GENERAL DISTRIBUTION

WEST VIRGINIA
DIVISION OF CORRECTIONS
& REHABILITATION

NUMBER: 410.12

EFFECTIVE DATE: 06 September 2022

SUBJECT: MEDICAL RESPITE APPLICATION PROCEDURES

POLICY DIRECTIVE

PURPOSE:

To maintain a uniform and efficient process by which requests from inmates can be reviewed to determine whether a release of such inmate under a medical respite can be recommended to the Governor.

REFERENCE:

None.

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject including DOC Policy Directive 410.12, dated 01 November 2009.

APPLICABILITY:

All facilities within the Division of Corrections and Rehabilitation (DCR) that house adult inmates serving a sentence for a felony crime. This Policy is available for general distribution and shall be made available for inmate review upon the effective date.

DEFINITIONS:

Immediate Future: Immediate future shall be construed to mean generally a period reasonably expected to not exceed one hundred twenty (120) days in the best judgment of the inmate's treating physician or facility physician.

Terminal Illness: Terminal illness shall mean a medical condition, or disease suffered by an inmate from which the inmate is not expected to recover, and which is expected to bring about the death of the inmate in the immediate future.

Unit Team: For the purposes of this Policy, staff that are assigned to a facility or specific inmate housing unit that are responsible to oversee/manage the daily needs of inmates and ensure that all agency security and program requirements are followed and met. These staff play a vital role in a successful reentry program through programming, management, and supervision so inmates have the tools necessary to reenter society. Members of the "unit team" typically consist of unit managers, case managers, substance abuse therapists, and correctional counselors.

POLICY:

I. Inmates convicted and serving felony sentences who by means of a terminal illness or extremely serious medical condition and who do not pose a substantial risk to society if allowed to leave their place of confinement may apply to return to their family or home environment in order to live out their last days at home or to otherwise address a medical need which may not reasonably be provided by the Division of Corrections and Rehabilitation. (This shall be construed to mean medical procedures which may not be provided without being physically removed from the State of West Virginia. The Commissioner may apply this definition to other circumstances with flexibility to other medical needs on a case-by-case basis. For this purpose, costs of the medical procedure shall not be considered.) The Governor has the final authority with respect to granting a medical respite.

II. An inmate seeking a medical-based release (medical respite) may obtain a Medical Respite Application (**Attachment #1**) from any member of his/her unit team or healthcare staff.

A. When the inmate requests this form, the unit team member or healthcare staff shall counsel the inmate that medical respites will not be recommended for basic medical needs and are reserved for the end stages of life and other extreme and rare circumstances.

B. Upon receipt of the form, the inmate shall submit the completed Application to the Superintendent. If an Application is received by any employee other than the Superintendent, the employee shall forward the Application to the Superintendent of the inmate's respective facility. The Superintendent may designate a staff member(s) to address the clerical duties and functions involved in this process.

III. Within five (5) days of receipt of the Medical Respite Application, the Superintendent shall request a Medical Report (**Attachment #2**) from the facility's healthcare provider.

A. The healthcare provider shall provide a response within ten (10) days.

B. If the Medical Report and Application fail to demonstrate that the inmate is within the final days of a terminal illness or that the inmate has a medical condition which

otherwise justifies his/her release on a medical respite, the Superintendent shall immediately prepare a letter to the Commissioner advising that the Medical Report does not support granting a medical respite (**Attachment #3**). Copies of the Application and the Medical Report shall be attached to the letter.

C. Upon receipt, the Commissioner shall review and either:

1. Transmit the information to the Governor with a recommendation for denial (**Attachment #4**); or

2. Return the information to the facility for further consideration as set forth below (**Attachment #5**).

D. Whenever the Superintendent or the Commissioner believe that the Application and Medical Report may support granting a medical respite, the Superintendent shall solicit the sentiment of the sentencing court, Prosecuting Attorney, and victim(s) simultaneously (**Attachments #6 and #7**). The letter requesting sentiment shall allow approximately seven to ten (7-10) calendar days for a response.

