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A CALL FOR GREATER COMPASSION

How Pennsylvania's Compassionate Release Statute Reinforces Cruelty

Abolitionist Law Center —— December 2024

Dedication

This report is dedicated to those who have been killed in, and by, jails and prisons; who have died in cages; who suffered apart from their loved ones; and who have been robbed of their dignity, autonomy, and humanity by the criminal punishment system.

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ALC Client Curtis Perry Credit: Rain Gideon

Introduction

Compassionate release is generally understood as a mechanism by which a court grants early release from prison to sick or elderly incarcerated individuals.[1] However, compassionate release laws vary widely by state and are far less "compassionate" in practice than the name implies. In Pennsylvania, compassionate release eligibility under state law is rare and the process by which it must occur is inarguably cruel. While there are minor reforms that could minimally improve the particularly harsh realities of compassionate release, the truth is that the process is broken, creates perverse incentives, and is beyond repair. Ultimately, it would be a waste of energy and resources to try and transform this process into a truly compassionate one; instead, advocates should focus on a more upstream approach: advocating for broad parole eligibility for sick, elderly, and rehabilitated incarcerated individuals - rather than seeking medical transfer once individuals are already extremely ill.

Pennsylvania's compassionate release statute, 42 Pa. C.S. 9777, permits a temporary deferral of a criminal sentence for incarcerated individuals who are terminally ill, so they may be transferred to a location where they will receive palliative care, whether at home with their loved ones or in a medical facility where they can receive more appropriate medical care tailored to their needs. Unfortunately, the statute's strict requirements

limit eligibility to only a small proportion of the gravely ill, only granting release to those who receive a prognosis of less than a year to live from a treating physician.

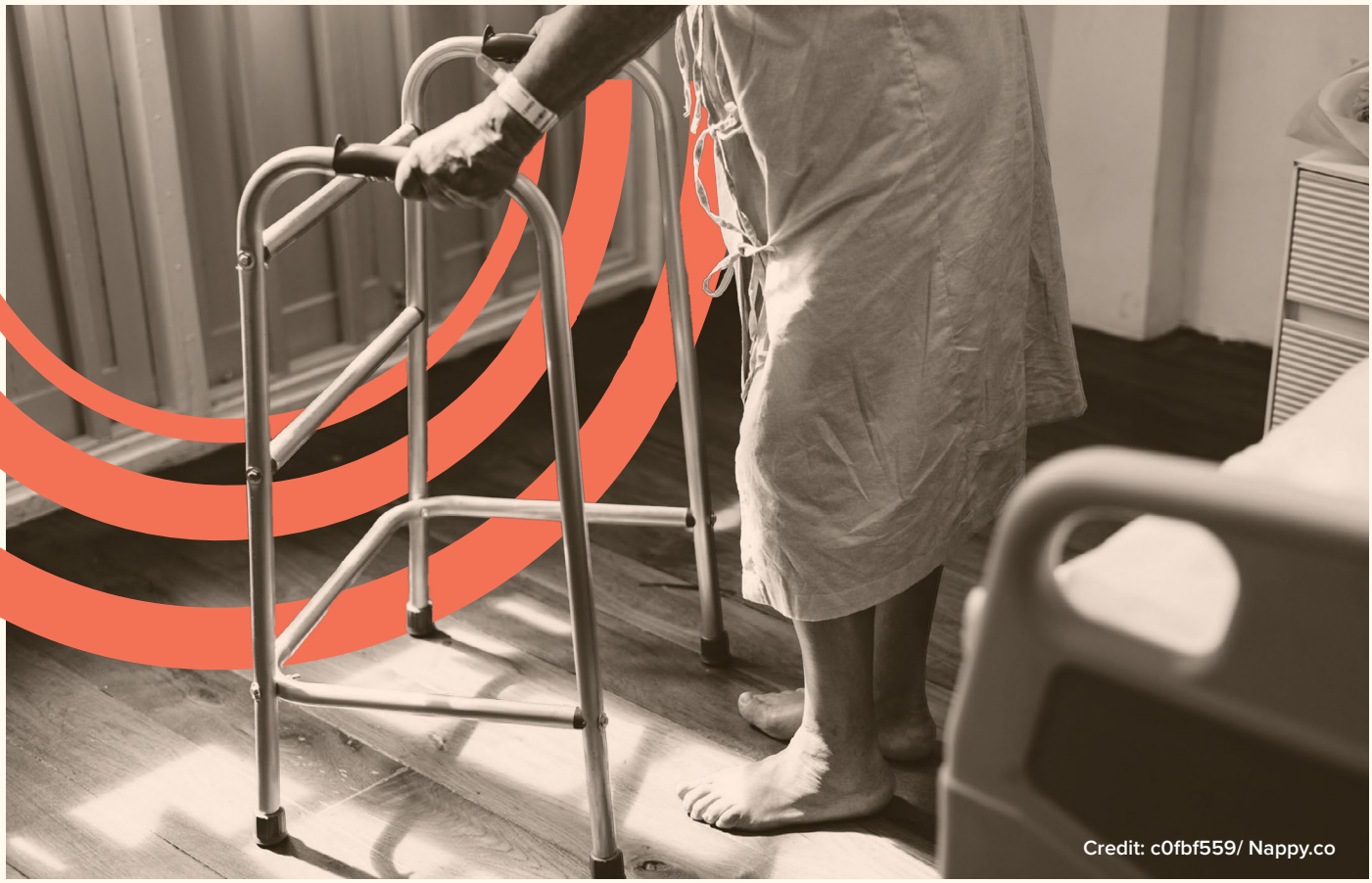
Even for those who manage to qualify under the statute, the process remains onerous. Individuals must manage to contact one of very few lawyers in the state with experience handling compassionate release matters, obtain their medical records, find an in-home provider or long-term care facility willing to accept them as a patient (in most cases with no funds) despite their incarceration status, and then convince a judge that they should be released into the community—all while they suffer under the weight of a devastating medical diagnosis and the prognosis of a rapidly approaching death. The process is byzantine at best, and cruel at worst. Compared to compassionate release laws in other states, the advocacy organization Families Against Mandatory Minimums (FAMM) gave Pennsylvania's Medical Transfer Statute an "F" or a failing grade for its narrow eligibility criteria, the PA Department of Corrections' procedures and policies related to eligibility assessment, and the lack of assistance with release planning.[2] In 2020, Former Pennsylvania Secretary of Corrections John Wetzel described the law, saying: "It's not compassionate, nor do we release anybody."[3]

