Elise Desiderio Written Testimony Geriatric Parole

Uploaded by: Elise Desiderio

Position: FAV

MARYLAND OFFICE OF THE PUBLIC DEFENDER

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POSITION ON PROPOSED LEGISLATION

BILL: HB 157 - Correctional Services – Geriatric and Medical Parole

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 01/27/2023

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on House Bill 157. This written testimony focuses on the geriatric parole provisions within the Bill.

Across the country, elderly populations within prison systems are increasing.[1] Since 2003, the fastest growing age group in the prison system has been persons aged 55 and older.[2] The Maryland Department of Public Safety and Correctional Services reports that as of July 2022, **14,983** people were housed within the Division of Correction.[3] Of those, **2,035 were between the ages of 51 and 60 and 1105 were over 60**. *Id.*

Several considerations specific to incarcerated seniors demonstrate the need for legislation directed at expanding options for their release. **First**, elderly persons have particular health and safety concerns that living in prison exacerbates. **Second**, elderly persons are less likely to reoffend upon reentering the community than younger persons. **Third**, incarcerating elderly persons is more expensive for the State and its taxpayers than incarcerating younger persons.

First, elderly inmates' health needs are more complex than those of younger inmates. Elderly persons in prison are more likely to be living with chronic health conditions than their

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[1] Brie A. Williams, *et al.*, *Addressing the Aging Crisis in U.S. Criminal Justice Healthcare*, 45 J. Am. Geriatric Soc. 1150-56, author manuscript at *3 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/pdf/nihms363409.pdf (citing U.S. Dep't of Justice, Bureau of Justice Statistics, Office of Justice Programs, *Prisoners Series 1990 – 2010*, http://bjs.ojp.usdoj.gov/index.cfm?ty=pbse&sid=40).

[2] U.S. Dep't of Justice, Bureau of Justice Statistics, *Aging of the State Prison Population, 1993-2013* (May 2016), https://www.bjs.gov/content/pub/pdf/aspp9313.pdf.

[3] Maryland Department of Public Safety and Correctional Services, Division of Correction, *Inmate Characteristics Report FY 2022*, https://dpscs.maryland.gov/publicinfo/publications/pdfs/Inmate%20Characteristics%20Report%20FY%202022%20Q4.pdf.

younger counterparts.[4] "On average, older prisoners nationwide have three chronic medical conditions and a substantially higher burden of chronic conditions like hypertension, diabetes and pulmonary disease than both younger prisoners and older non-prisoners."[5]

Research suggests a correlation between prison life and decline in health. In a 2007 study, researchers interviewed 51 incarcerated men in prison in Pennsylvania with an average age of 57.3 years as well as 33 men in the community with an average age of 72.2.[6] The researchers compared the rates of high cholesterol, high blood pressure, poor vision, and arthritis between the two groups, finding that the data suggested that the health of male inmates was comparable to men in the community who were 15 years older. *Id.* A similar study published in 2018 of 238 participants similarly found that "[a]mong older adults in jail with an average age of 59, the prevalence of several geriatric conditions was similar to that found among community[-]dwelling adults age 75 or older."[7]

Additionally, elderly incarcerated persons, particularly those with elevated health concerns, "are at an elevated risk for physical or sexual assault victimization, bullying, and extortion from other prisoners or staff compared to their younger counterparts."[8] Older prisoners also report higher stress and anxiety than their younger counterparts, "including the fear of dying in prison and victimization or being diagnosed with a severe physical or mental illness."[9] Correctional institutions struggle to meet elderly prisoners' health needs. "Prisons typically do not have systems in place to monitor chronic problems or to implement preventative measures."[10]

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[4] Tina Maschi, Deborah Viola, & Fei Sun, *The High Cost of the International Aging Prisoner Crisis: Well-Being as the Common Denominator for Action*, 53 The Gerontologist 543-54 (2012), https://academic.oup.com/gerontologist/article/53/4/543/556355.

[5] Brie A. Williams, *et al.*, *Addressing the Aging Crisis in U.S. Criminal Justice Healthcare*, J. Am. Geriatric Soc. 1150-56, author manuscript at *3 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/pdf/nihms363409.pdf.

[6] Susan J. Loeb, Darrell Steffensmeier, & Frank Lawrence, *Comparing Incarcerated and Community-Dwelling Older Men's Health*, West J. Nurs. Res. 234-49 (2008), https://pubmed.ncbi.nlm.nih.gov/17630382/.

[7] Meredith Greene, *et al.*, *Older Adults in Jail: High Rates and Early Onset of Geriatric Conditions*, Health & Justice (2018), author's manuscript at *4, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5816733/pdf/40352_2018_Article_62.pdf .

[8] Maschi, *supra*, at 545 (citing Stan Stocovic, *Elderly Prisoners: A Growing and Forgotten Group Within Correctional Systems Vulnerable to Elder Abuse*, 19 J. of Elder Abuse & Neglect 97-117 (2008)). https://www.tandfonline.com/doi/abs/10.1300/J084v19n03_06.

[9] *Id.* (citations omitted); *see also* Stephanie C. Yarnell, Paul D. Kirwin & Howard V. Zonana, *Geriatrics and the Legal System*, 45 J. of the Am. Academy of Psychiatry & the L. Online 208-17 (2017), http://jaapl.org/content/jaapl/45/2/208.full.pdf.

[10] *At America's Expense: Mass Incarceration of the Elderly*, Am. Civil Liberties Union, 28-29 (2012), https://www.aclu.org/report/americas-expense-mass-incarceration-elderly.

The COVID-19 pandemic exacerbates these health concerns. The threat of COVID-19 is not over: as of January 26, 2023, the virus has infected more than **102 million** people in the United States[11] and more than **1.3 million** Marylanders.[12]

People living in prisons are especially vulnerable to COVID-19. The CDC has cautioned that "[c]orrectional and detention facilities are high-density congregate settings that present unique challenges" to effective COVID-19 testing, mitigation, and treatment.[13] Prisons are closed spaces in which detainees sleep, eat, recreate, and share hygiene facilities in close proximity to each other and do not have the freedom to distance themselves from their peers. Under these conditions, communicable diseases like COVID-19 spread more readily through touch inside correctional facilities.[14] From the start of the pandemic to June 25, 2021, the Marshall Project tracked reported cases of COVID-19 among incarcerated people, until the data became impossible to continue collecting.[15] The organization noted **398,627** confirmed COVID-19 cases reported among incarcerated persons across state and federal prisons, which is thought to be a significant undercount. *Id.*

COVID-19 is especially dangerous for incarcerated **seniors**. The CDC cautions that "[m]ore than 81% of COVID-19 deaths occur in people over age 65."[16] Those with underlying medical conditions, which seniors are more likely to have, are also at increased risk of severe illness with COVID-19.[17] The mortality rate for persons with COVID-19 and certain comorbidities are significantly higher than the mortality rate among those without these comorbidities.

