RESOLVED, That the American Bar Association supports compassionate release of terminally ill prisoners and endorses adoption of administrative and judicial procedures for compassionate release consistent with the "Administrative Model for Compassionate Release Legislation" and the "Judicial Model for Compassionate Release Legislation," each dated April 1996; and

FURTHER RESOLVED, That the American Bar Association supports alternatives to sentencing for non-violent terminally ill offenders in which the court, upon the consent of the defense and prosecuting attorneys, and upon a finding that the defendant is suffering from a terminal condition, disease, or syndrome and is so debilitated or incapacitated as to create a reasonable probability that he or she is physically incapable of presenting any danger to society, and upon a finding that the furtherance of justice so requires, may accept a plea of guilty to any lesser included offense of any count of the accusatory instrument, to satisfy the entire accusatory instrument and to permit the court to sentence the defendant to a non-incarceratory alternative. In making such a determination, the court must consider factors governing dismissals in the interest of justice.
INTRODUCTION

The unchecked spread over the last decade and a half of the Human Immunodeficiency Virus (HIV) within the prison populations, and among the poorer segments of society from which the inmate population is primarily drawn, has resulted in a dire situation wherein large numbers of incarcerated individuals are suffering with, and dying from, complications associated with AIDS while in prison. The costs to the U.S. taxpayer of keeping and caring for any terminally ill inmate, including those with AIDS, are substantial. Therefore, when an individual's health has deteriorated to such a point that he or she poses no serious threat to society, society would best be served by discharging that individual to the less costly family, medical, and social services networks outside the prisons. This approach logically should extend as well to alternatives to sentencing for non-violent offenders who have AIDS. Although our society clearly is concerned with ensuring the punishment of those who break the law, the humanitarian issues raised by the terminally ill inmate cannot be overlooked.

Further, in an era when the U.S. prison population is continually growing, both public policy experts and law enforcement/corrections leaders are searching for sensible ways to reduce the pressures of overpopulation on the system. The American Bar Association is in a unique position to recommend model legislation regarding compassionate release and alternatives to sentencing for non-violent persons living with AIDS and other terminal illnesses. Such a recommendation not only would address societal costs and humanitarian concerns, but also would help address the prison crowding concerns in a rational way.

BACKGROUND

In New York State, intravenous (IV) drug users and their partners constitute the fastest growing population with HIV and AIDS.1 Fifty to 80 percent of all IV drug users develop symptoms of HIV infection, and most of the IV drug users become involved in the criminal justice system. In California, medical expenses for a terminally ill inmate were $75,000 a year as of 1990, and as much as $3,500 a day for prisoners who were so ill that they had to be taken to a hospital.2 These were individuals with AIDS-related illnesses, such as PCP pneumonia, cancer,

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1Report of the New York State Bar Association's Special Committee on AIDS and the Law (Nov. 1993).
TB, and others. Thus, from the perspective of those involved in criminal justice, the scourge of AIDS cannot be viewed in isolation. It is part of the drug crisis, and one cannot respond to the problems engendered by AIDS without looking at the issues raised by IV drug usage.

Numerous reports acknowledge the linkage between IV drug abuse and the spread of HIV/AIDS. So do similar studies from the American Bar Association and the Bar of the City of New York, as well as the New York State AIDS Institute on AIDS in Correctional Facilities. Various scholarly studies address this issue, including Marjorie Russell's extensive analysis, published in the 1994 issue of the Widener Journal of Public Law.

One of the most dramatic effects of the large number of HIV-positive people entering the criminal justice system has been a health crisis in jails and state prisons throughout the country. The results of a recent study of this problem in New York's correctional system are startling. Approximately 10,000 of the state's 63,000 inmates in 1993 were believed to be HIV infected. More than 1,300 inmates died of AIDS-related diseases -- five died of AIDS in 1982; 213 died in the first ten months of 1993. Indeed, more inmates have died of AIDS-related diseases in New York than of all other causes combined. And these numbers have only increased since the date of the study.

Two implications for public policy follow. First, can terminally ill AIDS patients receive adequate care in prison or jail facilities, or in secure wards in city or state hospitals? Second, what public interest is served by incarcerating terminally ill patients -- especially those in later stages of illness -- in correctional facilities or locked or guarded wards, at public expense?

