OSC

Relieving the Crisis of Dying in Prison

MEDICAL RELEASE REFORM

By Justin Low | March 2023

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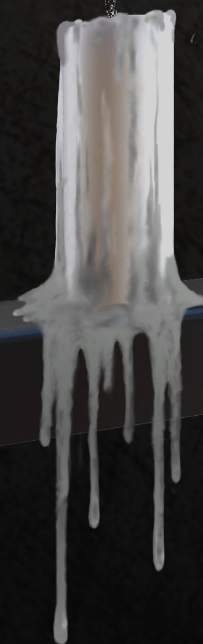
The Oregon Justice Resource Center (OJRC) is a 501(c)(3) nonprofit founded in Portland, Oregon, in 2011. We work to promote civil rights and improve legal representation for communities that have often been underserved in the past: people living in poverty and people of color among them. Our clients are currently and formerly incarcerated Oregonians. We work in partnership with other, like-minded organizations to maximize our reach to serve underrepresented populations, train public interest lawyers, and educate our community on civil rights and civil liberties concerns. We are a public interest law firm that uses integrative advocacy to achieve our goals. This strategy includes focused direct legal services, public awareness campaigns, strategic partnerships, and coordinating our legal and advocacy areas to positively impact outcomes in favor of ending mass incarceration.

“A prison death shatters all hopes and dreams— however faint or undeserved— of a second chance; of the opportunity for a new life that is not defined, distorted and limited… by [the] past.”[1]

— **Mark J. Wilson,** *former hospice volunteer at Oregon State Correctional Institution*



Introduction

FROM 2016 TO 2021, the state of Oregon was among the top five states in the country for having the oldest adult in custody (AIC) population. During that time period, Oregon saw a 20% increase in the share of those in custody who were 60–79 years old.[2] Over the same six years, 259 AICs passed away in Oregon Department of Corrections' (ODOC) facilities.[3] Together, these statistics point to a grim reality facing Oregon and its aging AIC population, one that requires compassionate and specialized medical care because the current care services in ODOC are far from sufficient and appropriate. In-custody deaths are cruel and inhumane experiences for the individuals affected and their loved ones, they are taxing and traumatic for the staff and volunteers tasked with providing end-of-life care and services, and they require extensive financial costs to taxpayers that could be mitigated by allowing those in custody to seek care and comfort outside of prison during their final days.

Currently, there is only one option, other than clemency, that AICs can pursue to be released when experiencing severe or terminal medical conditions. It is called early medical release (EMR),[4] and it has been woefully insufficient in delivering swift and accessible resolutions for these time-sensitive requests. Lacking transparency, medical expert opinions, and timely handling, Oregon's EMR process has approved less than 7% of applicants from 2013 to 2020.[5] The rest of the applicants are either denied due to sentence ineligibility (such as life without parole and mandatory minimum sentences), get held up in the process due to needless logistical issues, or pass away before their application is reviewed. In any case, these individuals are subjected to an antiquated and capricious process that views EMR and end-of-life care as a public safety and control issue, rather than an urgent medical matter.

The system by which ODOC and the Oregon State Board of Parole and Post-Prison Supervision (BOPP) manage requests for EMR requires a significant overhaul, one that exchanges the absence of predictability and broader eligibility, for one that is empathetic, reliable, and medically appropriate. This report will share the personal stories and journeys of those who have been impacted by the current end-of-life care system at ODOC, shed light on the process individuals go through during hospice care or EMR, and provide insights into legislative solutions—referred to as compassionate medical release reform—that can begin to address some of the glaring issues with the current EMR process.

Everyone deserves the opportunity to receive quality medical care, and to be amongst friends and family in their final days. This is rooted in the simple desire to be considered with compassion, treated with dignity, and recognized with humanity. No one should have to die in incarceration.

