

Compassionate Medical Release Informational Briefing

House Committee on Public Safety

October 22, 2026



Thank you!

We are so grateful for the opportunity to share about compassionate release with you today.

Who is FAMM?

- FAMM is a non-profit, **non-partisan** organization founded in 1991 to elevate the voices of people impacted by the justice system in policy reform spaces.
- FAMM has more than **75,000 members** nationwide, including people in Hawai'i who have experienced incarceration and their loved ones.

What does FAMM do?

- FAMM's mission is to create a more fair and effective justice system that respects individual **accountability** and **dignity** while keeping our communities **safe**.
- FAMM advocates in Congress, state legislatures, federal and state agencies, courts, and more to:

- Reform unduly harsh **sentences**
- Adopt independent prison **oversight**
- Provide opportunities to **revisit** and review prison sentences for appropriateness

How did we get here?



What is compassionate release?

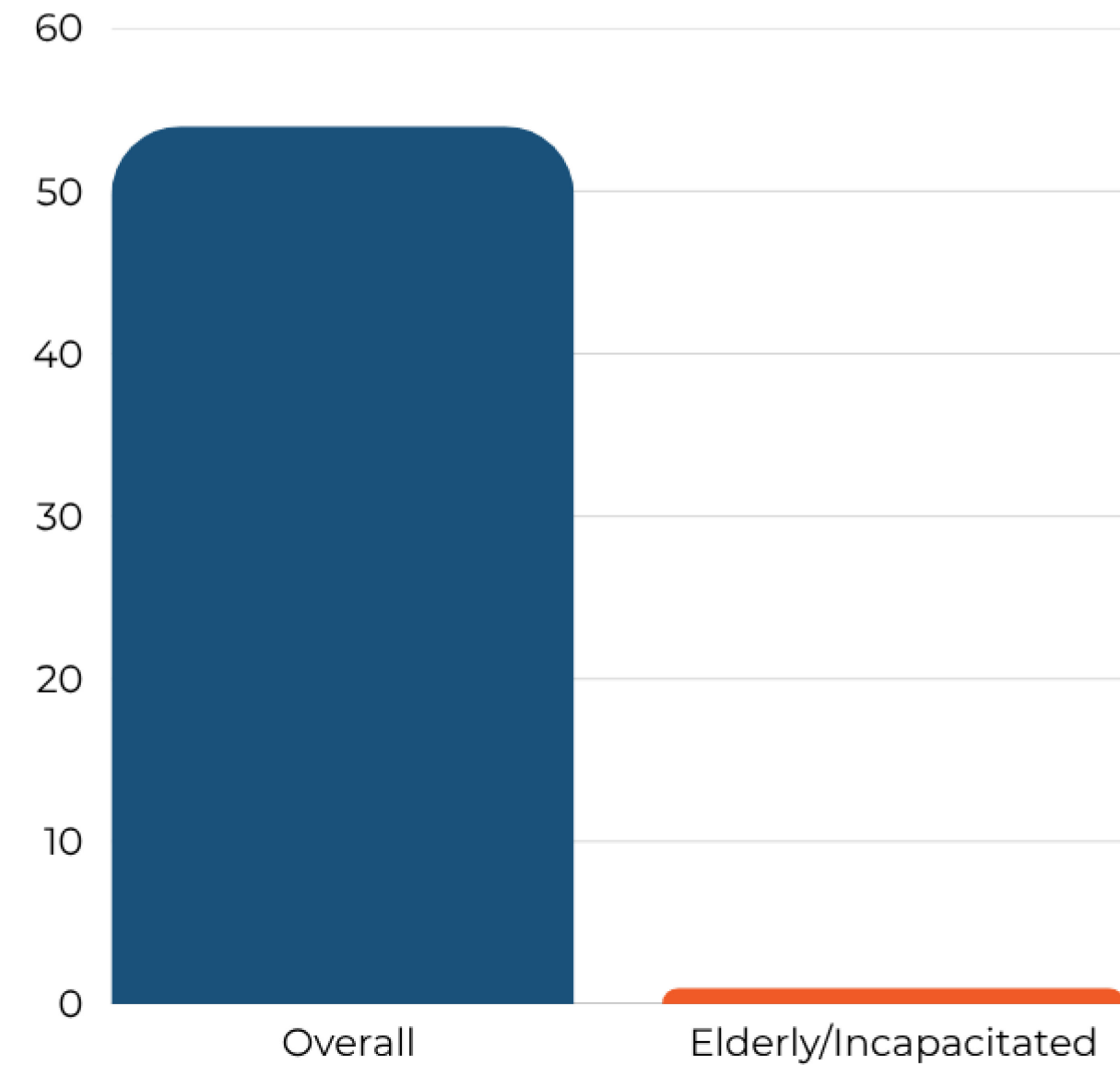
- Compassionate or medical release describes programs created by lawmakers that allow people to be considered for release for **medical reasons**.
- Compassionate release is especially important when an individual is:
 - Too ill or cognitively impaired to be aware of punishment
 - Too sick to participate in rehabilitation
 - Too functionally compromised to pose a risk to public safety

Why is compassionate release important?

People who are advanced in years, debilitated by serious medical condition, and/or near the end of life are the **most complex** and **expensive** to incarcerate, and the **least likely to reoffend** .

The least likely population to reoffend

- The overall recidivism rate in Hawai'i is **54%**.
- The recidivism rate for people who are sick, elderly, and/or incapacitated nationwide is as low as **less than 1%**.



The most complex to care for

- A small number of people take a disproportionate amount of DCR **staff capacity** and **facility resources** :

Acute care needs

Infirmiry space

Daily care from medical staff

External appointments

Corrections officer supervision

The most complex to care for

Staff Wellness

60% of corrections staff developed a serious health condition due to job stress.

Over 75% of corrections staff felt emotionally drained.

Staff Vacancy Rate

- 29% in non-uniform staff.
- 28% across all staff.

