons).

⁶² Nineteen (31%) of the natural deaths receiving palliative care happened in community hospital. Four of the 60 (6%) were granted parole by exception while 15 (25%) were by temporary absence.

receive care over an extended period of time or, more likely, transferred for their final hours or days). Nor is there data available about where the non-palliative natural death cases died.

2. Parole by exception

CSC has reported that between 2005–2015, 350 people died of natural causes while in custody and most of these were expected deaths.⁶³ During a similar period of time (2007–2017) there were only 28 requests for parole by exception.

21 of the 28 requests for parole by exception were granted during this period.⁶⁴ All of the requests were based on serious medical conditions: brain injury, cancer, end-stage liver failure, Amyotrophic Lateral Sclerosis, mental health, and some unspecified terminal illnesses. The requests granted were for individuals with a terminal condition except in two situations in which the PBC determined that the condition was not terminal but continued incarceration would amount to excessive hardship. The requests denied included a case of end-stage liver failure with a poor prognosis requiring palliative care, a terminal illness diagnosis with a prognosis of weeks to months, a case of stage four cancer with a prognosis of weeks to a few months, and a case of severe mental illness with suicidal ideation.⁶⁵

CSC reports reveal a similarly low rate of parole by exception for individuals who ultimately die a natural or expected death. For example, the OCI's Annual Report 2015 noted that:

Parole by Exception (compassionate release) provisions of the Corrections and Conditional Release Act were explored in 36 of 55 of the palliative care cases. Of those, 14 applications were made to the Parole Board of Canada for review; only 4 were granted. In 19 of 55 palliative care cases, the rapid course of illness did not allow sufficient time to explore alternatives to incarceration. Five inmates refused to submit an

⁶³ Correctional Service Canada, *Annual Report 2017*, *supra* note 18 at 6.

⁶⁴ See Parole Board of Canada, *Parole by Exception 2007-2017*, document obtained through an Access to Information Request A-2017-000021, February 2018 [Parole Board of Canada, "Parole by Exception"].

⁶⁵ See *ibid.*

exception request; for some their wish was to remain at a CSC facility to receive end-of-life care.⁶⁶

3. Royal Prerogative of Mercy

Reviewing data back to 2005, we found evidence of 49 requests for the Royal Prerogative of Mercy (although it is unclear whether this number includes only illness-based requests). None of these requests were granted.⁶⁷ We could not find a single instance of the Royal Prerogative of Mercy being exercised to enable a federally incarcerated individual to receive end-of-life care in the community.

C. Reflections and concerns

Given CSC's responsibility to consider alternatives to incarceration for "palliative or terminally ill offenders,"⁶⁸ to support these individuals as they apply for release on the grounds of poor health, and to ensure their safe transition to community or to community institutions,⁶⁹ one might reasonably ask why so few federally incarcerated individuals receive their palliative care and die outside the prison context.

There is no evidence to enable us to meaningfully answer this question in relation to denials of the Royal Prerogative of Mercy. We know that in the two cases for which we found reasons for denial, the individuals were considered too high risk to be released into community.⁷⁰ We do not know whether either of these cases involved requests based on health condition. We do not know how many of the complete set of requests for the exercise

⁶⁶ Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 22.

⁶⁷ See Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 5. See also Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2015-2016*, (Ottawa: OCI, 2016) at 12.

⁶⁸ Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 23.

⁶⁹ See *ibid* at 31–34.

⁷⁰ See *ibid* at 5.

of the Royal Prerogative were based on illness. Nor do we know the reasons for denial for the vast majority of the requests. However, the Royal Prerogative of Mercy can only be requested after all other avenues for release have been exhausted and it can take significant amounts of time for those avenues to be exhausted and then even longer for a request for the exercise of the prerogative to be considered. Therefore, it may be that individuals simply die before they are able to make such requests or to have them considered. Furthermore, some evidence suggests that a lack of awareness among potentially eligible individuals may be a significant reason for the existence of so few cases of the Royal Prerogative of Mercy in the health care context. In a recent study of 197 individuals over the age of 50 who presented various rates of chronic, acute, and terminal illnesses, none of the participants were aware that they could apply for the Royal Prerogative of Mercy.⁷¹

One could speculate that concerns about the cost of security escorts and lack of availability of health care services and beds in community hospitals play a part in the low rates of use of the mechanism of temporary absences. One could also speculate that any lack of access to health care services and beds in community hospitals may be due to an unwillingness on the part of health care providers and institutions to take care of individuals in federal custody. Furthermore, the length of time it can take to get a decision on an application for a temporary absence may also play a part in the low rates (at least for those individuals who are relatively near to death). However, there is no evidence to justify offering anything more than speculation.⁷² Much more evidence is needed about the use of temporary absences as a means of accessing end-of-life care in the community.

There is some evidence to suggest that at least five kinds of deficiencies in the parole by exception rules and practices at least partly explain the low numbers of federally incarcerated individuals accessing end-of-life care in

⁷¹ See Iftene, “Case for a New Compassionate Release Provision”, *supra* note 36 at 936.

⁷² While a comparative analysis is beyond the purpose of this paper, it is worth noting that there is some limited information from other jurisdictions about challenges in releasing sick individuals due to public perception and difficulties securing a hospital bed. See e.g. John F Linder & Frederick J Meyers, “Palliative Care for Prison Inmates ‘Don’t Let Me Die in Prison’” (2007) 298:8 JAMA 894; Brie William & Rita Abraldes, “Growing Older: Challenges of Prison and Re-Entry for the Aging Population,” in Robert B Greifinger, ed, *Public Health Behind Bars* (New York: Springer, 2007) 56.

community via parole by exception.

First, as demonstrated in the study mentioned above, there is a lack of awareness regarding the option of applying for a Royal Prerogative.⁷³ Second, section 121 is very restrictive. As explained above, individuals who are serving life sentences are not eligible under this section unless they are “terminally ill.”⁷⁴

Third, an individual cannot apply for parole by exception without CSC’s support. The parole officer must initiate the pre-release.⁷⁵ As noted by the Office of the Correctional Investigator (OCI), many potentially meritorious requests are not brought before parole boards because caseworkers are unwilling or unable to go through the necessary administrative steps.⁷⁶ Often, even when the caseworker supports the application, the process is lengthy and bureaucratic, and the applicant dies before their case is heard. As noted above, the OCI Annual Report 2014–2015 reports that “[i]n 19 of 55 palliative cases, the rapid course of illness did not allow sufficient time to explore alternatives to incarceration.”⁷⁷ It is not clear whether this is because the process of exploring alternatives took so long or the course of the illness was truly precipitous.

Fourth, to be successful in a request for consideration for parole by exception, “substantive medical evidence” is required from the prison doctor showing that the individual’s health is likely to suffer serious damage if the person continues to be incarcerated or that continued incarceration would constitute excessive hardship in the person’s circumstances.⁷⁸ It is possible

⁷³ See *ibid.*

⁷⁴ *Corrections and Conditional Release Act*, *supra* note 3, s 121(2).