The Costs of Incarcerating Medically Vulnerable People

The Physical Cost

The most pressing costs that medically vulnerable AICs experience within ODOC institutions are the harsh physical realities that come with aging inside the carceral system. The sole act of being incarcerated has been shown to bring about new health conditions and illnesses in an individual that did not exist prior to incarceration. Speaking on how incarceration impacts AICs, Attorney Juan Chavez explained to *Street Roots*, "Their bodies are physiologically older because of socioeconomic or health-related things that have happened in their lives or that are currently happening to them in prison."[6] Increased physical aging, and the ailments that come with it, can be brought about by isolation, substance use, poor nutrition, inadequate preventative and primary care before or during incarceration, and the violent nature of prison itself.[7] Common health issues experienced by aging AICs include cancers, cardiovascular and respiratory issues, dementia, impaired mobility, and loss of hearing and vision.[8] A report from the *Journal of the American Medical Association* further supports these findings: "[A]ging AICs have an average of three chronic illnesses and as many as 20% of them have a mental illness."[9]

The carceral system was never built with the aging population's needs in mind, let alone the proper physical and mental care of individuals of any age or need. From a structural standpoint, aging AICs often require lowered beds and bunks, physically accessible cells, ramps and wide pathways for mobility devices, or elevators that can help individuals with limited mobility better navigate through their facility.[10] From a programmatic point of view, most correctional programming for AICs is related to education and job training, but those are not always the type of re-entry programs that meet the needs of older and less-able-bodied AICs. From a skills and staffing capacity, qualified medical staff is scarce in prisons, and other corrections staff lack the training and mindset necessary to compassionately aid aging AICs.[11] Finally, from a systems perspective, the prison system does not treat individuals like patients with time-sensitive health care needs. For example, for AICs that require nurse aid or medication, there is no direct or immediate path to receiving care.[12] AICs must either ask correctional staff to send for direct nursing care or notify officers anytime they need access to something as simple as over-the-counter medications.[13] In either situation, an AIC needing

medical treatment relies on a non-medical professional that gatekeeps their access to life-saving care.

Finally, the health risks that aging AICs are subjected to through continued incarceration are cruel: the immune system diminishes over time, prisons can become crowded, and incarceration itself is a brutal and stressful environment. An AIC's immunity can drop exponentially with age and with the abuse experienced in prison. This compromised immunity is then threatened by the cramped and tight environment of overcrowded prisons where bacteria and viruses can thrive and overwhelm. The *Bend Bulletin* described incarceration during the height of the COVID-19 pandemic, which exemplified a health crisis that ran rampant due to the aforementioned factors, as an "unwelcome death sentence."[14] Offering AICs the opportunity to be considered for compassionate medical release will improve the quality of living for the medically vulnerable and reunite families, all while transitioning the prison system away from responsibilities it is not qualified or capable of handling.

The Human Cost

A cost that is not often discussed in research articles and policy roundtables when it comes to incarcerating the medically vulnerable is the human cost. Many individuals who apply for EMR while on hospice never benefit from the process; and the seven percent that do make it through are still subjected to logistical hurdles before being released, like providing proof of access to medical care and housing once released. The bulk of individuals that do not seek EMR, or are denied, must endure their medical condition or end-of-life process in prison. For AICs with severe medical conditions, their continued incarceration only exacerbates their pain, progression of illness, or overall loss of quality of life. Issues that can arise include loss of access to or ability to participate in AIC programming, loss of work placements, difficulty in accomplishing activities of daily life (i.e., bathing, eating, moving, toileting, etc.), and loneliness.

For those that enter hospice for their end-of-life process, the infirmary becomes their home, which can keep them separated from friends and family during the final moments of their life. Loved ones that do attempt to visit an incarcerated patient in hospice express that ODOC's administrative processes for visitation can be a logistical labyrinth. To start, friends and family

> **"A lot of folks get misdiagnosed, so by the time they get properly re-diagnosed, they're already at the very end and it's too late to do anything."**
>
> **– Troy Ramsey, formerly incarcerated hospice volunteer at Oregon State Penitentiary (OSP)**

can only begin the process of visiting if word gets out in time and through the proper channels. Each AIC has just one emergency contact who will receive word from ODOC if a health emergency occurs. If the emergency contact is inaccessible when ODOC reaches out, there is seldom any additional, proactive outreach by carceral staff to track that person down or identify an alternative contact person.

Even worse, if the emergency contact is estranged from the individual in custody or is not on good terms with any other friends or family that should be notified of the AIC's diminishing health, other people that might want to visit in person may not find out until it is too late. The task of ensuring folks in the community receive word about an AIC entering hospice then falls on peers and hospice volunteers to conduct outreach on behalf of the individual, who by that point may not have the physical or mental capacity to make calls or write letters out themselves.