I turn now to research demonstrating lower recidivism rates among elderly persons released from prison. The United States Sentencing Commission examined 25,431 federal offenders released in 2005, using a follow-up period of eight years for its definition of

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[11] *COVID-19 Dashboard*, Johns Hopkins University, Center for Systems Science and Engineering, https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (last visited Jan. 26, 2023).

[12] *Coronavirus Disease 2019 (COVID-19) Outbreak*, Maryland Department of Health, https://coronavirus.maryland.gov/ (last visited Jan. 26, 2023).

[13] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last visited Dec. 8, 2020).

[14] Dan Morse & Justin Jouvenal, *Inmates Sharing Sinks, Showers and Cells Say Social Distancing in Impossible in Maryland Prisons*, The Washington Post (Apr. 10, 2020), https://www.washingtonpost.com/local/public-safety/inmates-sharing-sinks-showers-and-cells-say-social-distancing-isnt-possible-in-maryland-prisons/2020/04/10/5b1d5cf8-7913-11ea-9bee-c5bf9d2e3288_story.html.

[15] *A State-By-State Look at 15 Months of Coronavirus in Prisons*, The Marshall Project, https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (last visited Jan. 26, 2023).

[16] *People with Certain Medical Conditions*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last visited Jan. 26, 2023).

[17] *Id.*

recidivism.[18] For the eight years after their release, the Commision calculated a rearrest rate of 64.8% for the released persons younger than 30, 53.6% for the released persons between the ages of 30 and 39, 43.2% for the released persons between 40 and 49, 26.8% for the released persons between 50 and 59, and 16.4% for the released persons older than 59. *Id.*

The Commission's data shows that the recidivism rate drops off most sharply after the age of 50. Moreover, before age 50, released persons are most likely to be re-arrested for assault. *Id.* After age 50, they are most likely to be re-arrested for a comparatively minor public order offense like public drunkenness. *Id.* The American Civil Liberties Union has also compiled data collected nationally and from various states demonstrating that older incarcerated persons across the country have a "lower propensity to commit crimes and pose threats to public safety."[19]

It is also more expensive to incarcerate elderly persons than their younger counterparts. At the national level, "[b]ased on [the Bureau of Prisons'] cost data, [the Office of the Inspector General] estimate[s] that the [Bureau of Prisons] spent approximately $881 million, or 19 percent of its total budget, to incarcerate aging inmates in [fiscal year] 2013."[20] "According to a National Institute of Corrections (NIC) study from 2004, taxpayers pay more than twice as much per year to incarcerate an aging prisoner than they pay to incarcerate a younger one."[21] These outsized costs are in large part due to the increased healthcare costs associated with elderly persons in prison.[22] Maryland feels this economic strain more acutely than many other states do. From 2010 to 2015, the national median spending per inmate on healthcare was $5,720 per fiscal year, while the state of Maryland spent $7,280 per fiscal year.[23] From 2001 to 2008, per-inmate healthcare spending rose 103% in Maryland from $3,011 per fiscal year to $5,117 per fiscal year.[24]

The public policy interest in retribution has been satisfied by the many years most elderly persons have already spent in prison. Expanding options for parole release for seniors in prison is the right thing to do. Giving weight to their age when evaluating parole suitability is a laudable step.

House Bill 157 will create a meaningful geriatric parole standard. Currently, geriatric parole is codified in Criminal Law 14-101, the statute that defines sentences for subsequent

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[18] Kim Steven Hunt & Billy Easley, U.S. Sent'g Comm'n, *The Effects of Aging on Recidivism Among Federal Offenders* (2017), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171207_Recidivism-Age.pdf.

[19] *At America's Expense: Mass Incarceration of the Elderly*, American Civil Liberties Union (2012), https://www.aclu.org/report/americas-expense-mass-incarceration-elderly.

[20] Dep't of Justice, Office of the Inspector Gen., *The Impact of an Aging Inmate Population on the Federal Bureau of Prisons*, i (Feb. 2016), https://oig.justice.gov/reports/2015/e1505.pdf.

[21] *At America's Expense: Mass Incarceration of the Elderly*, Am. Civil Liberties Union, 27 (2012) (citing B. Jaye Anno *et al.*, U.S. Dep't of Justice, Nat'l Inst. of Corr., *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates*, 10 (2004)).

[22] *Id.*; Zachary Psick, *et al.*, *Prison Boomers: Policy Implications of Aging Prison Populations*, Int. J. Prison Health, 57-63 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812446/pdf/nihms940509.pdf.

[23] Pew Charitable Trusts, *Prison Health Care Costs and Quality* (Oct. 18, 2017), https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

[24] *Id.*

crimes of violence. Under the current law, only repeat violent offenders are eligible for geriatric parole. Last year, Chairman Blumberg testified before the Judicial Proceedings Committee that the current statute is unworkable. House Bill 157 simply moves the geriatric parole provision into the Correctional Services article and at the Commission's suggestion, sets the standard for review for elderly individuals who have served at least 15 years at every two years. Under the amended language, approximately 650 individuals will qualify for geriatric parole.

Maryland has the opportunity to reduce mass incarceration, save the state millions of dollars, contribute to safer communities, and allow Maryland's incarcerated seniors the opportunity they deserve to live their twilight years with dignity, breathing free air.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on HB157.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.

Authored by: Elise Desiderio, Assistant Public Defender II, elise.desiderio@maryland.gov.

MD Catholic Conference_HB 157_FAV.pdf
Uploaded by: Garrett O'Day
Position: FAV

MARYLAND CATHOLIC CONFERENCE

January 31, 2023

HB 157
Correctional Services – Geriatric and Medical Parole

House Judiciary Committee
Position: SUPPORT

The Maryland Catholic Conference offers this testimony in SUPPORT of House Bill 157. The Catholic Conference is the public policy representative of the three (arch)dioceses serving Maryland, which together encompass over one million Marylanders. Statewide, their parishes, schools, hospitals and numerous charities combine to form our state's second largest social service provider network, behind only our state government.