Medical staff perspective

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*Caring for medically fragile incarcerated patients requires **extraordinary overtime** from both **correctional officers and nursing staff**. Correctional officers must provide 24-hour hospital security coverage during off-site admissions—often for weeks at a time—while nurses must staff an overfilled infirmary increasingly dominated by high-acuity patients.*

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Medical staff perspective

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Over the past year, multiple correctional officers died, and in recent years the Department also lost a primary physician at Halawa Correctional Facility who died, a physician known to frequently delay his own care while attempting to meet the growing demands of medically complex patients.

These deaths occurred in a workforce already under extreme strain from chronic overtime, staffing shortages, and sustained burnout.

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Medical staff perspective

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This level of strain directly affects staff retention, patient safety, and the Department's ability to respond to psychiatric crises and suicide risk.

*Halawa has experienced alarming rates of suicide and serious self-harm, and **every nurse or officer assigned to constant medical supervision of a debilitated patient is one fewer staff member available to intervene elsewhere.***

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The most expensive population to incarcerate

The average cost of incarceration in Hawai'i is **\$112,505 per person annually** . For incarcerated people who are sick, there are numerous **additional** costs:

Prescriptions

Hospitalizations

Medical equipment

Medical staff time

MedEvac

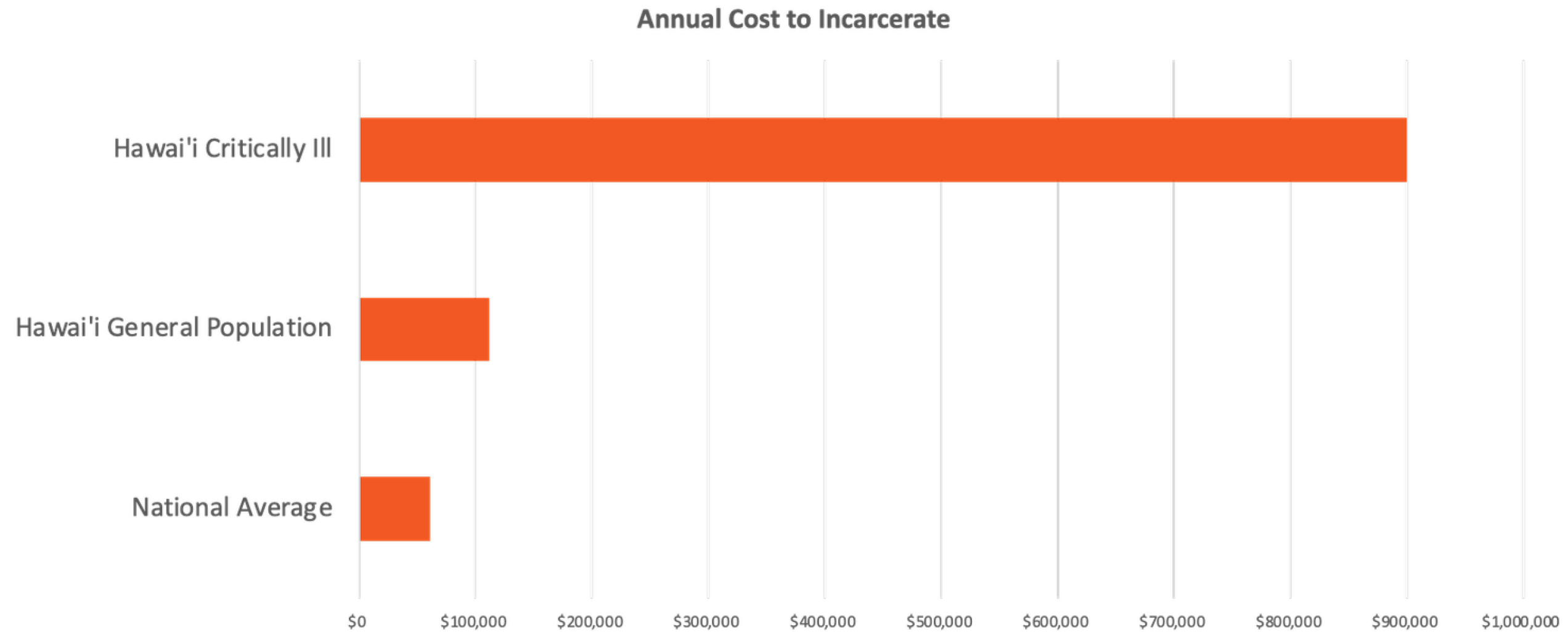
Surgery

Corrections officer overtime

Imaging

Specialty
appointments off -site

The cost burden on Hawai'i



The estimated cost to incarcerate people who are critically ill is **six to nine times higher** than the general population – reaching **\$1 million or more** per year.



Case study: a patient with cancer

For a patient with cancer in DCR custody between September 2025 to January 2026, costs included:

- Out of facility medical costs, including hospitalizations and surgeries: **\$276,830**
- Transports to and from appointments: **\$64,000**, not including additional COs for transport and hospital shifts
- Medications: **\$9,000**
- Medevac from Arizona to Halawa: **\$100,000**
- Nursing care at Halawa: **\$240,000**

In only **five months** , this patient costed DCR and the State nearly **\$700,000**. To keep this individual in custody, this would cost **\$1,515,000** for a single year.

Case studies: impact on the provision of care

For a patient in DCR custody with a rare disease, the cost for a single month of that individual's non-formulary prescription took up **90% of DCR's entire budget for prescriptions** for all people in custody.