Discovering that an individual is receiving hospice care in ODOC is only one of the major hurdles in getting friends and family to visit. ODOC's stringent protocols and procedures make the visiting process unnecessarily complicated—and they highlight how, even in a person's last days, control and subjection are always a priority for the prison agency. From getting proper authorization and clearance to visit an ODOC facility, to being limited to specific visiting hours (usually from 7:00 am to 10:00 am or from noon to 3:00 pm), an individual receiving hospice care while in custody does not have open access to friends and family members as they would if they were on hospice beyond the bars of the prison. It is only when a hospice patient approaches their final 24–72 hours that two visitors are allowed to be with them at all times (referred to as "standing vigil"), to ensure that the individual does not pass away while alone. For those that do not end up receiving visitors while on hospice, this role is filled by their peers serving as around-the-clock volunteers and company up until their last breath.

While not strictly a human cost—but one that is incurred directly by family and friends rather than the state—loved ones must account for transportation, take time off work to be able to visit during the strict visiting hours, arrange lodging options if they do not live within a reasonable distance of the prison facility, and navigate the agency's red-tape all on their own when visiting a patient. Even if all the personal logistics line up for a family member or friend to make a visit, they could still be shut out due to administrative lockdowns and other short-term restrictions that the prison facility could be experiencing at that time. Instead of being able to prioritize time spent with a dying loved one, friends and family must spend precious time, energy, and money to make the logistical preparations necessary to gain limited access to their patient that is on hospice.

Lastly, as if these barriers and human costs were not enough, family members and friends that are under the age of 18 or have a past conviction on their record are prohibited by ODOC facility rules from visiting hospice patients in the infirmary. This means that minor children of hospice patients cannot spend the last few months, weeks, or hours with their parent before they pass away, nor can loved ones—who might be the only relative or support system the patient has—who have been convicted of a prior offense. This system was not built to treat people with the dignity all humans deserve during their final hours, and its unnecessary barriers and restrictions exacerbate pain for community members that just want to be by their loved one's side.

Nobody should have to die in prison. At least three-quarters of the people I've sat with—it's been a tragedy that their family can't come in more, that they couldn't be around friends and family, and that they couldn't be around grandchildren. It is just too difficult to get community members into the prison system when someone is on hospice. These patients don't pose a percentile of danger to the community."

– Kyle Hedquist, formerly incarcerated hospice volunteer at OSP

The Fiscal Cost

As it currently stands, ODOC's Health Services budget, which funds hospice and infirmary care, is the agency's second largest expenditure. This cost is directly borne by Oregon taxpayers through the state's General Fund.[15] While a commonly cited report from the National Institute of Corrections states that aging AICs cost "two to three times more" to incarcerate than younger AICs,[16] more recent reports find that incarcerating aging AICs can cost three to nine times more than younger, healthier AICs.[17] [18] When it comes to medical costs, a 2019 report from the U.S. Department of Justice found that carceral institutions with the highest percentage of aging AICs ended up spending five times more per AIC on medical care ($10,114 per year) than institutions with the lowest percentage of aging populations in custody ($1,916 per year).[19] When it came to pharmaceutical costs, the difference was greater: Bureau of Prison institutions with the highest percentage of aging AIC populations spend 14 times more on medication per AIC ($684 per year) than those with the lowest percentage of aging AICs ($49 per year).[20]

Oregon's ranking among the top five states with the greatest percentage of aging AIC populations makes these costs particularly relevant. The issue of aging state prison populations is a direct consequence of courts and prisons

"I've known men that are on a pill regimen that costs $8,000 to $12,000 a month because Oregon [AICs] are not covered by Oregon Health Plan."