For decades, politicians and policymakers enacted mass imprisonment policies and severe sentencing statutes, resulting in an ever-growing proportion of elderly incarcerated persons requiring extensive medical care.

Since 2009, approximately 55 people have been granted compassionate release under Pennsylvania's statute.[4] The Abolitionist Law Center (ALC) began representing individuals who qualify for compassionate release in 2021. Since that time, 20 of ALC's clients were granted medical transfer to be released from prison so they could spend their remaining days in the community free from razor wire, guards controlling every aspect of their lives, and the dehumanizing regime of incarceration. Despite these efforts, many individuals die before they are able to obtain a grant of medical transfer, either due to administrative or court delays, or a delayed prognosis.

For decades, politicians and policymakers enacted mass imprisonment policies and severe sentencing statutes, resulting in an ever-growing proportion of elderly incarcerated persons requiring extensive medical care. Delayed and substandard medical care create new health crises and worsen existing ones. The need for compassionate release is greater than ever; however, it is only a stopgap solution for systemic over-incarceration. While this report identifies several ways to improve upon the current statute and practices, robust decarceration is necessary.

Notably, Pennsylvania's overuse of life-without-parole sentences – referred to more accurately as death by incarceration (DBI) sentences – heavily contributes to the number of aging individuals


Credit: c0fbf559/ Nappy.co

incarcerated throughout the state. The commonwealth's draconian DBI sentencing policies are punitive, torturous, racist, and often imposed on children and young adults, whose brains have not finished developing, according to modern neuroscience.

The United Nations Human Rights Committee recently called for the United States to establish a moratorium on imposing DBI sentences and to permit parole eligibility for all incarcerated people.[5] Their demand reflects a growing recognition that this needlessly cruel practice is driving the increasing need for compassionate release throughout the state.

Because the need is so great and the eligibility so limited, individuals who are granted compassionate release are generally limited to those who have a strong community to support and advocate for them. They have friends and family who stay in regular contact with them, who repeatedly contact prisons when their medical needs are not being met, reach out to attorneys to pursue compassionate release, and support them if released.

The work ALC does in this field would be impossible without community support. Many case referrals come from other incarcerated individuals, family members, former clients, or community advocates. As ALC looks to future improvements in the compassionate release process and towards systemic decarceration, we heavily rely on the expertise of impacted individuals and the advocacy of their loved ones.

This report summarizes the statutory requirements for compassionate release, points to additional issues with the current process, highlights the stories of several individuals who applied for medical transfer, and looks to broaden parole eligibility as the path forward for sick and older incarcerated individuals.

Compassionate Release Statute

Compassionate release is authorized under Pennsylvania Statutes Title 42 § 9777, which became law in 2009. The statute permits temporary deferment of an individual's sentence so that they may be placed in a hospital, nursing home, or licensed hospice care location. An individual is eligible for such a transfer if that person is seriously ill and has a life expectancy of less than one year. Individuals must additionally demonstrate that their medical needs can be more appropriately addressed in an alternative setting and that their transfer would not pose an undue risk of escape or danger to the community. There must be a medical provider who is willing to accept the individual as a patient and who agrees to notify the Pennsylvania Department of Corrections (DOC) and the court of any material changes in an individual's health condition. The statute additionally mandates that, should a petition for compassionate release be filed, the District Attorney's Office, the correctional institution where the individual currently resides, and any registered crime victims be provided with notice and an opportunity to be heard on the petition.

Certain additional requirements exist depending on where an individual seeks to be transferred: individuals who wish to be transferred to a medical facility must not have any detainers lodged against them, and those who wish to be released to the home of a loved one must be non-ambulatory, meaning

ALC Client Bradford Gamble and his family. (Bret Grote, Rupalee Rashatwar, Alex Giesel, Teddie Kelly Joe Piette, Genesis Hernandez, Bradford Gamble)

they cannot perform normal daily activities without the assistance of a person or mobility device. Even if these requirements are met, individuals are placed on an ankle monitor until their death, even though many of these individuals are bedbound.

This section details the strict conditions that § 9777 imposes on those in DOC custody who seek compassionate release under the statute so they can die with a modicum of compassion and dignity.

LIFE EXPECTANCY OF LESS THAN ONE YEAR

In order to qualify for compassionate release in PA, a treating physician must find that an individual has a life expectancy of less than one year.[6] This requirement alone is extremely limiting. Even if an individual is very sick and likely to die in less than a year, physicians are cautious about giving such a diagnosis. Indeed, one study demonstrated that doctors overestimate life expectancy 63% of the time.[7] Their prognoses are "systematically optimistic," resulting in an overall overestimation of life by a factor of 5.3.[8] Therefore, many individuals may actually qualify for compassionate release but are not given the requisite prognosis until much later (if at all).

