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Down to the Felt: How Ohio's Lackluster Statutory Scheme Gambles with the Lives of Mothers and Innocent Children

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**DOWN TO THE FELT:
HOW OHIO’S LACKLUSTER STATUTORY SCHEME
GAMBLES WITH THE LIVES OF MOTHERS AND
INNOCENT CHILDREN**

JIM RAINONE*

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I. INTRODUCTION

On Christmas morning, 1998, an eight-month pregnant Pamela Clifton went into labor while incarcerated in a women's correctional facility in Colorado.¹ She approached guards for help, but was told to return to her cell so the guards could complete roll call.² Pamela was finally able to see the facility's medical staff roughly seven hours later.³ Pamela, however, found no solace within the walls of the medical center. Rather, the staff nurse sent Pamela back to her cell because she was having a "false alarm."⁴ This was shocking to Pamela, especially after she told the nurse she needed to have her water medically broken before giving birth. Pamela returned to the nurse the next night, but was faced with horrific circumstances: the nurse could no longer detect a fetal heartbeat.⁵ Pamela was transported to a community hospital, where it was determined that her fetus died. She later delivered a stillborn baby.⁶

Sadly, this brand of injustice is not specific to Pamela.⁷ Women in numerous institutions have also been subjected to such mistreatment.⁸ As recent as 2013, women comprised roughly seven percent of the total prison population.⁹ Roughly five to six

* Jim Rainone is a 2016 graduate of the Cleveland-Marshall College of Law. He would like to thank Professors Alex Frondorf and Jonathan Witmer-Rich for their guidance and advice this note would be where it is without their support.

¹ *Clifton v. Eubank*, No. OO-cv-02555-JLK, 2006 WL 3746694, at *1 (D. Colo. Dec. 18, 2006).

² *Id.*

³ *Id.* at 2

⁴ *Id.* The Colorado District Court noted that "a physician might not always diagnose pregnancy labor as requiring medical treatment, I find, however, that any lay person would recognize the obvious need a woman in labor has for a doctor's attention." *Id.* at 4.

⁵ *Id.* at 2.

⁶ *Id.*

⁷ See Rachel Roth, *Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women*, 18 *UCLA Women's L.J.* 79, 95-102 (2010) (describing various examples of barriers to prenatal care for incarcerated women).

⁸ See Diana Mertens, *Pregnancy Outcomes of Inmates in a Large County Jail Setting*, 18 *Public Health Nursing* 45, 51 (2001); *Monmouth County Correctional Institution Inmates v. Lanzaro*, 834 F.2d 326 (3rd Cir. 1987) (3rd Circuit held unconstitutional a New Jersey prison policy requiring pregnant inmates to obtain court-ordered releases to have an abortion while under county custody); *Jamison v. Nielsen*, 32 Fed. Appx. 874 (2002) (9th Circuit would have accepted pregnant prisoner's §1983 claim had she been able to prove the guards possessed a culpable mental state when not providing her with adequate medical care when requested).

⁹ See USDOJ – Prisoners in 2013, available at <http://www.bjs.gov/content/pub/pdf/p13/pdf> (last accessed Feb. 15, 2014).

percent of those women are pregnant during their incarceration.¹⁰ These numbers represent over 7,000 incarcerated mothers each year.¹¹

Ohio, thankfully, does not have publicized examples of similar injustice . . . yet.¹² This provides legislators with the opportunity to take proactive steps to prevent such horrific events from happening.

Currently, Ohio's statutory regime does not explicitly provide a standard degree of care owed to pregnant inmates.¹³ The American criminal justice system is gambling with both the health of the mothers and their unborn children by not providing pregnant inmates with adequate prenatal care. No established principle of punishment, including incarceration, justifies punishing a criminal's family.¹⁴ Our society values

¹⁰ See National Women's Law Center, *Mothers Behind Bars* (2010) at 11, available at <http://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf> (last accessed Feb. 15, 2015).

¹¹ *Id.*

¹² In fact, certain Ohio correctional facilities offer programs that allow infant children to live with their mothers during their incarceration. Steve Inskeep, NPR (Aug. 13, 2008), *In Ohio, Inmate Mothers Care For Babies In Prison*, available at <http://www.npr.org/templates/story/story.php?storyId=93548405>.