This means that **only 10% of the budget is available for the thousands of other individuals in custody** who need medications, including prescriptions without which patients will die – like insulin

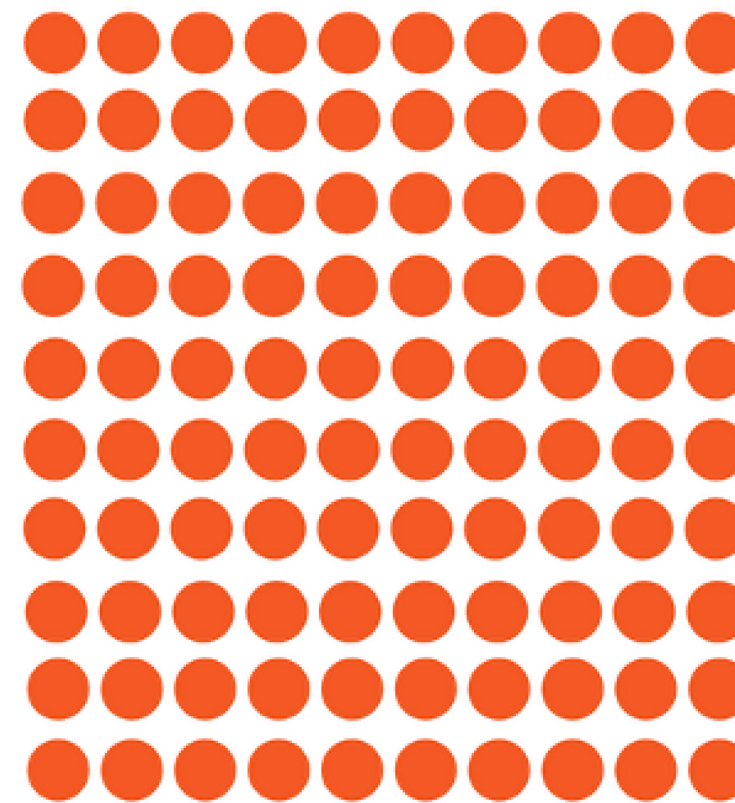
Patients on dialysis require off-site treatments three times per week. This takes corrections officers away from the facility from approximately **2-10pm three times a week**. Because staff are away, **no other movement is possible** during these times - no other patients can have appointments.

DCR currently has a **backlog of about 300 medical appointments** for other patients that have not happened because of the strain of dialysis patients alone on correctional resources.

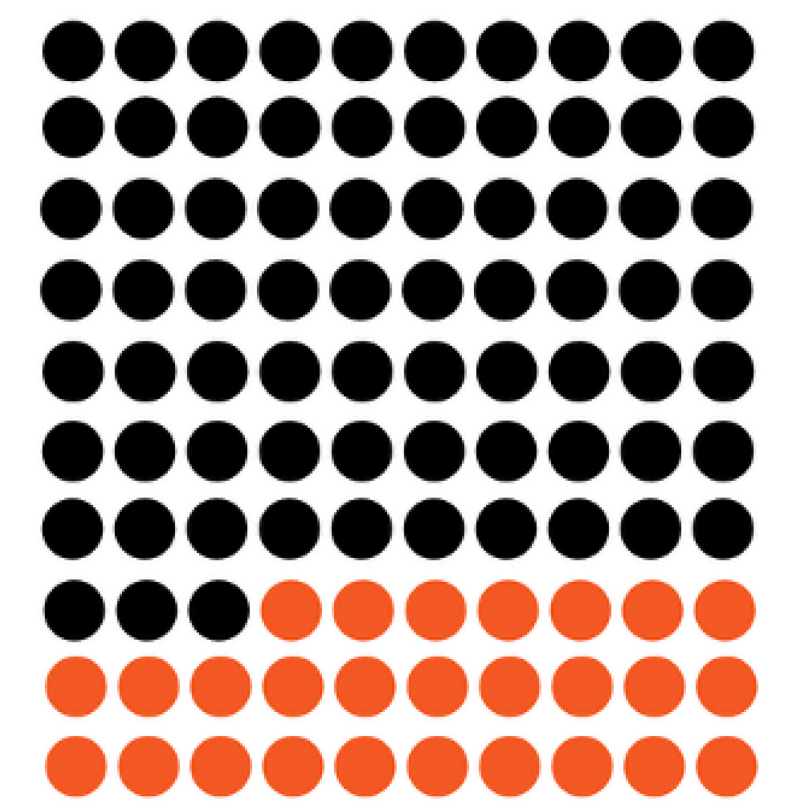
State cost vs. federal coverage

In general, DCR and the State are responsible for 100% of the costs for incarcerated people who are critically ill.

If these individuals are granted compassionate release and on Medicaid, the **federal government covers 60 -90%** of these costs, depending on the Medicaid program the patient is enrolled in, instead of the State



*100% cost to the
State when in
custody*



*Federal funding is 73% of
total Medicaid spending in
Hawai'i*

Family perspective

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My loved one is terminally ill. We had to fight for him to return to the island, because we were afraid of him dying alone in Arizona. He was Medevaced back to Halawa.

Between his many surgeries, lengthy hospitalizations, and the Medevac, I can only imagine how costly his care has been for DCR.