– Kyle Hedquist

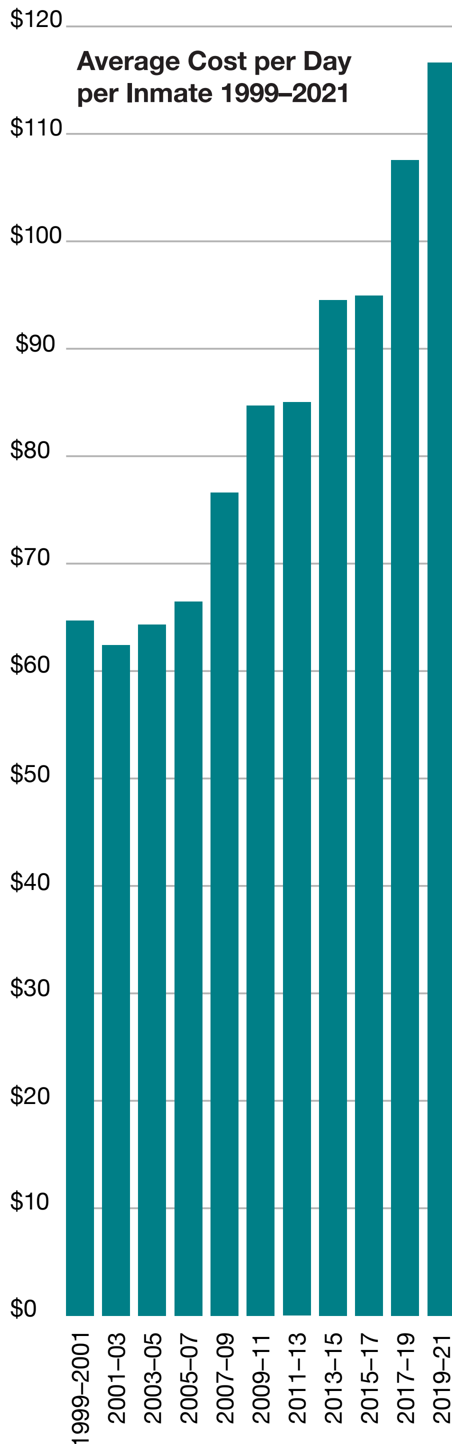


FIGURE 1: *The average cost of incarceration per individual, provided by Oregon's Legislative Fiscal Office.[27] Dollar amounts have not been adjusted for inflation.*

increasingly sentencing older individuals to prison, district attorneys seeking longer sentences and penalties in the name of improving public safety, and individuals growing older while serving lengthy sentences imposed during the 1990s and earlier.[21] Subsequently, the confluence of these factors has led to increased aging AIC populations nationwide that require additional care, support, and treatment. In Oregon, ODOC's Health Services budget reflects this trend: its 2011–2013 biennial budget operated at just under $200 million, which increased to a 2019–2021 biennial budget of over $285 million.[22] The estimated 42.5% increase in ODOC's Health Services budget in less than a decade tells just how severe the situation has become as the agency's responsibility toward the health and well-being of its rapidly aging AIC population has exponentially increased.

Instead of squandering state dollars on maintaining the status quo, which contributes to negative health outcomes,[23] the state could create a path for AICs to be released due to severe medical reasons. The state could then take the money that is saved to reinvest in rehabilitation programs, reentry resources, and carceral medical care that meets community expectations. Based on conservative estimates from Oregon's Legislative Fiscal Office and ODOC, creating a mechanism that provides compassionate medical release for aging and ailing AICs could result in roughly $4 million in savings by the first two biennia.[24]

This is likely an underestimate: these figures are based on the average bed space costs per AIC (see **Figure 1**), yet the individuals that would benefit from compassionate medical release typically cost the state much greater than the average AIC due to additional health and pharmaceutical costs. While the savings may seem modest at first glance, the 2022 Joint Task Force on Corrections Medical Care noted that a process like compassionate medical release could "… free up DOC workforce and facility capacity to provide care to other AICs [and]… The Legislative Assembly [could] reinvest any savings that result back into DOC to continue to promotion of access to care and services for AICs that meets community standards."[25]

In testimony to the Oregon Legislature in 2021 in support of a new compassionate medical release process, the American Conservative Union Foundation wrote, "We simply cannot afford for our prisons to be… highly secured [inpatient facilities] when doing so clearly does not translate to public safety. The cost to both our finances and our communities would just be too great and unfair…."[26] Nationally, compassionate medical release reform has broad and bipartisan support, and Oregon's potential legislative reforms could lead to a process that is medically informed, more empathetic toward patients and their families, and more fiscally responsible with taxpayer dollars.

“A lot of people when they’re on hospice they need to be helped to go to the bathroom, help to wipe, they need all kind of assistance, help to shower and all that.”

– Troy Ramsey

“The infirmary or hospice program may take care of patients as best as they possibly can, but at the end of the day, it’s still a prison. There are still bars, guards, and punishment looming over you.”

