MOPD SB 562 support.pdf
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POSITION ON PROPOSED LEGISLATION

BILL: SB 562 Correctional Services – Geriatric and Medical Parole

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: February 23, 2022

The parole system in Maryland is broken. SB 562 is a bill that aims to improve two areas of that system, parole for persons who should be released due to their medical condition and persons who should be released based on their age. The Maryland Office of the Public Defender urges a favorable report from this Committee on SB 562 based on its improvements to the medical parole system and articulating necessary geriatric parole requirements.

1. 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:

a) Too few applicants qualify for medical parole under the existing stringent standard.

Between 2015 and 2020, the Parole Commission granted a mere 1/3 of the 339 medical parole applications it received, relegating far too many terminally ill and physically incapacitated inmates—who are simply too ill to pose any risk to public safety—to die behind prison walls, separated from their loved ones and with less than optimum medical and palliative care compared to what is available outside of prison.

SB 562 expands the scope of eligibility by including those inmates who are "so chronically debilitated or incapacitated "*as to require medical management that would be better*

provided by specialized community services." Not only is it the humane thing to do to release inmates whose medical needs exceeds the capacity of the prison health care system, the exorbitant cost savings to the taxpayers makes this a "win-win."

b) Under the current medical parole statute, the applicant is not afforded a hearing.

SB 562 allows the applicant, within 30 days of his request for medical parole, to request a meeting with the Parole Commission. The Commission must then meet with the inmate, his representative, and/or a member of the inmates' family within 30 days. The decision whether to grant medical parole cannot be made before such a meeting takes place, where one has been requested. Providing the Parole Commission with a more comprehensive picture of the inmate, his medical condition(s) and, if applicable, his family situation enables the Commission to render a more informed and reasoned decision whether to grant medical parole.

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

SB 562 provides for an updated, dynamic medical assessment that more effectively and holistically demonstrates a medical parole candidate's degree of debilitation and specific medical needs. The new assessment also takes into account the future risk to public safety if the individual is released and whether the correctional system can adequately provide necessary medical care and rehabilitation if parole is denied.

d) The current medical evaluation requirements are inadequate

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 need not adopt that recommendation.

SB 562 provides that, if the inmate requests a medical evaluation by an independent medical professional, "the Commission shall place priority consideration on the findings of the evaluation and any medical condition detailed in the evaluation in considering whether to grant medical parole." This addition to the law appropriately acknowledges the informative nature of a medical

evaluation and assigns greater weight to it than the numerous other factors to be considered by the Commission in determining whether to grant medical parole.

Finally, the existing medical parole statute contemplates the return of the medical parolee to the Division of Correction in the event the Parole Commission "has reason to believe" he is no longer "so debilitated or incapacitated as to be physically incapable of presenting a danger to society." SB 562 removes the threat of re-incarceration.

In short, SB 562 takes critical steps to improve Maryland's medical parole process and in doing so will ensure that Maryland's ill, debilitated, and extraordinarily vulnerable incarcerated persons will have a chance at the relief they desperately need.

2. *Geriatric Parole*

In addition to better protecting its terminally ill and physically incapacitated incarcerated persons, Maryland must improve its parole system for the oldest incarcerated persons. SB 563 aims to do so.

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 fiscal year 2019, 18,244 people were housed within the Division of Correction.[3] Of those, 2,362 were between the ages of 51 and 60 and 962 were over 60. *Id.* For numerous reasons, it is both ineffective and unnecessary to continue to incarcerate many of Maryland's oldest persons currently confined in the Division of Corrections. SB 562 acknowledges these flaws and aims to create a way for these persons to access parole hearings where the parole commission may consider the many special circumstances faced by, and created by, elderly inmates.

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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, *Operations*, 41 (Nov. 14, 2019), http://dlslibrary.state.md.us/publications/Exec/DPSCS/DOC/COR3-207(d)_2019.pdf.

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 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]

Second, elderly incarcerated persons, particularly those with elevated health concerns, are exceedingly vulnerable. They "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

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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.

typically do not have systems in place to monitor chronic problems or to implement preventative measures."[10]

The COVID-19 pandemic exacerbates these health concerns. 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.[11] 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.[12] As of June 2021, there have been **398,627** COVID-19 cases reported among incarcerated persons across state and federal prisons.[13]

COVID-19 is especially dangerous for incarcerated **seniors**. The CDC cautions that "[t]he risk for severe illness with COVID-19 increases with age, with older adults at highest risk."[14] "An analysis of more than 114,000 COVID-19 associated deaths during May – August 2020, found that 78% of the people who died were aged 65 and older[.]" *Id.* Those with underlying medical conditions, which seniors are more likely to have, are also at increased risk of severe illness with COVID-19.[15] The mortality rate for persons with COVID-19 and certain comorbidities are significantly higher than the mortality rate among those without these comorbidities.

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[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.

[11] *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).

[12] 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.

[13] *A State-By-State Look at Coronavirus in Prisons*, The Marshall Project, https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (last visited February 23, 2022)

[14] *COVID-19 Guidance for Older Adults*, Centers for Disease Control and Prevention, https://www.cdc.gov/aging/covid19-guidance.html (last visited Dec. 16, 2020).

[15] *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 Dec. 16, 2020).

Third, there are 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 recidivism.[16] For the eight years after their release, the Commission 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."[17]

Fourth, it is 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."[18] "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."[19] These outsized costs are in large part due to the increased healthcare costs associated with elderly persons in prison.[20] 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

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[16] 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.

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

[18] 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.

[19] *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)).