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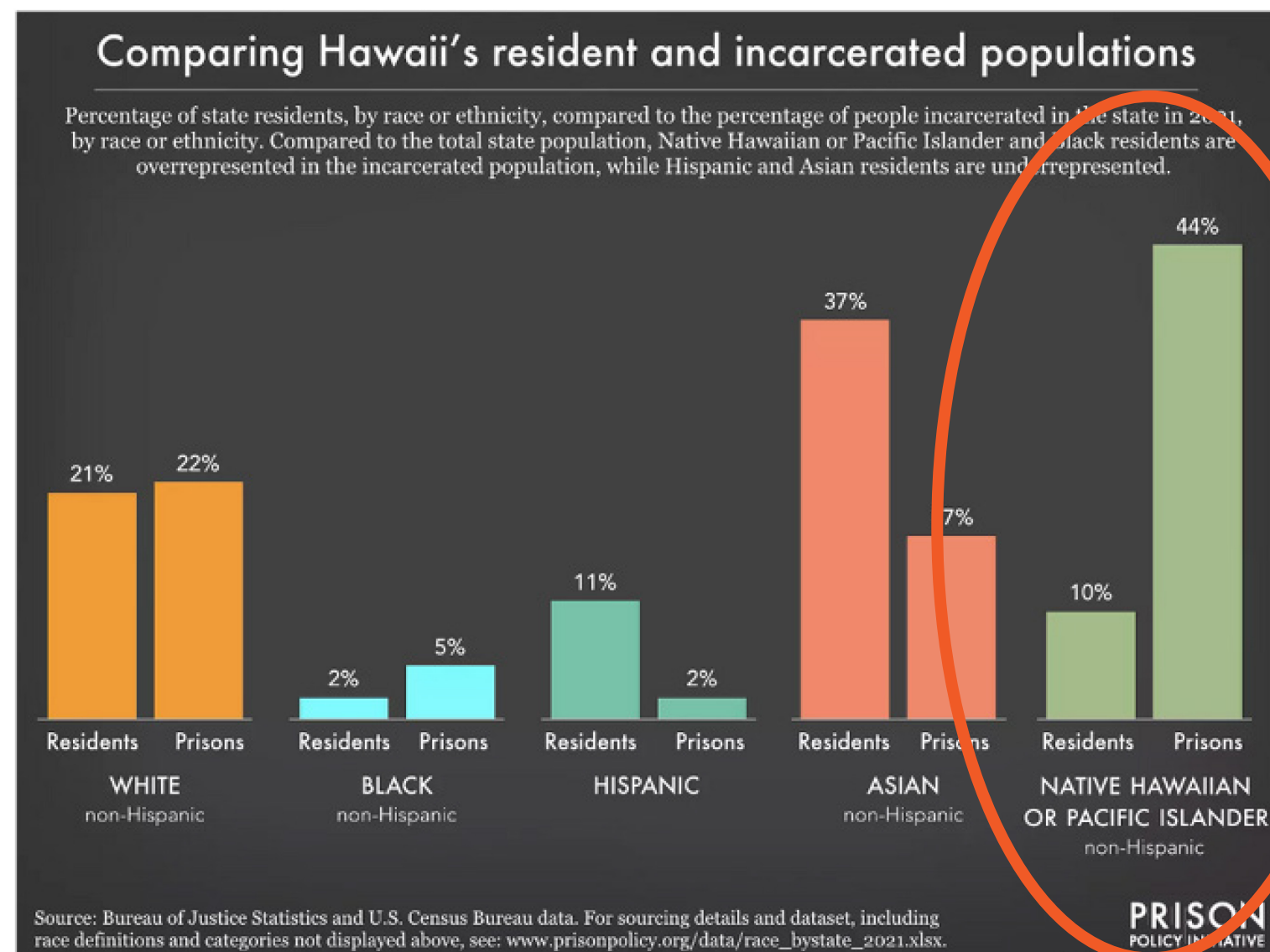
Family perspective

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*The prison is **not equipped** at all to provide the level of care my brother needs with his rare form of cancer. It's freezing cold in the infirmary. His hands are shaking from the cold when we visit, and being in this environment makes him want to give up. Every time he is in the hospital, his hands and ankles are handcuffed to the bed – even though he is bedridden.”*

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Why does compassionate release of particular importance in Hawai'i?



- Native Hawaiians are **disproportionately** represented among the incarcerated population.
- Native Hawaiians represent 10% of the population, but 44% of the people in prison.

OHA's perspective

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Compassionate release reflects Hawai‘i’s deeply rooted values of aloha, mālama, and kuleana, especially for people who are nearing the end of their lives or experiencing profound illness.

*The ability to receive care from ‘ohana, to engage in cultural and spiritual practices, and to maintain meaningful relationships is foundational to healing and dignity, particularly at the end of life. **These essential elements of care and connection cannot be replicated within a correctional facility**, especially for individuals who are terminally ill, medically fragile, or cognitively impaired.*

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OHA's perspective

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*Long-term incarceration carries **substantial intergenerational impacts** , including destabilizing family networks and creating barriers to reintegration.*

For Native Hawaiian 'ohana already facing structural inequities, the prolonged incarceration of an elder or seriously ill family member can deepen harm and extend trauma, particularly when that individual's condition has progressed to a point where dignity and humane care are better provided in a community setting with appropriate supports.

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FAMM and compassionate release

FAMM has led advocacy efforts for compassionate release for **25 years**.

- In that time, in collaboration with legislators and local partners, our work has helped achieve:
 - Reforms to federal compassionate release that transformed the statute from among the worst programs in the nation to the best, resulting in the release of **4,500 medically vulnerable people** during COVID
 - A federal compassionate release **clearinghouse** that has led to freedom from incarceration for hundreds of sick, dying, and elderly people
 - **Strengthened** compassionate release programs in many states

Hawai'i in the national landscape



- Hawai'i is the only state in the country whose compassionate release program is **not governed by statute**.
- Hawai'i is also the only state in the country where a Department of Corrections has explicitly **opposed compassionate release legislation**. Instead, there are many examples of a state **DOC testifying in support** of compassionate release legislation, frequently citing to fiscal concerns and overcrowding in state prisons as main reasons for supporting compassionate release.

This is a **real opportunity** for Hawai'i to not only align with best practices, but to become an **example for the rest of the country**.

Purpose of Hawai'i Compassionate Medical Release Statute

Statutes promote clarity, continuity, and collaboration. Benefits afforded by a statute in Hawai'i include:

- **Transparency** and **accountability**
- **Process** improvements
- Appropriate **eligibility**
- Stability and durability
- **Stakeholder** involvement

The absence of a compassionate release statute means that people who **need** compassionate release languish and even die in prison.

HI compassionate release in the national landscape: medical criteria

Best practices

- Categories consider care needs, cognitive impairment, incapacitation, and terminal illness

This ensures that populations who are dying, impaired, whose care cannot be appropriately provided in prison, and who are costly and complex, are eligible for consideration.

Current practices

- ✓ Hawai'i currently aligns, and if codified, could be an example for the rest of the country

HI compassionate release in the national landscape: eligibility

Best practices

- The majority of states where Parole Boards make compassionate release decisions treat people serving mandatory and/or life without the possibility of parole (LWOP) sentences as eligible for consideration

This is because states all across the country recognize that continuing to incarcerate this population is the most resource -intensive with the least public safety benefit.

Current practices

-  People serving LWOP or with incomplete mandatory minimums are not eligible, even if they are critically ill and their care is costly and complex for DCR.