Life expectancy is not a perfect science; physicians make expert opinions based on age, sex, comorbidities, and other factors.[9] Many physicians are also uncomfortable with or unable to estimate life expectancy, and even when

they do their estimates are often inaccurate or are based on information completely irrelevant to statutory considerations.[10] Prison physicians have sometimes been hesitant or inconsistent in how they estimate life expectancy. One physician asserted in his medical notes that a compassionate release applicant was eligible due to the fact "he [was] a Chrisitian and [had] accepted the sacrifice of Jesus Christ the Son of God as payment for his sin..."[11] A different physician in another case did not feel confident that a 68-year-old quadriplegic petitioner with a stage 4 pressure wound had less than one year to live, but this individual ended up passing away just one month later.[12]

Additionally, one physician may estimate a different life expectancy than another. While people outside of prison can and often do get second opinions, especially for serious illnesses, the PADOC does not necessarily give incarcerated individuals that choice. Their primary physician is generally the medical director for the prison facility where the person is housed, and usually oversees the care of hundreds or even thousands of other individuals. Typically, in order to see a specialist, such as a neurologist or gastroenterologist, prisoners must wait for the PADOC to schedule an appointment and transport them to an outside medical facility.[13] In many cases, individuals seeking an appointment with a specialist experience long delays.[14] Unlike those outside of prison, they cannot see a different doctor if they are unhappy with the quality of medical care or want to explore alternative treatment options.[15]

Incarceration itself is a comorbidity: research indicates that for each year lived behind bars, a person can expect to lose two years from their life expectancy.[16] As a result of the difficulty in accurately estimating prognosis, many individuals diagnosed with more than one year to live die much sooner.[17]

While even medical professionals have trouble accurately estimating life expectancy, they remain the most authoritative source on the matter. Judges who preside over compassionate release petitions should defer to physicians' diagnoses and life expectancy estimates rather than rely on their own personal assessments of how sick a petitioner appears. An individual's outward appearance and demeanor cannot be relied upon exclusively as an indication of their overall health. Individuals who outwardly seem perfectly healthy may decline rapidly and without warning. It is also common for individuals to experience a phenomenon known as terminal lucidity, wherein that individual has a period lasting up to several days of increased energy and awareness shortly prior to death.[18] For these reasons, nothing but a professional medical diagnosis should be used to estimate an individual's life expectancy and

"Incarceration itself is a comorbidity: research indicates that for each year lived behind bars, a person can expect to lose two years from their life expectancy."

overall health while this statutory requirement exists.

The result of the strict one-year life expectancy requirement is that by the time someone becomes medically eligible, they are often extremely ill, posing numerous barriers to successfully obtaining compassionate release.

Due to the urgency created by the one year life expectancy requirement, all compassionate release hearings should be treated as emergency hearings by default, as any delay can result in the petitioner becoming mentally incapacitated or dying prior to their court date. Sadly, many individuals pass away prior to their hearing date.[19] Others have died within days of their medical transfer, robbing them of valuable time with their loved ones.[20]

Another issue with the current process is that those with advanced illnesses are often taken to and from a local hospital

ALC Client Mack Truesdale

"It is dehumanizing to subject individuals in this state of mental unwellness to bleak prison conditions without allowing them to be in the presence of a caring family member or loved one"

for treatment, sometimes for long periods and with little or no advance notice. Attorneys often have difficulty getting in touch with hospitalized clients directly, as hospitals will sometimes not permit access to or contact with their incarcerated patients.[21] This often creates long delays in preparing petitions for court filings.

Finally, there is the additional risk that the individual's health can decline to the point that they are unable to make medical or legal decisions for themselves, adding another layer of complication and delay to representation. Sometimes, family and friends are only able to reunite outside prison walls when their loved one is at this stage.

Altering the life expectancy requirements could make the statute less restrictive, as other states have done, including South Carolina, South Dakota, Vermont, and the District of Columbia.[22] Requiring merely that an individual be seriously ill, in tandem with proposing a release plan, would provide a far more effective, compassionate avenue of relief for disabled, elderly incarcerated individuals who might be suffering from advanced illness but for whom the prison doctor has not predicted will die within a year.

MORE APPROPRIATE MEDICAL CARE

In virtually all circumstances where an individual is petitioning for compassionate release, they meet the statutory requirement [23] that more appropriate medical care can be provided outside of prison due to the

inadequate quality of healthcare provided in correctional institutions. Medical staff in correctional settings tend to be spread thin and often struggle with staff shortages.[24] Even for relatively young and healthy individuals, medical and mental health care in prisons is systematically inconsistent and lacking.[25] This substandard care is often more pronounced with older and aging incarcerated individuals due to their greater healthcare needs.[26] No state correctional institution in Pennsylvania is a licensed hospice facility and they are not built to be accessible for elderly or sick individuals, let alone able to adequately address the overwhelming and specialized medical needs of older individuals.