[20] *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.

per fiscal year, while the state of Maryland spent $7,280 per fiscal year.[21] From 2001 to 2008, per-inmate healthcare spending rose 103% in Maryland from $3,011 per fiscal year to $5,117 per fiscal year. *Id.*

Finally, 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. Seventeen states have already recognized the importance of such parole programs, Maryland should join them.[22] We have 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. SB 562 takes an important step in this direction.

For these reasons, the Maryland Office of the Public Defender respectfully requests this Committee to issue a favorable report on Senate Bill 562.

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

[21] 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.
[22] Essex, Amanda, and Karen McInnes. *State Medical and Geriatric Parole Laws*, National Conference of State Legislators, 27 Aug. 2018, https://www.ncsl.org/research/civil-and-criminal-justice/state-medical-and-geriatric-parole-laws.aspx.

MD Catholic Conference_FAV_SB 562.pdf
Uploaded by: Garrett O'Day
Position: FAV

MARYLAND CATHOLIC CONFERENCE

ARCHDIOCESE OF BALTIMORE † ARCHDIOCESE OF WASHINGTON † DIOCESE OF WILMINGTON

February 24, 2022

SB 562
Correctional Services – Geriatric and Medical Parole

Senate Judicial Proceedings Committee

Position: Support

The Maryland Catholic Conference offers this testimony in SUPPORT of Senate Bill 562. The Catholic Conference represents the public policy interests of the three (arch)dioceses serving Maryland, including the Archdioceses of Baltimore and Washington and the Diocese of Wilmington, which together encompass over one million Marylanders.

Senate Bill 562 would allow the parole commission to utilize a dynamic risk assessment instrument to determine whether certain inmates who are at least 60 years of age should be released on parole. It also allows for expansion of medical parole. Older inmates who have served much of their sentence merit a parole hearing to see if they are rehabilitated and can re-enter society. In A Catholic Perspective on Crime and Criminal Justice (2000), the Catholic Bishops state: "*We believe that both victims and offender are children of God. Despite their very different claims on society, their lives and dignity should be protected and respected. We seek justice, not vengeance. We believe punishment must have clear purposes: protecting society and rehabilitating those who violate the law."*

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.

Senate Bill 562 would restore hope for elderly offenders or 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 Senate Bill 562.

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SB0562_MarylandPrisonersRights_FAV.pdf
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Position: FAV

TESTIMONY IN SUPPORT OF BILL # SB0562/ HB0600
Correctional Services - Geriatric and Medical Parole

Date: 02/24/2022
From: Maryland Prisoners' Rights Coalition
Re: SUPPORT FOR BILL# SB0562

To: Chairman Smith, Vice-Chair Waldstreicher, and Members of JPR

Thank you for bringing this important bill forward and allowing us 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 prisons.

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 healthcare and the quality of healthcare administered within the prisons. As you can imagine, COVID-19 has only exacerbated this. Yearly, we receive hundreds of calls regarding these conditions, requiring us to intervene with facilities to advocate for everything from not receiving prescribed medications to healthcare 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 contributed by the lack of access to and quality of healthcare in the Maryland correctional system.

Many incarcerated individuals are never able to obtain relief and languish behind the walls of our correctional system. 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, unnecessary deaths, and ultimately legal liabilities.

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 our research, we found DPSCS lacking proper medical records and having unclear policies.

We even submitted interrogatories that were returned with vague information. Furthermore, over the years, our investigation found egregious practices and subpar healthcare standards. The lack of accurate medical records, unclear policies, and stark practices, caused directly by neglect, ultimately exacerbate the ailments of the severely and terminally ill causing negative health outcomes for them. 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, but 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, which is currently Corizon, that has been nationally and historically in litigation for abuses and violations. They were cited for not upholding their contract of care, and have, because of the aforementioned, been terminated in multiple states.

Corizon 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 doubles for inmates over the age of 60, costing an additional $5.2 million per year - these figures don’t include people under 60 with serious illness, so imagine that. This amounts to almost $26 million over 5 years. Corizon’s bid and contract over five years are $680 million. With a $680 million contract, BUT overall expenses approaching $800 million over five years, how does Corizon propose to meet the needs of this population? These numbers speak volumes and press the need for medical and geriatric parole.

Providing those with terminal and debilitating conditions 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 by DPSCS, while it is great that DPSCS would like to make improvements and we agree this would be a huge job, continues to make excuses and plans for improvement that are many years away and that are not reasonably obtainable without expert assistance. This bill is a way that these changes can begin to come about in a much-needed expedient manner that at least follows a minimum standard of care and protocol. 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, we have a serious issue.

We cannot stress the importance of this legislation and reform to the access to and quality of healthcare for incarcerated individuals enough. This is a civil, social, economic, legal, and moral issue, which also bears GREAT FINANCIAL COSTS to the Maryland taxpayers.

We 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 SB0562/HB0600.

Respectfully,

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

SB562 Written Testimony Lila Meadows.pdf
Uploaded by: Lila Meadows
Position: FAV

To: Senate Judicial Proceedings Committee
From: Lila Meadows, University of Maryland School of Law Clinical Law Program, 500 W. Baltimore Street, Baltimore, Maryland 21201
Re: In Support of Senate Bill 562
Date: February 22, 2022

Senate Bill 562 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. Senate Bill 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.

<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 requires 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 his 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 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 are in agreement that the damage to my client's lungs is permanent and there is no prognosis for improvement.

Senate Bill 562 would require MPC to consider a more comprehensive report detailing an individual's medical prognosis and would also clarify the process for obtaining an outside medical evaluation, a process already allowed by statute. 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. This means that for almost the entire population of elderly Marylanders confined to the DOC almost no one is eligible for release under our geriatric provision.

Beyond the problems with the construction of the statute, the law provides no guidance to the Maryland Parole Commission regarding suitability for geriatric parole. Senate Bill 562 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.