The Lake County Jail has recently come under fire for allegedly failing to provide care to an inmate. Per local news sources, Dondrea Carter approached jail medical staff around 10pm, complaining of chest and jaw pain, chest tightness, and vomiting. The jail nurse subjected Carter to an EKG, which showed an elevated hearth rhythm. The nurse released Carter back to her cell and informed her she would see a doctor the following day. Roughly an hour later, Carter collapsed on the floor in pain and was taken to a nearby hospital. She died the next day – her birthday. The autopsy revealed that Carter had died of a heart attack due to atherosclerotic coronary artery disease. Carter's family is seeking compensatory damages in federal court. The county sheriff look to defend the jail by showing this was a health issue, rather than an issue on wrongdoing on their part. See Tom Meyer, *Investigator: Guards ignore heart attack victim at Lake County jail*, available at <http://www.wkyc.com/story/news/investigations/2015/01/08/investigator--heart-attack-malik-dondrea-carter/21452437/> (last accessed Jan. 18, 2015), Tracey Read, *Lake County Jail employees accused of allowing sick inmate to die*, available at <http://www.news-herald.com/general-news/20150108/lake-county-jail-employees-accused-of-allowing-sick-inmate-to-die> (last accessed Jan. 18, 2015). Carter's case could potentially provide a sizeable platform of support for the proposed legislation below.

¹³ See generally Ohio Rev. Code Ann. § 5120.10 (West 2014) (describes the minimum standards for jails, rule promulgation process, and specifications of the director's powers and abilities to delegate).

¹⁴ Joshua Dressler, *Cases and Materials on Criminal Law* 30-39 (Thompson-West, 4th ed. 2008); Dressler identifies two important inquiries: 1) "Who should be punished?" and 2) "[o]f those whom we punish, how much punishment is appropriate?" *Id.* at 30. Pursuant to these enquiries, Dressler notes that "since punishment involves pain or deprivation that people wish to avoid, its intentional imposition by the state requires justification." *Id.* Not providing adequate availability of prenatal care, ultimately endangering the health of a pregnant prisoner's child, is not codified statutorily or justified in any way. Dressler identifies a series of principles justifying punishment: 1) General Deterrence, 2) Individual Deterrence 3) Incapacitation, and 4) Rehabilitation. *Id.* at 34-46. General deterrence examines how the punishment of this particular individual will have a deterrent effect on society as a whole. *Id.* at 34. Individual deterrence examines the effect punishment will have on the particular individual's propensity for recidivism. *Id.* at 34-35. Incapacitation-based theories posit that incarceration "prevent persons of dangerous disposition from acting upon their destructive tendencies." *Id.* at 35.

the health and sanctity of children, and gambling with their health wholly conflicts with those values. To preserve our values, and ultimately protect the interests and basic rights of the mothers and children, Ohio needs to implement a statutory scheme that provides mandatory care for pregnant prisoners.

This article examines three facets of the pregnant prisoner prenatal and post-birth care issue. First, it examines the injustice that pregnant prisoners are subjected to. Next, it examines other states' statutory regimes to identify adequate and inadequate features. Specifically, it will examine the Pennsylvania regime because of its relevance and reputation for being the most accommodating to these women.¹⁵ Finally, it will propose a statutory regime for Ohio that provides mandatory care standards, means of accomplishing mandatory care, penalties for both the institution and its individual actors when care is not provided, and show how a statutory regime without these changes put mothers and their unborn children at risk for poor treatment, even death, like Pamela.

II. BACKGROUND

As of 2013, over 111,000 women were incarcerated within the American federal and state prison systems.¹⁶ This comprises roughly seven percent of the overall prison population.¹⁷ Over the past twenty years the female prison population has increased more than six-fold – a significantly greater rate than the male population.¹⁸ As a result, every year more than 7,000 women are pregnant during their incarceration.¹⁹ These

Finally, rehabilitation theories purport that punishing individuals will give them the opportunity to reform their character and person and be reincorporated into society. *Id.* at 36. However, rehabilitation is rarely used in our system of justice. *Id.* Here, none of these theories of punishment have an impact upon the availability of prenatal care for incarcerated women. Withholding or not providing adequate prenatal care is wholly separate from the crime these women have already been punished for. Imposing additional punishment upon their sentence lacks justification from any principle of punishment.

¹⁵ See *Mothers Behind Bars*, *supra* note 10, at 11.

¹⁶ See USDOJ – Prisoners in 2013; These numbers can vary, however, depending on the reporting source, and constraints applied.

¹⁷ *Id.*

¹⁸ Ronald L. Braithwaite, Henrie M. Treadwell, Kimberly R.J. Arriola, *Health Disparities and Incarcerated Women: A Population Ignored*, 95 Am. J. Pub. Health 1679, 1679 (October 2005).

¹⁹ *Mothers Behind Bars*, *supra* note 10, at 11. See also Braithwaite, *supra* note 18, at 1680 (stating that roughly 5-10% of women enter prison pregnant). Leda Pojman provides an illustration of the “typical” female prisoner:

[t]he female prisoner usually incarcerated for predominately non-violent offenses such as property and drug crimes, is around 31 years of age, and is an ethnic or racial minority from an urban background. Prior to incarceration, more than one-third have been victims of sexual abuse and more than one-half have been physically abused. Fifty-three percent were unemployed at the time of their arrest and most have low levels of education. Their recidivism rate is high and most have at least one prior conviction.