Bill 157 would allow the parole commission to employ a dynamic risk assessment to determine whether certain inmates who are at least 60 years of age should be released on parole. It would also allow for expansion of medical parole, in particular those inmates deemed to be "chronically debilitated or incapacitated".

The Catholic Church roots much of its social justice teaching in the inherent dignity of every human person and the principals of forgiveness, redemption and restoration. Catholic doctrine provides that the criminal justice system should serve three principal purposes: (1) the preservation and protection of the common good of society, (2) the restoration of public order, and (3) the restoration or conversion of the offender. Thus, the Church recognizes the importance of striking a balance between protecting the common good and attentiveness to the rehabilitation of the incarcerated. The Conference submits that this legislation seeks to embody these principals and purposes, relative to intersection between our justice system and our communities, victims and offenders. Older inmates who have served much of their sentence or are medically incapacitated or need treatment outside of the prison system certainly merit the mercy of a consideration for re-entry into society.

House Bill 157 would restore hope for elderly offenders or for those in need of certain medical treatment seeking to reincorporate themselves into society, where they can be cared for by the community, as opposed to behind bars. This is particularly warranted where they pose no danger to society. The Maryland Catholic Conference thus urges this committee to return a favorable report on House Bill 157.

2023-01-31 HB 157 (Support).pdf
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January 31, 2023

TO: The Honorable Luke Clippinger
Chair, Judiciary Committee

FROM: Hannibal G. Williams II Kemerer
Chief Counsel, Legislative Affairs, Office of the Attorney General

RE: HB 0157 – Correctional Services – Geriatric and Medical Parole – **Support**

The Office of Attorney General (the "OAG") urges this Committee to favorably report House Bill 157. This legislation, sponsored by Vice Chair Moon, would require the consideration of an inmate's age, and the extent to which the inmate is likely to recidivate or pose a threat to public safety, in the determination of whether to grant parole. House Bill 157 would require an inmate who is at least sixty years-old and has served at least fifteen years of the imposed sentence, and is not registered or eligible for registration as a sex offender, to have a parole hearing every two years. The bill would also provide for medical parole upon a licensed medical professional's determination that an inmate is terminally ill or chronically debilitated or incapacitated, in need of extended medical care better met by community services, and is physically incapable of presenting a danger to society. The bill also contains procedural and reporting requirements for these parole hearings.

Geriatric and medical parole – also known as "compassionate release" – are premised on "a humanitarian desire to allow people to spend their remaining days outside of prison in the company of their family and friends, as well as practical considerations of the high cost and minimal public safety value of incarcerating people who are old or gravely ill."[1] Despite the overall prison population declining across the U.S., the number of incarcerated older adults has increased.[2] These individuals typically pose minimal risk to public safety and lower rates of recidivism due to age and physical condition.[3] Without expanded access to geriatric and medical

[1] Rebecca Silber, Léon Digard, Jesse LaChance, *A Question of Compassion: Medical Parole in New York State*, VERA INSTITUTE OF JUSTICE (April 2018), https://www.vera.org/publications/medical-parole-new-york-state.
[2] *Id.*
[3] JUSTICE POLICY INSTITUTE, *Compassionate Release in Maryland: Recommendations for Improving Medical and Geriatric Parole* (January 2022) at 4–5 (available at https://justicepolicy.org/wp-content/uploads/2022/02/Maryland-Compassionate-Release.pdf) ("In 2012, a Maryland court determined a series of cases involved unconstitutional jury instructions. This resulted in 235 individuals, many of whom had committed serious violent offenses, becoming

parole in Maryland, the elderly population in State prisons will continue to grow, increasing the State's costs in providing necessary health and end-of-life care to inmates, and serving little benefit to public safety.[4]

Additionally, HB 157 provides that any savings as a result of these provisions will revert back to the Department of Public Safety and Correctional Services for use in carrying out these parole hearings, as well as increase pre-release and re-entry resources for inmates released on parole, which will better assist those released from prison in reintegrating into the community.[5]

For the foregoing reasons, the Office of the Attorney General urges a favorable report on House Bill 157.

cc: Members of the Judiciary Committee

eligible for release. The average age of those released due to the Unger decision was 64, and they had served an average of 40 years in prison. In the eight years since the ruling, these individuals have posted a recidivism rate of under three percent. This is much lower than the 40 percent rate of recidivism after only three years for all persons released from Maryland prison. The rate for the aging Unger population is so low that the cohort was five times more likely to pass away from old age than to recidivate for a new crime.").

[4] *Id.* at 1.

[5] H.B. 157, 2023 Legis. Sess, 445th Gen. Assemb. (Md. 2023) § 7-310(D).

House Bill 157 Written Testimony.pdf
Uploaded by: Joshua Sexton
Position: FAV

To: House Judicial Proceedings Committee
From: Joshua "Jay" Sexton, University of Maryland School of Law Clinical Law Program
500 W. Baltimore Street, Baltimore, Maryland 21202
Re: In Support of House Bill 0157
Date: January 26, 2023

The Gender Violence Clinic at the University of Maryland School of Law represents criminalized survivors of violence—people who have been victims of gender-based violence (intimate partner violence, rape, sexual assault, human trafficking, and violence related to gender identity and/or sexual orientation) and whose incarceration (current or former) is related to in some way to that violence. The clinic's clients include several incarcerated individuals who have sought medical parole or who are aging in prison. The clinic enthusiastically supports the reforms to both medical and geriatric parole that are embodied in House Bill 157.
House Bill 0157 makes necessary changes to the Maryland parole process that will require the Maryland Parole Commission to take into account the ages and medical conditions of those incarcerated individuals who are most in need of help. While medical and geriatric parole do exist conceptually under current law, the statistics will show that neither of the current processes are functioning the way the General Assembly intended.

It should come as no surprise that prisons are not equipped to handle the needs of elderly incarcerated individuals or those with severe illnesses or injuries. Data shows that on average, it can cost the state 2-3 times more per year to care for a incarcerated individual who is sick or elderly than it does to care for a incarcerated individual who is younger and healthier. That cost reflects incarcerated individuals who, in the Clinic's experience, are often receiving the most minimal care and who do not typically have access to the standard of care available in the community. Those incarcerated individuals with life-threatening, debilitating illnesses should be able to seek proper treatment outside of their facilities, rather than be forced to endure whatever remedies exist in their infirmaries at great cost to the State.

