End-of-life Care in the Prison Environment – #35 (October 2026)



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Aging Prison Population

Care homes behind bars – coping with an ageing prison population

BBC NEWS (**U.K.**) | Online – 30 September 2026 – In one of Scotland's largest prisons a unique experiment is taking place in an area called The Basement. Aside from having lost their liberty through crime, the inmates who gather there for meetings at HMP Edinburgh all have something in common. They are getting old. Some of them are displaying symptoms of dementia, while others are simply using the facility because it offers the company of men from a similar generation. For the prison staff who run the meetings, they offer an alternative way of looking after prisoners with needs such as frailty or social isolation that are hard to meet within a prison setting. HMP Edinburgh is currently looking after 934 inmates – more than 60 more than it was designed for. Sixty five of them are aged 65 or over. The logistics of accommodating them is more complex than the numbers alone. **Full text:** https://bit.ly/4xUdLTM

Number of elderly prisoners increasing rapidly: Oversight council calls for adapted policy

BELGA NEWS AGENCY (**Belgium**) | Online – 23 September 2026 – The Central Supervisory Board for the Prison System (CTRG) is calling for a better and integrated policy to address the needs of the older population in prisons. Currently, 719 detainees over the age of 60 are held in our prisons. Many of them will spend their final years behind bars. However … many prisons are not prepared for the additional care and logistical challenges that a larger elderly population will bring. The CTRG advocates for a general policy for the elderly that combines safety, care, human dignity, and social responsibility. They propose establishing a specialised structure within a dedicated elderly unit and an integrated geriatric care and support model. Better preparation for reintegration that considers the context of an older person, as well as a clear framework for **end-of-life care** in detention, are also deemed necessary by the oversight council. **Full text:** https://bit.ly/4AoWXHf

Alternative federal budget 2026-2027: Incarceration

Health, aging, and the high costs of incarceration in Canada

C C P A
CANADIAN CENTRE for POLICY ALTERNATIVES
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| Online – 16 September 2026 – Canada's prison population is an aging population, in no small part due to the rise of life-sentenced people (a figure now approaching almost 29% of all federally sentenced people), despite the well-documented reality that people "age out" of crime and pose significantly lower public-safety risks as they grow older. Maintaining an aging prison population is both illogical and costly, with escalating healthcare expenditures. Compounding the lack of infrastructure and resources is the fact that long-term incarceration reduces life expectancy by approximately 20 years. Prisons' harsh, violent, and unstable living conditions exacerbate pre-existing conditions and create disorders in previously healthy people. The burden of chronic illness created in prisons is ultimately downloaded onto provincial health systems (**see sidebar**). One legislative reform that would greatly reduce costs, improve individual health outcomes, facilitate continuity of care and support successful reintegration is an amendment to the *Canada Health Act's* definition of "insured person." **Full text:** https://bit.ly/4AnExGw

> The [proposed] Alternative Federal Budget will establish a *National Older-Adult Decarceration Strategy* that creates clear pathways for transitioning aging and medically complex individuals out of federal custody and into provincial healthcare systems, long-term care, **palliative care**, or community-based supports. This strategy will reduce federal healthcare expenditures, improve health outcomes, and ensure that older adults receive care in appropriate settings rather than in prisons that are structurally and clinically unequipped to meet their needs.

N.B. See 'Governance of Prison Healthcare: "People in prison exist in a twilight zone between criminal justice and health systems," End-of-Life Care Behind Bars website (July 2025): https://bit.ly/4objyQ4 ***BRA***

Maintaining security: A grounded theory analysis of how correctional officers identify and respond to health- and age-related changes

HEALTH & JUSTICE (**U.S.**) | Online – 14 September 2026 – Incarcerated older adults are aging in a carceral system focused on security, rather than health. As such, correctional officers (COs) are central in the lives of incarcerated individuals (**see sidebar**). Understanding how COs observe and communicate changes in incarcerated older adults' health status could close an important gap in our understanding of aging in prison. COs can and do identify health- and age-related changes, but multiple barriers prevent them from reporting these changes. This lack of communication could contribute to delays in care and contribute to negative health outcomes for the incarcerated person. There is an urgent need for public policy, prison systems, and research to develop and implement strategies to improve CO understanding of health and aging and develop effective systems of communication between COs and prison healthcare teams. **Abstract:** https://bit.ly/4xPO0Vt