HI compassionate release in the national landscape: process

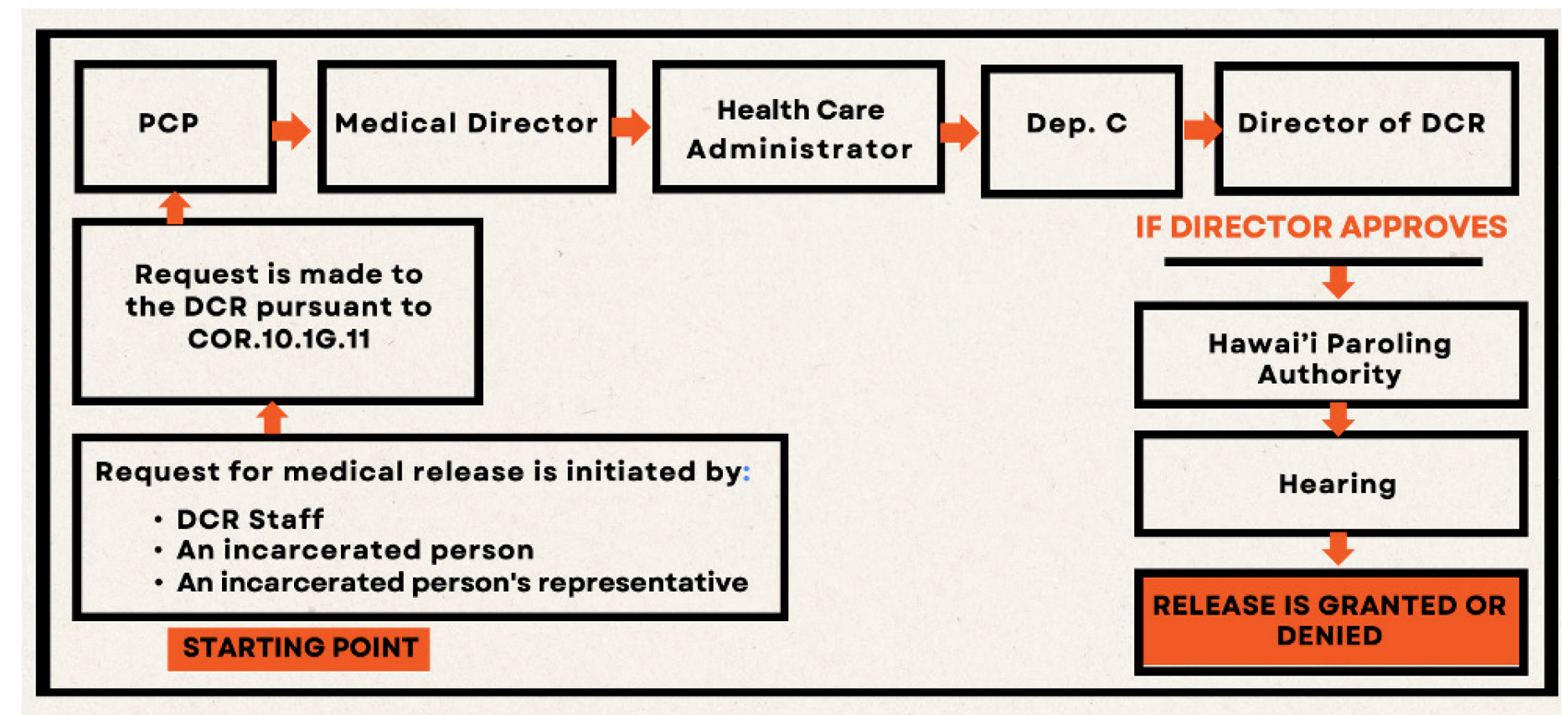
Best practices

- Guideposts, including streamlined decision-making and clear timelines, are best practice

This ensures that cases involving rapid decline receive prompt attention and appropriate review

Current practices

- ✗ No timelines, and complicated process with many layers



HI compassionate release in the national landscape: factors

Best practices

- In model states across the country, legislators provide guidance to decision-makers about how to weigh release, conditions, and revocation decisions that differentiate parole from compassionate release.
 - Parole focuses on the individual **applicant** - their program participation, rehabilitation, their remorse, and their ability to become a productive member of society
 - Medical release focuses on the **system** - the impact on DOC and taxpayers to keep a severely ill person in custody

Differentiating compassionate release from other forms of parole empowers parole boards to consider factors that are relevant and specific to compassionate release - diagnosis, prognosis, impact on the Department, and non -static facts about risk.

Current practices

- Compassionate release is subject to **all regular parole considerations**
- **Parole conditions** also apply – for example: “You shall actively seek and retain employment. You shall immediately notify your parole officer in the event of termination of employment and be governed by your officer's instructions.”
- Revocation does not consider if the alleged violation related to medical conditions, such as **physical inability** to dial a phone for a check-in

HI compassionate release in the national landscape: factors

Examples

WISCONSIN

*“The impact on Department **resources**, **financial impact** on the Department and cost of the individual’s medical treatment.”*

DELAWARE

*“The impact that the person’s continued incarceration may have on the **provision of medical care** within the Department, including consideration of **overcrowding** .”*

KANSAS

*“The individual’s **capacity** to cause physical harm”*

ILLINOIS

*“The individual’s **present** likelihood of and **ability** to pose a substantial danger to the physical safety of a specifically identifiable person or persons.”*

CALIFORNIA

*“There shall be a presumption favoring [compassionate release] if an individual meets the medical criteria. The presumption may only be overcome if the individual is an unreasonable risk of danger to public safety based on their **current physical and mental condition** . An unreasonable risk of danger exists when there is an unreasonable risk the individual will commit a new violent felony.”*

HI compassionate release in the national landscape: data collection and reporting

Best practices

- Majority of states collect data and report publicly about compassionate medical release
- In many, these are required by the legislature on designated timeframes

This allows for transparency and accountability

Current practices

No reporting requirements

Community placement

Hawai'i is a **rare, shining example** of community-agency collaboration to find suitable community placement.

People who have been granted compassionate release have already been determined to be **low risk**, and are placed on **supervision**.