"The current design of most correctional facilities does not accommodate aging or age-related physical or cognitive changes. The use of bunk beds is one example; lack of accessible bathrooms is another. Incarcerated individuals often have to walk significant distances and use stairs to reach dining or other necessary facilities, and wheelchair ramps or elevators are not always available. In addition to these environmental factors, there are specific so-called prison activities of daily living (PADLs) that may be uniquely challenging for older adults. PADLs include standing in line for medications and/or food and dropping to the floor for alarms. The inability to complete PADLs has been associated with depression and increased severity of suicidal ideation in those aged ≥50 years, particularly among men."[27]

In addition to overcoming inaccessible prison layouts, individuals who meet the statutory criteria for compassionate release often require assistance for daily living activities such as walking, using the bathroom, bathing, dressing, and eating. Due to the limited number of medical staff available in carceral facilities, the task of assisting these individuals typically falls to other incarcerated individuals—often unpaid "volunteers".[28] These volunteers provide invaluable and caring services, but they are not licensed medical professionals.[29] Additionally, because of required cell lockdown times, it is often not possible (or permitted) for these volunteers to be available around the clock, so incarcerated individuals who are very sick may have to go long periods without being able to eat, drink, or use the bathroom, especially at night.[30]

Another point to consider is that people often become forgetful, confused, and agitated towards the end of life.[31] It is dehumanizing to subject individuals in this state of mental unwellness to bleak prison conditions without allowing them to be in the presence of a caring family member or loved one, or at the very least a trained medical professional who can explain to them what is happening and help them calm down during such episodes. Sadly, some people at this stage no longer remember why they are in prison, adding to their confusion.[32] It is

"Sadly, many individuals pass away prior to their hearing date. Others have died within days of their medical transfer, robbing them of valuable time with their loved ones."

clear that prisons are simply not equipped to provide the around-the-clock care needed for people with advanced illnesses and that an outside medical facility that is specifically staffed, equipped, and designed to provide more medically appropriate care for such individuals experiencing cognitive and mental decline is necessary. To be absolutely clear: the solution is not to begin to provide hospice-level care in prisons. Prisons are not – and should not seek to be – places that provide end-of-life medical care. Instead, we should be seeking decarceral solutions to end the needless warehousing of individuals whose release would pose no public safety risk.

UNDUE RISK OF ESCAPE OR DANGER TO THE COMMUNITY

Per the statute, medical transfer is only permitted if doing so does not pose a risk of escape or danger to the community. It additionally adds that: "[i]n making this determination, the sentencing court shall consider the inmate's institutional conduct record, whether the inmate was ever convicted of a crime of violence, the length of time that the inmate has been imprisoned and any other factors the sentencing court deems relevant." [33] While the risk of reoffending is always a possibility with any form of early release or community supervision, the risk is especially low for individuals who are sick and require intensive medical care.

Individuals petitioning courts for compassionate release are terminally ill, usually elderly, and

are often serving DBI sentences for crimes committed when they were very young.[34] Some people seeking compassionate release were convicted of crimes nearly half a century ago, and are very different people by the time they petition the court.[35] Additionally, petitioners are often wheelchair-bound and easily fatigued. Sometimes, they are not even lucid. Because of these reasons, people seeking compassionate release are unlikely to have incentive, capability, or desire to escape from hospice care or to commit new crimes. Individuals seeking compassionate release are seeking dignity in care and the ability to be with family members at the end of life.

PLACEMENT IN A NURSING HOME, HOME HOSPICE, OR HOSPITAL

Unfortunately, the statute's requirement that an individual have a life expectancy of one year or less is mirrored by limitations in Medicaid coverage. Medicaid, which is what many incarcerated individuals rely on once they are granted compassionate release, will generally not pay for hospice care unless an individual has a life expectancy of six months or less.[36]

Provider and facility bias adds additional complications as many refuse to accept individuals who are released from prison as patients, regardless of the severity of their medical condition. They do not consider the circumstances of their crime, the time that's passed since any crime was committed, or even the fact that a judicial determination was made that an individual poses no danger to public safety. ALC has contacted over 50 nursing home facilities in the state, and only a few are willing to accept patients granted compassionate release.

In order to be transferred to a home to receive palliative care, an incarcerated individual must have an available home to be transferred to. Not all individuals know a person who has a home in Pennsylvania with extra space and who is willing to care for them around the clock. Unfortunately, because some of these petitioners have been incarcerated for so long, they may have strained relationships with loved ones, or have lost contact entirely. Some may no longer have any surviving loved ones they remain in contact with. Others must rely on family members quitting their jobs or substantially rearranging their lives to make compassionate release at home a possibility.

For petitioners seeking to reside with family members out of state, the DOC has taken the questionable position that such transfers are not possible under the Interstate Compact for Adult Offender Supervision, which permits parole supervision to be transferred to other states, further restricting individuals' abilities to reconnect with family at the end of life when their family members are not PA residents.[37]

> "To be absolutely clear: the solution is not to begin to provide hospice-level care in prisons. Prisons are not – and should not seek to be – places that provide end-of-life medical care."

MATERIAL CHANGES IN HEALTH

For individuals to be granted a medical transfer under the statute, the medical facility that is offering to provide medical care for that individual must agree that they will notify the DOC and the Court of any material changes in the health status of the petitioner, along with any other information that the DOC requires.[38] The statute does not define "material change," but the primary change that would be relevant to the eligibility criteria would be a change in the individual's medical diagnosis that makes their condition no longer terminal. This leads many who are granted compassionate release to fear experiencing even a temporary or marginal improvement in their health at the risk that the DOC or DA may petition to have them returned to prison.

No terminal diagnosis or prognosis can have guaranteed accuracy; individuals may live beyond the time predicted, and it is actually more common that they will die much sooner than predicted.[39] So long as an individual's medical diagnosis remains terminal within an estimated one year or less, they remain medically eligible for compassionate release per the statute's requirements.