⁷⁵ See *ibid.*, ss 55–60 (this means that the parole officer will have to assess the best alternatives to incarceration. It is the parole officer who has to collect the paperwork including the risk assessments, psychological assessments and medical documentation. They must write their own assessment of the individual, compile recommendations for community options, contact family members and victim, etc.).

⁷⁶ See Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 24.

⁷⁷ *Ibid* at 22.

⁷⁸ Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 23.

that prison doctors are wary of supporting section 121 applications⁷⁹ due to the potential for professional liability.⁸⁰ Moreover, the requests granted by the PBC seem to be mostly grounded in section 121(1)(a) terminal illness.⁸¹ This is unsurprising as terms like “undue hardship” and “health likely to suffer serious damage” are vague and there is no guidance on how CSC and PBC are to interpret them, or what concrete evidence would be sufficient to prove the individual meets these requirements. This lack of precision may contribute to the bureaucratic challenges faced by those seeking timely release and undermine section 121 as a meaningful avenue for release.

Fifth, as noted above, once an individual has met the threshold for consideration for parole by exception under section 121, the criteria used by the PBC to make their decisions seem unrelated to health. Rather, Commissioner’s Directive No 712-1 states that the PBC is to review all the documents they would review for regular parole.⁸² The factors reviewed for regular parole include the amount of time served in prison, type of conviction, completion of correctional programs, attitude during incarceration, availability of a release plan, employment and housing for when released, and psychological and risk assessments.⁸³ These factors are exceedingly problematic in the context of release for grievous illness. This concern can be illustrated through a review of the available data on parole by exception cases from 2007–2017.⁸⁴ It is clear that, as one would expect, given the factors the considered by PBC, that the regular parole factors (as opposed to health concerns) are determinative in the cases considered under section 121. In

⁷⁹ See Parole Board of Canada, “Parole by Exception”, *supra* note 64.

⁸⁰ See Iftene, “Case for a New Compassionate Release Provision”, *supra* note 36 at 937; Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2010–2011* (Ottawa: OCI, 2011) at 34.

⁸¹ See Parole Board of Canada, “Parole by Exception”, *supra* note 64.

⁸² Correctional Service Canada, *Pre-Release Decision Making*, Commissioner’s Directive No 712-1 (Ottawa: CSC, 7 December 2015) at para 56.

⁸³ See Kelly Hannah-Moffatt & Caroline Yule, “Gaining Insight, Changing Attitudes and Managing ‘Risk’: Parole Release Decisions for Women Convicted of Violent Crimes” (2011) 13:2 Punishm Soc 149 at 157–59. See also Parole Board of Canada, “Policy Manual”, *supra* note 45, ss 8–13; Renee Gobeil & Ralph Serin, “Preliminary Evidence of Adaptive Decision-Making Techniques Used by Parole Board Members” (2009) 8:2 Intl J Forensic Ment Health 97 at 100–01.

⁸⁴ See Parole Board of Canada, “Parole by Exception”, *supra* note 64.

at least four of the seven rejected requests, there was evidence of terminal or significant illness that could have justified the conclusion that continued confinement would constitute excessive hardship. However, the reasons listed for rejection by the PBC were related to the incarcerated individual's risk assessment, including, not having a viable release plan, not participating in programming to reduce risk while incarcerated, and the nature and severity of the offence.⁸⁵

While safety is certainly a reasonable criterion to consider in granting or denying parole, in the context of grievous illness, reintegration and rehabilitation seem distantly related to the merits of releasing an incarcerated individual into the community for end-of-life care. Furthermore, it is unreasonable to base decisions on factors such as 'program attendance' where the individual did not attend the programs due to the length of the waitlists for the programs or the fact that their illness prevented them from doing so.

The low numbers of individuals receiving health care in community through parole by exception may be explained by the fact that many individuals who are sick enough to qualify may also be too sick to push forward an application.

In sum, when a federally incarcerated individual becomes terminally ill, or continued confinement would constitute excessive hardship, or their health is likely to further deteriorate due to incarceration,⁸⁶ CSC has a responsibility to explore options for transfers to community. However, the three mechanisms that would allow for such transfers appear to be of limited use where the individuals desire treatment and to ultimately die in the community.

As has been demonstrated, a significant number of individuals are likely to spend the course of their illness in federal prison, and they will want end-of-life care. Therefore, we turn now to a consideration of end-of-life care

⁸⁵ See *ibid.*

⁸⁶ See *Corrections and Conditional Release Act*, *supra* note 3, s 121(1).

provided within Canadian correctional facilities.

IV. ACCESS TO END-OF-LIFE CARE IN FEDERAL CORRECTIONAL FACILITIES

A. Palliative care

1. In theory

CSC provides health care services for federally incarcerated individuals. It does so in its prisons, its own regional hospitals, and community facilities. Provincial and territorial health ministries are not involved in federal correctional health care, and federal facilities do not fall under the same accreditation process as community facilities.⁸⁷

The standards that CSC must meet in the implementation of health care services come from a variety of sources. First, CSC has a duty under international standards and national statutes to provide incarcerated individuals with health services comparable to those in the community. For instance, Canada is signatory to the *UN Basic Principles for Treatment of Prisoners*⁸⁸ and the *Mandela Rules*,⁸⁹ both of which require that prisoners (sic) have access to the same health care services as those available in the community.

Second, in addition to its international and statutory obligations, CSC is bound by a legal duty of care owed to those in its custody.⁹⁰ This duty of

⁸⁷ See Daniel Antonowicz & John Winterdyk, “A Review of Deaths in Custody in Three Canadian Provinces” (2014) 56:1 Can J Criminol & Crim 85 at 89.

⁸⁸ *Basic Principles for the Treatment of Prisoners*, GA Res 45/111, UNGAOR (1990) at Principle 9.

⁸⁹ *The United Nations Standard 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 24–35.

⁹⁰ See *Criminal Code*, *supra* note 5, s 197(1)-(i); Adelina Iftene, Lynne Hanson & Allan Manson, “Tort Claims and Canadian Prisoners” (2014) 39:2 Queen’s LJ 655 at 670–75; *Levasseur v Canada*, 2004 FC 976 at paras 70–71; *Lipcsei v Central Saanich (District of)* (1994), 8 BCLR (3d) 325 (BCSC), [1995] 7 WWR 582 at para 16; *Steele v Ontario*, [1993] OJ No 2010 (ONCJ) at 8, 42

care dictates that the services available to incarcerated individuals must be adequate at all times, regardless of comparable community services.⁹¹

Third, the *CCRA* and *CCRR* govern health matters for federally incarcerated individuals. Section 86 of the *CCRA* states that an individual must have access to essential health care and reasonable access to non-essential health care, both of which are to be provided at “professionally accepted standards.”⁹² The legislation does not establish what constitutes “essential” versus “non-essential health care” or what the standards are or how they should be achieved. It is also notable that the language does not emulate the standards identified in international instruments.

In sum, CSC must match at least that which is available in community. When the “professionally accepted standards” are higher than that, CSC needs to meet those standards. Further, the level required by the independent duty of care must be met even if it is a higher level of services than available in the community or according to professionally accepted standards.