From an earlier posting on the End-of-Life Care Behind Bars website

Why prison officers matter in end-of-life care

ROYAL COLLEGE OF NURSING (**U.K.**) | Online – 27 August 2026 – Prisoners die at a median age of 67.5 years, compared with 86.7 in the general population. Behind these numbers are real people dying in real cells, and the people most consistently present with them are not nurses or doctors, they are prison officers. Across two decades of literature, not a single study has examined prison officers' experiences of **end-of-life care** as its primary focus. Their experiences, perspectives and emotional lives had been consistently overlooked. Most troubling: none of this appears to have meaningfully changed in twenty years. Should a prison officer provide care, or should they be caring? These are not the same thing. **Full text:** https://bit.ly/4chZ05s

Share this resource with a colleague.

Switzerland's aging prison population: Safety, care, and courage

CUSTOMMAPPOSTER | Online – 14 September 2026 – While those over 60 constitute a mere 6% of the incarcerated population, this segment is experiencing the most rapid growth, forcing a re-evaluation of what it means to manage a prison system. This trend ... forces us to confront the intersection of aging, vulnerability, and the inherent harshness of incarceration. What makes this situation particularly fascinating is how prison life itself acts as an accelerant for the aging process. Swiss prisons, like many correctional facilities worldwide, were not designed with geriatrics in mind. The fact that older inmates now represent a significant and growing proportion of the population means that existing infrastructure is likely inadequate. However, there are glimmers of hope, and the Lenzburg prison in Aargau is presented as a role model. The creation of specialized units for prisoners over 60, complete with daily visits from home care workers and a focus on maintaining autonomy, is a significant step. **Full text:** https://bit.ly/4dbRs4w

Compassionate Release

Is it time to move beyond death by incarceration?

THE PHILADELPHIA CITIZEN (**U.S.**) | Online – 8 September 2026 – At State Correctional Institute Phoenix, we heard from men who have been incarcerated for 35, 40, nearly 50 years. They are part of an aging prison population increasingly confronting dementia, cancer, chronic illness, reduced mobility, **hospice care**, wheelchairs, specialist appointments... Prisons were not designed to function as nursing homes, long-term care facilities, or hospices. Pennsylvania taxpayers are paying for this (**see sidebar**). What public-safety purpose is served by incarcerating elderly people who may present little meaningful risk to the public? Research on aging and crime has long established the general pattern that criminal offending declines significantly with age. That does not mean every elderly incarcerated person should be released. It means age and decades of demonstrated rehabilitation are relevant to risk – and our laws should be capable of recognizing that fact. **Full text:** https://bit.ly/4gEIMWC

An interesting article that "slipped through the cracks"

Let them go home: Georgia spends its most expensive dollars on the people least likely to reoffend

GEORGE PRISONERS' SPEAK (**U.S.**) | Online – 14 March 2026 – Georgia is spending $70,000 a year to incarcerate a 65-year-old man who, according to every credible study on aging and crime, has less than a 4% chance of committing another offense. That same $70,000 could fund a teacher's salary... It could pay for a year of community mental health services for dozens of at-risk youth. It could house a returning citizen in transitional housing for three years. Instead, it pays for a prison bed, a mounting stack of medical bills, and the slow warehousing of a human being who poses virtually no threat to anyone. As of March 2026, Georgia holds 12,958 people aged 50 and older in its prisons – more than one in four of the entire incarcerated population. These are the most expensive people in the system and, by every available measure, the least dangerous. **Full text:** https://bit.ly/4q0oLwx

Ageing prison leavers: A conceptual framework for the care and support needs of formerly incarcerated older adults

WORKING WITH OLDER PEOPLE (**U.S.**) | Online – 7 September 2026 – The intention of this conceptual paper is to explore the largely un-noted needs for care and support for older adults who have been released from prison, particularly in relation to the care needs pathway from care planning during the prison sentence to reintegration into the community and, if relevant, support for **end-of-life care**. Ageing prison leavers experience a distinctive combination of accelerated physical and cognitive ageing, thin family and social networks and structural gaps at the point of release, where prison-based continuity of care abruptly ends. The framework [discussed] provides practitioners, statutory social care agencies and probation and prison services with a common framework in which to audit the provision that is currently offered to ageing prison leavers and highlight current trends of provision of support that is focused on the custody and pre-release phase but which is sparse in the community stages. **Abstract:** https://bit.ly/4A6yWnY

Cont.