Leda M. Pojman, *Cuffed Love: Do Prison Babies Ever Smile?*, 10 Buff. Women's L.J. 46, 47 (2001-2002).

statistics show the American prison system is gambling with the lives of thousands of innocent children.²⁰

A. Doctor-Recommended Prenatal Care

Prenatal care, visits, and consultations provide various benefits to both expecting mothers and their children. Prenatal care is “the attention given to the expectant mother and her developing baby.”²¹ Doctors recommend, on average, roughly seventeen²² prenatal checkups throughout the typical 40-week gestational period.²³ Number and necessity of appointments increase if the pregnancy is high-risk.²⁴ High-risk factors include age, weight, issues arising from previous pregnancies, prior health conditions, and pregnancies involving twins or other multiples.²⁵

During the first visit, the doctor runs tests to check for issues such as anemia, infections, sexually transmitted infections and diseases, and immunity to rubella and chicken pox.²⁶ After the initial visit, general checkups will include checking the mother’s blood pressure and weight, checking the baby’s heart rate, and measuring the baby’s growth.²⁷ These appointments and visits are not only necessary to monitor the mother and child’s health, but to educate the mother on proper lifestyle choices that will improve her baby’s health.²⁸ These changes include dietary allowances, abstaining from consumption of alcohol and caffeine, staying active, and many other things.²⁹ The educational aspect of the visits is key. General tenets, such as not consuming alcohol during the pregnancy, are well known, but other minute factors are

²⁰ Parental incarceration is undoubtedly a prevalent issue in our society and culture. In 1999, “an estimated 336,300 U.S. homes had minor children affected by the incarceration of a parent.” *Id.* at 48.

²¹ U.S. Dept. of Health and Human Services, Prenatal Services, available at <http://mchb.hrsa.gov/programs/womeninfants/prenatal.html> (last accessed Dec. 3, 2014).

²² This article acknowledges that not all women can, or will, access the recommended amount and type of prenatal care. Issues such as healthcare coverage, monetary needs, availability, and many other issues, can, and do, prevent women from obtaining this ultimate degree of care. However, presence of these issues does not deter the recommendations and standard of care purported by healthcare professionals. *Id.*

²³ *Prenatal Care and Tests* at 5, available at <http://www.womenshealth.gov/pregnancy/you-are-pregnant/prenatal-care-tests.html> (Last accessed Dec. 3, 2014); One visit per month from weeks four-28, two visits per month for weeks 28-36, and weekly visits from week 36 to the date of birth; *see also How Often do I need Prenatal Visits?*, WebMD at 1 (last accessed Dec. 3, 2014).

²⁴ *Id.* at 12.

²⁵ *Id.*

²⁶ *Id.* at 6-7. It is wholly acknowledged that using outlets such as midwives instead of doctors is a legitimate practice. However, this note will assume the position that doctors will be handling the prenatal visits for the incarcerated prisoners.

²⁷ *Id.* at 6.

²⁸ *See Staying Healthy and Safe*, womenshealth.gov, available at <http://www.womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.html> (last accessed Feb. 14, 2015).

²⁹ *Id.*

not common knowledge.³⁰ Educating the mother provides immense benefits to both her and her child.³¹

B. Prenatal Care in Prisons

The availability of prenatal care for women in prison is a microcosm of the struggle these women face to obtain any form of adequate health care. Women's prisons receive little attention because female offenders comprise a small portion of the overall prison population.³² This is partly attributable to the demonization of female offenders.³³ The American prison system's outdated patriarchal perceptions forcefully compare women to the "ideal woman," and those who do not comply with the image are chastised.³⁴ Female offenders are regarded as "doubly deviant" – they have not only broken the law, but they have also violated social norms and mores that "mark womanhood."³⁵

Generally, pregnant prisoners are transported to outside medical facilities to give birth because the prisons are not medically equipped for the procedures.³⁶ The care that is available to women in the correctional facility is limited and mediocre; and prison medical professionals are often under skilled.³⁷ As a result, the necessity for transportation to a separate facility is increased. However, the transportation process presents issues of its own. The security precautions put added stress on the mother and increase the risk for injury.³⁸ This process increases the likelihood that complications will result during the pregnancy.³⁹

Finally, the mothers are subjected to not only the physical traumas of childbirth, but are also forced to abandon the custody of their child, causing emotional trauma.⁴⁰

³⁰ These include: how to handle cravings, how much weight the mother should expect to gain, the importance of dental health, and environmental risks. *Id.* at 14-15.

³¹ *Id.*

³² Tammy Anderson, *Issues in the Availability of Healthcare for Women in Prison*, available at <http://www.udel.edu/soc/tammya/pdfs/IssuesintheAvailabilityofHealthcareforWomeninPrison.pdf>, at 3.