NOTICE AND OPPORTUNITY TO BE HEARD REQUIREMENTS

The compassionate release statute also requires that the Commonwealth, the prison incarcerating the petitioner, and any registered crime victim be given notice and an opportunity to be heard in regards to the petition. Generally, the superintendent of the prison will weigh in with whether, in their determination, the Department of Corrections has any "security concerns." There is nothing in the statute that defines what constitutes a security concern and it is left to the discretion and interpretation of the prison superintendent. In some cases, even a single, nonviolent misconduct has been the basis for an alleged security concern.[40]

Victim notification is handled by Office of the Victim Advocate (OVA), a state agency that lobbies for carceral policies in the name of victims' rights and notifies individuals who have registered with them as crime victims about an offender's status.[41] The requirement to notify "registered crime victims" is referring to those individuals registered as such with the OVA, which includes family members of those who are considered crime victims.[42] Despite the unambiguous statutory text that applies only to "registered" victims,[43] non-registered victims are sometimes sought out by the District Attorney's Office and/or the OVA and are allowed to testify.

District Attorney opposition and cooperation on medical transfer petitions varies widely county by county. On one end of the spectrum is the Allegheny County District Attorney's Office, which consistently contests release, even in cases where it has conceded that an individual's medical transfer would pose no public safety risk.[44] For example, in response to a petition that had Governor Josh Shapiro's support, Allegheny County District Attorney Zappala (who, in theory, represents the Commonwealth) heavily contested all of a defendant's efforts to introduce evidence and even insisted that the defendant must testify and be cross-examined, despite the defendant being a near-death quadriplegic who could not speak for long periods of time.[45]

NON-AMBULATORY

One of the requirements to be transferred to a home for palliative care is that the person must be non-ambulatory.[46] Non-ambulatory is a medical term used to describe an individual who requires the help of a person or mobility device to perform daily living activities, such as " going to the grocery store, walking a few blocks, or picking up a plate of food and walking with it."[47]

ALC Client Mack Truesdale and his sister Reda Kroma

Individuals who can walk short distances unaided are not necessarily ambulatory per the medical definition of the term.[48] Unfortunately, in some cases, otherwise eligible incarcerated individuals have been labeled as "ambulatory" when they meet the medical definition for non-ambulatory.[49]

This adds yet another eligibility requirement to an already limiting process. Additionally, the statute already requires consideration of whether or not an individual is a public safety risk and generally imposes some form of electronic monitoring, so consideration of ambulatory ability is redundant. Even ambulatory individuals may quickly become non-ambulatory as their condition deteriorates, at which point it may be too late to petition for medical transfer.

ELECTRONIC MONITORING

The compassionate release statute also states that individuals who are granted medical transfer would be "subject to" or "under" electronic monitoring.[50] Thus, all individuals for whom ALC has procured release were fitted with ankle monitors upon their discharge from prison. Edema, or swelling, is a common end-of-life symptom, especially in one's lower limbs.[51] Several of ALC's clients have had issues with their ankle monitors becoming dangerously tight, inhibiting proper blood flow and have needed the DOC to continuously loosen the ankle monitor in response. Given how advanced an individual's medical condition is when they are terminally ill, the insistence on an ankle monitor is unnecessarily restrictive and in many cases harmful. Individuals who are barely lucid and require assistance for standing, eating and bathing, are needlessly subjected to electronic monitoring in a manner that is dangerous for their health. Removing this monitor would not pose a risk to public safety, especially in cases where the person is clearly not a risk of danger or escape due to their failing health. It is paradoxical to think that individuals who are sent to die with their families would seek to escape the very place they have longed for: home.

Pennsylvania's Aging Prison Population

Pennsylvania has some of the harshest sentencing laws in the nation, resulting in a high proportion of aging individuals in Pennsylvania prisons. For instance, a death (accidental or intentional) that occurs as a result of a felony is considered second-degree murder in Pennsylvania and carries a mandatory minimum sentence of life without parole, i.e. death by incarceration.[52] Even a lookout or getaway driver can be charged for an accidental killing committed by their co-conspirator.[53] This harsh minimum sentence does not take into account any particularities about an individual defendant's maturity, the circumstances of the offense, or whether there was any intent to take a life.[54] Many other states do not permit death by incarceration sentences to be imposed at all for felony murder, and some do not even recognize felony murder as a crime.[55] First-degree murder also carries a mandatory minimum sentence of death by incarceration in Pennsylvania, death by execution being the only other available sentence.[56] Pennsylvania is one of only seven states that fully denies parole eligibility to anyone with a life sentence.[57] As a result of these mandatory sentencing schemes, Pennsylvania has one of the highest numbers of people serving death-by-incarceration sentences in the country.[58]

Approximately 37,303 people were imprisoned by the State of Pennsylvania as of December 31, 2021.[59] Of those, 5,222 people, or 14.3 percent, are serving a life sentence. Additionally, 5.8 percent will be imprisoned for more than 50

Credit: Joshua Vaughn via The Appeal

years, 18.9 percent will serve a maximum of 20-50 years, 19.8 percent have a maximum of 10-20 years; and 23 percent are serving a maximum sentence of 5-10 years.[60] Meanwhile, the average age of the state's prison population is 41.7 years.[61] Taken altogether, this means that at least 14,436 people, or 39 percent of those incarcerated inside Pennsylvania's prisons, will be elderly –between the ages of 51 and 91 –while serving their sentence. [62]

AGING AND CRIME

Many individuals serving death by incarceration sentences were sentenced when they were in their early 20s.[63] It is well established by modern neuroscience that the brain continues developing until the mid-20's.[64] Namely, the prefrontal cortex — which controls impulse, aggression, anticipation of consequences, planning and goal setting — is one of the last regions of the brain to fully mature, doing so well into one's 20s.[65] Because adolescents' brains are not fully developed, they do not have adult levels of judgment, ability to assess risk, or gauge the consequences of their actions.[66] As a result, adolescents are inherently more likely to take risks and be susceptible to peer pressure.[67] Recent U.S. Supreme Court jurisprudence has cited this research in concluding that juveniles are less culpable than adults and thus less deserving of punitive consequences.[68] The same logic regarding decreased culpability should extend to young adults as

"There is no demonstrable public safety benefit created by continuing to incarcerate rehabilitated elderly individuals for acts committed decades ago in their youth."

well. There is no demonstrable public safety benefit created by continuing to incarcerate rehabilitated elderly individuals for acts committed decades ago in their youth.