The changes that House Bill 157 would make to Maryland's medical and geriatric parole scheme are desperately needed to bring relief to people behind prison walls. Among the changes that are most critical in the bill is removing the Governor from medical parole decisions for individuals serving life sentences. Consider the circumstances of one Gender Violence Clinic client:

> In the time this individual has been incarcerated, their health has deteriorated rapidly. They suffer from several chronic conditions which has left them almost entirely blind and wheelchair bound. This person can barely see or walk in a prison that is not handicap accessible, resulting in the individual essentially being confined to their room for fear of injuring themselves outside. They are not capable of fulfilling their own basic needs and require almost full time assistance with eating, bathing, dressing, and going to the restroom. The prison is not equipped with to handle an incarcerated individual with this level of illness and injury, and it falls upon other incarcerated individuals to help them with their daily needs. The individuals poses no future threat to public safety, both because of the rehabilitative work they have done while in prison but also because of their condition and would be more appropriately treated in the community. While the Maryland Parole Commission has recognized the merit of this individual's medical

parole request, the Governor denied release and the individual continues to struggle to navigate the prison environment today.

As for the population of older incarcerated individuals, these numbers continue to rise and do so at a rapid rate. According to the latest statistics from the Bureau of Justice, reported just weeks ago, there were 178,200 persons age 55 or older in state or federal prison at the end 2021, a 7% increase from 166,600 at the end of 2020. As Americans continue to live longer lives, so will those Americans who are incarcerated and serving extended sentences. An ACLU report from 2012 predicted this group of incarcerated individuals could reach as high as 400,000 by the year 2030. As the prison population continues to age, we will see more incarcerated individuals with serious illnesses and other medical conditions, which again will only cost the State more resources to handle and slowly turn the State's correctional facilities into warehousing hospitals for the sick and elderly.

House Bill 157 would not open up the flood gate and result in the release of all incarcerated individuals who are over the age of 55 or have an illness, nor would it impair the Commission's ability to take into account the impact on public safety release in any particular case would have. Statistics have shown that the elderly and sick and among the lowest in terms of recidivism rates. Under the language of the bill, the Commission is still required to consider factors like the nature of the crime, victim impact, and the individual's record inside the institution. All this bill does is give the Parole Commission the tools it needs to make a well-informed decision concerning parole for geriatric and sick incarcerated individuals.

HB157 Medical Geriatric Testimony - LMeadows.pdf
Uploaded by: Lila Meadows
Position: FAV

To: House Judiciary Committee
From: Lila Meadows, University of Maryland School of Law Clinical Law Program, 500 W. Baltimore Street, Baltimore, Maryland 21201
Re: In Support of House Bill 157
Date: January 31, 2023

House Bill 157 makes necessary reforms to Maryland's geriatric and medical parole schemes to move Maryland towards having a true mechanism for compassionate release for elderly and infirm incarcerated men and women. According to recent estimates from the Department of Public Safety & Correctional Services, there are currently 1,233 individuals over the age of 60 in the Department of Corrections (DOC). Approximately 650 of those individuals have already served over 15 years in prison. While there is no data to suggest how many of those individuals present with acute or chronic medical issues, as this population continues to age, DOC will continue to struggle to provide the necessary medical and nursing care at great cost to the state. Data provided by the Maryland Parole Commission (MPC) in response to an MPIA request is instructive. In 2020, the first year of the COVID-19 pandemic when vaccines were not yet available, MPC received medical parole requests from 201 individuals. The Commission granted only 27 of those requests – less than 15%. From 2015 – 2020, only 86 individuals were approved for medical parole. House Bill 157 reforms both the medical and geriatric parole process to ensure these processes are meaningfully available to sick and elderly incarcerated individuals who require care beyond what DOC is set up to provide. Given the extremely low rates of recidivism among elderly individuals released from prison, utilizing geriatric and medical parole is not only the humane thing to do, but it also makes fiscal sense without compromising public safety.

House Bill 157 moves Maryland towards a having legally sound standards for medical and geriatric parole. Nothing in House Bill 157 lessens the Commission's obligation to take both public safety or victim impact into account when considering an individual for release under the medical or geriatric parole standards. The Commission is still required to make a determination whether release is compatible with the welfare of public safety and the likelihood that an individual will recidivate if released.

In 2021, the General Assembly took the historic and long overdue step of depoliticizing Maryland's parole process by removing the Governor's authority over parole decisions of individuals serving life sentences. While that step was necessary to move Maryland towards having a functional parole system, it was not sufficient. Medical and geriatric parole affect not only individuals serving life sentences, but the entire correctional population. House Bill 157 moves Maryland closer to having a functional parole system.

<u>Medical parole</u>

Individuals seeking medical parole can ask MPC for consideration by filing a written request under the statute. Current law under MD Code Correctional Services 7-305 requires the Commission to consider an individual's diagnosis and prognosis. In practice, to assess an individual's medical condition and whether it meets the standard in the statute and regulations, the Maryland Parole Commission relies almost entirely on the Karnofsky score provided by

DOC clinician. The Karnofsky score is a measure of functional impairment that can be useful in understanding an individual's limitations but cannot provide a substantive picture of the full medical condition. In my experience, MPC has required a Karnofsky score of 30 or below in order for an individual to merit further consideration for medical parole. The following are examples of clients I have represented who have scored a 40 on the Karnofsky Performance Index and were denied medical parole:

- A client who clearly met the legal standard of being so incapacitated as to pose no threat to public safety. Mismanagement of their diabetes led to the amputation of their leg. While they waited for a prosthetic device that never materialized, they cycled in and out of the prison infirmary because they were unable to care for themself in general population. While in the infirmary, they fell out of the bed, resulting in what clinicians described as a "brain bleed." Not long after their fall, they were taken to a regional hospital for congenital heart failure. They required assistance from nursing staff or other incarcerated individuals to perform all activities of daily living and at times, did not understand that they were in prison. Despite their condition, they were initially denied medical parole.
- A client who had contracted COVID-19 early in the pandemic when DOC staff housed them with another incarcerated individual who was symptomatic. They spent two months at a regional hospital in the ICU on a ventilator before being returned to DOC custody. They now live in the prison infirmary where they are unable to perform most activities of daily living, including showering and walking even short distances, without the aid of supplemental oxygen. DOC clinicians and an independent medical expert agree that the damage to my client's lungs is permanent and there is no prognosis for improvement.