But public policy considerations often are preempted by statutory structures that severely limit the discretion of judges, prosecutors, and corrections officials to release late-stage, terminally ill patients. Most state statutes preclude changing, suspending, or interrupting a sentence of imprisonment once the term of imprisonment has begun. In many instances, this leaves a defendant with no legal alternative to a lingering death behind prison walls. In some cases, judges have modified jail sentences, at the urging of defense counsel and with the

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3See e.g., Governor's Statewide Drug Abuse Council, New York (1990); and, President Bush's National Drug Control Strategy (1989).

"Russell, "Too Little, Too Late, Too Slow: Compassionate Release of Terminally Ill Prisoners -- Is the Cure Worse than the Disease?" 3 Widener Journal of Public Law (1994).

4Report of the NYSBA Special Committee on AIDS and the Law, supra note 1.

5See, e.g., New York Criminal Procedure Law §430.10.
acquiescence of prosecutors, notwithstanding that such amendments are not authorized by law. Such acts of compassion should not require civil disobedience. Statutory reform is needed.

This Recommendation and Report addresses sentencing and post-sentencing phases. When a prison sentence for a late-stage, terminally ill patient is, in fact, a death sentence, or when the prisoner has served part of his or her sentence and has only a few weeks or months to live, courts and correction systems should be able to abide by the law and either release the prisoner or provide alternatives to incarceration to allow the individual to spend his or her final days with family and friends and die with dignity.

"Compassionate release" programs also benefit the criminal justice system as a whole because costs of caring for a terminally ill prisoner far exceed those for a healthy prisoner. Again, using California's example, in 1990, an "ordinary" prisoner could be maintained at an annual cost of about $18,600; terminally ill or elderly patients cost the state $67,000 apiece, more than three times the "ordinary" amount. These figures do not differ markedly from state to state. With the most recent available statistics several years old and the cost of everything, including prison care, on the rise, these numbers represent the low end of the spectrum. The same holds true for alternative sentencing programs.

The proposed policy would by no means equate an HIV-positive test result with a license to commit crimes. Nor would it provide carte blanche for judges or corrections administrators to ignore legislatively imposed minimum sentences. Offenders able to serve their sentences should do so, unless medical realities provide compelling justification for release or alternative sentencing. Release would be warranted only when continued incarceration is unnecessary to ensure public safety or satisfy the purposes of the sentence.

By the same token, of course, HIV/AIDS should not be a reason to punish further any prisoner. Release should not be denied capriciously merely because of the inmate's HIV/AIDS status. Further, to maintain the continuity of care during the transition from prison to the community for whatever time the prisoner has left, every inmate with the disease should be assisted in finding medical care and support services in his or her community; for example, by helping prisoners register with community-based care management services prior to release where such services are available and are desired by the inmate.

PLEA BARGAINING AND SENTENCING

Statutory plea bargaining requirements differ among jurisdictions. Many statutes contain some restrictions that limit the prosecutor's discretion to offer pleas to lesser charges in some circumstances. The effect of these limitations and their sentencing counterparts is to require many defendants to serve a minimum sentence of incarceration, even when the court and the prosecutor consider the sentence to be inappropriate. Another consequence may be unnecessary
expenditures and other drains on already overburdened court systems because many defendants opt for jury trials instead of pleas when the consequences are the same.

While the wisdom of plea bargaining and sentencing limitations has long been debated, they are particularly inappropriate in instances of seriously ill defendants. For example, a defendant who is physically incapacitated and unlikely to survive for six months has no rational incentive to plead guilty to a charge carrying a mandatory minimum sentence of more than one year. All concerned then face a disturbing dilemma: Should the defendant be given a speedy trial, in hopes that an acquittal or a conviction for a lesser offense will result? Or should the defendant’s case be dismissed in the interests of justice, notwithstanding that the offenses charged may be heinous? Or should the defendant’s case simply be adjourned, repeatedly, in the expectation that the case will be abated by reason of death before any difficult decisions need be made?

In some situations, the most rational decision would be to allow the offender to be sentenced, either after a plea of guilty or after trial, to a non-incarcerative sanction that allows the offender to receive medical care and treatment in a non-custodial setting, but that also provides for whatever level of supervision is necessary to protect the public.

Given the variation among sentencing provisions, the following language, adapted to specific statutes, would provide for this approach:

Notwithstanding the above provisions, the court, upon the consent of the defense and prosecuting attorneys, and upon a finding that the defendant is suffering from a terminal condition, disease or syndrome and is so debilitated or incapacitated as to create a reasonable probability that he or she is physically incapable of presenting any danger to society, and upon a finding that the furtherance of justice so requires, may accept a plea of guilty to any lesser included offense of any count of the accusatory instrument, to satisfy the entire instrument. In making such a determination, the court must consider factors governing dismissals in the interest of justice.

