When care meets choice behind bars: Integrating palliative care and VAD pathways in prisons

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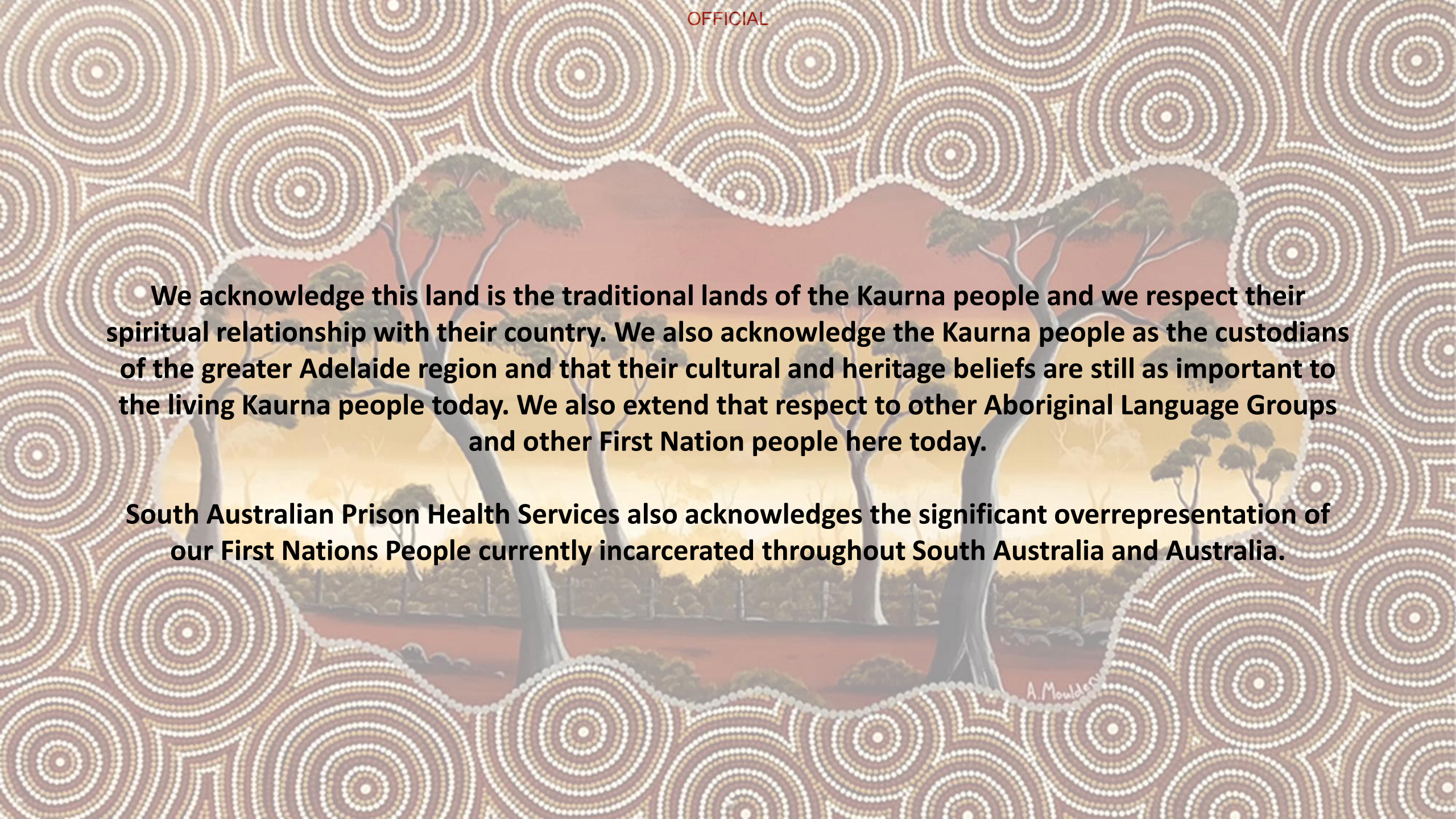


We acknowledge this land is the traditional lands of the Kaurna people and we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the custodians of the greater Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today. We also extend that respect to other Aboriginal Language Groups and other First Nation people here today.

South Australian Prison Health Services also acknowledges the significant overrepresentation of our First Nations People currently incarcerated throughout South Australia and Australia.