The health care standards CSC has set for itself cover the following areas relevant to this paper: the process of requesting and providing health care,⁹³ managing refusal to consent and involuntary treatment,⁹⁴ and responding to medical emergencies.⁹⁵ The standards specific to palliative care are found in the 2009 document *Hospice Palliative Care Guidelines for Correctional*

ACWS (3d) 562; *Sutherland v R*, 2003 FC 1516 at para 65; *Swayze v Dafoe*, [2002] OJ No 3681 (ONCJ) at para 47, 116 ACWS (3d) 781.

⁹¹ See Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 17.

⁹² See *Corrections and Conditional Release Act*, *supra* note 3, s 86.

⁹³ See Correctional Service Canada, *Health Services*, Commissioner’s Directive No 800 (Ottawa: CSC, 27 April 2015) at para 3, online: <www.csc-scc.gc.ca/politiques-et-lois/800-cd-eng.shtml> [perma.cc/6GZE-EM98].

⁹⁴ See Correctional Service Canada, *Consent to Health Care Assessments, Treatment and Release of Information*, Guideline 800-3 (Ottawa: CSC, 27 April 2015) at paras 4–6, 10, online: <www.csc-scc.gc.ca/acts-and-regulations/800-3-gl-eng.shtml> [perma.cc/LR4W-FZXU] [Correctional Service Canada, “Guideline 800-3”].

⁹⁵ See Correctional Service Canada, *Response to Medical Emergencies*, Guideline 800-4 (Ottawa: CSC, 30 January 2017), online: <www.csc-scc.gc.ca/politiques-et-lois/800-4-gl-eng.shtml> [perma.cc/PK6Y-CRRW].

Service Canada.⁹⁶ The policy documents regulating the provision of health care are vague and frequently lack definitions for key terms (e.g., terminal illness). The guidelines for palliative care are also relatively inaccessible – they are available only through an Access to Information request.

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.”⁹⁷ 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.⁹⁸ However, given the pervasiveness of permissive rather than prescriptive language throughout the document, it has been argued that the guidelines are essentially discretionary.⁹⁹

2. In practice

In response to an Access to Information request filed with CSC in regard to the availability and duration of palliative care, we received the following response: “We can tell you that CSC has processes in place to respond to end-of-life health care needs of offenders. Palliative care within CSC aims to assist older/ palliative offenders in living their remaining time in comfort.”¹⁰⁰

⁹⁶ See Correctional Service Canada, *Hospice Palliative Care Guidelines for Correctional Service Canada* (Ottawa: CSC, 2009). It is worth noting here that, unlike the other CSC policy documents relating to health care, this one is only available through an *Access to Information Act* request. It is unknown why this is the case.

⁹⁷ *Ibid* at 17–19.

⁹⁸ See *ibid* at 5.

⁹⁹ We are grateful to one of the anonymous reviewers for this insight.

¹⁰⁰ Letter from Stephanie Brisson, Acting Director of Access to Information & Privacy Division, Correctional Service Canada, to Dr Adelina Iftene, Schulich School of Law, Dalhousie University (12 July 2018), responding to a request under the *Access to Information Act*, RSC 1985, c A-1. It is worth noting here that CSC seems to assume that palliative care is only for end of life, yet it is well-established that patients can benefit from palliative care for months and even years.

We were also told that more information could not be shared due to privacy concerns.¹⁰¹ We therefore turned to independent research that has been conducted on health care in prisons generally and evidence from CSC data on deaths in custody and attempted to draw some inferences and conclusions from those sources about palliative care in correctional facilities.

a. Health care

Research conducted on health care in prisons provides evidence about the delivery of health care that, while not specific to palliative care, has obvious significant implications for the same. For example, the lack of sufficient medical professionals across institutions leads to long wait times to see physicians, even for urgent matters.¹⁰² Most institutions do not have a nurse on site at all times.¹⁰³ Interruptions to medication provision have been regularly noted.¹⁰⁴ Issues relating to the availability and administration of medication are particularly relevant to palliative care.

There appears to be serious issues with respect to the availability of appropriate medications, especially in relation to the management of pain, which is of clear significance in the context of palliative care. The autonomy of physicians to prescribe a course of treatment appears to be restricted due to what the OCI has characterized as “ill-defined security, administrative, or operational concerns.”¹⁰⁵ The CSC National Drug Formulary¹⁰⁶ provides only a limited set of options for the management of chronic pain, and the options that are available are not always the most efficacious form of treatment.¹⁰⁷ Requests from physicians for drugs that are not on the formulary

¹⁰¹ See *ibid.*

¹⁰² See Correctional Service Canada, Document A 2017-0302 (Ottawa: CSC, 2018) obtained through an *Access to Information Act* request [Document A].

¹⁰³ See Iftene, “Pains of Incarceration”, *supra* note 13 at 73.

¹⁰⁴ See Kouyoumdjian, *supra* note 19 at 219; Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 8.

¹⁰⁵ Office of the Correctional Investigator, *Annual Report 2015*, *supra* note 11 at 9.

¹⁰⁶ See Correctional Service Canada, *National Drug Formulary* (Ottawa: CSC, 2016) obtained through an *Access to Information Act* request.

¹⁰⁷ See Canada, Office of the Correctional Investigator, *National Drug Formulary Investigation Summary of Findings and Recommendations* (Ottawa: OCI,

are denied so often that physicians often stop prescribing anything other than what the formulary permits.¹⁰⁸ Tylenol 3 is often the only prescription medication available.¹⁰⁹ Morphine is only available in some institutions and, even then, only sometimes.¹¹⁰ One study reported that, of 197 people, 62% reported significant and constant pain.¹¹¹ While most study participants were receiving prescription medication, only 25% (50) of them reported that the pain was managed satisfactorily.¹¹²

Prison rules that govern the administration of medications can also have a negative impact on the management of pain. For example, in all prisons where direct observation therapy is applied medication intake is supervised for security reasons.¹¹³ Certain classes or dosages of medication simply cannot be used, regardless of how sick the individual is, how ineffective the alternative treatment is,¹¹⁴ and regardless of the fact that this runs counter to the principles of proper pain management which require “staying ahead of the pain” through frequent dosages.¹¹⁵ In addition, in most institutions, medication must be picked up in person by standing in line, sometimes for an hour or two. In some institutions, lines form outside, regardless of the weather.¹¹⁶ In one study, this was reported as the most common reason why individuals on prescription medication did not to take their daily medication: their symptoms were too severe for standing in line, or the weather

27 January 2015) at ss 3–4, online: <www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20150127-eng.aspx> [perma.cc/8Q5V-TVJT] [Office of the Correctional Investigator, *National Drug Formulary Investigation*].

¹⁰⁸ See *ibid.*

¹⁰⁹ See Iftene, “Pains of Incarceration”, *supra* note 13 at 72.

¹¹⁰ See *ibid.*

¹¹¹ See *ibid* at 70.

¹¹² See *ibid* at 72.

¹¹³ See *ibid* at 72–73.