COMPASSIONATE RELEASE

Twenty-six states and the District of Columbia have at least one form of compassionate release program that specifically addresses terminally ill inmates. Those jurisdictions with no compassionate release program specific to terminal illness have at least one general method by which a terminally ill inmate could seek release. 

2"Compassionate Release of Terminally Ill Prisoners", Draft Report of the Corrections and Sentencing Committee of the Criminal Justice Section of the American Bar Association, p. 6
Among the states having one or more compassionate release programs that specifically address terminal illness, there are four general mechanisms for release: court proceedings, clemency and commutation, administrative releases, and medical parole. The administrative model gives the power to a parole board or other agency to rule on the inmate's application. In the judicial model, the court, instead of a parole board, determines whether to release the inmate based on his or her terminal illness. Both of these models set firm timetables for each step in the process.

In the federal system, compassionate release operates through the court system. One of two procedures is used, depending upon the sentencing scheme under which the inmate was sentenced. For inmates serving paroleable sentences, the court, on motion of the federal Bureau of Prisons, may reduce the minimum term to advance the parole eligibility date, and the inmate then will be scheduled for a hearing under the regular parole process.\(^4\) For inmates serving certain non-paroleable sentences, the court, on motion of the Bureau of Prisons, may reduce the sentence to release the inmate.\(^5\)

Every compassionate release state except Minnesota excludes some prisoners from eligibility for compassionate release based on the type of crime committed or sentence imposed. In New York, for example, a prisoner is ineligible if he or she was convicted of first or second degree murder, first degree manslaughter or any sexual offense, such as rape, sodomy or sexual abuse.\(^6\) Delaware and Florida exclude inmates under a sentence of death, and Delaware also excludes those sentenced to life imprisonment without possibility of parole for first-degree murder.\(^7\)

All states require a medical evaluation of the inmate in connection with the application (1995). This Report includes an excruciatingly detailed review of the compassionate release programs throughout the country.


\(^{6}\)N.Y. Exec. Law §259-r(1)(a).

for compassionate release. While most of these states require that the inmate's illness be terminal, the term is defined in varying ways and, in fact, is not defined in every jurisdiction. In some jurisdictions, the medical eligibility is defined by statute, while in others it is left to the interpretation, either in writing or in practice, of the agency with primary responsibility for implementing the process. For example, South Carolina requires a life expectancy of one year or less, while other states use a six-month life expectancy. Still others specify no time frame. Florida permits release of inmates who are terminally ill, without specifying a maximum life expectancy, as well as those who are permanently incapacitated. Other states, such as Minnesota and New Jersey, also permit release for serious medical conditions that are not terminal.

In the federal system, release is authorized for "extraordinary and compelling" circumstances that could not reasonably have been foreseen by the sentencing court. Recently, the federal Bureau of Prisons has sought compassionate release primarily in cases of prisoners with a terminal illness for whom death is imminent. Only Delaware and Missouri restrict release to cases in which the inmate needs treatment that the Department of Corrections cannot furnish. The degree of danger the inmate poses to society generally is considered when release to the community is sought.

Since 1988, the New York City Department of Corrections has had a compassionate release program for defendants held in the city's local jails. Doctors treating city inmates make referrals of patients whose medical conditions appear to justify compassionate release. The inmates then are supplied with a medical release form and details of the program. If an inmate

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13For example, the District of Columbia, Nebraska and Tennessee.

14N.Y. Exec. Law §259-r(1)(a).


16Minnesota permits release for "a grave illness or medical condition." Minn. Stat. Ann. §244.05(8). New Jersey permits release for a serious illness when incarceration is deleterious to the inmate's health. N.J. R. Crim. R. 3:21-10.


agrees to release his or her medical information, a physician prepares a write-up of the defendant’s medical condition and life expectancy. The General Counsel’s Office reviews the submissions and, in appropriate cases, forwards the materials to defense counsel and the prosecutors.

In the New York City program’s first five years of existence, more than 200 defendants obtained release through this program. Nevertheless, some unnecessary roadblocks hinder this well-conceived program.