Model of Palliative Care:

A Pathway for People who are Incarcerated

In 2021 SA Prison Health in collaboration with the Central Adelaide Palliative Care Services developed a Model of Care for people in custody with the following statement underpinning the model: “It doesn’t matter who I am, or where I live, I get the care I need when I need it” (National Palliative Care Strategy, 2018).

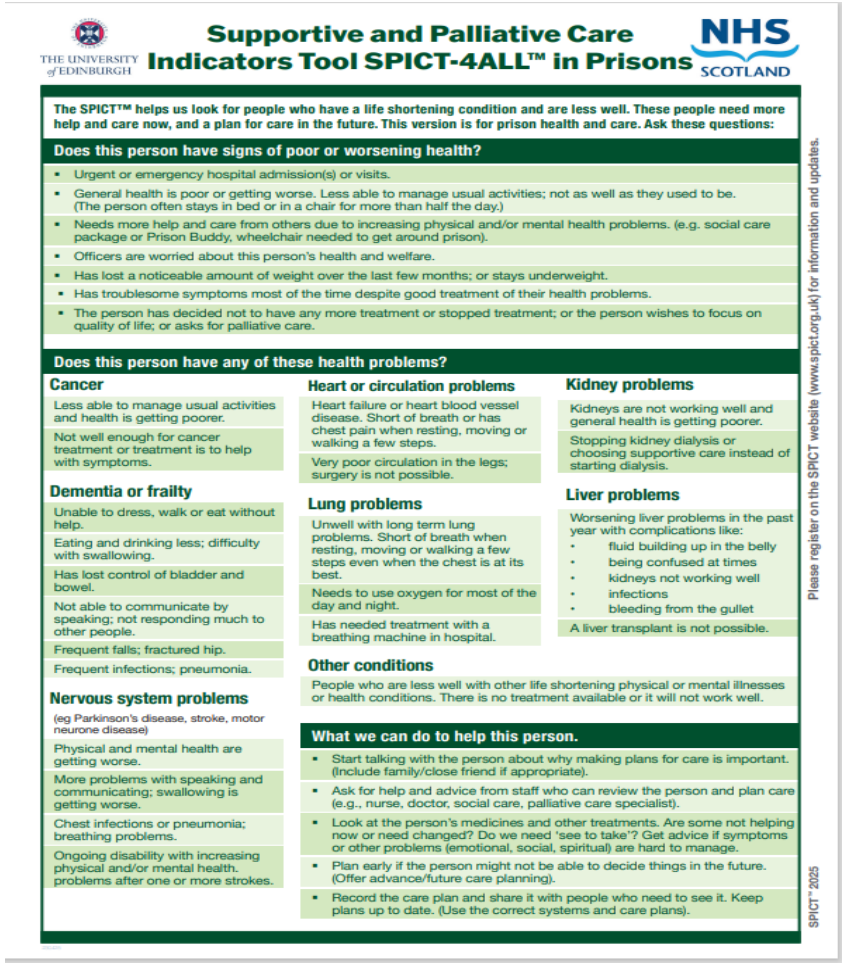
The development of the pathway is underpinned by close collaboration between SA Prison Health Service (SAPHS), the SA Department for Correctional Services (DCS) and the Central Adelaide Palliative Care Services.

Palliative care can be provided at any time depending on a person’s needs. It is now accepted that combining palliative care with active treatment improves symptom control, quality of life, and family satisfaction.

People who are incarcerated have long been identified as a population who have unmet needs at the end of life. They are not always able to access the same care, support and clinical services as the rest of the community.

Pathway to Palliative Care

- New life-limiting illness → refer to SAPHS Nurse Consultant / Site Link Nurse
- Case review SAPHS & Public Hospital EMR
- Assess with SPICT-4ALL™ (Prison version)
- Patient discussion & consent to refer to CAPCS
- Formal referral to CAPCS Community Team
- Joint patient review: CAPCS, SAPHS NC, Link Nurse (in-person/video)
- Ongoing care: symptom monitoring, family meetings, specialist liaison, goals of care review, seven step pathway, plan for death, release options?
- 3-monthly oversight meetings: SAPHS, DCS, CAPCS representatives



THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool SPICT-4ALL™ in Prisons

NHS SCOTLAND

The SPICT™ helps us look for people who have a life shortening condition and are less well. These people need more help and care now, and a plan for care in the future. This version is for prison health and care. Ask these questions:

Does this person have signs of poor or worsening health?