¹¹⁴ See *ibid.*

¹¹⁵ See US, National Cancer Institute, *Support for People with Cancer: Pain Control* (Washington, DC: US Department of Health and Human Services, 2014).

¹¹⁶ See Iftene, “Pains of Incarceration”, *supra* note 13 at 73.

was harsh.¹¹⁷

b. Deaths in custody

CSC has reported that between 2009–2010 and 2015–2016, 50% of those who died natural (but not unexpected) deaths in custody received palliative care.¹¹⁸ Because of the broad definition of “death in custody”¹¹⁹, it is difficult to establish how many of these individuals were in a cell, the infirmary of a federal correctional facility, a federal correctional health facility or a community hospital. Nor is it clear how many of those who did not receive palliative care could have benefited from it. It is also not clear for how long they received palliative care. Nor is it clear whether the palliative care that is being reported consisted solely of pain management or also included the full range of palliative care interventions (e.g., drugs, acupuncture, and counselling) to response to a host of symptoms that palliative care deals with (e.g., nausea, breathlessness, and psychosocial suffering).

In a 2013 mortality review, CSC reported that of the 35 expected natural deaths reviewed, 88% received palliative care.¹²⁰ While 30 of the deaths occurred in a CSC facility, 5 were found to be in a community hospital.¹²¹ There is no data indicating for how long the individuals received palliative care nor any information pertaining to the the scope and quality of the care received. The reviewer assessed that only 36% (11) of cases were handled in a manner that adhered to professional standards and the final report specified that the general deficiencies pertained to form completion, filling DNR orders, and a few of them presented problems in terms of timely access to

¹¹⁷ See *ibid.*

¹¹⁸ See Correctional Service Canada, *Annual Report 2017*, *supra* note 18 at 16.

¹¹⁹ *Ibid* at 5 (“Death in custody refers to any death where the originating incident occurred in a Federal institution, not including community residential facilities (e.g., Community Correctional Centre or Community-Based Residential Facilities) or deaths that occurred during an unescorted temporary absence” at 5).

¹²⁰ See Correctional Service Canada, *Mortality Review for Deaths by Natural Causes* (Ottawa: CSC, 2013) obtained through the Office of the Correctional Investigator [Correctional Service Canada, *Mortality Review*].

¹²¹ See *ibid.*

care, diagnosis, medication, counselling, and referrals.¹²² This 2013 CSC mortality review was investigated by the OCI. For its investigation, the OCI reviewed the same cases as CSC, and, subsequently, another 80 mortality reports.¹²³ The OCI investigators found significant issues in how those cases were managed pre-death.¹²⁴ The independent medical consultant who reviewed a subset of the mortality reports for the OCI concluded that, “in nearly half (seven cases) the review of the health care records raised issues regarding the quality of health care provided to the deceased inmates.”¹²⁵ Yet, the OCI notes, “[t]he mortality review reports for these cases simply state that practices were in line with ‘applicable’ professional standards.”¹²⁶ Significant issues were related to making the correct diagnosis (one inmate’s lung tumour was misdiagnosed for two years) and treatment (one inmate was given a treatment contraindicated for his comorbidity).¹²⁷ Documentation regarding the treatment of inmates was often incomplete and there was generalized lack of progress notes or follow up information.¹²⁸ The OCI also criticized how data was recorded by CSC and how mortality reviews were conducted.¹²⁹ For instance, some patient files contained recommendations for treatment but often lacked notes on whether the treatment was received at all and whether it was successful. Where the treatment was not administered, a justification was also lacking. The OCI provides extensive examples of such gaps.¹³⁰ The inadequacy of data renders the assessment of the scope and quality of health care provided, the establishment of factors that led to the death of the individual, and the holding of individuals and institutions

¹²² See *ibid* at 18.

¹²³ See Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 9–11.

¹²⁴ See *ibid* at 9.

¹²⁵ *Ibid* at 17.

¹²⁶ *Ibid*.

¹²⁷ See *ibid* at 18.

¹²⁸ See *ibid* at 17.

¹²⁹ See *ibid*.

¹³⁰ See *ibid* at 19–20.

accountable difficult.

3. Reflections and concerns

Based on the data provided above, there are good reasons to be concerned about the palliative care provided to federally incarcerated individuals, including: long wait times to see medical specialists; the cost of escorts for delivery of care in community hospitals; the lack of full-time medical staff in many prisons and CSC regional hospitals, restrictions on the ability of physicians to prescribe appropriate medications, and barriers to appropriate delivery of medications.

The lack of comprehensive data on issues related to palliative care, the lack of robust policy frameworks indicating which and how community standards apply, the results from mortality review investigations, and the general shortcomings of the prison health care system call into question CSC's statements that palliative care and pre-death care in its institutions meet "professionally accepted standards."¹³¹ Successful reform would include implementing:

- A better system of monitoring and keeping records;
- Strategies to find alternatives to incarceration for individuals receiving end-of-life care;
- Law reform to stop release to the community for palliative care from being contingent on factors outside the control of individuals or irrelevant to the community's safety; and
- Policy and practice restructuring to improve palliative care in prisons for exceptional situations in which the person who could potentially benefit from it cannot or does not wish to be released into

¹³¹ Correctional Service Canada, *Mortality Review*, *supra* note 120 at 5.

the community.

B. Withholding and withdrawal of potentially life-sustaining care

1. Withholding and withdrawal of potentially life-sustaining treatment (including artificial nutrition and hydration)

The *CCRA* and some internal policy documents regulate the issue of consent to medical treatment as it applies to federally incarcerated individuals. According to section 88 of the *CCRA*, treatment should not be given to an individual unless he or she has voluntarily consented to it.¹³² Furthermore, any patient is entitled to refuse treatment at any time (whether such refusal triggers the withholding of new treatment or the withdrawal of treatment already in place). However, the consent or refusal must be informed. Section 88(2) sets out the criteria for obtaining informed consent. The individual must have the capacity to understand the consequences of their decision. As well, he or she must be advised of the likelihood and degree of improvement, remission, control, or cure as a result of the treatment, degree of risk associated with the treatment, alternatives to the treatment, likely effects of refusing the treatment, and the right to refuse or withdraw from treatment.¹³³

Where a federally incarcerated individual is incapable, provincial and territorial laws apply¹³⁴ which means that a valid advance directive must be followed or, if there is not one or the instruction directives are not valid in the particular province or territory, consent must be sought from a substitute decision maker. The basis for the decision making by the substitute decision maker is generally the patient's wishes if known, their beliefs and values if wishes not known, and best interests if wishes, beliefs, and values are not

¹³² *Corrections and Conditional Release Act*, *supra* note 3, ss 88(1)–(2).