House Bill 157 would clarify the process for obtaining an outside medical evaluation, a process already allowed by statute and require MPC to give those evaluation equal weight to that of DOC physicians. This is a critical change given that many of the sickest incarcerated individuals are receiving care from outside providers who have a better sense of that individual's condition and prognosis than DOC physicians. While Commissioners are not medical professionals, comprehensive medical evaluations that move beyond reliance on the Karnofsky score will help Commissioners better understand whether an individual's diagnosis and prognosis meet the legal standard for consideration under the statute.

These changes are necessary to ensure truly vulnerable and infirm individuals are able to seek release and receive care outside of the correctional setting. Continuing their incarceration of these clients and those like them comes at a great human and financial cost. Continuing the confinement of someone with a debilitating medical condition who poses no threat to public safety and who could receive better medical treatment in the community is inhumane. It is unjust. It costs the State of Maryland an exorbitant amount of money that would be better invested elsewhere in our system.

<u>Geriatric parole</u>

Under current law, Maryland has a geriatric parole provision in name only. Eligibility for geriatric parole is currently governed by MD Code Crim Law §14-101(f)(1) – the section of the code that deals with mandatory sentences for crimes of violence. This alone is a complete

anomaly. No other statutory provision governing parole is placed in the criminal law article of the Maryland Code. The construction of the statute leads to a truly peculiar result. As currently written, the law dictates that geriatric parole is only available to an individual who has reached age 60, served at least 15 years, *and is sentenced under the provisions of 14-101* – meaning only those who have been convicted of multiple crimes of violence are eligible. Despite representing many clients over the age of 60 who have served at least 15 years, I have never had a client who satisfies the subsequent crimes of violence section of the statute.

Beyond the problems with the construction of the statute, the law provides no guidance to the Maryland Parole Commission regarding suitability for geriatric parole. House Bill 157 would remove the geriatric parole provision from MD Code Criminal Law 14-101 and instead place the provision in the Correctional Services Article, where every other provision regarding parole is codified. It would also give the Maryland Parole Commission direction regarding how to evaluate candidates for geriatric parole, creating consistency with standard parole and medical parole consideration.

This written testimony is submitted on behalf of Lila Meadows at the University of Maryland Carey School of Law and not on behalf of the School of Law or University of Maryland, Baltimore.

Marian Grant testimony HB 174:SB 98.pdf
Uploaded by: Marian Grant
Position: FAV

HB 157/SB 98- Correctional Services – Geriatric and Medical Parole

FAV

Marian Grant, 13 Norris Run Ct, Reisterstown, MD 21136, 443-742-8872

I support this bill because of my experience as a palliative care nurse practitioner in Maryland.

In February of 2021, I was called to see an incarcerated individual at my hospital for palliative care. He was 74 years old with kidney failure, on dialysis, unable to walk or care for himself, and so confused he couldn't answer my questions. His chart said he'd gone back and forth from the maximum-security prison infirmary, where he'd been living, to my hospital several times in the previous weeks. This was because of an unfixable problem with his dialysis catheter. When I did a physical exam, I saw he was shackled to the bed. A prison guard sat in his room, ignoring us, and looking at his phone. I've cared for incarcerated individuals before but, for some reason, the injustice of this case really hit me.

I learned more: he and his family had sought medical parole but had been denied. This despite the fact that he had already served 40 years, was now clearly dying, and no longer posed any risk to the community. He did die in my hospital on a subsequent admission only a few weeks later. I'm not sure if his family was able to be there and fear no one on the hospital staff knew him or were comfortable caring for a dying man in shackles.

This case and others have led me to the following conclusions:

- It is both expensive and cruel to send people back and forth between prison and the hospital in their last days. This makes their care at the end of life inconsistent and fragmented.
- People who are so ill so as not to be a safety risk should be granted parole to die outside of prison, ideally with those who matter most to them. Not with strangers in the hospital.
- The state's prison health system does not offer hospice services, so any dying individuals should be paroled to get hospice care in the community instead. To not do so sentences them to substandard end-of-life care in prison or impersonal care in the hospital.

This bill will help by:

- Providing definitions for “terminal illness” and “chronically debilitated or incapacitated” with clear direction that conditions such as dementia and cognitive disability also qualify.
- Directing the Commission to consider whether the health care condition could be managed in the community.
- Allowing an incarcerated individual’s personal representative to request a meeting with the Commission regarding suitability for medical parole (I have heard that currently the Commission often denies those requests.)
- Requiring the Commission to give equal consideration to the opinion of an outside medical provider versus the in-house prison physician.

I would be happy to provide more information as requested and appreciate this opportunity to testify,

Marian Grant, DNP, ACNP-BC, ACHPN, FPCN, FAAN, RN

TESTIMONY MEDICAL PAROLE HB0157.pdf
Uploaded by: Maryland Prisoners Rights
Position: FAV

TESTIMONY IN SUPPORT OF BILL #HB0157

Correctional Services - Geriatric and Medical Parole

Date: 01/31/2023

From: Maryland Prisoners' Rights Coalition

To: Chairman Clippinger, Vice-Chair Moon and Members of the House Judiciary Committee

Re: SUPPORT FOR BILL #HB0157

Thank you for bringing this important bill forward and giving us an opportunity to illuminate the issue.

The Maryland Prisoners' Rights Coalition is a directly impacted organization, supported by advocacy partners, that works to improve the conditions of confinement for incarcerated individuals in Maryland correctional facilities.

We have spent many years identifying and analyzing the conditions of confinement in the State of Maryland that pose grave risks to prisoners' health and safety. Consistently, the most egregious condition of confinement is access to, and quality of, healthcare administered within correctional facilities. As you can imagine, COVID-19 only exacerbated this. We receive hundreds of calls annually regarding these conditions, requiring us to intervene with facilities to advocate for everything from prisoners not receiving prescribed medications to care for the chronically and terminally ill.

Maryland correctional healthcare has proven to be not only subpar and inadequate, but also in violation of the 8th amendment of the United States Constitution as cited in the Duvall Case (Duvall v Hogan). . Incarcerated individuals face insurmountable barriers just to file grievances for the medical abuses and neglect they endure, exacerbated by the lack of access to, and quality of, healthcare in the Maryland correctional system.