– Cynthia Rowe, hospice volunteer at Coffee Creek Correctional Facility (CCCF)

Current System

CURRENTLY, THE EMR SYSTEM is guided by ORS 144.122 and 144.126. Under these statutes, for AICs whose judgments allow for EMR, the BOPP may advance the release dates if the BOPP determines that "continued incarceration is cruel and inhumane"; release is "not incompatible with the best interests" of the AIC and society; and the AIC is "suffering from a severe medical condition including terminal illness" or "elderly and permanently incapacitated in such a manner that the AIC is unable to move from place to place without the assistance of another person." advance [28]

While deceivingly straightforward in process, the reality is all but. After an AIC meets the statutory requirements and applies to be considered for EMR, it is the BOPP's prerogative to determine whether to move forward with processing the application, how fast the application should be processed, and what subjective criteria can be utilized in approving or denying the request. The BOPP member composition also poses a significant barrier for those applying for EMR, as their collective professional and personal backgrounds are devoid of any medical experience. Currently, the Board is comprised of attorneys, former parole officers, and businesspeople.[29]

One of the other major issues with EMR in its current form is that the vast majority of individuals who could most benefit from the process are barred from the outset since they do not meet sentencing eligibility, even though they are medically eligible. Individuals serving ineligible sentences, such as life without parole and mandatory minimum sentences, make up the vast majority of EMR denials, and they also make up a significant portion of ODOC's medically vulnerable population.[30] Without substantial changes to state laws that determine which sentences are eligible for EMR, the system will never reach its full potential in providing relief to all that are medically eligible.

Consequently, the current system is ineffective and does not reflect the mission and goals of having a medical release system. EMR lacks consistency and expediency, it can be cumbersome for AICs and their loved ones to navigate on their own, the law contains too narrow of criteria to meet the needs of most AICs who could benefit from EMR, and application review is placed in the hands of individuals that do not have the professional background necessary to make objective, medically informed decisions.

Records collected from the BOPP provide strong support for these critiques and warrant a reimagining of how the state treats AICs seeking EMR. From 2013 to 2020, there were 131 AICs who submitted applications for EMR related to severe medical conditions.[31] Of those 131 applications, only nine (roughly 7% of total applicants) individuals completed the entire process, were granted release, and re-entered the general population.[32] On the other hand, 11 individuals passed away during their application process, while the rest of the 111 applicants were denied for reasons such as awaiting further tests to determine medical eligibility, not receiving a medical decision from medical experts, failing to meet the narrow medical eligibility criteria, judgment language making the AIC ineligible, or BOPP outright blocking approval due to "severity of crimes."[33]

Just as concerning as the denial rate of EMR applicants is the average wait time for those who are lucky enough to be approved—while the shortest wait was eight days, the longest was 557 days.[34] The average wait time among the nine applicants approved from 1/1/2013 to 12/30/2020 was 167 days.[35] This, in part, is due to the BOPP's substantial workload, which is already well beyond the capacity of its five-member board.

Currently, the BOPP offers eight different hearings for various parole and post-supervision purposes, in addition to overseeing the provision of victim services and the sex offender notification leveling program. Accounts from attorneys have shared that BOPP is only able to get to EMR hearings when they have time and capacity, thus adding further delay to what is already a very time-sensitive matter for EMR applicants. Simply put, the BOPP does not have the capacity for EMR and therefore should not be the primary entity in charge of this application process.

An individual's fight to endure a painful, debilitating medical battle while trapped in an unforgiving environment is already an arduous uphill fight. Enduring it for almost half a year—let alone over 18 months—is both appalling and unacceptable. Current Oregon laws do not mandate deadlines that the BOPP must follow, they do not offer a wider net of criteria for applicant eligibility, and they do not place the decision to release someone for a medical condition in the hands of those that are medically knowledgeable. The EMR process at its baseline is cruel and unusual and demands a change that better reflects the time-sensitive medical nature of these applications, and further reforms are needed to address not only who is medically eligible, but also which sentences are eligible.

> **"Most medical and nursing staff [here] are trained to save lives, not help somebody travel through the end of their life."**
>
> **– Susan Corbett, hospice volunteer at CCCF**

> “In order to visit someone on hospice you have to come through the prison to the infirmary. A lot of times a family member would…schedule a visit and get to the prison, and the institution would say they didn’t get that call. One guy, in particular, had a daughter that kept trying to get up there, but three or four days were wasted getting the run-around from ODOC staff. Three or four days for a patient on hospice could be deadly. So, there are plenty of unnecessary barriers.”

– Anthony Pickens, formerly incarcerated hospice volunteer at OSP

> “It’s a norm of prison administration that somebody in one area didn’t communicate to somebody in the next… Another problem is the amount of time that it takes for DOC to deal with admitting visitors, which cuts into their visit time…they might get in there and miss the only time their person was coherent and responsive.”