MEDICAL CARE IN PRISONS

It is difficult for anyone, let alone elderly or terminally ill individuals, to receive medical care in Pennsylvania state prisons.[69] Pennsylvania was in the bottom third of all states for health care spending on incarcerated individuals as of 2017.[70] Pennsylvania state prisons charge a $5 co-pay for medical attention, which is more expensive than Medicaid copays in Pennsylvania.[71] The pay rate for an incarcerated person in the DOC averages at 42 cents per hour, meaning that an incarcerated individual would need to work between 12-26 hours in order to afford one medical visit.[72] The high cost of these co-pays deters many incarcerated individuals from seeking medical treatment.[73] Because of this cost, many incarcerated individuals do not seek medical care for minor issues, which inevitably hinders prevention of more serious infections or illness.[74]

Even if incarcerated individuals pay to receive medical care, the medical attention is often below an acceptable standard of care. Prisons often hire physicians who have had their medical licenses suspended or revoked in other states due to gross negligence, medical malpractice, and professional misconduct.[75] Another issue is that most state prisons

only have five or six medical workers for a prison population of several thousand, forcing staff to triage patients, rather than provide comprehensive preventative care.[76] Additionally, all of Pennsylvania's state prisons contract with Wellpath, LLC, the country's largest for-profit healthcare provider for correctional facilities.[77] Wellpath LLC, like other private companies that contract with county jails, has been subject to numerous lawsuits and has been accused of prioritizing cost savings over patient care.[78] One example of these cost-saving measures is to wait until the incarcerated individual is so seriously ill or injured that they need to go to the hospital, because the county or state bears the cost of the hospital.[79]

Similarly, there is a strong incentive for diagnostic tools to be refused or delayed, "because for every lab test not run or a specialist visit not done, that's just additional profit that the company can pocket." [80] Studies in other states demonstrate how often delayed diagnoses occur for incarcerated individuals. In Washington State prisons, the time of diagnosis after the prisoner first reported symptoms ranged anywhere from 2 to 17 months, with an average of 6.5 months per prisoner. [81]

For those who are diagnosed late, the impact can be fatal. The World Health Organization has called for a "target of no more than one month from presentation to diagnosis for cancer cases," and for treatment of cancer cases to begin within the month of diagnosis.[82] In the same Washington State study, delay of diagnosis was associated with incorrect diagnosis for more than half of the cases reviewed, leading to delays in appropriate life-saving treatment.[83] With an average of 6.5 months before a prisoner receives diagnosis, the progression into treatment lags significantly behind the WHO's target.

As previously mentioned, an average incarcerated person's physical and mental health is worse than that of an average person in the general public.[84] The abysmal medical care in Pennsylvania jails and prisons means that even relatively short periods of incarceration can pose a potential health risk.

COST OF END-OF-LIFE CARE

End-of-life care is especially costly. It costs a state, on average, an estimated $66,294 per person per year to provide care for their aging prison population.[85] Even former DOC Secretaries of Corrections Wetzel and Little have stated that the cost of confining individuals sentenced to life makes little sense.[86] The cost of caring for incarcerated individuals in specialized medical care units is $182,625 per year—more than three times what it costs for those in general population.[87] At the federal level, the Department of Justice found that the Federal Bureau of Prisons institutions with the highest proportion of elderly incarcerated individuals were spending five times more on medical care and fourteen times more for medication per incarcerated individual when compared to the institutions with the lowest proportion of elderly incarcerated individuals.[88] Needlessly incarcerating sick and elderly individuals is an immense waste of state funds and resources.

"Needlessly incarcerating sick and elderly individuals is an immense waste of state funds and resources."

Client Stories

As of the date of publication, ALC has successfully petitioned for 20 individuals to receive compassionate release. Many of the challenges described in the report were borne out in these cases. We saw firsthand the devastating effect these barriers to release had on incarcerated individuals and their families, and the relative frivolity of most arguments in favor of continued incarceration. To center the humanity of those incarcerated, we have chosen to share – with permission – some of the experiences of our attorneys and our clients in these cases.

LARRY OATES

Larry Oates was a 75-year-old man who had been incarcerated for almost 50 years. He suffered from various comorbidities, including cancer that spread to his kidney and face. In July 2022, his physician estimated he had 3 to 6 months to live. Due to his condition, he was often in and out of the hospital, which made it difficult to speak with him and complete the necessary authorization forms. Mr. Oates was short of breath and had difficulty talking during the limited opportunities available for attorney phone calls. Unfortunately, Mr. Oates passed away August 9, 2022 before his petition was able to be filed. Mr. Oates's case highlights the need for all compassionate release hearings to be treated as emergency hearings and for the Commonwealth and the Courts to understand the very realistic possibility of quick and sudden decline.