- Urgent or emergency hospital admission(s) or visits.
- General health is poor or getting worse. Less able to manage usual activities; not as well as they used to be. (The person often stays in bed or in a chair for more than half the day.)
- Needs more help and care from others due to increasing physical and/or mental health problems. (e.g. social care package or Prison Buddy, wheelchair needed to get around prison).
- Officers are worried about this person's health and welfare.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person has decided not to have any more treatment or stopped treatment; or the person wishes to focus on quality of life; or asks for palliative care.

Does this person have any of these health problems?

Cancer

Less able to manage usual activities and health is getting poorer.

Not well enough for cancer treatment or treatment is to help with symptoms.

Dementia or frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Has lost control of bladder and bowel.

Not able to communicate by speaking; not responding much to other people.

Frequent falls; fractured hip.

Frequent infections; pneumonia.

Nervous system problems

(eg Parkinson's disease, stroke, motor neurone disease)

Physical and mental health are getting worse.

More problems with speaking and communicating; swallowing is getting worse.

Chest infections or pneumonia; breathing problems.

Ongoing disability with increasing physical and/or mental health problems after one or more strokes.

Heart or circulation problems

Heart failure or heart blood vessel disease. Short of breath or has chest pain when resting, moving or walking a few steps.

Very poor circulation in the legs; surgery is not possible.

Lung problems

Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.

Needs to use oxygen for most of the day and night.

Has needed treatment with a breathing machine in hospital.

Other conditions

People who are less well with other life shortening physical or mental illnesses or health conditions. There is no treatment available or it will not work well.

Kidney problems

Kidneys are not working well and general health is getting poorer.

Stopping kidney dialysis or choosing supportive care instead of starting dialysis.

Liver problems

Worsening liver problems in the past year with complications like:

- fluid building up in the belly
- being confused at times
- kidneys not working well
- infections
- bleeding from the gullet

A liver transplant is not possible.

What we can do to help this person.

- Start talking with the person about why making plans for care is important. (Include family/close friend if appropriate).
- Ask for help and advice from staff who can review the person and plan care (e.g., nurse, doctor, social care, palliative care specialist).
- Look at the person's medicines and other treatments. Are some not helping now or need changed? Do we need 'see to take'? Get advice if symptoms or other problems (emotional, social, spiritual) are hard to manage.
- Plan early if the person might not be able to decide things in the future. (Offer advance/future care planning).
- Record the care plan and share it with people who need to see it. Keep plans up to date. (Use the correct systems and care plans).

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™ 2025

Deaths in Custody

State or territory	Number of deaths 2023-2024	Prisoners in Q4 2023	Rate of death (deaths per 1,000 prisoners)
New South Wales	20	12,198	1.6
Victoria	11	6,279	1.8
Queensland	19	10,407	1.8
Western Australia	12	6,914	1.7
South Australia	11	3,113	3.5
Tasmania	0	774	0.0
Australian Capital Territory	1	378	2.6
Northern Territory	2	2,184	0.9

Work being undertaken by the Alexander Campbell, Justice Health Group Curtin University, Prof Stuart Kinner, Justice Health Group Curtin University looking at Rates of Death in South Australian Prisons: A Comparison with Other Australian Prison Systems

VAD History in South Australia

Historic day as SA legalises Voluntary Assisted Dying with State Parliament ratifying the VAD Bill on 24th June 2021, making South Australia the fourth state to legalise Voluntary Assisted Dying (after Victoria, Western Australia and Tasmania)

Implementation of the SA VAD Law and access to, came into effect on 31st January 2023

In 2024/25 406 applications were made with 387 permits issued, 343 Self Administered, 63 Physician assisted.

There have been 4 deaths of People in Custody to date in South Australian Prisons: 3 Self Administered in Hospital and 1 Physician Administered in the Prison Inpatient Health Centre

Patient One

- 81-year-old male serving a custodial sentence
- Diagnosed with metastatic colon cancer while in custody
- Engaged with palliative care and expressed a clear wish to pursue Voluntary Assisted Dying (VAD)
- Assessed and approved under VAD legislation; permit issued
- First individual in custody in the jurisdiction to be granted a VAD permit
- Requested that end-of-life care take place in a hospital setting with family involvement
- Collaboration between VAD team, SAPHS, and DCS to support patient preferences while adhering to custodial requirements
- Careful planning around hospital length of stay, patient expectations, hospital bed pressures and contingencies for return to secure custody if VAD not enacted
- Balancing patient's end-of-life wishes (e.g., wine, preferred food, iPad use, family access and time) with security and custodial regulations
- Consideration of family expectations and potential media interest in the case