E. In addition, the Superintendent shall make a determination regarding the suitability of the inmate to receive a favorable recommendation for a medical respite. In making this review, the following factors shall be considered:

1. The offense of the inmate including the versions of the event set forth in the pre/post sentence investigation report(s);

2. The age of the inmate;

3. The physical and psychological condition of the inmate;

4. The length of time remaining on the inmate's sentence;

5. Whether the inmate has recently been denied parole, or whether the inmate has a parole hearing forthcoming;

6. Whether the inmate has had his/her parole revoked;

7. Sentiment of the victim, prosecution, and sentencing court;

8. The inmate's facility behavior;

9. The release plan if a respite is granted including risk to members of the public; and

10. Any other factors deemed relevant.

F. After the review described above, the Superintendent shall prepare a recommendation to the Commissioner which discusses all of the relevant factors relied upon in reaching his/her decision, for or against recommending a medical respite (**Attachment #8**).

1. In the report, the Superintendent shall recommend to the Commissioner whether to determine that the inmate is suffering from a terminal illness or other medical condition to such an extent that the inmate would not pose a danger to society if released from custody.

2. Further, such a recommendation shall indicate whether the inmate is in the final days of a terminal illness or otherwise discuss in detail the medical basis.

3. If the inmate is not in such medical condition, the Superintendent shall recommend against a medical respite.

4. However, if the inmate's medical condition would justify a medical respite, the Superintendent must also consider whether the nature of the inmate's offense or other factors relating to the inmate would create an undue risk to public safety by granting a medical respite. The medical respite recommendation shall have attached the Application, Medical Report, sentiment, and all other relevant documentation. The Superintendent shall also indicate whether special terms and conditions, such as community supervision, electronic monitoring, or other conditions should be imposed.

   a. If community supervision is recommended, it shall be upon such terms and conditions as are specified by the Commissioner and may not necessarily be the same terms and conditions imposed upon parolees.

   b. Consideration shall also be given in order to ascertain whether such can be reasonably undertaken.

IV. Due to the fact that the power to grant or deny medical respites lies exclusively with the Governor, no inmate may be restricted from requesting a Medical Respite Application.

A. However, whenever an inmate has previously applied for medical respite and has been denied (and no material change in his/her circumstance has taken place), the Superintendent, with consultation from the healthcare provider, may summarily make a recommendation for denial to the Commissioner.

B. The Commissioner shall act upon the recommendation in the same manner as set forth above.

V. In the event that the Governor should deny the medical respite, the Superintendent shall notify the inmate upon the receipt of the denial (**Attachment #9**).

VI. In the event that the Governor should approve the medical respite, the Superintendent shall also notify the inmate upon the receipt of the decision (**Attachment #10**). Thereafter, the

Superintendent shall coordinate the implementation of the medical respite, including any special terms or conditions with the Commissioner's Office and the Governor's Office.

VII. All completed forms and documentation will be uploaded to the appropriate file in the Offender Information System (OIS).

ATTACHMENT(S):

#1 Medical Respite Application (3 pages)

#2 Medical Report for Medical Respite Application

#3 Letter to Commissioner (Not Supporting Medical Respite)

#4 Letter to Governor (Not Recommending Medical Respite)

#5 Letter to Superintendent Requesting Additional Information

#6 Sentiment Letter (Victim, Judge, and Prosecutor)

#7 Medical Respite Sentiment Form

#8 Medical Respite Recommendation (favorable or non-favorable) (2 pages)

#9 Memorandum to Inmate regarding Governor's Denial

#10 Memorandum to Inmate regarding Governor's Approval

APPROVED SIGNATURE: BDL 8/26/22

Brad Douglas, Acting Commissioner **Date**

MEDICAL RESPITE APPLICATION

Date: _____

Inmate's Name: _____
(First) (Middle) (Last)

OID#: _____ SS#: _____

Date and Place of Birth: _____
(Month/Day/Year) (City/County/State)

Instructions: **All items must be fully completed.** If additional space is needed in order to complete your application, please attach additional sheets. You **must**, however, indicate the corresponding question number to all added responses you are providing on attached sheets.