Where the defendant is incarcerated pending trial, with no additional warrants or holds, compassionate release may entail no more than petitioning the court that issued the original securing order to modify its conditions, either by lowering bail, by releasing the defendant to his or her own recognizance, or by setting another condition of release.

But where the defendant is a sentenced prisoner, compassionate release runs into two obstacles. First, most statutes provide for “conditional release” of defendants serving definite sentences (usually those of one year or less), at the discretion of local conditional release commissions. An inmate, however, generally must serve at least 60 days before becoming eligible for conditional release. In some cases, even 60 days of incarceration may prove inhumane where a defendant’s medical condition dramatically deteriorates. While judges and prosecutors may be willing to resentence a defendant to allow for release before 60 days has elapsed, the statutory scheme usually restricts the ability of the court to modify a sentence once it has begun to run.

In practice, prosecutors, judges and defense counsel have, in the interests of compassion, often honored the statute in the breach, by resentencing critically ill inmates notwithstanding the law. But mercy ought not require civil disobedience. These statutes should be amended to allow “conditional” release of terminally ill patients at any time and remove the restraints from judges and prosecutors to modify sentences where medical conditions require such compassion. Ideally, a special panel should be designated to hear these cases. Further, prisons and jails should have workable early-discharge and medical furlough programs providing for the timely release of inmates whose incarceration is no longer medically appropriate. These procedures should provide an expedited process for determination on an accelerated calendar.

MEDICAL (EARLY) PAROLE

Medical parole is usually supervised by the state’s Board of Parole. In New York, if a physician determines that the prisoner is “so debilitated or incapacitated as to be severely

\textsuperscript{10}See, e.g., New York Penal Law §70.40(2).
restricted in his or her ability to self-ambulate and to care for him or herself," the matter is sent to the Commissioner of Corrections, who has complete discretion to reject an application with no right to appeal. If the application is approved, the prisoner's papers, together with a discharge plan, are presented to the Parole Board for review. If a hearing is recommended by the Board, the prosecutor, the sentencing judge, and the defense attorney are contacted. The Parole Board must wait 15 days for comments before making a final decision, which is based upon both regular parole criteria and the prisoner's medical condition.

In the first year of this review process (through June 1993), the Department of Corrections received more than 200 applications for medical parole. Twenty-seven were certified for further consideration. Sixteen applicants were granted parole, of whom nine were released, two died, one was converted to regular parole before release, and four were awaiting release at the end of the reporting period. Six applications were closed without Board decision (four died, one reached regular parole eligibility, and one had a prior release date), and five applications were pending.20

The New York model has been deemed "both workable and needed" by a State Bar watchdog committee.21 But what appears to be lacking in these situations are services for inmates who are released. Some medicines lose their effectiveness or take on a negative impact if the administration of them is even briefly interrupted, especially where family or friends are unable to care for the individual at home. Care must be provided in a hospital or hospice setting.

Further, most correctional systems forget the terminally ill inmate upon release. Continuity of care during the transition from prison to the community for whatever time the prisoner has left is required. These inmates and their families should be assisted in finding medical care and support services in their communities. This might include assisting prisoners to register with community-based care management services prior to release where such services are available and are desired by the inmate.

CONCLUSION

With the sharp and steady increase in the number of prisoners nationwide, and the corresponding likelihood of encountering more terminally ill inmates, society may be faced more frequently with deciding whether a particular defendant should die in prison. The increase in the number of prisoners and, at least in some systems, the length of time those prisoners will serve also may force consideration of whether continued incarceration of late stage, terminally

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21Report of the NYSBA Special Committee on AIDS and the Law, supra note 1.
ill prisoners constitutes the most efficient use of prison resources. The legal system must formulate a clear policy toward compassionate release and early parole, in advance of a pressing need to make large numbers of release decisions. The increasing public attention to criminal justice issues may reduce official willingness to consider humanitarian gestures toward inmates and make it more difficult to deal with early release decisions in individual cases.

The existence in virtually every jurisdiction of some method for considering early parole or compassionate release based upon terminal illness underscores the fact that humanitarian concerns are not antithetical to the administration of justice. Unless a criminal justice system is willing to adopt the view that no circumstances justify early release of a prisoner, the existence of a clear, regularized process for considering requests for early release appears likely to improve the efficiency and fairness of the operation of the criminal justice system and to enhance community acceptance of release decisions. On the other hand, leaving unspoken and unresolved those circumstances that might justify early release may perpetuate an air of mystery, lead to uneven application of the law, and cause hesitation in acting on requests for early release for fear of criticism.