Related:

'Humane's pilot compassionate release program…,' Humane Prison Hospice Project (**U.S.**) | Online – 20 August 2026 – The participants, all of whom were formerly incarcerated "lifers," or people with life sentences, trained to become peer caregivers for people who will be compassionately released for care at the Francisco Homes in South Los Angeles. The Francisco Homes will set aside rooms for patients granted compassionate release, where peer caregivers will support patients and help create a calm, caring, and compassionate environment as they transition to the end of their lives. **Full text:** https://bit.ly/4yCSKh9

Prison Healthcare Services

Locked in, left behind: Clinical, psychosocial, and ethical dimensions of prison health – a narrative review

HEALTHCARE (**Romania**) | Online – 2 October 2026 – The literature synthesized in this review indicates that incarcerated populations experience disproportionately high rates of physical illness, mental disorder, and social marginalization and that this burden is produced jointly by pre-incarceration disadvantage, by the structural conditions of confinement, and by the incomplete realization of the principle of equivalence of care. Improving prison health systems requires coordinated action by healthcare professionals, policymakers, correctional institutions, and community organizations. On the basis of the evidence reviewed, the priorities most consistently supported are systematic health assessment at reception, protection of clinical continuity during custody and across the prison-community interface, reduced prison density, expansion of mental health and substance use treatment, and safeguarding confidentiality and professional independence in correctional healthcare. **Full text:** https://bit.ly/4rQdOPf

International Perspective

Prison health is public health: Incarceration, equity, and an urgent global agenda



SCIENTIFIC REPORTS | Online – 22 September 2026 – Prison health continues to be treated as a marginal correctional issue rather than what it fundamentally represents: a major public health concern. The health of incarcerated populations is inseparable from community health, health equity, and broader social development. When prison systems fail, the consequences extend far beyond prison walls. The U.N.'s Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) affirm the principle of equivalence of care… Despite this internationally recognised standard, significant inequities in access to healthcare persist. This editorial argues that prison health must be recognised as a core public health and health equity priority and that integrating correctional health into national health systems is essential to reducing health inequities, meeting international human rights obligations, and advancing global sustainable development goals. **Full text:** https://bit.ly/4d2q74S

N.B. See 'Governance of Prison Healthcare: "People in prison exist in a twilight zone between criminal justice and health systems," End-of-Life Care Behind Bars website (July 2025): https://bit.ly/4objyQ4 ***BRA***

Related:

'How to improve healthcare in prisons key reforms?' *Healthy Beginnings Magazine* (**U.S.**) | Online – 22 August 2026 – People in prison get sick more often and die younger than the general public. That is not an opinion. It is a documented pattern across decades of research. The healthcare they receive inside often fails them, and when they leave, they bring those untreated conditions back into their communities. Improving prison healthcare is not just a moral issue. It is a public health issue that affects everyone. The core problems are well known. **Full text:** https://bit.ly/4ipciku



How has this resource benefited you. Let us know: https://bit.ly/4cdWVFD

The health status of incarcerated people in Canada: A narrative review

FRONTIERS IN PUBLIC HEALTH | Online – 11 September 2026 – In Canada, correctional health governance is highly fragmented across 13 provincial and territorial jurisdictions and the federal government. While 76% of all incarcerated people are held in provincial or territorial centers, only British Columbia, Alberta, Nova Scotia, and Newfoundland and Labrador have aligned with international recommendations by transferring healthcare responsibility to their respective ministries of health. In all other jurisdictions, including federal correctional centers, healthcare remains under the same government department as security. Healthcare governance has direct implications for the delivery of healthcare in correctional centers. Ministries of Health have the institutional policies and procedures to implement community standards of care, and shifting responsibility to the Ministry of Health can facilitate improved continuity of care and better health outcomes. To address existing health inequities, further evaluation of these governance models in Canada is urgently needed. **Full text:** https://bit.ly/4hu3uYa