Senate Bill 562 moves Maryland towards a having legally sound standards for medical and geriatric parole. Nothing in Senate Bill 562 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.

Last session 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. Senate Bill 562 moves Maryland closer to having a functional parole system.

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.

O.Moyd Testimony on SB 562 Medical and Geriatric P
Uploaded by: Olinda Moyd, Esquire
Position: FAV

MARYLAND ALLIANCE FOR JUSTICE REFORM

Working to end unnecessary incarceration and build strong, safe communities

February 24, 2022

Chairman William C. Smith
Judicial Proceedings
Senate Office Building
Annapolis, MD 21401

RE: Senate Bill 562 – Favorable
Written Testimony - Olinda Moyd on behalf of The Maryland Alliance for Justice Reform

Dear Chairman Smith and Judiciary Proceedings Committee members:

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. It would also require:

- the development of a dynamic risk assessment instrument;
- the Maryland Parole Commission (hereinafter "the Commission") to complete an annual risk assessment;
- that the Commission conduct a hearing 6 months after the assessment;

Especially amid the spread of COVID in our prisons, we must make the release of elderly incarcerated people a priority. The DPSCS has reported twenty deaths due to COVD and most of them were persons over 60. 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 recently from the virus. Every week MAJR receives 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 yard, as an education and self-help group volunteer.

[1] DPSCS reports 35 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 – Feb. 19, 2022.

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 $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]

The consideration of Dynamic risk factors is critical to give people a fair chance

For decades, most paroling authorities, including the Commission, have considered only static factors when making parole decisions. This bill would require the development of a dynamic risk assessment instrument with strength based needs assessment to assist with identifying conditions for release.

To look at one's static history is merely to examine factors that are not amenable to deliberate intervention, such as prior offenses and age at first offense. Whereas, dynamic factors include consideration for potentially changeable factors, such as substance abuse and employability. A fair evaluation of change in people requires a look at dynamic risk factors – those things that one can change.

Some of the static factors evaluated during the parole eligibility process include:

- The person's age when he or she was sent to a juvenile or adult facility
- Supervisory release history if applicable
- His or her past imprisonments

Dynamic Factors
These factors are those that change during the time the person is in prison. They include:

- The person's current age
- Whether or not the parole petitioner is a member of a gang or a known security threat group
- What if any educational or vocational training he or she has completed in prison
- What certified on-the-job training the person has undertaken
- The person's disciplinary record in prison
- The person's current custody level
- Employability and marketable skills
- Community support and release plan

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

It is also imperative that the Commission carefully develop a dynamic risk assessment tool that does not contain inherent biases, as some have been criticized. The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) tool, which has been used by correctional officials for years, is designed to identify the likelihood of reoffending in the future. The COMPAS was found to have a higher false-positive rate for Blacks than whites, which meant that Blacks were more likely to have been misclassified as medium or high-risk by the COMPAS.[5] In a report from the Pretrial Justice Institute, they concluded that "these tools are derived from data reflecting structural racism and institutional inequity."[6] Parole boards that use assessment tools must carefully scrutinize how each factor impacts African-Americans. To guard against biases, they should ensure that the development of assessment tools is transparent and implemented with independent oversight and that the tools are evidence-based and culturally responsive.

Maryland lags behind in providing for geriatric release opportunities

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. We are delighted that Maryland will join them.

For these reasons, we urge a favorable report.

Olinda Moyd, Esq.
moydlaw@yahoo.com
(301) 704-7784

[5] . Rhys Dipshan & Victoria Hudgins, *Risk Assessment Tools Aren't Immune from System Bias, So Why Use Them?,* (July 17, 2020).
[6] Pretrial Justice Institute, *Updated Position on Pretrial Risk Assessment Tools* (Feb 7, 2020).

SB624_FAV_Carepatrol Baltimore.pdf
Uploaded by: Paula Sotir
Position: FAV

SB624 – Support

Paula Sotir
CarePatrol
psotir@carepatrol.com 410 494 9400

SB624 – Favorable
Finance Committee
February 24, 2022

Dear Chairman, Vice Chairman and Members of the Finance Committee

I am the owner of CarePatrol Baltimore and in support of SB 624. I have been helping seniors find assisted living and memory care for over 8 years. During this time, my team and I has placed over 1500 seniors in Baltimore and Harford County and Baltimore City. I have a Bachelor in Science of Nursing from Duke University for over 40 years, Master in General Administration - Health Care at the University of Maryland, Certified Senior Advisor and Certified in completing safety assessment in the home and teaching Dementia care. Our mission is to find safe communities for the seniors so that they can age in place.

I specifically want to support Senator Hettleman's efforts to require adherence to Hipaa law when sharing medical information. Why is this important now? The industry is growing both in the number of seniors that need this service and the number of companies helping seniors. The seniors and families are waiting longer to make this move into assisted living and their health care needs are increasing. This change has been happening over the past 4 and I have increased health needs for the seniors who have been isolated and not getting medical care during the past 2 years with covid.

A reputable referral advisor needs to fully understand the senior's healthcare in much more detail to refer those care options today but in the future also. Hospital and Nursing Home Social workers and care managers are now sharing with us information such as history and physician, physician therapy records, psychiatric history and medication lists through their electronic health records. We are then sharing that information with the assisted living and memory care communities to make the optimal recommendations and match their capabilities with the client's needs. Any other day of the week, it would seem preposterous for a hospital or nursing home to voluntarily give this information out to anyone outside the family without a HIPAA release.

Having the HIPPA release signed will guarantee that the information is protected according to established law. This would also guarantee that the referral advisor was either speaking with the senior themselves, their power of attorney, or a recognized responsible party. There will be full transparency on who is looking out for their best interest and it would stop the questionable practice of selling the senior's information to the highest 3rd party bidder such as hearing aid companies to hospital bed suppliers and a whole other host of unsolicited vendors.