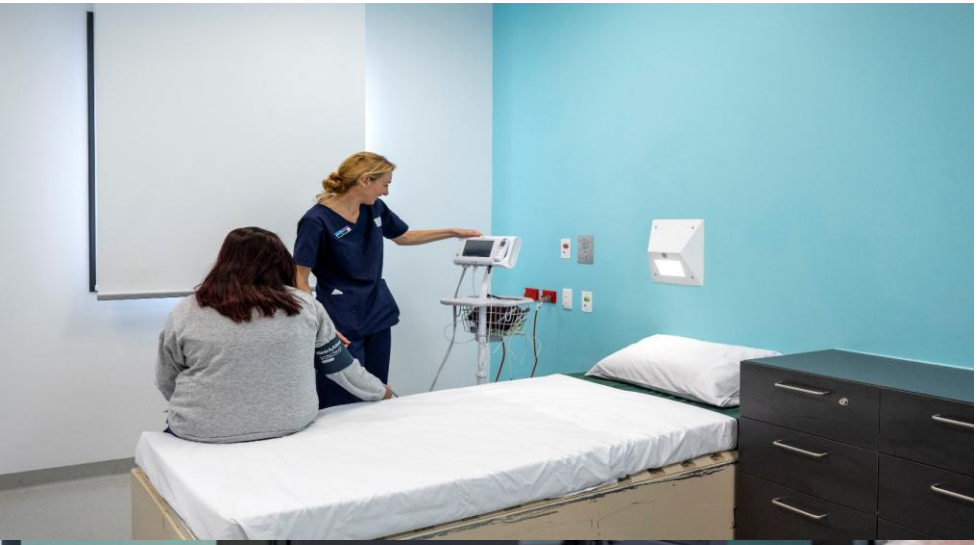
Patient Two

- 73 year old male, with Stage 4 lung cancer, strong family support
- Permit approved in community prior to incarceration
- New to custody when deciding to proceed
- Managed at a privately managed prison
- Request to undertake self-administration outside of prison environment
- Transported to hospital to self-administer, planned 24-hour admission
- Initial admission delayed to finalise court outcome (patient choice)
- Significant media attention and associated political interest across portfolios
- Close co-ordination between agencies using experience from first case
- Process ran smoothly

Patient Three

- 63-year-old male; no family or significant next of kin (NOK)
- Diagnosed with Interstitial Pulmonary Fibrosis (IPF), prognosis 2–5 years
- CAPCS involvement for symptom control assistance
- Deterioration: bed-bound, full-time oxygen, reliant on nursing staff for all care
- Assessed for lung transplant; deemed unsuitable
- Permit granted for self-administered VAD. To administer in prison
- Further decline prevented self-administration; permit updated for physician-administered VAD inside the prison health centre
- Operational plan with DCS for practitioner and VAD substance to enter prison
- No NOK; SAPHS staff member approved as witness at patient's request
- Privacy considerations for patient and conscientious objection for staff
- Patient died peacefully with practitioner and witness present inside the prison

Power Imbalance



- Palliative Care and VAD are based on autonomy—the right to make informed choices about life and death
- Autonomy is central to person-centred end-of-life care practices
- Custodial settings present power imbalances in both healthcare and security
- Can be mitigated by using external doctors and VAD practitioners
- The decision to pursue VAD is highly individual, influenced by personal values, circumstances, and relationships
- Long sentences often result in fractured family ties, reducing vital supports for patients
- Some patients prefer to die with trusted prison healthcare staff after developing relationships with them over the years
- Recognising vulnerability in decision making → Illness, isolation, and institutionalisation can affect a person's ability to freely express wishes

Respecting Individual Goals of Care

- Care is aligned with the person's values, cultural background, and end-of-life goals are explored and documented and consistently re-visited with the patient
- Patients are provided with clear, compassionate information about prognosis, care options, and outcomes congruent with being in a custodial setting
- Ensuring decisions are free from pressure → especially important in restrictive environments like custody
- Building trust → Consistent and compassionate care creates safe spaces for patients to express preferences freely with prison health staff
- Establishing clear lines of communication between VAD practitioners, Department for Corrections, and Prison Health teams
- Identifying potential clinical or legal barriers early, such as capacity concerns or equipment needs, location hospital vs prison health centre
- This is a health decision and should be treated with the same consideration and respect as any other health decision making process

PALLIATIVE CARE EDUCATION & TRAINING COLLABORATIVE

PEPA Program of Experience in the Palliative Approach

IPEPA Indigenous Program of Experience in the Palliative Approach

Funded by the Australian Government Department of Health

Bicycle Bandit Kym Allen Parsons was sentenced on Monday but has been allowed access to voluntary assisted dying. Picture: Mark Brake

SENTENCED TO LIFE

The victims of armed robber Kym Allen Parsons are still haunted by his crimes. Should he be allowed to die in peace when they have none?