N.B. See 'Governance of Prison Healthcare: "People in prison exist in a twilight zone between criminal justice and health systems," End-of-Life Care Behind Bars website (July 2025): https://bit.ly/4objyQ4 ***BRA***

U.S. jail and prison institutional research policies: A lever in access to research for incarcerated people



THE LANCET REGIONAL HEALTH | Online – 11 September 2026 – Incarcerated people are often excluded from health research, limiting the evidence available to address the specific needs of this population. U.S. federal regulations provide a foundation for research involving incarcerated people, but many prison and jail systems have developed institution-specific policies that further govern research. The authors analyzed U.S. carceral research policies and found substantial variation across systems, including approaches to ethical oversight and institutional discretion over research activities and dissemination of research findings. The wide variation in policies, power facilities have over research access, and potential censoring of findings highlights the need for more standardized practices (**see sidebar**). The authors propose policy changes that would better align carceral research policies with best practices in research governance, facilitating ethical research access and strengthening the evidence needed to address the health needs of this marginalized population. **Full text:** https://bit.ly/4yywLYJ

From an earlier posting on the End-of-Life Care Behind Bars website

Conducting Ethical Health Research in Prisons: Guidance for Prison Health Researchers

UNIVERSITY OF SOUTHAMPTON (**U.K.**) | Online – Accessed 19 August 2026 – The history of unethical health research in prisons, research that has contravened the human rights of those in prison, underscores the need for ethical guidance specific to prison settings. The authors also recognise that many current international and national guidelines aiming to protect people living in prisons from the harms of unethical research unintentionally prevent people living in prison from meaningful participation and prevent them benefiting from research progress. This systematic exclusion represses the voices and distorts research findings, denying people living in prisons the benefits of research conferred on people in the community. **Access report at:** https://bit.ly/4ibXV2I

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Artificial intelligence in prison healthcare

CORRECTIONAL NEWS (**Finland**) | Online – Accessed 10 September 2026 – As artificial intelligence (AI) begins to shape every aspect of correctional systems, healthcare stands out as one of its most promising yet complex frontiers. Prisons face chronic healthcare crises: overcrowding, staff shortages and limited access to specialized treatment. The COVID-19 pandemic accelerated digitalization across correctional systems, making telemedicine, digital self-help and AI-assisted monitoring a permanent part of the landscape. Within this new ecosystem, AI is not merely a technical upgrade – it has become an ethical and operational imperative. The Council of Europe's recommendation on AI in prisons and probations … identifies healthcare as one of the key areas where AI may support diagnosis and follow-up medical treatment – provided it does not replace face-to-face care.[1] The principle of "human-centered AI" is therefore critical: technology should enhance medical access and safety, not automate human care. **Full text:** https://bit.ly/46UCMTG

From an earlier posting on the End-of-Life Care Behind Bars website

Artificial intelligence in correctional healthcare: Designing for access, inclusion, and trust

JAMA INTERNAL MEDICINE (**U.S.**) | Online – 3 August 2026 – AI, including large language models, predictive analytics, and other clinical support tools, is rapidly reshaping healthcare delivery. These technologies may improve access and extend workforces but without attention to equity they risk reinforcing disparities and mistrust. These tensions are particularly salient within carceral healthcare. The U.S. incarcerates a higher proportion of our population than any other nation, making the criminal legal system a *de facto* health system for the 2 million individuals detained in prison... Digital exclusion compounds vulnerabilities, with incarcerated individuals often unable to access electronic health records or other digital health tools. **Abstract:** https://bit.ly/4hT9OKF

1. 'Recommendation of the Committee of Ministers to member states regarding the ethical and organisational aspects of the use of artificial intelligence and related digital technologies by prison and probation services,' Council of Europe (2024). **Full text:** https://bit.ly/3T0LMUa

N.B. For a broader view of AI from the perspective of **palliative and end-of-life care** see the latest posting on the Literature Search page of the website of the International Association for Hospice & Palliative Care at: https://bit.ly/4q8IsAJ