I applaud and support Senator Hettleman's regulation which protects Maryland seniors by legally giving us the information we need to make a safe placement and to stop the selling of their private healthcare information.

I urge the Senate to pass SB624 to help protect our vulnerable seniors.

SB0562-283325-01.pdf
Uploaded by: Shelly Hettleman
Position: FAV

SB0562/283325/1

AMENDMENTS
PREPARED
BY THE
DEPT. OF LEGISLATIVE
SERVICES

23 FEB 22
11:44:08

BY: Senator Hettleman
(To be offered in the Judicial Proceedings Committee)

AMENDMENT TO SENATE BILL 562
(First Reading File Bill)

On page 2, after line 25, insert:

"**(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

(2) (I) "CHRONICALLY DEBILITATED OR INCAPACITATED" MEANS HAVING A DIAGNOSABLE CONDITION THAT IS UNLIKELY TO IMPROVE NOTICEABLY IN THE FUTURE AND PREVENTS THE INDIVIDUAL FROM COMPLETING MORE THAN ONE ACTIVITY OF DAILY LIVING, INCLUDING EATING, BREATHING, DRESSING, GROOMING, TOILETING, WALKING, OR BATHING, WITHOUT ASSISTANCE.

(II) "CHRONICALLY DEBILITATED OR INCAPACITATED" INCLUDES CONDITIONS SUCH AS DEMENTIA OR A SEVERE, PERMANENT MEDICAL OR COGNITIVE DISABILITY IF THE CONDITION PREVENTS THE INDIVIDUAL FROM COMPLETING MORE THAN ONE ACTIVITY OF DAILY LIVING.

(3) "TERMINAL ILLNESS" MEANS A DISEASE OR CONDITION WITH AN END–OF–LIFE TRAJECTORY.";

in lines 26 and 29, strike "(a)" and "(b)", respectively, and substitute "**(B)**" and "**(C)**", respectively; and strike beginning with "who" in line 29 down through "**SERVICES**" in line 32.

On page 3, in line 2, after "subtitle" insert "**IF THE INMATE:**

(1) IS CHRONICALLY DEBILITATED OR INCAPACITATED;

(2) SUFFERS FROM A TERMINAL ILLNESS;

(3) REQUIRES EXTENDED MEDICAL MANAGEMENT, WITH HEALTH CARE NEEDS THAT WOULD BE BETTER MET BY COMMUNITY SERVICES; OR

(4) HAS BEEN RENDERED PHYSICALLY INCAPABLE OF PRESENTING A DANGER TO SOCIETY BY A PHYSICAL OR MENTAL HEALTH CONDITION, DISEASE, OR SYNDROME".

On page 3, in lines 3, 13, 23, and 28, strike "(c)", "**(D)**", "**(E)**", and "**(F)**", respectively, and substitute "**(D)**", "**(E)**", "**(F)**", and "**(G)**", respectively.

On page 5, in lines 5 and 24, strike "**(G)**" and "(h)", respectively, and substitute "**(H)**" and "**(I)**", respectively.

On page 6, in line 4, strike "**(I)**" and substitute "**(J)**".

SB562_Hettleman_FAV.pdf
Uploaded by: Shelly Hettleman
Position: FAV

SHELLY HETTLEMAN
Legislative District 11
Baltimore County

Judicial Proceedings Committee

Joint Committee on Children, Youth, and Families

Joint Committee on the Chesapeake and Atlantic Coastal Bays Critical Area

The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

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Shelly.Hettleman@senate.state.md.us

TESTIMONY OF SENATOR SHELLY HETTLEMAN
SB 562- CORRECTIONAL SERVICES - GERIATRIC AND MEDICAL PAROLE

"Between 2015 and 2020, the Maryland Parole Commission approved 86 medical parole applications and denied 253. Further, the Governor granted nine medical parole requests from individuals serving life sentences and rejected 14 requests. Most notably, the lowest yearly approval rating occurred during the height of the pandemic in 2020 at seven percent". [1]

SB562/HB 600 – Correctional Services – Geriatric and Medical Parole enables inmates, attorneys, family members, and medical professionals to request medical parole from the Maryland Parole Commission.

This bill is meant to provide inmates protection and potential parole based on their age, medical condition, and moral qualifications.

"Currently, there are about 650 individuals over the age of 60 in Maryland's prison system who have served at least 15 years." [2]These individuals are eligible to be evaluated for release However, , Maryland seldom relies on these compassionate/Geriatric and Medical Parole release policies to release the elderly and infirm from prison, despite posing a minimal risk to public safety and a significant cost burden on the state budget

The United States Prison System has experienced an excessive growth from an estimated 200,000 in the 1970's to almost 1.5 million in 2019. Research shows that this growth is not due to crime, but by dramatic changes in policies that send people to jail for more time. In Maryland alone, 8 in 10 people who are serving the longest terms are Black.

Additionally, Maryland has one of the most daunting processes. There is no required medical examination for inmates and they never receive a hearing. Instead, a physician reviews medical records, designates a "Karnofsky" score measuring functional impairment and sends a recommendation to the Maryland Parole Commission. This is often in the form of an email or memo.

Therefore, due to the inflexibility and lack of compassion that impacts the Maryland Parole Commission many of these cases result in unwarranted deaths and grievances on family members.

With this I urge the committee to vote in favor of SB 562.