Many incarcerated individuals are never able to obtain adequate care and languish behind the walls of our correctional facilities. That is both cruel AND unusual. Denial of healthcare is an 8th Amendment violation and needs to be addressed; given that, the issue will lead to compounded health problems leading to unnecessary death for the incarcerated and ultimately legal liabilities for the state and the contracted provider.

When we receive calls from our clients as part of our intake process, we ask them to complete a request for information form (ROI), which we submit to DPSCS for our clients' records. During the course of our research, we found that DPSCS lacked proper medical records and had unclear policies.

We also submitted interrogatories that were returned with vague information. Further, our investigation over these past years have found egregious practices and subpar healthcare standards. The lack of accurate medical records, unclear policies, and starkly inadequate practices, caused directly by neglect, ultimately exacerbate negative health outcomes for our clients. If and when these men and women return to society, they have a multitude of health problems that require specialized care - problems that if they were treated properly would not have catastrophic health implications, like in the case of a gentleman named Donald Brown, Vivian Penda's son.

The Maryland correctional healthcare system cannot and does not serve those who have serious medical issues. Not only is it a waste of millions of dollars in contracts, there is also a serious cost to the wellbeing

of our communities and even higher legal liability.

One question we have gotten is, “what about those who provide health care services to inmates?” There lies the problem; we found that:

- Healthcare provided by DPSCS vendors is self-regulated and is not subject to any standards of compliance.

- Because of inconsistent care, DPSCS facilities historically fail their federal correctional accreditation (ACA and NCCH).

DPSCS contracts a medical contractor, currently YesCare (formerly Corizon), that has a long record nationally of litigation for abuses and violations. They were cited for not upholding their contract of care, and have, due to these inadequacies, been terminated in multiple states.

YesCare lacks the capacity to provide long-term medical care for the chronically ill, the terminally ill and the elderly. As an example, the medical cost for an inmate under the age of 60 who is considered healthy in Maryland per year is $7,956. This cost doubles to approximately $16,000 annually for inmates over the age of 60, According to DPSCS there are 1,233 incarcerated citizens over the age of 60 (2020 total of aLL 20,421 prisoners,19,515 men and 906 women). If we multiply this number we find that this group bears an additional $9.81 million per year[1] - these figures don’t include people under 60 with serious illnesses, so imagine the expanded cost when they are included. This amounts to almost $49 million over 5 years. YesCare’s bid and contract, (made when they were named Corizon), over a five year period is $680 million[2]. With a $680 million contract, BUT overall expenses approaching $812 million over five years, how does YesCare propose to meet the needs of this population? These numbers speak volumes about YesCare’s inability to meet the needs for which they are contracted, and presses the need for medical and geriatric parole reform.

Providing those with terminal and debilitating conditions in Maryland correctional facilities the opportunity for parole is a strong first step in correcting a long history of healthcare neglect, and offers a viable opportunity for proper care for those debilitated in Maryland prisons. While it is great that DPSCS claims to want to make improvements, and we agree this would be a huge undertaking, they continue to make excuses and plans for improvements that are many years away and that are not reasonably obtainable without expert assistance. This bill is a way that these changes can begin in an expedient manner that at least follows a minimum standard of care and protocols. We currently have evidence that the practices and procedures of the healthcare providers DO NOT follow minimum standard protocol. With DPSCS reporting almost half of their population as being designated as chronically ill, Maryland has a serious issue as a large portion of this chronically ill population is geriatric.

We cannot stress enough the importance of this legislation to reform the access to, and quality of healthcare, for incarcerated individuals in Maryland. This is a civil, social, economic, legal and moral issue, which also bears GREAT FINANCIAL COSTS to the Maryland tax payers. This problem cannot wait for changes in the distant future; it needs to be addressed now, starting with offering the viable pathway we’ve laid out for medical and geriatric parole. As a representative for the entire incarcerated population of the state of Maryland, their families, and loved ones, we strongly urge you to support and give a favorable report for HB0157.

Respectfully,
The Maryland Prisoners’ Rights Coalition
MPRC Partners and the Directly Impacted Governance Committee

[1] "Building on the Unger Experience: A cost-benefit analysis of releasing aging prisoners." *Open Society Institute - Baltimore,* 2019. http://goccp.maryland.gov/wp content/uploads/Unger-Cost-Benefit3.pdf.

2 Award of Contract ID #Inmate Medical Care and Utilization Services; DPSCS # Q0017058 to Corizon Health Inc.. Department of Budget and Management, Supplement B, December 19,2018., p. 132.

3 https://dpscs.maryland.gov/community_releases/DPSCS-Annual-Data-Dashboard.shtml

MHowington_HB0157.pdf
Uploaded by: Michael Howington
Position: FAV

My name is Michael Howington, an inmate at the Jessup Correctional Institution, and I am writing to you in support of HB0157, which would deliver enhanced compassionate release opportunities for infirm and/or elderly persons in prisons. The inadequate medical care within correctional institutions and rare opportunities to be approved for medical or geriatric parole have led to a large population of inmates, like me, who remain incarcerated despite posing a minimal risk to public safety and a significant cost to taxpayers.

I began serving my life sentence in 1980, and I am now 71 years old. I am a Vietnam Combat Veteran, and PTSD and drug addiction that developed after my service contributed to the crimes I committed. When I started serving my sentence, I was filled with anger and hate. In 1984, I was shot for trying to escape prison, and I served 4 years in lock up for my actions. In 2000 my life was beginning to change; I gave my life to the Lord and I have less anger towards the world and have been sober for 20 years. In the institution, I work to help other inmates change their lives the way I changed mine. I have been certified as an Observation Aide and have been commended for my outstanding assistance with the staff and inmate population. I have been a pastor since 2006 and helped start a ministry at the JCI regional hospital, where we visit terminally ill patients. However, I have not been able to visit with these inmates in the last 12 years because of my personal health issues.

While incarcerated, I had two strokes and have been confined to a wheelchair for over 9 years. I have changed significantly as a person while serving my sentence. I would like to spend my last years with my children and grandchildren to teach them the things that I have learned in my life. I would like to work with any state agency to work with youth to deter them from a life of crime. I have so much to offer given my experiences in life and in prison.

Due to the low yearly approval rating for compassionate release cases, like mine, I may never be released, despite providing positive reference letters from correctional officers, community religious leaders, certificates of completion for various programs, and a home plan for my release. Something must be done to simplify this process to allow for the release of inmates in my situation. For these reasons I ask you to issue a favorable report on HB 0157. Thank you.

