STATE OF WEST VIRGINIA

DIVISION OF CORRECTIONS

POLICY DIRECTIVE

NUMBER: **410.12**

DATE: **01 November 2009**

SUBJECT: **Medical Respite Application Procedures**

AUTHORITY: **WV Code 25-1-1 et. seq.**

I. POLICY: It is the policy of the West Virginia Division of Corrections to establish and maintain a mechanism of which requests from inmates can be reviewed in order to determine whether a release of such inmate under a Medical Respite can be recommended to the Governor. The Governor has the final authority with respect to granting a Medical Respite. However, it is the obligation of the West Virginia Division of Corrections to process requests for Medical Respites and to make sound recommendations to the Governor regarding the same. Accordingly, the goal and objective of this Policy Directive is to establish a uniform and efficient process by which inmates who, by means of a terminal illness or extremely serious medical condition (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 West Virginia Division of Corrections.

II. CANCELLATION: Policy Directive 410.12, dated 01 April 2006

III. DEFINITIONS: All words used herein shall be accorded their ordinary meaning unless otherwise set forth below.

Commissioner: Commissioner means the Commissioner of the Division of Corrections.

Warden/Administrator: Warden/Administrator means the Chief Executive Officer of the respective unit of the Division of Corrections.

Governor: Governor means the Governor of the State of West Virginia.

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.

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 institution/facility/center physician.

Medical Need Which May Not Be Reasonably Provided By Corrections: Medical need which may not be reasonably provided by Corrections 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 the purpose of this definition, costs of the medical procedure shall not be considered.

IV. APPLICABILITY: All units within the Division of Corrections, except for the young adult inmates incarcerated at the Anthony Correctional Center.

V. PROCEDURE:

A. Application

1. An inmate seeking a medical based release (Medical Respite) may obtain an application for a Medical Respite (Attachment #1) from any member of his/her Unit Team and/or health services staff.

2. When the inmate requests this form, the Unit Team member or health services staff shall counsel the inmate that Medical Respites will not be recommended for basic medical needs.

3. The inmate shall be instructed that Medical Respite recommendations are reserved for the end stages of life and other extreme and rare circumstances.

B. Submission to the Warden/Administrator and Medical Report

1. Upon receipt of the application, the inmate shall submit the application to the Warden/Administrator (the Warden/Administrator may designate a staff member(s) to address the clerical duties and functions involved in this process).

2. Within five (5) days of receipt of the Medical Respite Application, the Warden/Administrator shall request a Medical Report from the institution/facility/center's healthcare provider (Attachment #2).

3. The healthcare provider shall provide a response (including any certifications by the management staff) within ten (10) days.

4. 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 Warden/Administrator shall immediately prepare a letter to the Commissioner advising the Commissioner of the receipt and review of the Medical Respite Application and of the fact 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.

5. Upon receipt of letter, Medical Respite Application, and Medical Report, the Commissioner shall review and either:

   a. transmit the information to the Governor with a recommendation for denial

   b. return the information to the institution/facility/center for further consideration as set forth below (Attachments #4 and #5)

6. Whenever an application for a Medical Respite is received by any employee other than the Warden/Administrator, an employee shall forward the application to the Warden/Administrator of the inmate's respective institution/facility/center.

C. When Medical Report Indicates Possible Need for Respite

1. Whenever the Warden/Administrator or the Commissioner believe that the application and Medical Report may support granting a medical respite, the Warden/Administrator shall solicit the sentiment of the sentencing court, Prosecuting Attorney, and victim(s) simultaneously (Attachment #6 and #7).

2. A letter requesting sentiment shall allow approximately seven to ten (7-10) days for a response.

3. In addition thereto, the Warden/Administrator 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:

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

   b. the age of the inmate

c. physical and psychological condition of the inmate

d. the length of time remaining on the inmate's sentence

e. whether the inmate has recently been denied parole, or whether the inmate has a parole hearing forthcoming

f. whether the inmate has had his/her parole revoked

g. sentiment of the victim, prosecution, and sentencing court

h. the inmate's institution/facility/center behavior

i. the release plan if a respite is granted including risk to members of the public

j. any other factors deemed relevant

D. Final Recommendation

1. After the review described in Section V, C of this Policy Directive is complete, the Warden/Administrator 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).

2. In the report, the Warden/Administrator 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. 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 Warden/Administrator shall recommend against a medical respite.

4. However, if the inmate's medical condition would justify a medical respite, the Warden/Administrator 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 referenced in this Policy Directive.