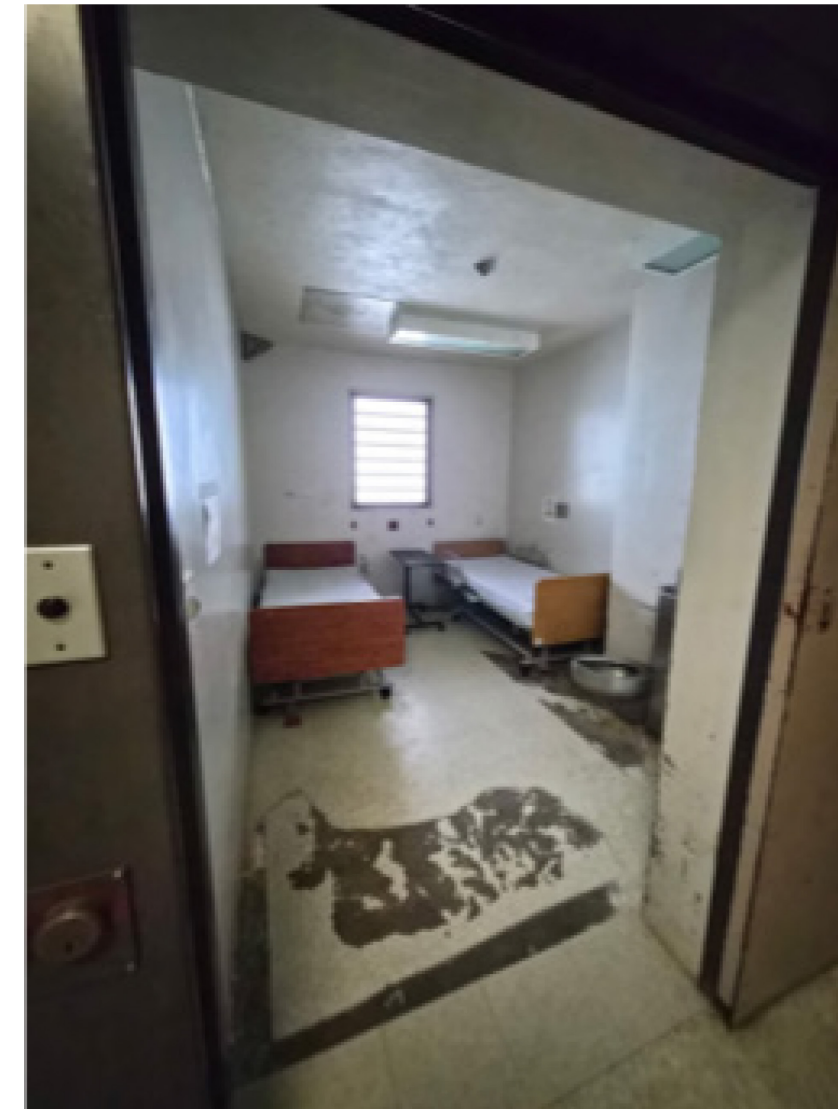


When long-term care facilities refuse to accept prisoners who have been granted compassionate release, it leaves state taxpayers footing a larger bill. The annual cost to incarcerate an individual in Hawai'i with complex needs is up to eight times the \$112,505 average of housing one person in prison, according to FAMM. In comparison, the average Medicaid reimbursement for long-term care patients at a Hawai'i Health Systems Corp. facility is about \$135,000 a year.

Experiences in the infirmary at Halawa



The infirmary unit



An infirmary cell

Medical staff perspective

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Halawa Correctional Facility operates an infirmary, not a hospital, skilled nursing facility, or long-term care center. This distinction is critical when evaluating what constitutes appropriate and humane medical care.

The facility lacks:

- *Continuous on-site physician or advanced practice provider coverage*
- *Dementia-appropriate housing or safety design*
- *Long-term rehabilitation services*
- *Specialized equipment required for total-care or end-of-life patients*
- *Staffing ratios necessary for medically complex, dependent patients*

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Medical staff perspective

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*Despite these limitations, the infirmary is increasingly required to care for individuals with advanced dementia, stroke-related disability, terminal cancer, and other high-acuity conditions, often for prolonged periods of time. This care exceeds the infirmary's intended scope and places patients in settings that are clinically inappropriate for their needs, while simultaneously **straining staff and compromising care** for others.*

Correctional facilities are not designed to function as nursing homes, hospice units, or dementia care centers. Continuing to rely on them as such is neither humane nor sustainable.

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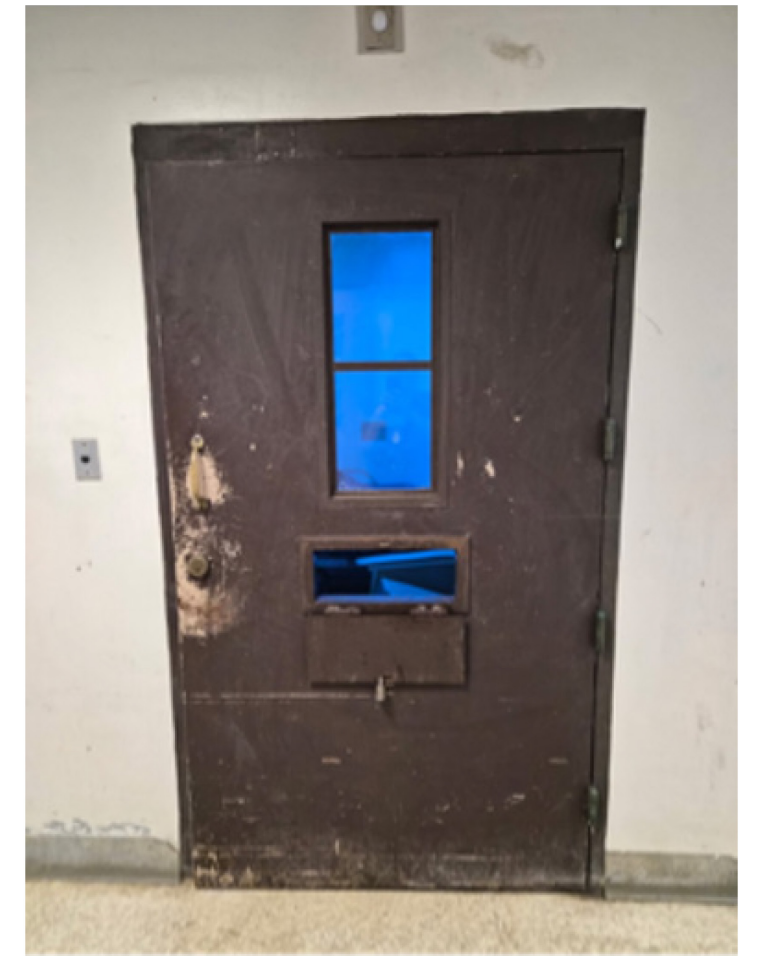
Hospice at Halawa