O.Moyd Testimony on HB157 Medical and Geriatric Pa
Uploaded by: Olinda Moyd, Esquire
Position: FAV

MARYLAND ALLIANCE FOR JUSTICE REFORM

Working to end unnecessary incarceration and build strong, safe communities

RE: HB 157 – Favorable

Written Testimony - Olinda Moyd on behalf of The Maryland Alliance for Justice Reform
Submitted: January 27, 2023

The Maryland Alliance for Justice Reform supports a favorable report on this bill for several reasons.

This bill would add to the existing statute an opportunity for people over 60 to be considered for parole consideration. The bill also affords individuals with chronically debilitating or incapacitating conditions the opportunity for more meaningful medical parole consideration.

The DPSCS continues to report the number of COVID-related deaths among staff and the inmate population. At the time of this writing, the DPSCS dashboard shows 8 staff deaths and 37 deaths among the inmate population. Some of them were elderly individuals who were even more vulnerable due to their medical conditions. Mr. Andrew Parker was in his early 60's and had been in prison for 39 years and Mr. Charles Wright had been in for 30 years and was also in his 60's – both died in prison from COVID. Every week MAJR continues to receive letters from men and women who fit this age group who are afraid of dying from COVID in prison.[1]

The bill creates an opportunity for release for elderly prisoners

Due to extreme sentencing, Maryland is experiencing growth in our aging prison population. Along with an aging population come increased costs for healthcare and other conditions associated with growing old. There are thousands of geriatric-aged individuals still in the prison system. I see them on walkers and in wheelchairs as I cross the prison yards.

It is estimated that Maryland imprisons approximately 3,000 people over age 50, and nearly 1,000 individuals who are 60 or older.[2] Based on data showing the geriatric population has higher care costs, a fiscal analysis concluded that continued confinement of this age group for an additional 18 years (based on the expected period of incarceration, the age at release and the projected life expectancy of the Ungers), would amount to nearly $1 million per person, or

[1] DPSCS reports 3t inmate deaths and 8 staff deaths from COVID-19. The number of persons testing positive for the omicron variant has increased significantly in recent months. See DPSCS Daily Dash reporting,Cumulative COVID – 19 Cases page, viewed, January 27, 2023.

[2] Report by The Justice Policy Institute, *Rethinking Approaches to over Incarceration of Black Young Adults in Maryland,* (November 6, 2019).

$53,000 a year. This is compared to the $6,000 a year to provide intensive reentry support that has proven to successfully reintegrate them back into the community.[3]

For those individuals who continue to serve lengthy sentences, most individuals desist from crime as they get older, and they eventually present little threat to public safety. Experts agree that for persons otherwise ineligible, age-based parole is an appropriate consideration.[4]

Maryland lags behind in providing medical and geriatric release opportunities

Medical parole is parole that is granted based on humanitarian and medical reasons. Now is the time for Maryland to act in a more humane way towards individuals who are aging and dying behind our prison walls. This bill broadens who can request a medical parole for an individual and allows for a meeting with the MPC on behalf of an individual who meets the criteria. This bill also outlines the documentation, assessment and decision-making process.

In the federal system persons may apply for geriatric parole pursuant to the US Parole Commission Rules and Procedures, Title 28, CFR, Section 2.78.

Medical and geriatric parole typically go hand-in-hand. Nearly every state has a policy allowing for people with certain serious medical conditions to be eligible for parole, known colloquially as medical parole. In 45 states, the authority for the release of these individuals has been established in statute or state regulation. Additionally, at least 17 states have geriatric parole laws in statute. These laws allow for the consideration for release when a person reaches a specified age. At least 16 states have established both medical and geriatric parole legislatively. It is time for Maryland to pass this legislation.

For these reasons, we urge a favorable report.

Olinda Moyd, Esq.
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[3] Report by The Justice Policy Institute, *The Ungers, 5 Years and Counting: A Case Study in Safely Reducing Long Prison Terms and Saving Taxpayer Dollars*, November 2018.
[4] E. Rhine, Kelly Lyn Mitchell, and Kevin R. Reitz, Robina Inst. of Crim. Law & Crim. Just., *Levers of Change in Parole Release and Revocation* (2018).

HB 157 Compassionate Release OPD Fav.docx.pdf
Uploaded by: Rachel Kamins
Position: FAV

MARYLAND OFFICE OF THE PUBLIC DEFENDER

Natasha Dartigue
Public Defender
Keith Lotridge
Deputy Public Defender
Melissa Rothstein
Chief of External Affairs
Elizabeth Hilliard
Acting Director of Government Relations

POSITION ON PROPOSED LEGISLATION

BILL: HB 157 - Correctional Services - Geriatric and Medical Parole

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 1/27/2023

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on House Bill 157. This written testimony focuses on the medical parole provisions within the Bill.

The medical parole system in Maryland is dysfunctional and inhumane. The eligibility criteria for medical parole are unduly restrictive and, as a result, the release of chronically debilitated and terminally ill incarcerated persons is seldom granted. Present law also denies the Parole Commission critical information in determining whether to grant medical parole.

Under current law, those eligible to apply for medical parole must be "so chronically debilitated or incapacitated by a medical or mental health condition, disease, or syndrome as to be physically incapable of presenting a danger to society." There are many problems with both this standard and the processes implementing it.

(1) Too few applicants qualify for medical parole under such a stringent standard. Between 2015 and 2021, the Parole Commission ***granted 111 and denied 362*** medical parole applications it received, relegating far too many terminally ill and physically incapacitated incarcerated persons—who are far too sick to pose any risk to public safety—to die behind prison walls, separated from their loved ones and receiving subpar medical and palliative care as compared to what is available outside of prison.

House Bill 157 expands the scope of eligibility by rendering eligible incarcerated person (1) deemed by a licensed medical professional to be "chronically debilitated or incapacitated" ***or***

(2) suffering from a terminal illness that requires extended medical management that would be better met by community services than the health care provided in prison ***or*** (3) physically incapable of posing a danger to society as a result of their physical or mental health condition. Patently, releasing incarcerated persons whose health care needs exceeds the capacity of the prison health care system is the humane thing to do. It also ameliorates the exorbitant cost to Maryland taxpayers, making HB 157 a clear "win-win."

(2) Under the current medical parole statute, the applicant is not afforded a meeting with the Maryland Parole Commission in connection with the request for medical parole.