³³ See Kathleen Evans, *Media Representations of Male and Female 'Co-Offending': How Female Offenders are Portrayed in Comparison to their Male Counterparts*, *Internet Journal of Criminology*, ISSN 2045-6743 (2012) at 4.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Anderson, *supra* note 32, at 6.

³⁷ *Id.* at 5.

³⁸ *Id.* at 6.

³⁹ *Id.*

⁴⁰ *Id.* "Women in prison consider separation from their children to be the most painful aspect of their imprisonment." Cathy R. Schen, *When Mothers Leave Their Children Behind*, 13 HARV. REV. PSYCHIATRY 233, 236 (2005). The fear of losing custody of their children is a major concern of incarcerated mothers. *Id.* This fear becomes the source for various psychological issues for these mothers. *Id.* at 234-237.

This trauma has severe emotional and psychological impacts on the mothers.⁴¹ Resulting trauma and stress leads to women distancing themselves psychologically from their fetuses.⁴² This ultimately leads to long-term negative effects on the children.⁴³

II.EFFECTS OF INADEQUATE PRENATAL CARE ON THE MOTHER AND CHILD

Failing to obtain adequate prenatal care has negative effects for both the expectant mother and her child. Mothers who receive late or no prenatal care are more likely to give birth to children with health problems.⁴⁴ Women who receive no care are three times more likely to give birth to a low-weight baby.⁴⁵ Further, the infants of women who receive no prenatal care are five times more likely to die.⁴⁶ This is a consequence of lower birth weight.⁴⁷ Lack of prenatal care is associated with a 40% increase in the

⁴¹ See Judith Merenda Wismont, *The Lived Pregnancy Experience of Women in Prison*, 45 J. OF MIDWIFERY & WOMEN'S HEALTH 292, 292-93 (July/August 2000). "Psychological dimensions of childbearing in prison are influenced by the prison environment and the distinct psychosocial characteristics of the prison population." *Id.* at 293. Incarcerated mothers reported feeling anger, regret, and depression regarding their separation from and inability to care for their children. *Id.*

Female prisoners are already subjects of various psychological issues before those resulting from the pregnancy are considered. See generally Mark I. Singer, Janet Bussey, Li-Yu Song, Lisa Lunghofer, *The Psychosocial Issues of Women Serving Time in Jail*, 40 Social Work 1 (1995). See generally Mark I. Singer, Janet Bussey, Li-Yu Song, & Lisa Lunghofer, *The Psychosocial Issues of Women Serving Time in Jail*, 40 SOCIAL WORK 103, 104 (1995).

⁴² Wismont, *supra* note 41, at 293.

⁴³ See Julie Smyth, *Dual Punishment: Incarcerated Mothers and Their Children*, 3 COLUMBIA SOCIAL WORK REVIEW 33, 33-41(2012).

⁴⁴ Child Trends Data Bank, *Late or No Prenatal Care*, available at <http://www.childtrends.org/?indicators=late-or-no-prenatal-care> (last visited Dec. 3, 2014). "Late care" is defined as care beginning in the third trimester of the pregnancy. *Id.* A study by Krueger and Scholl showed that women receiving inadequate prenatal care were two to three times more likely to have a preterm delivery than women who received adequate prenatal care. Paul M. Krueger, Theresa O. Scholl, *Adequacy of Prenatal Care and Pregnancy Outcome*, 100 J. Am. Osteopathic Assc. 485, 488 (2000).

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Low birth weight is defined as any birth weight less than 2500g. Michael S. Kramer, Et. al., *Challenges in defining and classifying the preterm birth syndrome*, 206 Am. J. of Obstetrics and Gynecology 108, 109 (2012).

See James A. Lemons, Et. al., *Very Low Birth Weight Outcomes of the National Institute of Child Health and Human Development Neonatal Research Network, January 1995 Through December 1996*, 107 Pediatrics 1, 1 (2001) (describing a study conducted that showed a direct relationship between lower birth weight and risk of neonatal death). Children with a birthweight of 1500g or less are classified as having a "very low birthweight," and have an even greater mortality rates. *Id.*

See Steven L. Gortmaker, *The Effects of Prenatal Care Upon the Health of the Newborn*, 69 Am. J. Pub. Health 653, 653, 656 (1979) (describing the relationship between prenatal care and birthweight). "Thus, if prenatal care exerts any effects upon infant mortality, it is likely that

risk of neonatal death overall and a doubling of the risk among women delivering at or after 36 weeks gestation.⁴⁸

A. Effects of Inadequate Prenatal Care on the Child

Inadequate prenatal care is also associated with premature birth.⁴⁹ Premature birth can lead to long-term physical and intellectual development issues for children.⁵⁰ Premature birth takes place when the mother gives birth, or is forced to give birth, before 37 weeks of gestation.⁵¹ These children emerge from the womb suffering from immediate health issues. Many prematurely birthed children suffer from lung and breathing problems, such as asthma and bronchopulmonary dysplasia,⁵² because the lungs have not developed yet.⁵³