5. If the Warden/Administrator finds that a medical respite should be recommended, the Warden/Administrator shall also indicate whether special terms and conditions, such as community supervision, electronic monitoring, or other conditions should be imposed.

6. 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. Consideration shall also be given in order to ascertain whether such can be reasonably undertaken. Upon receipt of the same, the Commissioner shall address each in the same manner as set forth in Section V, B of this Policy Directive.

E. Successive Applications

1. 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.

2. However, whenever an inmate has previously applied for medical respite application and has been denied (and no material change in his/her circumstance has taken place), the Warden/Administrator, with consultation from the healthcare provider, may summarily make a recommendation for denial to the Commissioner as outlined in Section V, B of this Policy Directive.

3. The Commissioner shall act upon the recommendation in the same manner as set forth in Section V, B of this Policy Directive.

F. Decision of the Governor

1. In the event that the Governor should deny the medical respite, the Warden/Administrator shall notify the inmate upon the receipt of the denial (Attachment #9).

2. In the event that the Governor should approve the medical respite, the Warden/Administrator shall also notify the inmate upon the receipt of the decision (Attachment #10).

3. Thereafter, the Warden/Administrator shall coordinate the implementation of the medical respite, including any special terms or conditions with the Commissioner's Office and the Governor's Office.

G. Operational Procedures

1. Each institution/facility/center shall implement an appropriate Operational Procedure that provides the specific means by which this Policy Directive shall be implemented.

2. However, any Operational Procedure supplemented shall not be at variance with or otherwise modified any provision of this Policy Directive.

APPROVED SIGNATURE: Jim Rubenstein November 1, 2009

Jim Rubenstein, Commissioner Date

MEDICAL RESPITE APPLICATION

Date: _____

Name: _____
(First) (Middle) (Last)

DOC Number: _____ 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 for your application to be complete please attach additional sheets. You **must**, however, indicate the corresponding question number to any and 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	*Term*	*Effective Sentence Date (cc/cs)*

2. Identify the county(ies) 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. In what prison programs (education, 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 to release information regarding my medical condition, criminal history, treatment and plans to appropriate authorities.

_____
(Inmate Signature) (Date)

_____
(Staff Witness Signature) (Position) (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:_____**WVDOC#:**_____

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

Date

Commissioner _____
West Virginia Division of Corrections
1409 Greenbrier Street
Charleston, WV 25311

Re: Medical Respite Application

Name _____
DOC # _____

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 institution/facility/center'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.

Sincerely,

_____
Warden/Administrator

Date

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

Re: Medical Respite Application

Name _____
DOC # _____

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 Warden/Administrator 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: Warden/Administrator
file

TO: Warden/Administrator _____

FROM: Commissioner _____

DATE: _____

RE: Medical Respite Application

Name: _____

DOC # _____

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

Date

Name _____(Victims/Judge/Prosecutor)
Address _____
City/State/Zip Code _____

RE: Medical Respite Application
Name _____
DOC # _____

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.

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

Sincerely,

_____
Warden/Administrator

cc: file

MEDICAL RESPITE SENTIMENT FORM

TO: **Warden/Administrator** _____

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

Date

Commissioner _____
West Virginia Division of Corrections
1409 Greenbrier Street
Charleston, WV 25311

RE: Medical Respite Recommendation
Name _____
DOC # _____

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 _____ DOC # _____.

Should you be inclined to grant this applicant a medical respite, the West Virginia Division of Corrections 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 _____ DOC # _____, suffers from a terminal illness as defined in 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 institution/facility/center 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,

_____
Warden/Administrator

Initials

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

cc: file

MEMORANDUM

TO: _____ DOC # _____
[Inmate Name]

FROM: _____
[Name of Warden/Administrator]

DATE: _____

RE: Medical Respite Application

The Governor of the State of West Virginia has asked the Division of Corrections 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 West Virginia Division of Corrections 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 institution/facility/center in meeting both your medical and programming needs.

Sincerely,

_____
Warden/Administrator

cc: Commissioner

MEMORANDUM

TO: _____ DOC # _____
[Inmate Name]

FROM: _____
[Name of Warden/Administrator]

DATE: _____

RE: Medical Respite Application

The Governor of the State of West Virginia has asked the Division of Corrections 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 West Virginia Division of Corrections 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 institution/facility/ center staff (as necessary) of the conditions and the date of your medical respite.

Sincerely,

_____
Warden/Administrator

cc: Commissioner