It is therefore recommended that states and the federal government review their compassionate release procedures to ensure that they can accomplish their intended purpose and ensure the expeditious handling of such cases. Prisoners and correctional authorities alike should be aware of the availability of compassionate release and procedures for obtaining it. Correctional authorities should ensure that prisoners qualifying for such release are identified quickly and that their applications are acted upon in an expeditious and judicious manner. This Association therefore should support adoption of model legislation in the areas of compassionate (early) release from prison for terminally ill inmates and alternatives to sentencing for non-violent terminally ill prisoners.

Respectfully submitted,

Abby R. Rubenfeld, Chair
Section of Individual Rights and Responsibilities

August 1996
RECOMMENDATION/APPENDIX

ADMINISTRATIVE MODEL FOR COMPASSIONATE RELEASE LEGISLATION
(April 1996)

(a) Authorization: The [Parole Commission] [Department of Corrections] shall be authorized to grant parole [release] of any prisoner, [at any time,] [irrespective of whether he or she is presently eligible for parole,] whose medical condition is terminal within the meaning of paragraph (b), below. [This section applies to any prisoner except...]

(b) Standard: If the [Parole Commission] [Department of Corrections] finds from the evidence that the prisoner is likely to die within one year or less, the [Parole Commission] [Department of Corrections] shall release the prisoner upon [medical parole] [conditional release] unless it finds by a preponderance of the evidence that the prisoner poses a danger of committing additional crimes, that the prisoner will not receive adequate care upon his or her release, or that [medical parole] [conditional release] would denigrate the seriousness of the offense.

(c) Application process: In order to apply for such relief, the prisoner or a medical officer of the Department of Corrections shall file an application for [medical parole] [conditional release] with the [Parole Commission] [Director of the Department of Corrections]. In the case of an application filed by a medical officer, the application shall be accompanied by an affidavit of the medical officer attesting to the nature of the prisoner's illness, the treatment he or she is receiving, the prognosis, and the extent of the prisoner's incapacitation from the illness. A copy of each such application shall be served on the prosecutor.

(d) Medical Report: Within [72 hours] after the filing of any application by a prisoner, the [Parole Commission] [Department of Corrections] shall refer the application to the medical unit of the Department of Corrections for a report concerning the nature of the prisoner's condition, the treatment he or she is receiving, and the prognosis. Within [five days], the medical unit shall forward the medical report to the [Parole Commission] [Director of the Department of Corrections]. These time lines are meant to ensure speedy review and must be adhered to. However, the prisoner's application should not fail simply because, due to extraordinary circumstances, the review time frames were not adhered to.

(e) Summary disposition of unmeritorious applications: Within [seven days] of receiving the medical report or affidavit, as the case may be, the [Parole Commission] [Department of Corrections] shall determine whether the application, on its face, demonstrates that relief may be warranted. If the face of the application clearly demonstrates that relief is unwarranted, the [Commission] [Department] may deny the application without a hearing or further proceedings,
and within [seven days] shall notify the prisoner in writing of its decision to deny the
application, setting forth its factual findings and a brief statement of the reasons for denying
release.

(f) Procedure for hearing:

(1) If the application demonstrates that the prisoner may be entitled to relief,
the [Parole Commission] [Department of Corrections] shall set the case
for
hearing, which shall be held within the next [seven days] (unless the
prisoner requests additional time).

(2) Notice of the hearing shall be sent to the prosecutor and the victim(s), if
any, of the offense(s) for which the prisoner is incarcerated, and the
prosecutor and the victim(s) shall have the right to be heard at the hearing
or in writing or both.

(3) At the hearing, the prisoner shall be entitled to be represented by an
attorney (at the prisoner's cost if there is any cost) or other representative.
Rules of evidence shall not apply, and the evidence may be taken in the
form of affidavit.

(g) Decision: Within [seven] days of the hearing, the [Parole Commission] [Department
of Corrections] shall issue a written decision granting or denying [medical parole] [conditional
release] and explaining the reasons therefore. If the [Parole Commission] [Department of
Corrections] determines that [medical parole] [conditional release] is warranted, it shall impose
as conditions of [parole] [release] at least the following:

(1) that the prisoner not commit another crime;

(2) that the prisoner maintain his or her residence;

(3) that the prisoner maintain established reporting requirements with his or
her parole officer;

and such other conditions as the [Parole Commission] [Department of Corrections] concludes
are necessary or appropriate in the particular case, including the requirement that the prisoner
undergo periodic re-examination of his or her medical condition.
(b) **Review:** If the [Parole Commission] [Department of Corrections] determines that [medical parole] [conditional release] is not warranted, the prisoner shall have the right to seek review of the decision in the court in which he or she was convicted; such review shall be limited to the question whether the [Parole Commission] [Department of Corrections] abused its discretion. The appeal shall be expedited and not subject to further review.