[1] https://justicepolicy.org/wp-content/uploads/2022/01/Maryland-Compassionate-Release.pdf

[2] https://justicepolicy.org/wp-content/uploads/2022/01/Maryland-Compassionate-Release.pdf

JPI.support_SB0562.MG Parole.pdf
Uploaded by: T. Shekhinah Braveheart
Position: FAV

Testimony to the House Judiciary Proceeding Committee
House Bill 0600/Senate Bill 0562 — Compassionate Release: Medical/Geriatric Parole Reform
Justicepolicy.org

Shekhinah Braveheart, Justice Policy Institute
Danny Varner, Father of the late Ms. Barbara Hampton

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 0600, 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. This testimony is offered jointly with Mr. Danny Varner, the father of Barbara Hampton, a woman who was incarcerated at the Maryland Correctional Institution for Women for 15 years, suffering battles with stage-four ovarian cancer. Barbara's case illustrates the inadequacies and challenges associated with administering sufficient medical care in a carceral setting, and thus provides a meaningful opportunity to re-examine Maryland's compassionate release policy. This Bill is critical to ensure stories like Ms. Hampton's and others are not repeated in the future.

Expand Eligibility and Develop Standards for Compassionate Release.

There are a number of eligibility barriers for individuals applying for geriatric or medical parole release. Ms. Hampton, because of her "life without parole" sentence, was among those deemed ineligible.

However, the primary obstacle, in most cases, is the lack of clarity in how the law applies and the standard of eligibility. Maryland's legislative language is so ambiguous it results in excluding mostly everyone, "an inmate who is 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." The statutory criteria remain perpetually restrictive because Maryland's state legislature did not develop the policy in conjunction with medical professionals to statutorily define conditions such as "chronically debilitated."

The medical parole process does not include an in-person examination by a physician, but instead utilizes the Karnofsky Performance Status Scale to assess an individual's suitability based on a series of medical file reviews. A physician issues a short memo/email to the parole commissioners that includes the score, and if it is *below 20*, patients are typically considered a viable candidate for release.

According to the scale, a score of 20 indicates very sick, hospital admission necessary, active supportive treatment necessary; 10 is moribund, fatal processes progressing rapidly. *The applicants are often permanently ill, not chronically ill as outlined in the statute, by the time they reach a score of 10*. There is a provision in the law that allows a person to receive an outside medical assessment, but it is rarely used.

Even more so, the parole process does not include an in-person assessment by the Maryland Parole Commission (MPC). This likely becomes a contributing factor to the MPC's track record of limiting the

scope of approvals. Among qualified individuals, between 2015 and 2020, 86 medical parole applications were approved and 253 were denied. The Governor granted just nine medical parole requests from individuals serving life sentences and rejected 14. Notably, the lowest yearly approval rating occurred during the height of the COVID pandemic in 2020 at seven percent.

Low-risk offenders place a significant burden on correctional health services[1]. Despite posing minimal risk to public safety and a significant cost to taxpayers, Maryland seldom relies on compassionate release policies to release the elderly and infirm from prison. Even with massive spending, facilities are unable to provide adequate protection and care to keep individuals healthy and safe.

According to the Maryland Department of Public Safety and Correctional Services (DPSCS), the annual cost of incarcerating one person is $46,000 per year, which includes a $7,956 allocation for medical and mental health services. Like how health insurance premiums increase with older age, the medical allocation increases 34 percent in the prison system. This results in an $18,361 allocation for the geriatric population, or a low estimate of $36.5 million per year for the 650 individuals over 60 years old.

Correctional healthcare accreditation organizations do not evaluate providers based on the Institute of Medicine standards. [2]Accreditation only guarantees the minimum standard of care for constitutional compliance. Healthcare contractors are responsible for all specialty care and procedures under $25,000. This leads to a financial incentive for the contractor to restrict care and not provide rehabilitative services to those that need them.

> "Barbara's continued health challenges were not met with the attention and care most people would even give their pets. Medical staff at MCI-W administered Barbara's treatment and access to outside medical care as if it were an extra burden placed upon them. And despite complying eventually, the approach of correctional personnel was almost adversarial—especially after Barbara's *third* stage-four cancer recurrence."
>
> −Danny Varner

As Barbara's cancer required treatment at an offsite facility, correctional-transportation officers often made her miss her appointments, and the prison dietary department refused to consistently provide her the proper nutritional food prescribed by her physicians—even *after she filed several formal complaints* to the Warden about the mistreatment.

"She was a human being too physically frail to harm anyone in the community", says Mr. Varner. "I had to listen to my child cry non-stop because she was in so much pain, knowing that there was nothing I could do to help". Even with the assistance of Senator Jill Carter, Barbara was not released within a compassionate time frame. Through a last-minute sentence commutation by Governor Hogan, Barbara Hampton was eventually released to a care facility where she lived for a few hours; dying before her father could arrive from Washington state.

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[1] "Compassionate Release." FAMM Maryland, December 2021. https://famm.org/wp-content/uploads/Maryland_Final.pdf.

[2] Clarke, Matthew. "Neither Fines Nor Lawsuits Deter Corizon From Delivering Substandard Health Care", Prison Legal News. https://www.prisonlegalnews.org/news/2020/mar/3/neither-fines-nor-lawsuits-deter-corizon-delivering-substandard-health-care/.

“I believe she finally gave up the fight because she was free at last”, Mr. Varner states.

The Justice Policy Institute and Mr. Danny Varner urge this committee to issue a favorable report on HB 0600.

SB0562_VivianPenda_FAV.pdf
Uploaded by: Vivian Penda
Position: FAV

TESTIMONY IN SUPPORT OF BILL #SB0562
Correctional Services - Geriatric and Medical Parole
From: Vivian Penda, Directly Impacted Mother
Date: 02/15/2022

Re: SUPPORT FOR BILL#SB0562

To: Chairman Smith, Vice-Chair Waldstreicher and Members the Judicial Proceedings Committee

My name is **Vivian Penda** and I am the mother of Donald Brown. I am 86 years old and two years ago at my age, I would not have imagined that I would be fighting for my son's life.