The psychology of waiting: Why time feels different in correctional healthcare

CORRECTCARE (**U.S.**) | Online – 25 August 2026 – Waiting is a universal experience. In the correctional healthcare environment, patients wait to be seen, receive results, and access treatment – often while also waiting for custody staff to escort them. At the same time, clinical staff wait for information, security clearance, patient transport, and access to spaces where care can safely take place. Even routine care depends on coordinated movement between custody and healthcare operations. Yet waiting is not simply the passage of time. It is a psychological experience shaped less by minutes on a clock than by uncertainty, control, and meaning. In corrections, the psychological impact of waiting is often intensified. Patients already experience reduced personal control over their daily lives. Schedules, movement, and access are externally structured. When healthcare access involves delays or unclear timelines, feelings of helplessness can increase. **Full text (scroll down to p.16):** https://bit.ly/3T464fz

Have you checked out the latest postings on the 'Current Thinking' page of the End-of-Life Care Behind Bars website lately? https://bit.ly/45882x8

Letters to the editor

End-of-life care for people who are incarcerated

JAMA NETWORK (U.S.) | Online – 1 October 2026 – We [the authors] appreciate the response to our article by Ms Ofori-Darko and Dr McClelland and agree wholeheartedly that the definition of palliative care for incarcerated patients should be comprehensive and match the community standard.[1,2] This standard includes all evidence-based interventions that palliate symptoms during serious, life-limiting illness. We also agree that short-course or single-fraction regimens of radiation therapy may be indicated for incarcerated patients with serious illness who may face additional barriers to longer-duration treatments. Other palliative treatments may also include some forms of chemotherapy, immunotherapy, antibiotics, blood transfusions, and diuresis. Some treatments may lose palliative effectiveness over time and thus be stopped as a person transitions to hospice care. **Access full text at:** https://bit.ly/3TYUl2e

1. 'End-of-life and hospice care for people who are incarcerated,' Original article published in *JAMA* Insights, 24 June 2026. **Access full text at:** https://bit.ly/4xTibvy

2. 'End-of-life and hospice care for people who are incarcerated,' Response to the original article published in *JAMA* Insights, 1 October 2026. **Access full text at:** https://bit.ly/4rIVx68

Government needs a national strategy for long-term prisoners

(**U.K.**) | Online – 29 September 2026 – The government should develop a dedicated 10-year strategy for long-term prisoners, to meet the needs of the growing number of prisoners serving long and indeterminate sentences...[1] The report ... is the culmination of the Trust's six-year Building Futures programme. The programme engaged more than 1,000 people serving long sentences from over 70 prisons across the U.K., alongside people released after serving long sentences, family members, prison staff, policymakers and academics. Participants talked about the importance of dignity, including at the end of life, and their fears about losing this and/or dying inside. Some shared instances of being unnecessarily cuffed when attending hospital visits or of seeing peers become frail and die. Concerns about these issues heightened with age and speak to evidence that shows increasing numbers of people in prison receiving palliative care. Many participants conveyed a sense of 'dying inside' due to the loss of purpose, identity, and relationships. **Download report (word search "palliative care") at:** https://bit.ly/4iR0Z4K

Expanding end-of-life options for incarcerated individuals

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE (**U.S.**), 2026;43(10):1119-1125. The aging prison population in the U.S. presents urgent challenges for providing appropriate end-of-life (EoL) care. Currently, there are two primary approaches to deliver this in a compassionate manner: medical release programs(MRP) and prison-based EoL care programs (EoLCPs). Using New York State as a case study, the authors argue expanded MRP represent the most ethical path forward, while acknowledging the continuing need for prison-based EoLCPs. Their analysis reveals significant barriers to accessing medical release, including lack of knowledge about the application processes, procedural inefficiencies, overreliance on prognostication, and social stigma. While prison-based programs offer some benefits, studies indicate they frequently fall short of community standards for EoL care, particularly regarding family involvement, pain management, and environment, including a shortage of beds and equipment. **Abstract:** https://bit.ly/3XZGMOk

To keep abreast of current thinking on palliative and end-of-life care check out 'Literature Search' on the website of the International Association for Hospice & Palliative Care at: https://bit.ly/3WWxUYC

Palliative care needs and experiences of people in prison: A systematic review and meta-synthesis