– Sterling Cunio, formerly incarcerated hospice volunteer at OSP

> “I kept trying to get up to Medical, and Medical kept telling me there was nothing wrong with me. So, I went through the hoops…steady denials, writing grievances, and going through that process—and then I finally got my family involved. I had my mother and sister-in-law come up and speak to DOC Medical…[a]nd DOC tried to tell them some watered-down version of what was really going on with me and they didn’t accept that. And they told them they weren’t going to leave until ODOC got something done.”

– Troy Ramsey, on trying to receive an official medical diagnosis before being sent to a DOC infirmary and placed on hospice

Compassionate Medical Release Reform

THE CURRENT EMR PROCESS must be reformed into a compassionate medical release system that acknowledges the humanity of each applicant and the medical-nature of each case. One groundbreaking solution that is much more adequately and appropriately responsive to the needs of individuals with severe medical conditions and aging complications, comes in the form of a compassionate medical release bill that would reform the current system. This bill, led by State Senator Michael Dembrow, State Representative Lisa Reynolds, Oregon Physicians for Social Responsibility, and the Oregon Justice Resource Center, would create a new path for AICs seeking compassionate medical release—one that is reviewed by medical professionals, provides support for AICs during the process, and establishes set timelines for applications to be processed in an expedient and consistent manner.

Initially introduced in the 2021 Legislative Session as SB 835 by Senator Dembrow, Senator Gorsek, and Representative Reynolds, and again in the 2022 Legislative Session as SB 1568 by Dembrow, Reynolds, Senator Prozanski, and Representative Bynum, both compassionate medical release bills were moved out of the Senate Committee on Judiciary with "do pass" recommendations.

However, due to the fiscal cost attached to each bill—which was considered independent of the projected savings from the policy—they were subsequently referred to the Joint Committee on Ways and Means, where they remained upon each legislative session's adjournment. Despite the fates of SB 835 and SB 1568, compassionate medical release has been reintroduced in the 2023 Legislative Session as SB 520, with the hopes of making it to the Governor's desk to be signed into law.

In contrast to the current EMR process, SB 520 moves the initial decision-making power over applicants to a committee of medical professionals, provides a much-need expansion of medical eligibility, establishes set deadlines for application review and hearing completion, and assigns necessary legal and personal support to help applicants navigate the process (see **Appendix A** for full details of SB 520).

SB 520 would establish the Medical Release Advisory Committee (MRAC) within the BOPP, which would be an independent group of 5-13 licensed medical professionals appointed by the governor to review compassionate

> **“Usually what happens is when [AICs] look into getting compassionate release, they’ll review the guidelines, and it’ll be predetermined like, ‘I don’t meet these strict requirements, so I’m not going to apply.’”**

– Susan Corbett

> “I know two different women who are in their 60s—one of them who has been incarcerated for 35 years and she’s very low-functioning—she has a walker, she’s clearly not going to re-offend.”

– Susan Corbett

> “Another person that I know has an eye disease where she’s almost completely blind now, and this place isn’t doing anything to accommodate her vision loss. She has macular degeneration and she’s in her late 60s... Sometimes she doesn’t even recognize my face. So she doesn’t even know it’s me when I see her in the corridor until I speak and she hears my voice.”

– Susan Corbett

> “ One of the guys that I was on vigil with, he couldn’t talk, he couldn’t walk, he couldn’t do anything on his own. So us hospice volunteers would clean him, change his adult diapers, and we would wheel him to the shower. The most he could do during any given time was moan.”

– Anthony Pickens

medical release applications and make release recommendations solely and objectively from a medical and public health perspective.

Once an application is completed, SB 520 allows for a release navigator to be assigned to an applicant to help with re-entry planning and ensuring continuity of care out in the community. If the MRAC recommends release, SB 520 mandates that an applicant will be appointed counsel to assist with the release court and BOPP's review. Throughout the application process, there are set timeframes by which the MRAC, BOPP, and release court must review the applicant, in order to make the system more responsive and expedient.

It should be noted that individuals serving Measure 11 Sentences or other sentences ineligible for EMR, like life without parole, may submit an application to the MRAC, but they will not be eligible for release. The MRAC may issue that individual a recommendation for release which could then help the applicant explore other legally available options for case review and release. Therefore, while passing SB 520 would significantly improve the current EMR system, it is just the first critical step that needs to be taken.