Prematurely birthed children are also at risk to suffer from long-term issues, including behavioral problems, such as ADHD, neurological disorders, such as cerebral palsy, or conditions such as autism, that affect the child's speech, social skills,

these effects occur via the relationship of prenatal care to lower birth weight." *Id.* at 656. Gortmaker also states that mothers experience a "substantially increased risk of a lower birth weight infant when receiving inadequate (as opposed to adequate) prenatal care." *Id.* See also David L. Howard, Donna Strobino, Susan Sherman, and Rosa Crum, *Within prisons, is there an association between the quantity of prenatal care and infant birthweight?*, 22 *Pediatric and Perinatal Epidemiology* 369, 374-75 (2008) (describing a positive relationship between prenatal care and infant birthweight among pregnant women in prison. However, this relationship was present only for women who entered prison and received prenatal care during their first trimester. Their presence and knowledge of availability of the program offered a direct correlation to the effect on the child's birthweight. Researchers found it difficult to theorize a single justification for the positive relationship not being present for women during their second or third trimester. The authors theorize that these women may not have known they were pregnant at the time of their incarceration – explaining why they did not pursue prenatal care through this program).

⁴⁸ Guttmacher Institute, J. Rosenberg, *Neonatal Death Risk: Effect of Prenatal Care is Most Evident After Term Birth*, available at <https://www.guttmacher.org/pubs/journals/3427002.html> (last accessed Dec. 3, 2014).

⁴⁹ See generally Kruger and Scholl, *supra* note 44.

⁵⁰ March of Dimes, *Long-Term Health Effects of Premature Birth*, available at <http://www.marchofdimes.org/baby/long-term-health-effects-of-premature-birth.aspx> (last accessed Jan. 16, 2015).

⁵¹ *Id.* Different sources and studies set different dates for the number of weeks at which preterm birth takes place. The earliest reputable study found through research has been 32 weeks. See Jane L. Hutton, Peter O.D. Pharoah, Richard W.I. Cooke, and Richard C. Stevenson, *Differential Effects of Preterm Birth and Small Gestation Age on Cognitive and Motor Development*, 76 *Archives of Disease in Childhood*, 75, 75 (1997).

⁵² March of Dimes, *supra* note 50. Bronchopulmonary dysplasia (BPD) is "a chronic lung disease that causes the lungs to grow abnormally or to be inflamed. Over time, the lungs usually get better, but a premature baby may have asthma-like symptoms throughout his life." *Id.*

⁵³ See Medline Plus, *Fetal Development*, available at <http://www.nlm.nih.gov/medlineplus/ency/article/002398.htm> (last accessed Jan. 16, 2015) (detailing the development process of the fetus throughout the 40-week gestational period).

and behavior.⁵⁴ Premature birth can also lead to hearing loss,⁵⁵ dental problems,⁵⁶ and intestinal issues.⁵⁷ Many premature infants have extensive surgeries to remedy the effects of the preterm birth. Often times infants will have portions of their intestines removed.⁵⁸ As a result, many preterm infants suffer from Necrotizing Enterocolitis (“NEC”),⁵⁹ a disease that damages the intestine, preventing it from processing and absorbing nutrients.⁶⁰ Children who suffer from NEC or have needed intestinal surgery can suffer from intestinal blockages from scarring that require additional surgery.⁶¹

Not every prematurely born child will suffer from these infirmities; however, the presence of these long-term issues presents a myriad of life-changing actions and decisions for the parents. For example, a child diagnosed with cerebral palsy⁶² or autism⁶³ as a result of preterm birth will require a lifetime of care and special consideration by the parents and loved ones. Thankfully, society is becoming more

⁵⁴ March of Dimes, *supra* note 50. These physical, behavioral, and cognitive conditions can all be present for children born after a recommended gestational period. However, likelihood of the presence of the conditions is exacerbated where children are born preterm. *Id.*

⁵⁵ Children born prematurely are more likely to have hearing loss. *Id.*

⁵⁶ Prematurely birthed infants are more likely to suffer from “[d]ental problems, including delayed tooth growth, changes in tooth color or teeth that grow crooked or out of place.” *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ Kareena L. Schnabl, John E. Van Aerde, Alan B.R. Thompson, Michael T Clandinin, *Necrotizing Enterocolitis: A Multifactorial Disease with No Cure*, 14 *World J. Gastroenterol.* 2141, 2142-43 (2008). NEC is one of the most common gastrointestinal emergencies for newborn infants, and tends to appear within the first three months of life for infants with low birth weights. *Id.* at 2142. Premature infants account for 90% of all neonatal NEC cases. *Id.* 20-40% of babies with NEC require surgery, and the mortality rate ranges between 20-50%, depending on a host of factors, such as race and sex. *Id.* NEC continues to represent a significant clinical problem, however, luckily, medical advances are making progress to increase survival rates. *Id.*

⁶¹ March of Dimes, *supra* note 50.