QUEENS UNIVERSITY OF TECHNOLOGY (**Australia**) | Online – Modified 16 September 2026 – Globally, the prison population is growing and ageing, as is the need for palliative care (PC). Yet, little is known about how people in prison perceive PC provision in this setting. [The aim of this study was] to identify: 1) perceptions of PC provision and dying in custody by people in prison; and, 2) perceived barriers and facilitators of person-centred PC provision in prison. Experiences of people in prison regarding PC related to two themes: 1) expectations versus experiences of PC; and, 2) prison context complicates access to and provision of PC. People in prison with PC needs want to feel safe, cared for, and acknowledged as they face an expected death. The prison environment can severely restrict access to PC, leaving people in prison feeling isolated and powerless. People in prison expect to receive high-quality PC, but their experiences often do not match their expectations. **Abstract:** https://bit.ly/4y1Udhk

Death and dying. Darned unpleasant behind bars!

HUMANITY FOR PRISONERS (**U.S.**) | Online – 14 September 2026 – Being attended by family can bring deep comfort to a dying person. But, often behind bars that just didn't happen. Dying in prison without loved ones present can cause deep emotional harm to both the dying individual and their family. Inmates often face their final moments alone, sometimes physically restrained or chained to medical beds. Dying prisoners are routinely denied the right to make meaningful medical or end-of-life decisions regarding their care. Terminally ill prisoners frequently experience untreated or undertreated physical pain due to substandard institutional medical protocol. The absolute fear of dying forgotten and disconnected from family remains one of the most severe emotional burdens of long-term incarceration! A number of men and women die in Michigan prisons each year with no family or friends present, and even, in come cases, no one to claim the body of the deceased. **Full text:** https://bit.ly/46vjjJm

End-of-Life Care in Prisons: Community Hospice Engagement (2)

Past Posting on the End-of-Life Care Behind Bars website



Cont.



We share our learning about facilitators and barriers to the provision of good palliative care in one prison and some solutions we have found to overcome various barriers identified.

Methods

Over 18 months the hospice has worked with our local prison on a project to improve the care for people living there with frailty. This has involved establishing a frailty screening programme, further holistic assessment of those identified as moderately or severely frail, quality improvement work and establishing monthly Frailty and Palliative Care MDT meetings. This has taken place alongside a package of education and training for those working with people living with frailty in the prison. As part of this, we have been exploring how to improve the provision of palliative and end of life care within the prison.

Results

Facilitators of good palliative care
• Growing recognition of need from all teams
• Partnership working across multiple teams
• Provision of social carers (24 hours a day in our local prison)
• Committed health team
• Specific hospice project
• Involvement and support from Scottish Prison Service (SPS)

Barriers to good palliative care
• Prison environment
• Concerns around use of CSCIs
• Lack of out of hours nursing provision
• Lack of information in the out of hours period
• Prognostication difficulties in people living with frailty
• Late planning

Throughout our local prison there was recognition of the large increase in people who were elderly, frail and/or have significant health care needs along with the growing number of deaths from physical causes. Teams recognised that this group were not the traditional prison population and were keen to learn more and improve the care provided.

The prison environment presents many challenges when caring for people living with palliative care needs and/or frailty

- Shortage of adapted cells
- Standard cell doors not wide enough for wheelchairs, hospital beds or hoists
- Often noisy chaotic environment with lack of privacy and peace
- Risk of exploitation by others
- Specific concerns around using CSCI due to the risks
- No nursing or medical presence in our local prison overnight
- Difficulty accessing information such as future care plans or medications out of hours.

Prior to the project, referrals to palliative care were limited, tended to be late in someone's journey and were mainly for people with cancer diagnoses.

Carrying out this work as a specific hospice project allowed us to develop relationships with staff in the prison and take time to understand the environment and facilitate new developments. Work has involved the primary care team, social carers, mental health team, social work team, chaplaincy team, rehab team, Scottish prison service staff, AHPs and local palliative care team. Monthly Frailty and Palliative Care MDT meetings brings everyone together, both to discuss how best to meet the needs of specific people in prison and look at wider issues around how care can be improved.

By combining work around frailty and palliative care, planning and palliative care involvement take place earlier. Information sharing has improved and prison healthcare staff are now able to complete digital RESPECT forms which can be viewed out of hours. Work is ongoing around improving provision of just in case medications and CSCIs and upgrading a cell to be used for people at end of life. Our education work in prisons is described elsewhere.