MIKE SMITHSON
7NEWS ADELAIDE CHIEF REPORTER

A ticking time bomb ethical issue has arisen in South Australia over voluntary assisted dying.

The community is rightly asking if a self-confessed criminal, who terrorised bank staff in small outlying branches on 10 occasions, should be allowed to die peacefully by his own hand in custody.

Bank robber, former police officer and firefighter Kym Allen Parsons on Monday finally pleaded guilty to a string of aggravated armed robberies from 2004-2014 and is now officially SA's worst serial hold-up crim.

He has terminal cancer and has been approved by SA Health for voluntary assisted dying, which comes under relatively new laws in the State.

Under the 2022 legislation, two accredited medical professionals must sign off on the applicant's terminal condition before they're given a prescribed kit containing a lethal chemical dose.

Media has long dubbed Parsons the "bicycle bandit" as that was his preferred transport method for fleeing each crime scene.

That term might sound flippant, but let's not forget he brandished a firearm during his evil deeds and stole hundreds of thousands of dollars which he poured into a real estate purchase and his other mounting debts.

His eventual arrest and confession followed a DNA match linking him to one of the crime scenes.

But even coughing up his guilt came just hours before he was to face trial.

Until then, the bailed 73-year-old had enjoyed the comparative freedom of home detention.

So, let's face the brutal facts.

This guy is a horrible person.

He's a former copper who should have been trusted to keep people safe and secure rather than leave them mentally scarred for life, after they faced the wrong end of his gun barrel.

He may be entitled to VAD as a diagnosed patient, but what takes precedence: serving a jail sentence yet to be determined by a judge, or dying with some form of dignity?

Personally, I consider he's forfeited his right to the comfort of taking his own life, possibly with family by his side.

SA authorities are keeping tight-lipped on all possibilities.

Where will he undertake his self-inflicted action and who'll be present?

If in prison, authorities say it's not considered a death in custody.

If it's in a public hospital, is he technically in custody and is his family allowed to be there?

Minister defends allowing terminally ill paedophile to end his life

By 9News Staff | 7:46pm Aug 30, 2023

'He has no rights left': Karl calls for Malcolm Day to be denied euthanasia right

By Tom Livingstone | 2 years ago

Today host Karl Stefanovic has called for convicted paedophile Malcolm Day to be denied the right to end his own life after serving just three years of a 20-year sentence.

Parsons given a hefty 35-year sentence but ...

Bandit takes victims for a ride until the end

Jailed bank robber takes life via VAD

DUNCAN EVANS

A bank robber who went on a 10-year crime spree has taken his own life through a voluntary assisted dying kit just two days after he was sentenced to 35 years in prison for his crimes.

Kym Parsons, 73, robbed 11 South Australian banks from 2004 to 2014, armed with a rifle and wearing a balaclava.

News › South Australia

Pedophile Malcolm Winston Day, 81, to become first prisoner to end own life under SA voluntary assisted dying legislation

A pedophile who is not eligible for release from prison for more than a decade is set to end his own life under SA's voluntary assisted dying legislation.

Todd Lewis Follow

@Toddlewis23 2 min read August 31, 2(

SA's notorious 'bicycle bandit' dies, Department for Correctional Services confirms

Lessons Learnt

- VAD in custody can trigger strong public and political responses, especially when cases become public via media interest
- Public opinion can influence political views on prisoner access to VAD
- Correctional healthcare must uphold community equivalence, including access to VAD at end of life
- Each VAD case includes a multi-agency debrief, leading to ongoing process refinement and collaborative relationships
- Initial stance discouraged VAD in custody, but a patient-centred, goal-based approach shifted this view over time and experiences with previous patients
- This evolved approach aligns with existing palliative care pathways and partnerships, particularly with Central Adelaide Palliative Care Services

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