ALC Client Frank Lowery

FRANK LOWERY

Frank Lowery was a 67-year-old man who had been incarcerated nearly 50 years. He had been complaining to medical staff for a long time about his difficulties breathing, but by the time he was taken to the hospital for a screening, he learned that his cancer had returned after more than a decade in remission and that he had terminal stage 4 lung cancer. Unfortunately, like so many others who have spent the vast majority of their lives incarcerated, all of Frank's friends and family were either deceased or had fallen out of touch with him. Since he did not have the option of a home hospice placement, he needed a nursing home in the community where he could reside. ALC successfully petitioned for Mr. Lowery's transfer to a long-term nursing care facility in Philadelphia, and his compassionate release was granted September 9, 2022.

Even in his delicate medical state where he required oxygen at all times, and after decades of incarceration, Frank still was electronically monitored and required permission to come and go from the facility. "What bothers me is," said Frank, "even in death, they won't let me alone. Why do they still want to hold on to me? Why? For what?" Frank passed away on February 20, 2023.

"What bothers me is," said Frank, "even in death, they won't let me alone. Why do they still want to hold on to me? Why? For what?"

STANTON STORY

Stanton Story was 70 years old and had been incarcerated for nearly 50 years when he petitioned for compassionate release in Allegheny County. While hearings in Philadelphia are treated as emergency hearings and hearing dates occur within a few days, Allegheny County does not approach petitions with the same urgency. The earliest date for a hearing that was initially proposed by then-President Judge and former prosecutor Kim Berkeley Clark was nearly a month after Mr. Story's petition was filed. ALC successfully requested an earlier date, though it was still 18 days after filing.

During the hearing, DOC physician Anthony Letizio testified that Mr. Story did not wish to forgo curative care. This testimony contradicted Mr. Story's wishes; however, Mr. Story could not be present in court. It can take six weeks for a criminal defendant to be brought into court for an in-person hearing. Ultimately, Judge Clark denied the petition based on hearsay that Mr. Story did not wish to forgo chemotherapy in favor of palliative care, despite this alleged fact being both contested by counsel and irrelevant to the requirements for compassionate release eligibility. Additionally, the record made clear that no treatment would change Mr. Story's terminal diagnosis; he was going to die in the very near future regardless of whether he received chemotherapy or not.

Subsequently, a motion for reconsideration re-clarifying these points was filed,[89] and his compassionate release was ultimately granted April 28, 2023—almost three months after his initial petition was filed. The Court's misunderstanding of the statute and delay in scheduling hearings wasted valuable time for Mr. Story and his family. Luckily, Mr. Story was still able to spend his final few weeks at home, though his mental state was not what it was when his first petition was filed. He passed away on June 9, 2023.

ALC Client Curtis Perry
Credit: Rain Gideon

CURTIS PERRY

Curtis Perry was granted compassionate release on December 14, 2023 at age 61 after 32 years of incarceration. He spent two years in the infirmary and observed several sick incarcerated people pass away. He described medical care at the prison as “bottom of the barrel” and observed medical staff intentionally leave people in their own waste, frequently miss or delay medication administration, ignore individuals who pushed their sick call button, and demonstrate a general lack of compassion.

“They’re not getting proper treatment,” said Mr. Perry of the sick and elderly populations at the prison. “They’re getting pushed to the side.” Mr. Perry himself recalls having missed several outside medical appointments because staff would not transport him to the hospital on days he had scheduled appointments. Mr. Perry currently resides with family and continues to receive home hospice care.

TIMMY MANUEL

Timothy Manuel was granted compassionate release on June 10, 2022, after spending 20 years in prison. Mr. Manuel began experiencing medical issues while incarcerated, and soon was coughing up blood. In May 2022, he was told that he had stage four lung cancer and only had a month to live. Mr. Manuel would have been eligible for parole in a few short years and his family eagerly awaited his homecoming. Mr. Manuel's condition was so severe that his family immediately began advocating for compassionate release and hospice care. Though 9777(a)(2) permits individuals to seek palliative care, some hospice and palliative care programs require patients to forgo curative care or aggressive treatment in order to maintain their status on the program's caseload due to Medicaid insurance requirements. In Mr. Manuel's case, he was not able to seek aggressive treatment while in hospice care.

Shortly after Mr. Manuel's petition for compassionate release was granted, he lost most of his ability to speak and became bedbound. His niece, Nikki Manuel, noted that Mr. Manuel could have gotten diagnosed several months earlier when he was first experiencing symptoms, possibly resulting in a better health outcome. "This whole thing is inhumane," said Nikki. "He's been sick for a while... we could have gotten this nipped in the bud before." Mr. Manuel passed away on November 18, 2022, five months after his compassionate release was granted.

"This whole thing is inhumane."

ALC Client Bradford Gamble, Rupalee Rashatwar and Jaquan Jordan

BRADFORD GAMBLE

Bradford Gamble was sentenced to death by incarceration at age 19. He spent 46 years in prison before his compassionate release was granted in 2022. “46 years is too much time,” he said of the sentence.[90] “My head’s been straight years ago. I don’t deserve to be in jail for 46 years.”[91] Mr. Gamble learned about his stage 4 terminal cancer diagnosis when prison officials slipped a piece of paper under his cell door. He petitioned for compassionate release and it was granted on March 5, 2022. While he was released on compassionate release, his hospice provider did not permit him to receive any additional care, which he had wished to receive.

Mr. Gamble was receiving chemotherapy at the time he was considering requesting compassionate release. Unfortunately, he would be unable to continue receiving chemotherapy as a hospice patient for that particular hospice care provider. In order to spend his remaining days with his family and transition with dignity, Mr. Gamble decided to abandon aggressive treatment, which he would have preferred to continue. It is an unfair choice for anyone. “You got to make a decision on your life like that,” said Mr. Gamble, snapping his fingers to emphasize the brief time he had to contemplate such a weighty choice.[92] Mr. Gamble passed away on August 14, 2022.