⁶² “Premature birth, occurring before 37 weeks, is a risk factor for development of many medical conditions, including cerebral palsy.” MYCHILD, *How does premature birth increase the risk of cerebral palsy?*, available at <http://cerebralspalsy.org/about-cerebral-palsy/risk-factors/premature-birth/> (last accessed Feb. 14, 2015). “[N]early half of the children who do develop cerebral palsy were born prematurely.” *Id.* “Many of the neurological conditions and causes associated with cerebral palsy (such as damage to the brain’s white matter, known as periventricular leukomalacia, or PVL) are closely linked to preterm delivery.” *Id.*

⁶³ See AUTISM SPEAKS, Emily de los Reyes and Judith Gardner, *Prematurity & Autism*, available at <http://www.autismspeaks.org/blog/2012/08/10/prematurity-autism> (last accessed Feb. 14, 2015) (Dr. de los Reyes posits that the most common factors predisposing infants to autism include: 1) low birth weight, 2) extreme prematurity (before 26 weeks), intrauterine infection during the pregnancy, and 4) the child being male). Dr. Gardner states that because the most crucial brain development takes place during the first two trimesters, prematurely born children are at an increased risk for neurological issues, such as autism. *Id.*

understanding and welcoming of children and adults with disabilities, and medical advancements are being made to treat or circumvent these types of issues. These happenings, heart-warming and assuring as they may be, cannot be asserted to justify the inadequacy of prenatal care afforded to women - especially our incarcerated mothers.

B. Effects of Inadequate Prenatal Care on the Mother

Prenatal care is of great significance to mothers, too.⁶⁴ Researchers posit that lack of prenatal care, unlike most factors associated with perinatal death, is theoretically preventable.⁶⁵ In theory, providing adequate prenatal care eliminates a whole host of issues that can arise during pregnancy.⁶⁶ This provides an ample opportunity for legislation to intervene and have an impact on our female population.

1. Educating the Mothers

Prenatal care is important because of the educational opportunities for the expecting mother. Doctors have the opportunity to instruct the mother and father, if he is present, as to the challenges they will face during the coming months and beyond.⁶⁷ A lack of education can result in improper diet, lifestyle, and compiling of emotional and psychological stress as a result of unpreparedness.⁶⁸

The impacts of prenatal care on the mother are not as visibly substantial as the impacts of adequate care on the child. The developmental process of the child, as it transitions from embryo to fetus and eventually an infant is a visible, obvious process that draws warranted attention. The impacts of prenatal care on the mother can become overshadowed by the focus on the child. Care for the mother, however, is equally, if not more, important as that of the child. Care for the child is undermined if the mother is not afforded the proper care.

Mothers face a myriad of challenges from the moment of conception to the day of birth, and these challenges continue after birth. In addition to taking care of a newborn, the new mothers are now allowing their bodies to heal. This process is both physical and psychological. Physical changes are more apparent than psychological changes. The mother copes with conditions such as nausea, pain, weight gain, and general discomfort⁶⁹ as her body goes through a literal metamorphosis to become a beautiful vessel of life.

⁶⁴ See David L. Olds, Charles R. Henderson Jr., Robert Tatelbaum, and Robert Chamberlin, *Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation*, 77 J. Am. Pediatrics 16 (1986) (study discovered that women who were visited by home nurses gave birth to newborns who were on average 395g heavier, and had a 75% reduction in the incidence of preterm delivery).

⁶⁵ Rosenberg, *supra* note 65, at 3.

⁶⁶ *Id.*

⁶⁷ See Child Trends Data Bank, *supra* note 44, at 1.

⁶⁸ *Id.*

⁶⁹ James Brann, M.D., *Physical Consequences of Pregnancy & Delivery*, available at www.womenshealthcaretopics.com/physical_health_consequences_of_pregnancy_and_delivery.htm (last accessed Jan. 17, 2015).