(i) **Revocation of [medical parole] [conditional release]:**

1. Violation of conditions of [medical parole] [conditional release]: If the prisoner violates any condition of [medical parole] [conditional release], his or her [medical parole] [conditional release] may be revoked in the same manner as for other violations of [parole] [conditional release], and the prisoner returned to prison to serve his or her sentence. Credit for time spent on [medical parole] [conditional release] shall not be counted toward service of the sentence.

2. Prisoner no longer terminal: If after release the prisoner is determined not to be likely to die within one year, [medical parole] [conditional release] shall be revoked, and the prisoner shall be returned to prison to serve his or her sentence. Credit for time spent on [medical parole] [conditional release] shall be counted toward service of the sentence.

(j) **Reapplication:** Denial of relief under this section shall not preclude the prisoner from reapplying for relief if there is a change in his physical condition or other pertinent circumstances.

(k) **Reporting requirements:** The [Parole Commission] [Department of Corrections] shall maintain statistics regarding: the number of requests made for [medical parole] [conditional release], the number of such requests that were granted, the number of such requests that were denied and the grounds upon which each such petition was denied, and the date on which the prisoner died, if applicable. Within three months of the end of the [fiscal] [calendar] year, the [Parole Commission] [Department of Corrections] shall compile these statistics in an annual report that shall be made available to the public.
(a) Authorization: At any time after the defendant is sentenced, the court, on motion of the defendant or the Department of Corrections or on its own motion, and after notice to the prosecutor, may reduce a sentence of imprisonment to time served, or substitute for the unexpired balance of a sentence of imprisonment a sentence of home confinement, probation, or supervised release, upon proof that the defendant has a medical condition that is critical. The court may reduce any sentence, whether or not the defendant has served any imposed minimum sentence, except in the following cases...

(b) Standard: If the court finds from the evidence that the defendant is likely to die within one year, the court shall reduce the prison sentence to time served, or substitute home confinement, probation, or supervised release, for the unexpired balance of the prison sentence, unless it finds by a preponderance of the evidence that the defendant poses a danger of committing additional crimes, that the defendant will not receive adequate care upon his or her release, or that release would denigrate the seriousness of the offense.

(c) Motion: In the case of a motion filed by the defendant, the motion shall be accompanied by an affidavit of the medical officer attesting to the nature of the defendant’s illness, the treatment he or she is receiving, the prognosis, and the extent of the defendant’s incapacitation from the illness. A copy of each such application shall be served on the prosecutor.

(d) Procedure for hearing:

(1) If the court determines that the defendant may be entitled to relief, the court shall set the motion for hearing in the next 10 calendar days, unless the defendant requests additional time.

(2) Notice of the hearing shall be sent to the prosecutor and the victim(s), if any, of the offense(s) for which the prisoner is incarcerated, and the victim(s) shall have the right to be heard at the hearing or in writing or both.

(3) Evidence may be taken in the form of affidavit.

(f) Decision: Within [10] days of the hearing, the court shall issue a written decision...
granting or denying the motion, setting forth its factual findings and explaining the reasons for its decision. If the court determines that relief is warranted, the court shall determine whether to reduce the prison sentence to time served, or instead to substitute a period of home confinement, probation, or supervised release. If the court chooses to substitute a period of probation or supervised release, the court shall impose as conditions of probation or release at least the following:

1. that the defendant not commit another crime;
2. that the defendant maintain his or her residence;
3. that the defendant maintain established reporting requirements with his or her probation officer;

and such other conditions as the court concludes are necessary or appropriate in the particular case.

(g) Review: If the court denies the motion, the defendant shall have the right to appeal, limited solely to the question whether the trial court, in denying the motion, abused its discretion.

(h) Revocation of release:

1. Violation of conditions of release: If the defendant violates any condition of release, his or her release may be revoked in the same manner as for other violations of probation or supervised release, and the defendant returned to prison to serve his or her sentence. Credit for time spent on release shall not be counted toward service of the sentence.
2. Defendant no longer late-stage terminal: If after release the defendant is determined not to be likely to die within one year, his or her release shall be revoked, and the defendant shall be returned to prison to serve his or her sentence. Credit for time spent on release shall be counted toward service of the sentence.