¹³³ See *ibid.*

¹³⁴ See *ibid.*, s 88 (5)

known.¹³⁵

The Commissioner's Guideline regarding Consent to Health Services Assessment, Treatment and Release of Information,¹³⁶ which is intended to help with the implementation of the *CCRA* consent provision, is vague and repetitive. It simply reiterates that the criteria for consent are set in the legislation, and that in cases of incapacity, provincial and territorial laws apply. It does, however, note that verbal or written consent must be documented in the health file of the patients. It also notes that where an individual refuses a course of treatment, alternative options, if available, should be presented.¹³⁷

There is very little case law dealing with the application of this legislation and of these policies and guidelines. Much of the case law seems to deal with the imposition of mandated treatment on individuals as per supervision orders or with individuals detained against their will in psychiatric facilities. There have been some challenges related to consent to psychiatric treatment,¹³⁸ consent to anti-androgen treatment of sex offenders (not for health reasons but to diminish risk),¹³⁹ and consent to undergo a risk assessment (determined not to be the same as consent for health services).¹⁴⁰ In one Nova Scotia decision, the Court grappled with consent to the treatment of a serious physical condition when an inmate was diagnosed with testicular cancer while incarcerated.¹⁴¹ The psychiatrist determined that the patient was not capable of consenting to treatment. While in hospital, the patient

¹³⁵ There is some variation across the country as there are differences regarding consent, substitute decision-making, and advance directives legislation. For more details, see Joanna Erdman et al, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis Canada, 2017) at 355–56, 457–61.

¹³⁶ See Correctional Service Canada, “Guideline 800-3”, *supra* note 94.

¹³⁷ See *ibid.*

¹³⁸ See generally *Proctor v Canada (AG)*, [2002] OJ No 350, 2001 CarswellOnt 10586 (WL Can) (this challenge pertained to events that happened 32 years prior).

¹³⁹ See generally *Kuipers v R*, 1994 CarswellNat 478 (WL Can), 74 FTR 306; *R v Chow*, 2015 CarswellOnt 19156, OJ No 6594 (Ont Ct J); *R v Robinson*, 2009 OJ No 5373, 85 WCB (2d) 751 (Ont Ct J).

¹⁴⁰ See generally *Benoit v Canada (AG)*, 2007 FC 150; *Inmate Welfare Committee William Head Institution v Canada (AG)*, 2003 FC 870.

¹⁴¹ See *Re Crewe*, 2007 NSSC 322.

nonetheless refused to consent to the recommended surgery and brought a claim to have the determination as to their incapacity reviewed. The Court found that the claimant could appreciate the consequences of their treatment decision and the declaration of incapacity was revoked.

The very limited case law on the issue of the withholding or withdrawal of medical treatment might lead one to conclude that the statutory provisions regarding the autonomy of an individual to refuse or withdraw from life-sustaining treatment are being implemented. This appears to be supported by CSC reports on causes of deaths. For instance, in its last mortality review, CSC noted that for all natural deaths that occurred between 2009–2010 and 2015–2016, in 34% of cases, refusal or non-compliance with treatment was a “relevant event” in connection to death, while in 28% of cases, information regarding compliance or non-compliance with treatment was not available in the medical file.¹⁴² Unfortunately, details regarding what “non-compliance” means (e.g., informed refusal of treatment, withdrawal from treatment, failure to diligently follow treatment, etc.) is not available in the CSC reports. It could, for example, mean that the person has autonomously rejected the treatment because they do not want it. However, it could also mean that the person understands the poor quality of health care they will receive and the hardships they will have to go through to get it and so decides not to “comply.” As previously discussed, it has been reported that incarcerated individuals on pain medication would regularly skip their treatment because standing in line outside for a Tylenol 3 was not worth the effort it required, and it in fact, worsened the pain.¹⁴³ This could be the case with other medications as well.

To reiterate, the OCI has conducted extensive investigations in the last few years on the mortality reviews conducted by CSC and in the medical files of people who have died in custody. In 2013, the OCI noted the non-compliance issue: mortality reviews do not further investigate the causes of “non-compliance” with treatment, whether general legal requirements surrounding consent and refusal were respected, what was done to improve compliance, or if alternative treatment was presented in accordance with the governing legislation. The OCI found this omission troublesome, especially in light of the fact that upon reviewing medical files for people who died, they established that, at least in some cases, legal requirements concerning consent were either clearly not met, or it could not be established whether

¹⁴² Correctional Service Canada, *Annual Report 2017*, *supra* note 18 at 16.

¹⁴³ See Iftene, “Pains of Incarceration”, *supra* note 13 at 73.

they had been met.¹⁴⁴ For instance, in many files it was simply noted that the “inmate did not show up for treatment” and this was treated as refusal.¹⁴⁵ The health records did not distinguish between refusing to attend and being unable to attend. There were also indications that in some cases, the nurse did not attempt to obtain confirmation that refusal was of the patient’s own volition. Finally, in some of the files indicating that the individual did not receive treatment, there was no documentation regarding consent, refusal, or withdrawal from treatment, as required by legislation.¹⁴⁶

The OCI provides three examples where an incarcerated person’s refusal of treatment did not appear to meet fundamental legal requirements. In the first example, the patient died of dementia and cancer. The impression given was that this individual was not capable of making end-of-life decisions, and yet there was a signed DNR order and no mention of a legal representative, family member, or substitute decision maker in the mortality review.¹⁴⁷ The second example is of a patient who died from lung cancer. In their file, it was noted that they refused chest x-rays and thus subsequent treatment. The OCI notes that in the file, there were no follow-ups and no progress reports. The individual had known mental health conditions. However, beyond the refusal notice, the file is silent about any information provided to them regarding the consequences of their decision or whether anything had been done to encourage or facilitate treatment.¹⁴⁸ The third example is a patient who died of tuberculosis after refusing any kind of medical testing. The same issues were noted here as in the previous case.¹⁴⁹

It is ultimately very difficult to evaluate how the common law principles and statutory provisions related to consent and refusal of treatment are being implemented. Furthermore, based on the vague data from CSC and the OCI’s reports, the apparent respect of a patient’s autonomy to refuse life-sustaining treatment is meaningless. On the contrary, the noted lack of progress reports and follow-up on patients, coupled with the concerns related to

¹⁴⁴ See Office of the Correctional Investigator, *Mortality Review Process*, *supra* note 27 at 20.

¹⁴⁵ See *ibid.*

¹⁴⁶ See *ibid* at 21.

¹⁴⁷ See *ibid.*

¹⁴⁸ See *ibid.*

¹⁴⁹ See *ibid.*

the quality of health care and availability of services presented in the previous section, raise questions regarding the capacity of those refusing treatment. Thus, it is unclear if in all cases their decision was informed, whether they truly had access to the treatment of their choice, and whether they even had the physical ability to present themselves to the infirmary for the scheduled treatment. While it is entirely appropriate for the CSC legislation and guidelines to require respect for capable people's refusals of treatment, it is also essential that they ensure that apparent refusals are actual refusals and that refusals are voluntary and informed.