Mothers are presented with additional challenges after birth. Common physical postpartum changes include: 1) separated pubic symphysis⁷⁰, 2) breast engorgement and mastitis,⁷¹ 3) after pains,⁷² and 4) fatigue and exhaustion.⁷³ Most commonly, new mothers work to lose the weight gained during the course of the pregnancy. The mother's bodily is also going through a healing process. Childbirth puts an immense amount of stress on a woman's body, especially within her vagina and uterus.⁷⁴ During the recovery process mothers experience various bodily happenings, including: 1) lochia,⁷⁵ 2) swelling of the legs and feet, 3) constipation, and 4) menstrual-like cramping. Some women develop thyroid problems in the year after giving birth.⁷⁶ Often times women will develop and underactive thyroid, causing fatigue, sleep problems, and low energy.⁷⁷ Occasionally, symptoms of an underactive thyroid will develop into Hashimoto's disease.⁷⁸ These women will require treatment for the rest

⁷⁰ Separated public symphysis occurs "when a narrow section of cartilage and legiment in the pelvic girdle separate during pregnancy. It is not a dangerous condition but may be painful." *Id.*

⁷¹ Mastitis is "an infection of the breast tissue that results in breast pain, swelling, warmth and redness of the breast." Mayo Clinic, Mastitis Definition, available at www.mayoclinic.org/diseases-conditions/mastitis/basics/definition/con-20026633 (last accessed Jan. 17, 2015). Mastitis typically affects women who are breast-feeding and occurs within the first three months after giving birth. *Id.* However, the condition is not exclusive to breast-feeding mothers. *Id.* The condition can leave mothers feeling exhausted, making it harder to care for their newborn. *Id.*

⁷² After pains occur during the postpartum period as the uterus shrinks back to its normal size. Brann, *supra* note 69. Luckily, after pains can usually be relieved by over-the-counter medications, such as Tylenol. *Id.*

⁷³ *Id.*

⁷⁴ This portion of the article is based upon the premise that the mother delivered vaginally. It is fully acknowledged that many women choose to have a Cesarean Section instead of delivering vaginally. While these women do not experience the same exact experiences of vaginal childbirth, their birth and postpartum challenges remain the same.

Occasionally during birth doctors may have to perform an episiotomy, where doctors make an incision in the perineum – the tissue between the vaginal opening and the anus – during birth. See Mayo Clinic, *Episiotomy: When it's Needed, When it's Not*, available at www.mayoclinic.org/healthy-living/labor-and-delivery/in-depth/episiotomy/art-20047282 (last accessed Jan. 17, 2015). Doctors previously performed episiotomies routinely during childbirth. *Id.* However, the new medical trend is to only use the procedure when: 1) extensive vaginal tearing is likely, 2) the baby is in an abnormal position, or 3) the baby needs to be delivered quickly. *Id.*

⁷⁵ Lochia is vaginal discharge of the tissue and blood that lined the women's uterus during pregnancy. It is discharged from the body in the weeks following delivery. See *Recovering from Birth*, available at www.womenshealth.gov/pregnancy/childbirth-beyond/recovering-from-birth.html (last accessed Jan. 17, 2015).

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* See Hashimoto's Disease Fact Sheet, available at www.womenshealth.gov/publications/our-publications/fact-sheet/hashimoto-disease.html (last accessed Jan. 17, 2015).

of their lives. Proper education of the coming changes and challenges allows the expecting and new mothers to properly plan and assess the coming months and years of their lives.

2. Hormonal Fluctuations

New mothers are also subject to a series of psychological issues. Pregnancy dramatically impacts women's hormone levels and regulation.⁷⁹ Nearly every hormone in a woman's body is affected, however, six hormones in particular are especially important.⁸⁰ These hormones go through severe fluctuation from the moment of conception into the months after birth. First, human Chorionic Gonadotropin ("hCG") production begins.⁸¹ hCG is the hormone detected by pregnancy tests that shows positive results.⁸² hCG is responsible for "jump-starting all of the other pregnancy hormones" in the body.⁸³ Second, estrogen levels skyrocket during the course of the pregnancy.⁸⁴ Estrogen levels are approximately 100 times higher during pregnancy than they normally are during a woman's period.⁸⁵ The decrease in estrogen post-birth is what causes hot flashes, vaginal dryness, and a decreased libido.⁸⁶

Third, progesterone levels fluctuate.⁸⁷ Progesterone prepares the uterus for the implantation of the fertilized egg, and essentially for the growth and development of the baby.⁸⁸ Progesterone also slows down the intestinal tract, which causes pregnant women to complain of acid reflux and constipation.⁸⁹ Progesterone levels return to

With Hashimoto's disease, the immune system makes antibodies that damage thyroid cells and interfere with their ability to make thyroid hormone. Over time, thyroid damage can cause thyroid hormone levels to be too low. This is called an underactive thyroid or hypothyroidism. An underactive thyroid causes every function of the body to slow down, such as heart rate, brain function, and the rate your body turns food into energy. Hashimoto's disease is the most common cause of an underactive thyroid. *Id.*

⁷⁹ Julie Revelant, *Your pregnancy hormones, explained*, available at www.foxnews.com/health/2012/05/30/your-pregnancy-hormones-explained/ (last accessed Feb. 12, 2015).