“My head’s been straight years ago. I don’t deserve to be in jail for 46 years.”

EZRA BOZEMAN

Mr. Bozeman sought compassionate release in May 2024, after becoming a quadriplegic two months earlier and suffering from a stage 4 pressure wound that had tunneled through all layers of his tissue down to the bone. He was 68 years old and had been incarcerated for 49 years. The Allegheny County District Attorney's Office opposed his medical transfer.

Mr. Bozeman submitted an affidavit in place of testifying, which counsel explained was due to his difficulty speaking as a result of excess mucus buildup—one of the many symptoms of his quadriplegia. But this, too, was opposed by the District Attorney's Office. "I want to hear him say it," demanded Deputy District Attorney Ronald Wabby.[93] As a result of the DA's objections, the hearing was continued for six days by Judge Susan Evashavik DiLucente in order for additional evidence to be presented. During those six days, Mr. Bozeman had to undergo emergency surgery and due to complications he was sent to the ICU. At the new hearing date the petition was granted, but unfortunately, Mr. Bozeman was placed on life support that morning and was unable to be transported anywhere until he was medically stable. He was never released from the hospital. Instead, the court had to again be petitioned to force DOC guards to leave Mr. Bozeman's hospital room and unshackle his paralyzed limbs from his hospital bed. Mr. Bozeman passed away in the hospital less than two weeks later on June 1, 2024.

ALC Client Ezra Bozeman and his fiancée, Christine Roess. Credit: Celeste Trusty / FAMM

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Potential Reforms

Repealing and replacing the current compassionate release law is the only way forward. Medical parole could replace this statute with a more humane alternative that would provide an opportunity for individuals to reenter and contribute to their communities, and it would empower the parole board to make determinations about individuals' readiness to return to their communities.

As of December 2024 when this report was published, there were bills before the PA state House and Senate that would repeal this law and replace it with a pathway for individuals to seek medical parole. SB 835 and HB 587 would create two pathways for parole release: The first is a pathway for medical release for those with chronic and debilitating medical conditions and the second is a pathway for geriatric release for those over the age of 55 who have served at least 25 years, or more than half their sentence. The parole board would make a safety determination about the release of each individual. Notably, this law would provide strict time limits requiring the DOC to notify individuals and family members within 72 hours of a terminal diagnosis, inform them about their ability to petition for parole, and require the DOC to provide medical records to the Parole Board. The Parole Board would be required to render a decision on an application within 10 days.

Abolish Prisons Rally 2023 Credit: ALC

While SB 835 has only been introduced, HB 587 has been heard by and voted out of the House Judiciary Committee but has been stalled on the House floor due to lack of support in the Democratic caucus. Currently, that bill is under consideration to be amended to model the Federal "First Step Act" and only allow for medical release, removing the pathway for geriatric release criteria. A similar bill, HB 2634, was introduced in 2022 by Republican Representative Kail. If adopted into law, this bill would expand opportunities for release to those with chronic and debilitating illnesses, serious cognitive or functional impairment, and deteriorating physical or mental health due to the aging process. These bills will need to be reintroduced in the 2025 Session of the PA House for lawmakers to consider passing them into law.

The medical parole bill would broadly expand who is eligible to be released to the community, providing individuals with an opportunity to actually spend their aging years meaningfully with family and contribute to their communities. It would provide a more compassionate pathway for terminally ill individuals to be released from prison as the DOC would have an affirmative obligation to work with families and timely decisions would be statutorily mandated. And the scope of people eligible to apply would be broadly expanded, opening the door for individuals with dementia, paralysis, blindness, and other

"Nothing but total abolition of the carceral state — to be replaced with effective, fair, restorative, community-based alternatives — will end the vast amounts of preventable illness and suffering that occurs behind bars."

chronic illnesses whose medical needs are not appropriately met in prison.

Ultimately, these issues will not be fully addressed through reform of the current law, policy change, or individual advocacy. The discarding of our sick and elderly is a symptom of capitalism and mass incarceration, both of which require that certain populations are considered unprofitable, threatening to the status quo, or otherwise disposable. Nothing but total abolition of the carceral state – to be replaced with effective, fair, restorative, community-based alternatives – will end the vast amounts of preventable illness and suffering that occurs behind bars. However, there are measures of harm reduction that can be implemented as we seek to move towards an abolitionist future which will certainly reduce the mistreatment and suffering of our sick and elderly.

Protester at Makiyah Bryant shooting protest in Columbus, Ohio April 2021
Credit: Paul Becker via Flickr

Conclusion

While there are many ways to streamline and expand the compassionate release process, a more structural change is needed to decarcerate our prisons. Until then, compassionate release only scratches the surface when it comes to addressing the medical needs of the sick and elderly who are living behind bars. The impracticality of needing to go case-by-case and fight for an individual's release when they are so close to death cannot be overstated, especially in light of Pennsylvania's large-scale epidemic of aging prisoners. Prisons cannot function as nursing homes, acute care facilities, hospitals, or hospices—no matter how much extra funding and support they receive. Medical care will always be an afterthought and not well-executed in institutions designed to cage and isolate human beings. There is no public safety benefit to incarcerating rehabilitated people indefinitely for crimes they committed decades ago in their youth. Absolutely nothing positive can be gained by caging such people for many decades, as many of our clients have experienced. Pennsylvania has chosen to discard our elderly to waste away and die without dignity in its prisons; a dramatic change in our state's sentencing practices is long overdue.

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