2. Voluntary stopping eating and drinking (VSED)

Neither the *CCRA* nor any policy documents or guidelines explicitly address the issue of federally incarcerated individuals who refuse oral hydration and nutrition for the purpose of hastening death.¹⁵⁰ Section 89 of the *CCRA* prohibits force-feeding anyone who had the capacity to understand the consequence of their decision at the time that they decided to fast.¹⁵¹ The only policy document that addresses the refusal of food is *Guideline 800-1 Hunger Strikes: Managing an Inmate's Death*.¹⁵² However, a hunger strike is defined by the Guideline as occurring when an incarcerated individual declares himself or herself on a hunger strike and refuses all food and liquid *other than water* for at least seven consecutive days.¹⁵³ In such situations, the Guideline requires that the incarcerated individual be observed by the nurse, their health be monitored with their consent, and efforts be made to negotiate the requests that motivated the hunger strike.¹⁵⁴ When the individual loses consciousness or the ability to consent, CSC is not only permitted, but required to intervene in order to preserve life.¹⁵⁵ How this intervention

¹⁵⁰ For a detailed discussion on VSED, see Jocelyn Downie, "An Alternative to Medical Assistance in Dying? The Legal Status of Voluntary Stopping Eating and Drinking (VSED)" (2018) 1:2 Can J Bioethics 48.

¹⁵¹ See *Corrections and Conditional Release Act*, *supra* note 3, s 89

¹⁵² See Correctional Service Canada, *Hunger Strikes: Managing an Inmate's Death*, Guideline 800-1 (Ottawa: CSC, 27 April 2015) [Correctional Service Canada, "Guideline 800-1"]

¹⁵³ See *ibid* at Annex A, 3.

¹⁵⁴ See Correctional Service Canada, *Hunger Strikes*, *supra* note 152, ss 3–25.

¹⁵⁵ See *ibid*, s 2.

squares with section 89 of the *CCRA* is unclear. For our purposes, this arguably does not matter as the Hunger Strike Guideline would not apply to VSED cases as under the definition provided within the Guideline, VSED is not a hunger strike.

There are few relevant court cases that provide guidance on prison authorities' duties (and none on CSC's specifically) when a person decides to stop eating or drinking, for whatever reason, but even fewer that deal with the specific issue of a person trying to hasten death. In *British Columbia v Astaforoff*¹⁵⁶, a 1983 decision of the BC Supreme Court, the Court ruled on a request from the BC Attorney General to provide an order compelling the provincial correctional authority to force-feed an individual. The Court established that the individual was attempting suicide and that their health was rapidly declining. The Court determined that while correctional authorities have a duty under the *Criminal Code* to provide incarcerated individuals with the necessities of life, it does not have a duty to force those necessities upon those who refuse them.¹⁵⁷ It also ruled that while aiding or encouraging suicide is a crime, standing by and not intervening is not a crime.¹⁵⁸ The BC Supreme Court thus decided that when the individual is lucid, they cannot be compelled to eat. The Court noted that the ruling may be different when the individual loses capacity but left this as an open question.¹⁵⁹

A subsequent case, *Burke v Prince Edward Island*¹⁶⁰, dealt with the other side of the coin: the entitlement of prison authorities to intervene. The Applicant, an inmate by the name of Burke was transferred to a hospital after refusing food and hydration in an attempt to commit suicide. The hospital was planning to force-feed Burke and he applied to the court for an order pursuant to section 24 of the *Charter*, that force-feeding would violate his section 7 rights under the same. The Court decided that while such a right may exist, there was not enough evidence before it and so it was not prepared to make such a declaration.¹⁶¹ However, it also ruled, applying *Astaforoff*, that there was no statutory or common law duty to keep the

¹⁵⁶ 47 BCLR 217, 1983 CarswellBC 238 [*Astaforoff*].

¹⁵⁷ See *ibid* at paras 14–15.

¹⁵⁸ See *ibid* at para 16.

¹⁵⁹ See *ibid* at para 20.

¹⁶⁰ 93 Nfld & PEIR 356, PEIJ No 75 [*Burke*].

¹⁶¹ See *ibid* at 3.

patient alive against his will.¹⁶² The Court went a step further and concluded that it is unlikely that the state has an entitlement to keep an incarcerated individual alive. While the Court refused to provide an order prohibiting force-feeding, it stated that if they proceed, they must accept whatever liability may befall them as a result of their actions carried out without the applicant's consent.¹⁶³

Thus, it seems clear that an incarcerated individual refusing oral nutrition and hydration, for whatever reason, cannot be force-fed or treated as long as he or she maintains the capacity to consent. It also appears, according to the language of the *CCRA*, that force-feeding is not an option, even after the individual loses capacity, so long as they were capable at the time the decision to fast was made and had not declared a hunger strike.

There is no data or other information on how often, if at all, VSED has been attempted by individuals who are federally incarcerated,¹⁶⁴ what the response to it was, or how it was monitored. It is difficult to believe, considering the large number of individuals with serious illnesses, the questionable quality of health services, and the lack of options for release, that VSED is not attempted on occasion. Given the problematic monitoring of medical treatment, progress notes, consent and refusal of treatment discussed in the previous section, it is reasonable to wonder how long it would take authorities to notice when someone is attempting VSED. It is unclear how and whether authorities would document the attempt, whether authorities would endeavour to make the patient comfortable while doing so, and whether they would contact next of kin. It is also reasonable to wonder what, if any, efforts would be made to find alternatives to incarceration for individuals

¹⁶² See *Burke*, *supra* note 160 at 2–3.

¹⁶³ See *ibid* at 4.

¹⁶⁴ There is no mention of VSED in any form in reports related to federally incarcerated individuals. It is possible that some cases were reported under non-natural death categories. For instance, suicide forms 51% of non-natural deaths between 2009–2010 and 2015–2016, and 4% of these were in the “other” category (which includes hanging, cutting, asphyxiation and ligature). Also, under “events related to the suicide” there is a category by the name of “people suffering of chronic conditions (physical),” 55% of whom committed suicide between 2009–2010 and 2015–2016. There is no explanation as to what this means and why the chronic conditions were deemed relevant. Given the appearance of VSED outside prisons, CSC would be well advised to start tracking it, if they are not already doing so.

who indicate their intentions and begin VSED.

A number of questions and concerns arise from the preceding review of the law and practice with respect to VSED for federally incarcerated individuals. For example, is it or will it be used as an alternative to MAiD when MAiD is unavailable or not desired by the individual? Do incarcerated individuals have meaningful alternatives to VSED (i.e., treatment with tolerable side effects)? Do prisons have physicians and nurses with the clinical competencies required to care for an individual dying through VSED? Protocols for VSED are needed but absent.

C. *Palliative sedation*

Palliative sedation is “the intentional administration of sedative medication to reduce a patient’s level of consciousness, with the intent to alleviate suffering at the end of life. It includes both intermittent and continuous sedation, as well as both superficial and deep sedation. It may be accompanied by the withdrawal of artificial hydration and nutrition.”¹⁶⁵ Palliative sedation accompanied by artificial hydration and nutrition will not hasten death. However, when artificial hydration and nutrition is withheld, it can, in some circumstances, hasten death. Palliative sedation without artificial hydration and nutrition (PS \bar{S} ANH) can be divided into three types: PS \bar{S} ANH that *will not* hasten death (Type 1); *might, but is not certain to* hasten death (Type 2); or *is certain to* hasten death (Type 3). Type 1 occurs when death is anticipated within approximately 24–48 hours, Type 2 occurs when death is anticipated within approximately 14 days, and Type 3 occurs when death is not anticipated for at least 14 days.¹⁶⁶

There is no data on, or guidelines for palliative sedation in CSC facilities. As with any other type of death in custody other than MAiD (which is defined in section 241.1 of the *Criminal Code*), the use of palliative sedation would be followed by a mortality review. However, none of the public mor-

¹⁶⁵ Carter, *supra* note 7 at para 42.