1. List all offenses, corresponding terms, and respective effective sentence dates for which you are currently serving time.
   Offense *Sentence* *Effective Sentence Date (cc/cs)*
   _____
   _____
   _____
   _____

2. Identify the county (or counties) where the offense occurred:
   _____

3. How did you plead on the above offense(s)?
   Guilty _____
   Not Guilty _____
   Plea Bargain/Other (describe) _____
   _____

4. If you plead not guilty, did you have a jury trial? _____

5. Give the names and address of the attorney(s) who represented you for the above offense(s):
   _____
   _____
   _____

6. How long have you been incarcerated on the above offenses)?
   Years: _____ Months: _____

7. Have you been before the Parole Board on the above offense(s): _____
If yes, when: _____ (month/year)

8. Current Parole Eligibility Date:_____(month/year)
Current Discharge Date: _____(month/year)

9. Last date that you, or someone for you, requested a medical respite and/or clemency.
_____(month/year)

10. While incarcerated what programs (educational, vocational or other) have you participated and completed? List them with dates:

Program	*Date Entered*	*Date Completed*

11. List all prior offense(s) for which you were convicted as an adult?

Offense	*Misd/Felony*	*Date*	*Disposition*

12. Describe specifically why should you be considered for a medical respite?

_____

_____

_____

_____

_____

_____

_____

_____

_____

13. Are you currently being treated by a physician at the correctional facility in which you are incarcerated: _____

_____

14. List all rule infractions during your incarceration:

Infraction	*Date*	*Disposition*

15. If granted a medical respite, how would you provide for your medical needs:

_____

_____

_____

_____

_____

_____

Residential Plan: I would reside with and at the following address: (Full Name & Full Address)

_____

_____

_____

_____

_____

Release of Information: I hereby authorize the WV Division of Corrections and Rehabilitation to release information regarding my medical condition, criminal history, treatment and plans to appropriate authorities.

_____

(Inmate's Signature) (Date)

_____

(Staff Witness Signature) (Title) (Date)

I certify that the above information is true and complete to the best of my knowledge:

Applicant's Signature_____ Date:_____

Medical Report for Medical Respite Application

Inmate:_____ **OID#:**_____

Diagnosis (Briefly describe current medical condition, including when originally diagnosed.)

Treatment: (Briefly describe current treatment plan)

Physical Capabilities: (Can subject get around on his own)

Prognosis:

If subject is granted a medical respite what type of aftercare treatment will be necessary:

Health Care Provider: _____ Date:_____

Report provided by West Virginia Division of Corrections and Rehabilitation.

(Facility Letterhead)

Date

Commissioner _____
Division of Corrections and Rehabilitation
1409 Greenbrier Street
Charleston, WV 25311

Re: Medical Respite Application
Inmate Name _____
OID # _____

Dear Commissioner _____:

Attached please find a copy of a medical respite application for the above-referenced inmate. This inmate is serving a sentence of_____ for the offense(s) of _____.

The inmate seeks a medical respite and asserts that he has the following medical condition: _____ _____. This matter has been reviewed with this facility's medical department, and it is my judgment that a medical respite is not advised for this inmate.

By copy of this letter, I will request that medical staff closely monitor this inmate's condition so that if there is a change in the inmate's medical condition, which may indicate more favorable consideration for a medical respite, that I am advised so that further consideration can be given.

If you require anything, further please do not hesitate to contact me.

Respectfully,

_____
Superintendent

cc: Facility Healthcare Provider

(Agency Letterhead)

Date

Honorable _____
Governor, State of West Virginia
State Capitol Building
1900 Kanawha Blvd.
Charleston, WV 25305

Re: Medical Respite Application

Inmate Name _____

OID # _____

Dear Governor _____:

Attached please find a copy of a medical respite application for the above-referenced inmate. You will also find a recommendation from the inmate's Superintendent for denial of a medical respite at this time.

I respectfully advise that I concur with this recommendation.

Please advise me if there is anything further that I can provide in this matter.

Sincerely,

_____

Commissioner

cc: Superintendent

(Agency Letterhead)

TO: Superintendent _____

FROM: Commissioner _____

DATE: _____

RE: Medical Respite Application

Name: _____

OID # _____

After a review of the above-referenced medical respite application, I would ask that you provide me with a full report pursuant to DCR Policy Directive 410.12. Please solicit all necessary sentiment and provide all required reports and attachments.

(Facility Letterhead)

Date

Name _____(Victim/Judge/Prosecutor)

Address _____

City/State/Zip Code _____

Re: Medical Respite Application

Inmate Name _____

OID # _____

Dear _____ (Name of Victim, Judge or Prosecutor):

Please be advised that the above-mentioned inmate has filed a medical respite application with our office. A medical respite, if granted, allows an inmate to be released early from his/her sentence. At this time, no decision has been made with respect to this matter.

However, this office is obliged to investigate the request and make a recommendation to the Governor as to whether the respite should be granted or denied. To that end, your input into this decision would be greatly appreciated.