Conclusion

There are many challenges and barriers to providing good palliative care in the prison setting. However, there is a growing need and much that can be done to improve the palliative care of people in prison.

Thank you to Hospice UK for a grant which supported the Prison Frailty Project.
Thank you to all the staff in HMP Glenochil.

References:
1 Hospice UK. Dying Behind Bars. Hospice UK. 2021
2 Rafferty, J. Deaths in Scottish Prisons 2019-2022. Strathcarron Conference. 2023
3 Schaefer, I. DiGiacomo, M. Hensley, N et al. Palliative Care Needs and Experiences of People in Prison: A systematic review and meta-synthesis. Palliative Medicine. 2022.

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N.B. Download conference poster presentation (2025) at: https://bit.ly/46Le7B2; related postings on the End-of-Life Care Behind Bars website – 'Engaging the Hospice Community in End-of-Life Care in Prisons' (Parts 1 & 2): https://bit.ly/4h3anNZ & https://bit.ly/3UEwYLj ***BRA***

Care Planning

A power in death: Death as a site of resistance in prison

SOCIAL SCIENCES (**U.S.**) | Online – 1 October 2026 – The prison is often discussed as an institution that imposes death, be it physical, social, or spiritual death. Resistance to prison, likewise, is often depicted through processes that affirm life – in "acts of living," such as creating strong peer networks, developing daily routines and practices of self-care, collective organizing inside or outside the prison or, more generally, actively hoping for and working toward release from prison. For some, however, resistance centers not only on life, but on death – seeking to control one's death, fighting against death as it is imposed by the system, or making efforts to die on one's own terms. This article examines ways in which incarcerated people approach death by choosing to die in ways that have meaning to them. The authors examine how incarcerated people create alternative pathways for autonomy and community in the death process, through "everyday death resistances," including refusing to accept prison medical care, strategizing to die on the mainline rather than in prison medical clinics, and finding a "good death" in hospice. **Full text:** https://bit.ly/4zebkg7

The articles, reports, etc., noted on each monthly posting on the End-of-Life Care Behind Bars website are a *representative* sample of current thinking on end of-life care in prisons. If you think any important articles, reports, etc., have been missed or overlooked, please let us know: https://bit.ly/4cdWVFD

Grief & Bereavement

The last seven minutes of one man's life in an Oregon prison

(**U.S.**) | Online – 11 September 2026 – Jacob was the third person who died this year in Eastern Oregon Correctional Institution, where I am incarcerated. During the summer, prison administrators finally agreed to schedule a memorial for all three men. Each dead man was allotted 20 minutes for remembrances. I suppose we were meant to feel comforted by the memorial. But the event felt more like an after-thought, the prison's attempt to sanitize our grief and check off the last box in what they hoped was a tidy way to deal with all the death. At the service, we exchanged memories about the people we lost. I wasn't there when Jacob died, but dozens of people who lived in the 100-man dormitory witnessed the final minutes of his life, when he fell from a chair to the floor, quietly gasping for air. That's part of why Jacob affected so many people. They saw him die. Grieving is different for incarcerated people. **Full text:** https://bit.ly/4gYfb9s

When loss has two addresses: Grief inside prison and at home

COMPASSION CROSSING (**U.S.**) | Online – 4 September 2026 – Grief does not stop at the prison gate**.** Incarceration does not erase family bonds. A person in prison may grieve a death, a serious illness, a damaged relationship, years of missed milestones, or the daily absence of people they love. Loved ones outside may experience their own losses. A spouse may grieve sharing decisions alone. A child may miss a parent at bedtime, school events, and holidays. A sibling may become the person who carries family updates, questions, and difficult news. Facility rules, security needs, distance, and available services can affect visits, calls, grief support, and participation in family events. These limits may make already difficult losses feel more isolating. Research has described incarceration as a setting where bereavement may be complicated by separation, limited privacy, and restricted access to ordinary mourning practices. **Full text:** https://bit.ly/4xEfMUS

Barry R. Ashpole, Ontario, CANADA **Biosketch:** https://bit.ly/3XMTRs4