House Bill 157 allows the incarcerated person or their representative to request a meeting with the Commission and requires the Commission to grant the request for a meeting, provided the inmate (1) is then housed in a prison infirmary or a hospital in the community or (2) has been frequently housed in such a facility without the preceding six months. Importantly, HB 157 gives the Commission the ***discretion*** to provide a meeting to an inmate who does not meet the aforementioned housing criteria. Requiring a meeting between the Commission and the inmate allows for the presentation of a more comprehensive picture of the inmate, his medical condition(s) and, if applicable, his family situation, and enables the Commission to render a more informed and reasoned decision about whether to grant medical parole in any given case.

(3) Under present law, medical parole candidates are evaluated using the Karnofsky Performance Status Scale, an outdated and inadequate assessment instrument for determining functional impairment.

House Bill 157 provides for an updated, dynamic medical assessment that more effectively and holistically demonstrates a medical parole candidate's degree of debilitation, specific medical needs, and prognosis.

(4) The current medical parole statute does not require a medical examination of the individual seeking parole. Instead, a doctor merely reviews existing medical information, assigns a "Karnofsky score," and then makes a recommendation to the Parole Commission. The Commission is not required to adopt that recommendation.

House Bill 157 allows the incarcerated person to obtain, at no cost, an independent medical evaluation, which consists of an in-person examination of the incarcerated person. The

findings of the independent medical evaluation and any medical conditions detailed in the evaluation are to be given equal consideration by the Commission. This addition to the law appropriately acknowledges the informative nature of a medical evaluation and assigns it equal weight among the numerous other factors to be considered by the Commission in determining whether to grant medical parole.

(5) Finally, under the current medical parole statute, the Commission's decision to grant parole to an inmate serving a life sentence must be approved by the Governor.

House Bill 157 removes the requirement of gubernatorial approval for medical parole, consistent with the removal of the Governor from the regular parole process through prior legislation.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on House Bill 157.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.
Authored by: Rachel Marblestone Kamins, Assistant Public Defender, Appellate Division, rachel.kamins@maryland.gov.

HB.0157_MGParole.pdf
Uploaded by: T. Shekhinah Braveheart
Position: FAV

JUSTICE POLICY INSTITUTE

Testimony to the House Judiciary Proceeding Committee
House Bill 0157/Senate Bill 0098 — Compassionate Release: Medical/Geriatric Parole Reform

Justicepolicy.org

Founded in 1997, the Justice Policy Institute (JPI) is a nonprofit organization developing workable solutions to problems plaguing juvenile and criminal justice systems. For over 25 years, JPI's work has been part of reform solutions nationally, as well as an intentional focus here in Maryland. Our research and analyses identify effective programs and policies, in order to disseminate our findings to the media, policymakers, and advocates, and to provide training and technical assistance to people working for justice reform.

JPI supports House Bill 0157, which would provide a fix to the language errors contained within Maryland's current medical parole statute, as well deliver enhanced compassionate release opportunities for infirm and/or elderly persons in prison.

Medical parole

Two years ago, this legislative body took the important and necessary step of removing the governor from the parole decision-making process for people serving a life sentence; thereby removing politics from parole in Maryland. That was a historic step that means Maryland governors can no longer undermine the Maryland Parole Commission (MPC). The long-term impact of that policy change will be less tax dollars spent for excessively long stays of incarceration with no demonstrable public safety benefit, less funds diverted away from important services like education and healthcare and will help to mitigate the huge racial disparities in the Maryland justice system.

Between 2015 and 2021, the MPC approved 112 medical parole petitions and denied 350, a 32 percent approval rate. Furthermore, during the COVID-19 pandemic, only 17 percent of parole petitions were approved for medical parole. Currently, the MPC receives a medical recommendation from the treating doctor, which includes the general prognosis, an individual's capacity, a Karnofsky Performance Score,1 and institutional information such as program participation. Unfortunately, this process is woefully inadequate to assess an individual's prognosis, and the reliance on an imprecise and inappropriate quantitative score has resulted in the denial of many deserving petitions.

During debate on the bill to remove the governor from the parole process we heard how the MPC is much better situated to evaluate someone for release due to their history of involvement with the incarcerated population. The governor was making decisions based off no interaction with the population whose fate he was deciding. The idea of making uninformed decision on medical parole recommendations is unfathomable. We have seen what happens when the governor makes uninformed decisions in the case of Donald Brown whose initial attempt for

[1]Maryland relies on the Karnofsky Performance Status Scale, without any in-person examination. A physician issues a short memo to the MPC that includes the score, and if it is below 20, they are typically considered a viable candidate for release. According to the scale, a score of 20 indicates that an individual is very sick, hospital admission is necessary, and active supportive treatment is required.

medical parole was denied by the previous governor. In the following month, Mr. Brown's health got worse and sparked a second attempt of medical parole. He was granted medical parole and was released from prison but passed away in a nursing home four days later. That was not medical parole. That was the state avoiding funeral cost.

Unfortunately, due to a technical error, the bill to remove the governor from parole did not remove the governor from the medical parole decision making process. The same logic and considerations that went into passage of that bill should be applied to removing the governor from medical parole. There is no legitimate policy goal, least of all protecting public safety, which supports keeping the governor in the medical parole process.

Geriatric parole

While Maryland law has a geriatric parole provision that was intended to benefit incarcerated individuals over the age of 60 who have served at least 15 years, in reality very few individuals are eligible because the law requires only those persons who meet those criteria and are serving sentences for subsequent violent offenses are eligible. This is problematic. If someone is sentenced to 80 years for a first-time offense when they are 40 years old, with standard parole eligibility at 50 percent, they will not be eligible for release until age 80. Geriatric parole is unavailable to them because it is a first-time offense. This technical issue within the geriatric parole law circumvents the spirit of an age-based release mechanism.

According to a forthcoming comprehensive report on the Maryland parole system, Six percent of the Maryland prison population, or 3,324 individuals, are over 50 years old. Additionally, Maryland currently has 2,341 people serving a life sentence, suggesting that the aging population will continue to grow. The older the individual, the more complications with health. A study in Pennsylvania concluded that an incarcerated population with an average age of 57 has similar health ailments to men in the general public with an average age of 72. A prison is not a hospitable setting for aging and is downright hostile for those individuals suffering from a chronic or terminal illness.

The Justice Policy Institute urges this committee to issue a favorable report on HB 0157.