At this time, this office is respectfully requesting that you forward any input that you wish to make so that it may be attached with the information delivered to the Governor's Office. For your convenience, please find a sentiment form that you may wish to use for this purpose. This information needs to be received by ____[date]_____ in order to submit all documents for consideration.

Should you have any questions, please do not hesitate to contact the West Virginia Division of Corrections and Rehabilitation.

In advance, thank you for your assistance in this matter.

Sincerely,

_____

Superintendent

MEDICAL RESPITE SENTIMENT FORM

TO: Superintendent _____

Address _____

if by fax send to (304) _____- _____

Name _____

Street _____

City/State/Zip Code _____

With respect to a medical respite for inmate _____ my position is as follows:

_____ I do not oppose a medical respite.

_____ I am opposed to a medical respite.

_____ I take no position for or against a medical respite.

_____ Other _____

Comments:

Please set forth any additional information you wish to be considered below (attach additional sheets if necessary):

_____

_____

_____

_____

_____

_____ _____

Signature Date

(Facility Letterhead)

Date

Commissioner _____
Division of Corrections and Rehabilitation
1409 Greenbrier Street
Charleston, WV 25311

Re: Medical Respite Application
Inmate Name _____

OID # _____

Dear Commissioner _____:

I am forwarding to your office a Medical Respite Application from inmate _____. The following summary and recommendation are presented for your review and consideration.

Medical Report

[Insert relevant information]

Current Offense

[Insert relevant information]

Past Criminal Offense(s)

[Insert Criminal History]

Sentiment

[Summarize sentiment of victim(s), Prosecutor and Court]

RECOMMENDATION (denied)

In view of the subject's criminal history, sentence, and medical condition, I do not recommend a medical respite for _____ OID # _____.

Should you be inclined to grant this applicant a medical respite, the Division of Corrections and Rehabilitation can conduct a home and treatment plan investigation. A Pre-Sentence Investigation Report is attached and will provide additional insight into _____ case history. As some of the information is sensitive and confidential in nature, we would respectfully request it being dealt with accordingly.

If my office can be of further assistance in this case, please do not hesitate to contact me.

RECOMMENDATION (granted)

In light of the foregoing, it is my judgment that inmate _____ OID # _____, suffers from a terminal illness as defined in DCR Policy Directive 410.12 and, if released, is not likely to pose an unreasonable risk to public safety given his/her current medical condition. My reasons for this decision are supported by the following:

_____

_____

_____

_____

If granted, the inmate will be residing with _____ at _____. The inmate's living arrangements have been investigated by staff at the facility and are set forth in the attached report.

I would also recommend the following additional terms and conditions:

_____ Supervision by a Parole Officer (Parole Services must be consulted)

_____ Electronic Monitoring (Parole Services must be consulted)

This medical respite shall terminate upon the expiration of _____ days unless sooner renewed.

Sincerely,

_____
Superintendent

Enclosures: Medical Respite Application
Medical Report
Pre-Sentence Investigation Report
Other Referenced Material

(*Facility Letterhead*)

MEMORANDUM

TO: _____ OID # _____
[Inmate Name]

FROM: _____
[Name of Superintendent]

DATE: _____

RE: Medical Respite Application

The Governor of the State of West Virginia has asked the Division of Corrections and Rehabilitation to provide him/her with a report and recommendation concerning your request for a medical respite.

A careful review of your case was made, and the Division of Corrections and Rehabilitation recommended that your request be denied. The Governor concurs with the recommendation and asked me to inform you of this decision.

I encourage you to continue to work with the staff at the facility in meeting both your medical and programming needs.

Sincerely,

_____
Superintendent

cc: Commissioner

(*Facility or Agency Letterhead*)

MEMORANDUM

TO: _____ OID # _____
[Inmate Name]

FROM: _____
[Name of Superintendent]

DATE: _____

RE: Medical Respite Application

The Governor of the State of West Virginia has asked the Division of Corrections and Rehabilitation to provide him/her with a report and recommendation concerning your request for a medical respite.

A careful review of your case was made, and the Division of Corrections and Rehabilitation recommended that your request be approved. The Governor concurs with the recommendation and asked me to inform you of this decision.

My office shall coordinate the implementation of your medical respite and will advise you, your unit team, medical staff, records office, and other appropriate facility staff (as necessary) of the conditions and the date of your medical respite.

Sincerely,

_____
Superintendent

cc: Commissioner