My son was incarcerated at WCI and in the system for 35 years for a string of burglaries to feed his drug habit.

My son started using drugs, heroin, at the age of 15 and over the years declined into severe drug abuse. He was eventually incarcerated.

During my son's incarceration, he accumulated several health conditions that just kept getting worse.

While in the infirmary, for something small. Donald fell from a prison infirmary breaking his hip and suffering a brain bleed; he had diabetes, a stroke, and had his leg amputated because of a foot infection.

Donald was confined to a wheelchair and dependent on others to do the simplest tasks. After a while my son became so disoriented and confused, he could not remember where he was sometimes. On top of all that, my son got COVID.

Every time I got news, it seemed like it was more and more bad news.

He got so bad we started to petition the Maryland Parole Commission to get him out of there and into a better medical care situation.

That commission denied our petition for medical parole. The worst part is they never said why!

They reversed it on June 18, 2020, but he was not released until July 2nd but I was unable to see him in person because of COVID restrictions at his nursing home.

My son died four days later.

Each of you in this place has the power to do something. I am here to ask you to listen, listen closely. If this was your family member, your child, your father, your brother you would want the same thing. BASIC HUMANE TREATMENT.

You have the power to give those who are severely ill the power to get treatment. My son was not a serial killer, not a child molester and yet the way the current medical parole process is, makes it IMPOSSIBLE for basic medical care. My child was no danger to public safety. He could hardly walk on his own. A Lot of people there are suffering in that way.

You all must make a change.

In my experience and opinion, staying in prison when you have multiple health issues makes it worse. This is a violation of basic humanity, so let's change it.

I support this bill because it will clarify this process, enabling those who no longer pose any threat to public safety because they are physically incapable to spend their final days beyond the prison walls.

I ask you as a mother and citizen of Maryland to PASS SB0562

Thank you,
Vivian Penda,
Mother of Donald Brown

SB0562_VivianPenda_FAV.pdf
Uploaded by: Vivian Penda
Position: FAV

TESTIMONY IN SUPPORT OF BILL #SB0562
Correctional Services - Geriatric and Medical Parole
From: Vivian Penda, Directly Impacted Mother
Date: 02/24/2022

Re: SUPPORT FOR BILL#SB0562

To: Chairman Smith, Vice-Chair Waldstreicher and Members of the Judicial Proceedings Committee

My name is **Vivian Penda** and I am the mother of Donald Brown. I am 86 years old and two years ago at my age, I would not have imagined that I would be fighting for my son's life.

My son was incarcerated at WCI and in the system for 35 years for a string of burglaries to feed his drug habit.

My son started using drugs, heroin, at the age of 15 and over the years declined into severe drug abuse. He was eventually incarcerated.

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While in the infirmary, for something small. Donald fell from a prison infirmary breaking his hip and suffering a brain bleed; he had diabetes, a stroke, and had his leg amputated because of a foot infection.

Donald was confined to a wheelchair and dependent on others to do the simplest tasks. After a while my son became so disoriented and confused, he could not remember where he was sometimes. On top of all that, my son got COVID.

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That commission denied our petition for medical parole. The worst part is they never said why!

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My son died four days later.

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I support this bill because it will clarify this process, enabling those who no longer pose any threat to public safety because they are physically incapable to spend their final days beyond the prison walls.

I ask you as a mother and citizen of Maryland to PASS SB0562

Thank you,
Vivian Penda,
Mother of Donald Brown

FAMM SB 562 Written Statement 2.24.22.pdf
Uploaded by: Molly Gill
Position: FWA

Written Testimony of Molly Gill
Vice President of Policy, FAMM
In Support of SB 562
Maryland Senate Judicial Proceedings Committee
February 24, 2022

I thank the Chair, Vice-Chair, and members of the Senate Judicial Proceedings Committee for the opportunity to provide written testimony in support of SB 562, a bill to improve Maryland's medical and geriatric parole programs. I write on behalf of FAMM, a national sentencing and corrections reform organization. We unite currently and formerly incarcerated people, their families and loved ones, and diverse people working to improve our system of justice.

For more than two decades, FAMM has been a leading voice for measures that allow for the safe release of medically vulnerable, aging, and dying individuals from our nation's prisons. Our system incarcerates people to deter crimes, punish those who commit them, protect the public, and rehabilitate those who will return home one day. FAMM believes that people should have a meaningful opportunity to leave prison when their continued incarceration no longer advances those purposes of punishment. At a minimum, we should consider people who are dying, aging, and those who are too debilitated to offend, too compromised to benefit from rehabilitation, or too impaired to be aware they are being punished.

Since 2018, FAMM has conducted comprehensive research into state compassionate release programs.[1] We maintain a set of memos on our website that document every program in the 50 states and the District of Columbia.[2] For each jurisdiction, we describe eligibility criteria, application requirements, documentation, and decision-making, as well as post-decision and post-release issues. We most recently updated these memoranda in December 2021.

We set out our findings in a report, "Everywhere and Nowhere: Compassionate Release in the States."[3] Our most disturbing finding was that while nearly every state, including Maryland, has some form of compassionate release, it is too seldom used. To understand why that is so, we examined and reported on the policies and practices that raise barriers to release.

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[1] While we use the term "compassionate release" to describe this authority, we are aware that many jurisdictions have different names for programs that enable early release for qualifying prisoners. Because of what we have learned of the insurmountable barriers to early release programs encountered by many sick and dying prisoners, we believe every program could benefit from taking a compassion-based look at what it means to go through the process. We call these programs "compassionate release" so that the human experience is foremost in our minds and those of policy makers.