¹⁶⁶ This framing of palliative sedation (which departs somewhat from the framing by some palliative care specialists) is fully explained and justified in Jocelyn Downie & Richard Liu, “The Legal Status of Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration” (2018) 2:1 McGill JL & Health 29 at 32.

tality reports mention any kind of palliative sedation as a cause of death.

Again, a series of questions and concerns arise. Is palliative sedation being used as an alternative to MAiD when MAiD is unavailable or not desired by the individual? Do federally incarcerated individuals have access to palliative sedation and alternatives to palliative sedation? Do CSC physicians and nurses have clinical competencies needed to provide palliative sedation? Do CSC regional hospitals have the physical and human resources infrastructure necessary to provide palliative sedation? Protocols for palliative sedation are needed but absent.

D. Medical Assistance in Dying (MAiD)

In February 2015, the Supreme Court of Canada held in *Carter v Canada (AG)*¹⁶⁷ that the *Criminal Code* prohibitions on medical assistance in dying violate the *Charter*:

[I]nsofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. ‘Irremediable’, [they added]..., does not require the patient to undertake treatments that are not acceptable to the individual.¹⁶⁸

On 17 June 2016, the Parliament of Canada passed and brought into force *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*.¹⁶⁹ This amendment to the *Criminal Code* established the federal statutory framework for MAiD in Canada.

¹⁶⁷ 2015 SCC 5.

¹⁶⁸ *Ibid* at para 127.

¹⁶⁹ Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016).

The eligibility criteria encompasses individuals who are:

- Eligible for health services funded by government in Canada (or would be but for minimum period of residence or waiting period);
- At least 18 years old;
- Capable of making decisions with respect to their health;
- Made a voluntary request;
- Gave informed consent to receive medical assistance in dying after having been informed of means available to relieve suffering, including palliative care;
- Have a grievous and irremediable medical condition, meaning:
 - They have a serious and incurable illness or disability;
 - They are in an advanced state of irreversible decline;
 - That illness or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
 - Their natural death has become reasonably foreseeable, without a prognosis necessarily having been made as to the specific length of time that they have remaining.¹⁷⁰

Section 19(1.1) of the *CCRA* states that the definition of MAiD as applicable to incarcerated people is the same as the one provided in section 241.1 of the *Criminal Code*.¹⁷¹ Section 19, which requires a mortality review after each death in custody, also specifically exempts deaths in custody that occurred as a result of MAiD from mortality reviews (although they are subject to quality management review).¹⁷² The implementation of MAiD for

¹⁷⁰ See *ibid*, s 241.2(1)

¹⁷¹ *Corrections and Conditional Release Act*, *supra* note 3, s 19(1.1); *Criminal Code*, *supra* note 5, s 241.1.

¹⁷² See *Corrections and Conditional Release Act*, *supra* note 3, s 19(1.1).

federally incarcerated individuals was left to CSC to determine.

CSC released their MAiD policy at the end of November 2017.¹⁷³ According to the policy, a federally incarcerated individual seeking MAiD must submit a request to the institution's Health Services. Within five days of submitting the request, they will be seen by the institutional physician or nurse practitioner, who will provide them with information regarding MAiD and schedule an assessment. The patient must sign a consent form for eligibility assessment in front of two independent witnesses.¹⁷⁴ After that, within seven days, the individual will undergo the first eligibility assessment conducted by the prison physician or the nurse practitioner. The individual cannot choose their assessor nor seek a second opinion if the institutional assessor believes the eligibility criteria are not met. However, if the first assessor believes the criteria are met, the individual will undergo a second assessment conducted by an external physician or nurse practitioner in the community.¹⁷⁵ If both assessors are of the opinion that the criteria are met, then the individual will be provided with the procedure after the required 10 day waiting period (or less if death or the loss of capacity is imminent). This MAiD policy appears to only contemplate the second assessment taking place in the community¹⁷⁶ and it,

assume[s] that the MAiD procedure will be completed external to CSC, namely, in a community hospital or health care facility. In exceptional circumstances, at the request of the inmate, a Treatment Centre or a Regional Hospital may be used,

¹⁷³ See Correctional Service Canada, *Medical Assistance in Dying*, Guideline 800-9 (Ottawa: CSC, 29 November 2017) [Correctional Service Canada, "Guideline 800-9"].

¹⁷⁴ See *ibid*, ss 9–13.

¹⁷⁵ See *ibid*, ss 14–17.

¹⁷⁶ See *ibid*, s 18.

provided:

- a. an exception has been approved by the Assistant Commissioner, Health Services, and
- b. the procedure includes a health professional external to CSC.¹⁷⁷

It is not clear whether all institutions that might have individuals who desire and qualify for MAiD have the infrastructure to bring in a second assessor or MAiD provider who is not a prison physician. Finally, no provision appears to have been made for individuals who are too ill or do not wish to transfer out of the prison for the second assessment and provision of MAiD. As the debate over forced transfers out of publicly-funded faith-based institutions has illuminated, some patients cannot be transferred without suffering extreme distress and without the risk of losing of capacity (which, in turn, means the person will have lost eligibility for MAiD).¹⁷⁸ Furthermore, some individuals may prefer to receive their end-of-life care within the correctional facility. For instance, some people have been in prison for decades, and the people closest to them are individuals incarcerated with them. They may thus wish to be with them in their final moments. The OCI refers to five incarcerated individuals who chose not to submit a request for parole by exception, explaining that “their wish was to remain at a CSC facility for their end of life care.”¹⁷⁹ However, there is no information about these cases and so it is difficult to assess how reasonable it is to conclude that they did not wish to be transferred out of the prison.

We turn now from a review of the law and guidelines to what takes place in practice. In October 2017, we filed a request through Access to Information with CSC, asking for the number of MAiD requests and how they have been addressed since the policy has been in place. Though CSC is statutorily required to send the information within 30 days from when the request was

¹⁷⁷ *Ibid*, ss 19–21.

¹⁷⁸ See Tom Blackwell, “BC Man Faced Excruciating Transfer After Catholic Hospital Refused Assisted Death Request”, *National Post* (27 September 2016), online: <nationalpost.com/news/canada/b-c-man-faced-excruciating-transfer-after-catholic-hospital-refused-assisted-death-request> [perma.cc/5H2C-KE9T].