(i) New motion based on changed circumstances: Denial of relief under this section shall not preclude the defendant from filing a subsequent motion for relief if there is a change in his physical condition or other pertinent circumstances.

(j) Reporting requirements: The Department of Corrections shall maintain statistics regarding the number of requests made for conditional release, the number of such requests that were granted, the number of such requests that were denied, and the date the defendant died, if
applicable. Within three months of the end of the [fiscal] [calendar] year, the Department of Corrections shall compile them in an annual report that shall be made available to the public. In order to facilitate the collection of relevant data, the court shall send to the Department of Corrections a copy of every motion for conditional release and of the decision on each such motion.
1. **Summary of Recommendation(s).**

This recommendation supports model legislation on compassionate release and alternative sentencing for non-violent offenders with HIV, AIDS, or other late-stage terminal illness in order to promote the adoption of a regularized process to provide clarity and uniformity in the application of this policy.

2. **Approval by Submitting Entity.**

The Council of the Section of Individual Rights and Responsibilities approved the report with recommendation at its spring meeting April 12, 1996. The AIDS Coordinating Committee approved the report with recommendation on April 13, 1996.

3. **Has this or a similar recommendation been submitted to the House or Board previously?**

   No.

4. **What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?**

   In August, 1976, the Association approved a policy urging states to examine the utility of alternative dispositions in criminal cases. In February 1990, a policy was adopted that urges the authorization of bodies within the criminal justice system to address the general problem of prison crowding. Most recently, in February 1996, the Association adopted a policy urging jurisdictions to review their sentencing laws applicable to terminally ill patients. The proposed recommendation is consistent with these policies, but goes beyond general and broad-based statements to encourage development and implementation of concrete solutions through adoption of model legislation specifically designed to address issues raised by care and custody of late-term terminally ill inmates.

5. **What urgency exists which requires action at this meeting of the House?**

   Prison populations across the country continue to rise, and the incidence of terminal illness among inmates has increased sharply due largely to the spread of HIV and AIDS among IV drug users likely to become involved in the criminal justice system. As a result, the question of how to deal with late-stage terminally ill prisoners has become a pressing concern. Existing federal
and state statutes that are applicable lack specificity and uniformity and therefore often yield harsh and uneven results. Adoption of the policy would enable the ABA to promote legal reform in the areas of compassionate release and alternative sentencing to achieve a regularizing influence on the process and allocate over-extended prison resources more effectively, while serving a humanitarian end.

6. **Status of Legislation.** (If applicable.)
Twenty-six states, the District of Columbia, and the federal system have laws authorizing some form of compassionate release. However, there is little uniformity of provisions, and their application has been ineffective. Similarly, although all states and the federal government have adopted alternative sentencing options, there is no consistency among jurisdictions in the application of options to cases of specific terminally ill inmates.

7. **Cost to the Association.** (Both direct and indirect costs.)
Adoption of the recommendation would result only in minor, indirect costs associated with staff time devoted to dissemination and support of the policy as part of the staff members' overall substantive responsibilities.

8. **Disclosure of Interest.** (If applicable.)
N/A

9. **Referrals.**
Co-sponsorship will be sought from the Criminal Justice Section and other ABA entities with an interest in this area.

10. **Contact Person.** (Prior to the meeting.)
Salvatore J. Russo, Chair, ABA AIDS Coordinating Committee
New York City Health & Hospitals Corporation
125 Worth Street, Room 527
New York, NY 10013
(212) 788-3300

Clifton J. Cortez, Jr., Director, AIDS Coordinating Committee
740 15th Street, N.W.
Washington, D.C. 20005-1009
(202) 662-1025
11. **Contact Person.** (Who will present the report to the House.)

   Robert F. Drinan, SJ, Section Delegate
   Georgetown University Law Center
   600 New Jersey Avenue, N.W.
   Washington, D.C. 20001

12. **Contact Person Regarding Amendments to This Recommendation.** (Are there any known proposed amendments at this time? If so, please provide the name, address, telephone, fax and ABA/net number of the person to contact below.)

   Salvatore J. Russo, ABA AIDS Coordinating Committee (address & phone listed above)

   There are no known amendments at this time.