The next step for compassionate medical release reform must address the glaring issue that sentence ineligibility creates for the medically vulnerable, ODOC, and BOPP. With the majority of medically eligible candidates for EMR constrained by sentence ineligibility, there is more work to be done once the EMR system is transformed into a medically-informed system. Any restriction on who can qualify dilutes the effectiveness of this policy change. There are many people who will meet the qualifications of SB 520—people with loved ones who want to be with them and people who are using a disproportionate amount of state dollars and resources—but will not be able to access the changes that come with the bill due to sentencing restrictions.

After passing SB 520, the Oregon State Legislature will need to expand sentence eligibility to medically vulnerable AICs that are serving life without parole or mandatory minimum sentences to help those that consistently get denied by the current EMR system. Without this next step in compassionate medical release reform, many individuals will be left behind, needlessly costing the state millions of dollars and depriving individuals of a chance to spend their remaining days on this earth with the ones they love.

Conclusion

> **“It’s always baffled me when people that couldn’t even sit up on their own would be denied the chance to die amongst the people they love and those that love them.”**

– Sterling Cunio

THERE IS A PHILOSOPHICAL story taught in the halls of education titled *The Ones Who Walk Away from Omelas* by Ursula Le Guin. The story depicts the utopian city of Omelas, whose blissful success, post-capitalist economy, and gold-shimmering buildings are all dependent on the suffering and misery of a locked-up child that is left in eternal hunger, pain, and misery. For the citizens that learn of this abuse and cannot reconcile paradise with cruelty, they choose to walk away.

Many are familiar with this story, the theory of utilitarianism, or the overarching theme present in many forms of popular media. However, few may know that the name Omelas was created by the author reading the sign Salem, OR backward while driving through the state. Although it is doubtful that Le Guin was making a direct critique of mass incarceration, incarcerated hospice patients, or in-custody deaths in her writing, the story’s overarching theme and its coincidental connection to the location of the State Capitol and Oregon State Penitentiary serve as an eerily fitting analogy.

The State of Oregon, its elected officials, and its voters must not resign themselves to the idea that the injustices done unto incarcerated individuals, especially those that are medically vulnerable, are an acceptable or

necessary price to pay for the façade that is "public safety." These are the lies one tells themselves to be protected from the harsh reality that a dying individual who cannot sit up or go to the bathroom on their own does not pose a threat to anyone—yet, they remain incarcerated, abused, and isolated from community. It is in these lies that one fabricates a shimmering mirage of comfort and peace, but which comes at the expense of someone else's desire for tangible comfort and peace. Until compassionate medical release reforms are implemented, and mass incarceration is dismantled, these two groups will perpetually exist, with the former impeding the latter.

Throughout the various interviews of individuals impacted by ODOC's end-of-life care system and hospice program, there existed universal acknowledgment of a singular point: regardless of harm caused in the past, no one deserves a prison death.

It may be tempting, in the face of the obscene reality that is Oregon's prison system to simply walk away. But it is incumbent on the many that enjoy privilege, power, and freedom to dismantle the system that hurts the few. Only then will we take a collective step closer toward a shared reality of true comfort and peace.

> **“Why can’t we as humans have enough compassion for someone else that’s dying to allow them the opportunity to go home—even if they are incarcerated for whatever they done—to have that opportunity to die in peace. Because that could be a real peace for them to be at home and pass away, instead of the turmoil that’s going on in the prison.”**

– Troy Ramsey

Appendix A—SB 520

SB 520 WOULD ESTABLISH a new committee housed in the BOPP, called the Medical Release Advisory Committee (MRAC).

The MRAC would consist of 5–13 voting members that are either physicians, physician assistants, or nurse practitioners licensed by the Oregon Medical Board. The members of the MRAC would be appointed by the Governor for four-year terms and cannot be employed or contracted with the Oregon Department of Corrections.

For applications that are incomplete, the MRAC is tasked with communicating to the applicant that additional information is needed. If the panel determines that an applicant is not eligible, the MRAC will notify the AIC immediately and then cease review of the application. Should an application be deemed complete and advance to full review, the MRAC would announce a decision regarding compassionate medical release within 45 calendar days. For applicants that apply under expedited review or who have a terminal illness, the MRAC must announce a decision within 14 calendar days.

Applicants currently serving sentences that are ineligible for parole, such as Measure 11 and life without parole sentences, may apply to the MRAC to receive a recommendation for release, but they will not be eligible to be released. Should they receive a recommendation for release from the MRAC, these applicants may use the recommendation to help them explore other legally available options for case review and release.