¹⁷⁹ Canada, Office of the Correctional Investigator, *Office of the Correctional Investigator Annual Report 2014-2015* (Ottawa: OCI, 2015) at 22.

received,¹⁸⁰ no documents were received within the 30 days. Additionally, we were not provided with a justification for the delay.¹⁸¹ The response to repeated phone calls made to inquire about the status of the request was, “this is sensitive information/has low statistics and has not been yet approved for release.”¹⁸² Finally, on 7 July 2018, nine months after our request was made, we received information on the number of MAiD requests, but not our requested elaboration on the decision-making process regarding MAiD requests. According to the information CSC provided, at the time of the Access to Information request, there had been eight requests for MAiD. Only one person, who was already in a community hospital, was deemed eligible for MAiD, and they died before the procedure was provided.¹⁸³

According to a CBC report on 25 February 2018: “CSC told CBC News it has received eight requests related to MAiD and, to date, three inmates have been approved for medically assisted death – though not all three have completed the procedure. Two of the inmates were already living in the community.”¹⁸⁴

The OCI 2017-2018 Annual Report, published on 29 June 2018, contains a discussion of “the first case of medical assistance in dying in federal corrections.”¹⁸⁵ The Report details that,

- The inmate was on palliative care for more than a year, suffering from a terminal illness.
- The Case Management Team started to work on a section 121 application for parole by exception (compassionate release) shortly after

¹⁸⁰ See *Access to Information Act*, *supra* note 100, s 7.

¹⁸¹ See *ibid*, s 9.

¹⁸² Document A, *supra* note 102.

¹⁸³ See Document A, *supra* note 102. It is unclear what “to date” means. The letter received in response indicated the date of 12 July 2018. The separate document attached to the letter and containing the numbers is titled: “Medical assistance in dying as of September 17, 2017”. It is possible that the numbers we received in July 2018 were almost one year old.

¹⁸⁴ Michael Cook, “Euthanasia Performed on Canadian Prisoner”, *CBC News* (5 March 2018), online: <www.mercatornet.com/careful/view/euthanasia-performed-on-canadian-prisoner/21098> [perma.cc/X7U8-5UFA].

¹⁸⁵ Office of the Correctional Investigator, *Annual Report 2018*, *supra* note 16.

terminal diagnosis. The request was rejected by the Parole Board of Canada one year later.

- The inmate requested medical assistance in dying at a Regional Hospital under CSC's authority, with a physician who was under contract with CSC. It is unclear if the inmate chose MAID because he was refused compassionate release.
- Two evaluations took place, and the inmate met MAID criteria. The physician who conducted the evaluations was not under contract with CSC.
- A date was chosen by the inmate, and family members were permitted to visit him at the CSC Regional Hospital on a number of occasions in advance of the procedure.
- On the chosen day, the inmate was escorted to an external community hospital by two armed correctional officers in an adapted medical transport. The inmate was restrained. Once in the hospital room, the restraints were removed. The inmate was left in the room with pre-approved family members.
- According to CSC reporting, the officers providing security escort waited "at the back, near the entrance." (Note: the wording in CSC's report is not clear as to whether the officers stayed in the room or just outside the room.)
- According to CSC, "the physician who performed the procedure, while under contract with CSC when he conducted the original assessment, was operating as an employee of the hospital in which the procedure took place, and not as a CSC physician."¹⁸⁶

This review of the law and practice with respect to MAiD yet again raises questions and concerns.

First, the inconsistency between the information released by the CSC in response to our Access to Information Request, the information reported by

¹⁸⁶ *Ibid* at 14.

CBC, and the information reported by the OCI is disturbing.

Second, the OCI's description of the first case of MAiD indicates that there were "two evaluations" of eligibility and indicates that a single physician provided "the evaluations" of eligibility.¹⁸⁷ There is no report of an independent practitioner providing the second assessment. If only one physician provided both of the two required assessments of eligibility, then the *Criminal Code* was clearly violated. The CSC is reported as having said "the physician who performed the procedure, while under contract with CSC when he conducted the original assessment, was operating as an employee of the hospital in which the procedure took place, and not as a CSC physician."¹⁸⁸ The CSC Guideline on Medical Assistance in Dying requires that the physician or nurse practitioner who actually provides the MAiD must be "a health professional external to CSC."¹⁸⁹ It is clear that the physician who provided MAiD was the institutional physician for the purposes of at least the initial eligibility assessment. It is therefore unreasonable to claim that he was "external to CSC"¹⁹⁰ when he provided MAiD. "External to CSC" does not mean physical location (i.e., being out of the prison) or the wearing of an external hat by someone who also wears an internal hat. It therefore appears that the CSC Guideline may have been breached.

Third, individuals may be denied parole by exception but be eligible for MAiD. The CSC guidelines encourages that all release options be considered prior to MAiD.¹⁹¹ However, there has been no reform to the current parole by exception rules and practices. As noted in the OCI Report from 2017, the criteria for MAiD and those to be released into community are not aligned, and some people may be eligible for MAiD but not be granted parole by exception.¹⁹² This is because eligibility for MAiD only requires that natural death has become reasonably foreseeable without the necessity for a prognosis for a specific length of time. In fact, since the legisla-

¹⁸⁷ See *ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ Correctional Service Canada, "Guideline 800-9", *supra* note 173, s 16.

¹⁹⁰ *Ibid.*

¹⁹¹ See *ibid.*

¹⁹² Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2016–2017* (Ottawa: OCI, 2017) at 19–20 [Office of the Correctional Investigator, *Annual Report 2017*].

tion was passed, a few individuals who suffer from an incurable grievous and irremediable condition (which does not have to be terminal) who have reached an advanced state of irreversible decline have been granted MAiD even though their deaths were estimated to be a number of years in the future. For example, a 79-year-old woman with advanced excruciatingly painful osteoarthritis was deemed eligible for MAiD.¹⁹³ Yet, as discussed above, people who are serving a life or indeterminate sentence cannot even be considered for parole by exception unless they are terminally ill. In addition, even people with clearly terminal conditions can be denied release because of issues that are of little relevance to health (such as prior attitudes during incarceration, completion of programs, etc.). If temporary absence and the Royal Prerogative of Mercy are also not available, the OCI's concern that MAiD may become the default option for individuals who meet all of the MAiD criteria but cannot get released into community for health care seems valid.¹⁹⁴

Fourth, it may not be feasible to provide palliative or other end-of-life care in community (because of a lack of beds or the cost of security escorts) yet feasible to provide MAiD in the community (a person may need days or weeks in a community hospital for the former versus less than a day for the latter). This may create a troubling incentive to request MAiD.

Fifth, the CSC MAiD policy is not consistent with the federal MAiD legislation. For example, the fact the patient is not entitled to a second assessment if the institutional assessor believes the criteria are not met, is problematic.

Finally, there may be logistical difficulties in bringing the second medical or nurse practitioner into prisons for the exceptional circumstance when transfer to community is not permitted (e.g., when parole by exception is denied) or possible (e.g., when there is a lack of facilities in community or it is impossible to move the person without risking significant suffering or loss of capacity). If these issues are not resolved, federally incarcerated individuals will be denied a medical service to which they are entitled and

¹⁹³ See *AB v Canada (AG)*, 2017 ONSC 3759 at para 31.

¹⁹⁴ See Office of the Correctional Investigator, *Annual Report 2017*, *supra* note 192 at 20.