[2] FAMM, Compassionate Release: State Memos (Dec. 2021), https://famm.org/our-work/compassionate-release/everywhere-and-nowhere/#memos.

[3] Mary Price, Everywhere and Nowhere: Compassionate Release in the States (June 2018), (Everywhere and Nowhere), https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf.

We also explored those that exemplify best practices. Finally, we included a set of recommendations for states working to implement or update programs.[4]

That research and analysis informs our support of SB 562. It contains sorely needed reforms. **Medical parole in Maryland is among the most poorly designed programs in the country.** This has led to disappointing outcomes. Between 2015 and 2020, only 86 of 339 requests for medical parole were approved.[5] That is an average of only 17 grants annually. Meanwhile, between March 2020 and June 2021, 31 people died in Maryland prisons of COVID-19 alone.[6] Maryland's Geriatric Parole is in even worse shape. We were baffled to learn that by law, only a tiny subset of the 650 elderly incarcerated people – those who have incurred multiple convictions for crimes of violence – are eligible to be considered for geriatric parole. **Maryland does not have functioning geriatric parole.**

Some features of SB 562 will address the barriers that exist in current law that have likely contributed to a poorly performing medical parole system. The bill also offers a comprehensive geriatric parole program. We commend this bill to the committee because we believe it will make possible the more efficient and robust use of medical and geriatric parole in Maryland.

Senate Bill 562 would create and standardize eligibility standards.

Senate Bill 562 will address one of the most significant problems with the Maryland medical parole program: Parole Commission regulations contradict the medical parole statute. On the one hand, the current Medical Parole statute makes certain people who are chronically debilitated or incapacitated eligible for consideration. However, Parole Commission regulations limit eligibility to people who are "imminently terminal" or have a condition making their continued incarceration purposeless.[7] More confounding is that the Medical Parole statute does not mention terminal illness at all, much less imminent death.

In our nationwide assessment of barriers to medical release programs, we found that poorly defined or inconsistent criteria frustrate program objectives. Missing definitions, lack of clarity, and dissonance between definitions in statutes and those in program regulations, leave corrections and parole authorities to supply their own definitions of qualifying conditions. Without sufficient guidance, the people who assess incarcerated people for eligibility and those who make the final decision whether to release them cannot be confident they are identifying and/or releasing the right people at the right time. They may fail entirely to act on deserving individuals.

Senate Bill 562 would refine eligibility criteria and oblige the Parole Commission to adopt regulations to implement the statutory criteria and other reforms made by the legislation.

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[4] Everywhere and Nowhere, Executive Summary, https://famm.org/wp-content/uploads/Exec-Summary-2-page.pdf.
[5] Fact Sheet: Medical/Geriatric Parole in Maryland, n.4.
[6] The Marshall Project, A State-by-State Look at Coronavirus in Prisons (July 1, 2021), https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons.
[7] *Compare* Md. Code Ann., Corr. Servs. § 7-309 (b) and Dep't of Public Safety and Correctional Services, Division of Correction Case Management Manual 100.0002, § 22 (D) (2) *with* Md. Code Regs. 12.02.09.04 (A).

Requiring the Commission to conform its regulations with the improvements in the statute will remove some impediments to medical parole.

FAMM has offered a **friendly amendment** to SB 562, attached at the end of this statement. Our suggestions will, if adopted, bring Maryland more in line with other states. For example, **the amendment would ensure terminally ill people are eligible for medical parole.** Neither the Medical Parole statute nor the current bill include terminal illness in eligibility criteria. In our nationwide review, we located only three other states that do not provide release for the terminally ill.[8] Note that our proposed amendment defines terminal in a way that does not include a prognosis of time left to live. Instead, it tracks the language used in the federal compassionate release statute.[9] A person would be considered eligible if they have a disease or condition with an "end-of-life trajectory." That language was offered by medical professionals with whom we have consulted. It is considered the gold standard because, as is well-known in medical circles, predictions about when a person will die are notoriously inaccurate. Physicians hesitate to predict life spans, or they err on the side of a generous prognosis out of concern for their patient's emotional wellbeing.[10] Our proposed language ensures that people who are dying can be considered for medical parole.

In the event the legislature would prefer a prognosis of time left to live, we urge that it be long enough to account for the time gathering and considering documents, and undergoing two stages of Parole Commission reviews. We believe anything shorter than 18-24 months might not give the process time to work. Time matters for people nearing the end of life.

Our amendment also suggests definitions for chronic debilitation and incapacitation, so that everyone assessing a person's eligibility are working with the same standard. For example, one offered definition would measure these conditions by determining whether the individual is unable to perform two or more activities of daily living. This measure is a standard used in a number of states and is understood by medical professionals to measure a person's functional impairment.

Senate Bill 562 would standardize application, documentation and assessment steps.

The current medical parole statute and the regulations published by the Parole Commission describe very different procedures for initiating a request and documenting eligibility and other factors, such as public safety. Senate Bill 562 would establish one standard for these procedures and oblige the Commission to adopt conforming regulations.

[8] FAMM, Compassionate Release, Delaware, https://famm.org/wp-content/uploads/Delaware_Final.pdf, Compassionate Release, Utah, https://famm.org/wp-content/uploads/Utah_Final.pdf, FAMM, Compassionate Release, Washington, https://famm.org/wp-content/uploads/Washington-Final.pdf.
[9] 18 U.S.C. § 3582 (c) (1) (A) (1).
[10] Brie A. Williams et al., Balancing Punishment and Compassion for Seriously Ill Prisoners, 155 Ann. Intern. Med. (July 19, 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3163454/.