The hospice cell, on the mental health block



Inside of the hospice cell



The door to the hospice cell

Correctional staff perspective

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People who are very sick often need a lot of care outside of the prison. Every time, two of us would have to lift them from the bed and try to clean them up, and then escort them to the doctors and back. Sometimes this took us away from the already understaffed facility for an entire shift, because the specialists were not nearby. It is not easy on the Correctional Officers.

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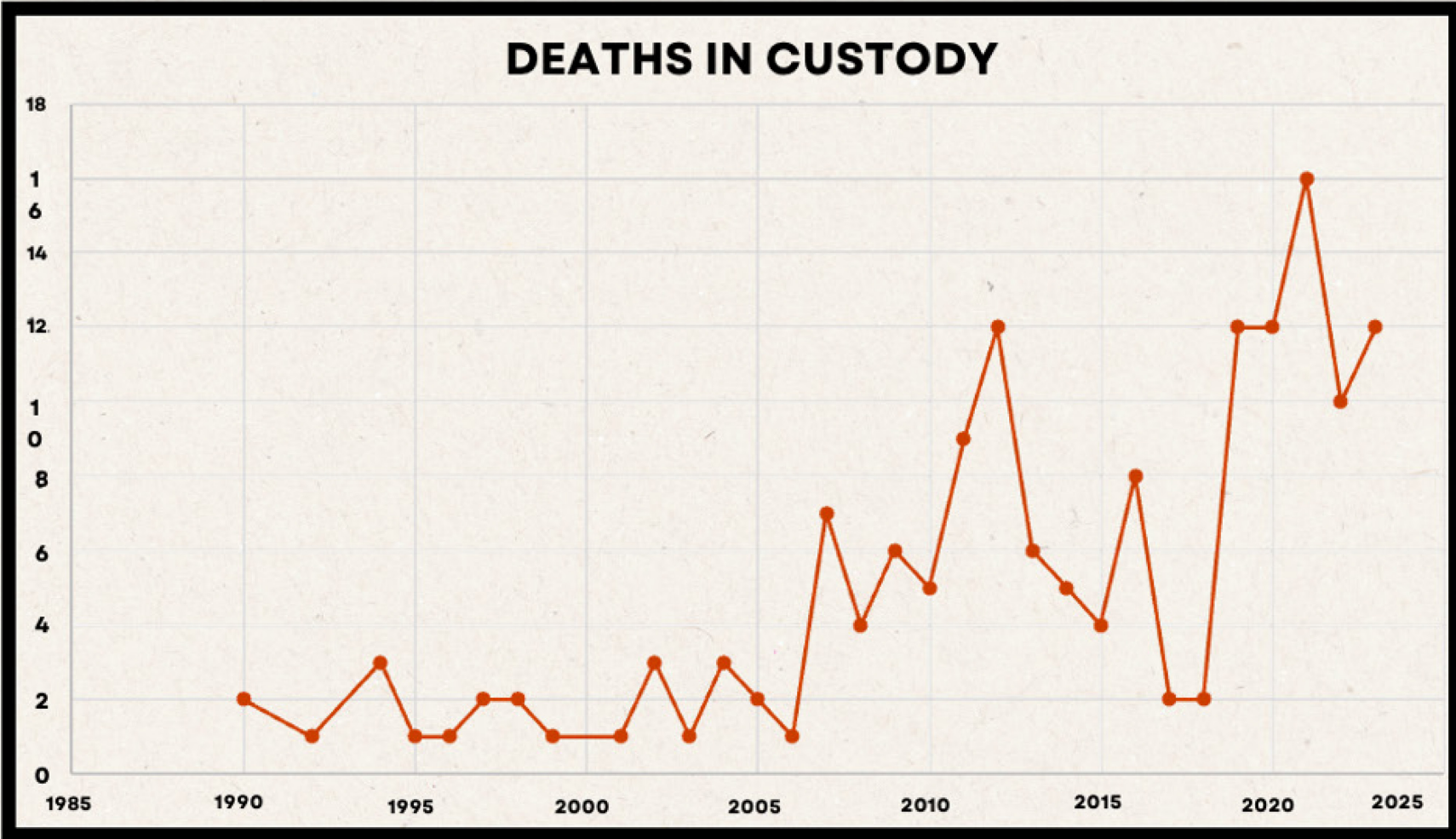
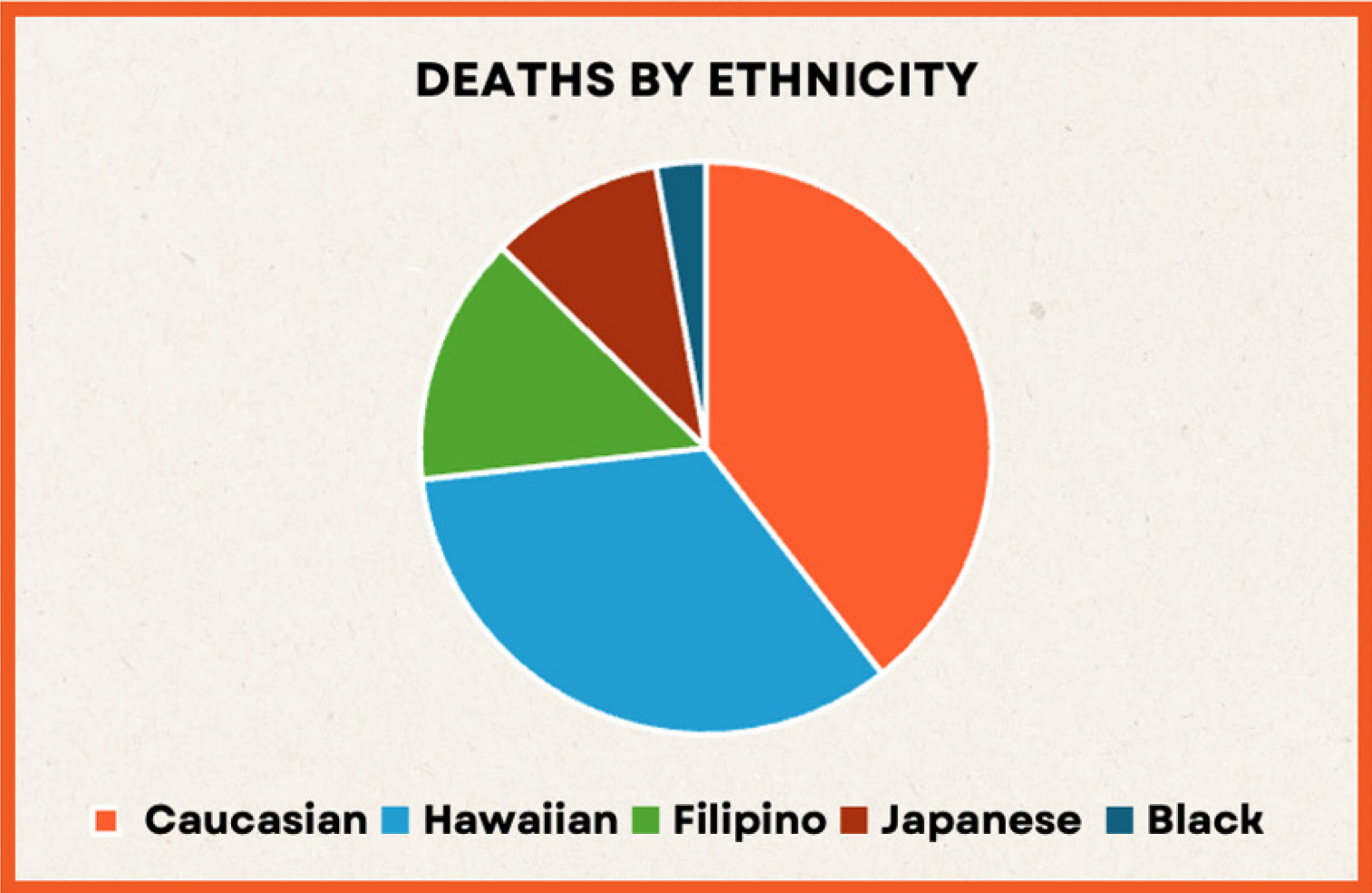
Correctional staff perspective