While the applicant awaits notification of a decision, they are assigned a "release navigator" whose task is to assist an applicant in developing a release plan. This can involve coordinating with family members for the transition, finding housing, and transferring medical care from the Department of Corrections to an outside provider. With the help of this release navigator, an applicant can make their case for compassionate medical release without being held up by the logistics of re-entry that have previously hindered EMR applicants when they went before the BOPP, such as providing evidence of access to immediate housing and medical care once released.

A simple majority vote of the MRAC will determine whether the committee recommends or denies an applicant for compassionate medical release. A successful applicant must meet one or more of the listed criteria:

a. (a) the applicant or referred AIC has a terminal illness with a prognosis of 12 months or less to live; or
b. (b) the applicant or referred AIC is unable to independently complete the activities of eating, toileting, grooming, dressing, bathing, or physical transfers or is unable to independently move from place to place, even with the use of a mobility device; or
c. (c) the applicant or referred AIC has an underlying condition that places the applicant or referred AIC at increased risk of serious medical complications or death if they are exposed to disease; or
d. (d) the applicant or referred AIC has a debilitating or progressively debilitating medical condition that: (A) poses an immediate risk to the applicant's or referred AIC's health or life; or (B) requires complex medical intervention or intensive, high needs.

The committee may also consider the following as additional factors during their application review: time left to serve by the applicant, the quality of life living with the described medical condition, and whether continued care through the Department of Corrections is inappropriate. If an application is denied, an appeal is not available for the applicant, but they can choose to reapply if a change in their condition occurs.

Should an applicant be approved, they will be notified immediately and appointed legal counsel by the Office of Public Defense Services for the next step: seeking official release through the BOPP or through review by the original trial court. Once the MRAC recommends release, the BOPP has 45 days from receiving the recommendation to hold a hearing and announce a decision. There is a presumption for the BOPP to accept the MRAC recommendation, unless there is clear and convincing evidence that the applicant poses a danger to the safety of the public or other persons and that the danger outweighs any reasons to assign compassionate medical release.

Applicants that must be reviewed for time served must have their attorney file a motion for compassionate medical release with the sentencing court, which the court is expected to approve unless they find clear and convincing evidence, based on evidence provided by the district attorney, that resentencing the applicant would create a threat to public safety. The sentencing court will then have 30 calendar days from the filing of the motion for compassionate medical release to hold a decision hearing.

Regardless of whether the applicant goes through the BOPP or sentencing court for final approval of compassionate medical release, the bill states that the victims related to the applicant's case must be notified. During the BOPP hearing, the victim will be given the opportunity to be heard, either by directly addressing the board or by submitting a written statement. Victims will be offered a similar opportunity should the compassionate medical release applicant need to go through the sentencing court process rather than BOPP.

Applicant submits application to be considered for compassionate medical release

Process through ORS 144.122 or 144.126

The BOPP makes a decision for early relief if an AIC:

(a) **has demonstrated an extended course of conduct indicating outstanding reformation;**
(b) **Suffers from a severe medical condition including terminal illness; or**
(c) **is elderly and is permanently incapacitated in such a manner that the prisoner is unable to move from place to place without the assistance of another person.**

New Statute (SB 520)

Application gets submitted to the Medical Release Advisory Committee (MRAC) for review.

Until Jan. 1, 2026, limit of five cases per month.

MRAC determines whether compassionate medical release is necessary for the applicant given the criteria outlined in SB 520.

"Release navigator" assigned to applicants to begin developing a release plan.

Expedited: 14 calendar days
Standard: 45 calendar days

MRAC denies the application. While appeal is not authorized, an applicant can reapply if there has been a change in their condition.

MRAC approves the application and makes the recommendation to release. Victim is notified immediately upon approval for relief.

Attorney/counsel appointed
Applicant goes to BOPP for relief.

(If an applicant's original sentencing decision must be reviewed for time served by sentencing court.)

Within 30 calendar days

Attorney will file a motion for medical release with the sentencing court.

The court will resentence to time served unless they find by clear and convincing evidence that resentencing the applicant would create a threat to public safety

Within 45 calendar days

The BOPP shall approve the MRAC's decision for relief unless they find by clear and convincing evidence that the applicant is a substantial threat to the public.

Applicant released.

FIGURE 2: *Compassionate medical release flowchart.*

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