For example, the Parole Commission operates under a regulation that provides that only the Warden can initiate the Medical Parole consideration. Current law and SB 562 allow the incarcerated individual, their counsel, a prison official, or any other person to file a request directly to the Commission.[11] Similarly, the documentation and assessment stages are inconsistent in current law and Commission rules.[12] Senate Bill 562 would set out a single procedure for gathering and reviewing the essential documents.

Senate Bill 562 also provides for a meeting, if requested, between the applicant or their representative and the Commission before the Commission decides whether to formally consider the applicant. That meeting must be held within 30 days of the request. We think this is a smart addition and especially commend the inclusion of a deadline for that meeting. We found in our evaluation of states, that establishing deadlines for steps in the process helped ensure that applications advance in a timely manner.

Senate Bill 562 would establish comprehensive geriatric parole in Maryland.

Senate Bill 562 will ensure Maryland joins 25 states nationwide that provide early release eligibility to people who are aging in their prisons. Doing so will help the state identify individuals who are among the most expensive to incarcerate and the least likely to pose a public safety concern.

Mandatory prison sentences and truth-in-sentencing laws mean that more people are serving prison terms, and those terms are longer and cannot easily be shortened. Our prisons are graying. While state prison populations overall are generally falling, the same cannot be said for their elderly populations.[13] It is estimated that by 2030, prisons will house more than 400,000 people who are 55 years old and older, making up nearly one-third of the prison population.[14]

Prisons face special challenges trying to meet the special needs of a geriatric population, many of whom have multiple chronic age-related medical conditions and disabilities. Elderly individuals need targeted supports such as ramps, lower bunks, and grab bars.[15] They need help getting to pill line, commissary, or the food hall, or in and out of wheel chairs and beds, and those with cognitive impairments need additional support.[16]

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[11] *Compare* Md. Code. Ann., Corr. Servs. § 7-309 (c) (2) *with* Md. Code Regs. 12.02.08.05 (B) and SB 562.
[12] FAMM, Compassionate Release in Maryland 2-3 and notes, https://famm.org/wp-content/uploads/Maryland_Final.pdf.
[13] E. Ann Carson, U.S. Dep't of Justice/Bureau of Justice Statistics, Prisoners in 2018, at 1 (Jan. 2018), https://bjs.ojp.gov/content/pub/pdf/p18.pdf.
[14] George Pro and Miesha Marzell. Medical Parole and Aging Prisoners: A Qualitative Study, 23 J. of Correctional Health Care 162, 162 (2017), https://www.liebertpub.com/doi/abs/10.1177/1078345817699608?journalCode=jchc.1.
[15] Human Rights Watch, Old Behind Bars: The Aging Prison Population in the United States 48-52 (Jan. 2012), https://www.hrw.org/sites/default/files/reports/usprisons0112_brochure_web.pdf.
[16] Steve Berry, et al., The Gold Coats – An Exceptional Standard of Care: A Collaborative Guide to Caring for the Cognitively Impaired Behind Bars 4-5, 31-32 (2016).

The cost of care for aging people in prison is between three and nine times more than for younger people.[17] **In Maryland, medical costs double for incarcerated people over the age of 60.[18]**

Among the other smart features of the geriatric parole provision is the requirement that the Commission annually identify and assess people who might be eligible for parole. Ensuring that potentially eligible people are identified and considered is an innovative reform, adopted by a growing number of states, such as North Carolina.[19] This requirement will ensure that no elder in prison is left without a chance to be considered for parole.

Many of the elders in Maryland's prisons have been locked up for years or decades. Geriatric parole will give the Commission the chance to assess whether their continued incarceration is in the public interest, using an evidence-based risk assessment tool and taking into account the impact of an individual's age on reducing their risk of recidivism.

Conclusion

FAMM is happy to support SB 562 and urges the Committee to consider suggested friendly amendment language that we believe will strengthen the Medical Parole Program.

Proposed Friendly Amendment to SB 562

Strike lines 26 through 32 of page 2 and lines 1 and 2 of page 3, insert the following text, and re-designate remaining subsections of Section 7-309 accordingly:

(a) This section applies to any inmate who is sentenced to a term of incarceration for which all sentences being served, including any life sentence, are with the possibility of parole.

(b) Under this section:

(1) "Terminal illness" means a disease or condition with an end-of-life trajectory

(2) "Chronically debilitated or incapacitated" means having any diagnosable medical condition – including dementia and a severe, permanent medical or cognitive disability – that is unlikely to improve noticeably in the future and prevents the individual from completing more than one activity of daily living without assistance. Activities of daily living include such activities as eating, breathing, dressing, grooming, toileting, walking, or bathing."

[17] Cyrus Ahalt, et al., Paying the Price: The Pressing Need for Quality, Cost, and Outcomes Data to Improve Correctional Health Care for Older Prisoners, 61 J. of the Am. Geriatrics Society 2013, 2014 (2013), https://pubmed.ncbi.nlm.nih.gov/24219203/.
[18] Open Society Institute, Baltimore, Building on the Unger Experience: A Cost-Benefit Analysis of Releasing Aging Prisoners, 8 (Jan. 2019), http://goccp.maryland.gov/wp-content/uploads/Unger-Cost-Benefit3.pdf.
[19] FAMM, Compassionate Release, North Carolina, at 1 (Dec. 2021), https://famm.org/wp-content/uploads/North-Carolina_Final.pdf.

(c) An inmate who

(1) is chronically debilitated or incapacitated by severe illness or medical condition or who suffers from a terminal illness, or

(2) requires extended medical management, with health care needs that would better be met by specialized community services, or

(3) who has been rendered by a medical or mental health condition, disease, or syndrome, physically incapable of presenting a danger to society

may be released on medical parole at any time during the term of that inmate's sentence, without regard to the eligibility standards specified in § 7–301 of this subtitle.