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*We are not hired to be nurse aides, and we are not skilled in IV pulls and changing diapers. **We are not qualified to take care of the sick inmates** . All we could do was try to check if they were still alive and breathing, and hope the nurse can come at some point. And the nurse was also overwhelmed. Taking care of people who are critically ill, who need a lot of care but who are not a safety risk, was an unnecessary strain on corrections staff. **Watching people die in shackles impacts corrections staff morale deeply** .*

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Deaths in custody



Family perspective

A 62-year-old gentleman with two forms of stage four cancer, who was on a feeding tube, recently passed before receiving compassionate release.

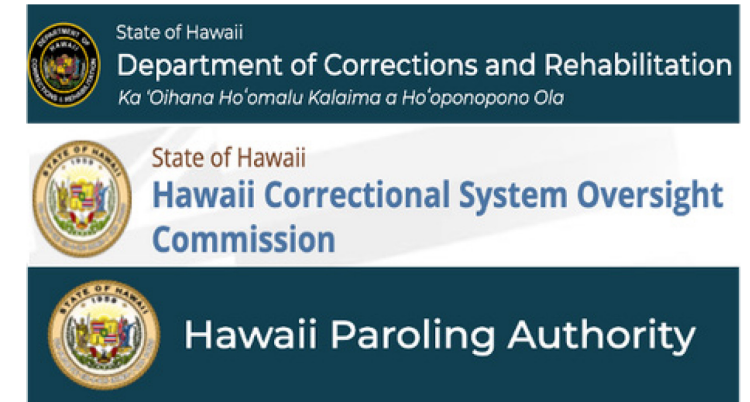
His loved ones had to come to the morgue to identify and retrieve his body. Not being able to see him, care for him, and heal together caused immense pain.

Here are the questions they asked:

- *If he was terminally ill for **so long** , why did he still die in prison?*
- *Was he in any **pain** when he passed?*
- *What clothes was he **wearing** when he died? A prison uniform?*
- *Was he **handcuffed** in a hospital, or in a cold cell when he passed away?*
- *Could he be dressed in the suit that he wore when he married our mom when he is **cremated** ?*
- *Was he **alone** when he died?*

Compassionate release bill

We are grateful to DCR, HPA, and HCSOC for their partnership in drafting this bill , which maintains what works, and solves problems that are resulting in painful deaths behind bars. The bill:



- ✓ **Streamlines** the compassionate release process and sets timelines;
- ✓ Establishes clear **eligibility** criteria so the right people can be considered for compassionate release;
- ✓ Institutes relevant **standards** for HPA to consider release and revocation, with a focus on **medical factors**
- ✓ Provides for **supervision** for people who are granted compassionate release;
- ✓ Forms a **working group** with stakeholder representation to draft administrative rules; and
- ✓ Creates **data collection** and **reporting** requirements to improve transparency.

Questions?

We are so grateful to be welcomed in Hawai'i, and we are available as a resource throughout the session!

Mahalo!

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