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.* hCG production begins at the time of fertilization and levels rapidly rise until around week ten when levels peak. *Id.* hCG is the hormone responsible for common issues during the first trimester of pregnancy – morning sickness, "fatigue, dizziness, breast tenderness, heartburn, constipation, and irritability." *Id.*

⁸⁴ *Id.* Estrogen is actually a compound of three hormones. *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.* Estrogen is the compound responsible for keeping the placenta healthy, allowing the baby's organs to develop. *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.* Progesterone also increases the woman's body temperature, causing regular night sweats. *Id.*

normal after birth.⁹⁰ Fourth, relaxin levels are significantly higher during pregnancy.⁹¹ Relaxin is produced for the purposes of relaxing pelvic joints and muscles.⁹² However, it has the added effect of relaxing other parts of the body, causing coordination issues and general clumsiness for pregnant women.⁹³

Fifth, oxytocin production increases substantially.⁹⁴ Production of oxytocin allows women to feel close to their baby.⁹⁵ Oxytocin causes the uterus to contract during labor to reduce pain, and causes the uterus to return to normal size and position after delivery.⁹⁶ Finally, prolactin production skyrockets during pregnancy.⁹⁷ Prolactin is the “milk-producing hormone” that “allows the breast glands to develop and the structure of the breast tissue to change in preparation for breastfeeding.”⁹⁸ Prolactin levels increase nearly 20 times more than pre-pregnancy levels and do not return to normal level until breastfeeding ends.⁹⁹ The significant changes and alterations to these six hormones is a microcosm of the change going on within the woman’s body during the course of her pregnancy and months after.

C. Psychological Issues as a Result of Pregnancy

The hormonal changes, combined with the stress and trauma of childbirth and realization that one now has a child combine to be the catalyst of various psychological issues for new mothers. Traditionally, postpartum psychiatric disorders are broken into three categories: 1) maternity blues, 2) postnatal depression, and 3) puerperal psychosis.¹⁰⁰ A large portion of women after giving birth experiences maternity

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.* Oxytocin also contributes to breast milk production. *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Ian Brockington, *Postpartum Psychiatric Disorders*, 363 THE LANCET 303, 303 (2004). Puerperal psychosis is a sudden onset of psychosis following childbirth. The most common form of puerperal psychosis “takes the form of mania, severe depression (with delusions, confusion, or stupor), or acute polymorphic (cycloid) psychosis.” *Id.* at 303. Studies show that puerperal psychosis appears in roughly one of every 1000 births. *Id.* Researchers are currently examining potential “triggers” that increase the likelihood for the onset of a psychosis such as these. *Id.* Advancement of modern drugs is alleviating and lowering the potential for psychotic episodes. *Id.*

blues.¹⁰¹ Maternity blues typically begins within a few days of giving birth.¹⁰² Maternity blues mirrors depression – the mother can have mood swings, become emotionally sensitive, and quickly transition between sad and anxious moods.¹⁰³ The effects of maternity blues typically wear off with roughly ten days of giving birth and do not require any specific treatment.¹⁰⁴

When depression continues much longer than this, the mother is suffering from postnatal or postpartum depression. Studies show that up to twenty percent of new mothers suffer from postpartum depression.¹⁰⁵ Determining a steadfast percentage of women who suffer from postpartum depression is difficult because not every woman pursues treatment or documents her condition. Postpartum depression manifests itself in feelings such as: 1) being overwhelmed with the new baby, 2) doubts about the ability to be a good mother, and 3) an unrealistic need to be a perfect mom.¹⁰⁶ More severe symptoms include: 1) thoughts of hurting the baby, 2) thoughts of hurting oneself, and 3) not having any interest in the baby.¹⁰⁷ Postpartum depression can be

¹⁰¹ Theorized percentages of how many women suffer from maternity blues vary. Estimates range from 25%-80%. See Gina Shaw, *After Baby is Born: Postpartum Depression and Relationships*, available at www.webmd.com/depression/features/postpartum (last accessed Jan. 17, 2015) (stating that maternity blues affect “80% of more of new moms in the first days after the baby is born”), Tadaharu Okano and Junichi Nomura, *Endocrine Study of the Maternity Blues*, 16 *Progress in Neuro-Psychopharmacology and Biology Psychiatry* 921, 928-29 (1992) (asserting that, on average, roughly 25% of women suffer from maternity blues). Okano and Nomura credit the disparity in estimates to conflicting definitions of maternity blues. *Id.* at 928.

¹⁰² See Royal College of Psychiatrists, *Postpartum Psychosis: Severe Mental Illness after Childbirth*, available at www.rcpsych.ac.uk/healthadvice/problemsdisorders/postpartumpsychosis.aspx (last accessed Jan. 17, 2015).

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ See Stanford University School of Medicine, Center for Neuroscience in Women's Health, *Pregnancy and Mental Health*, available at http://womensneuroscience.stanford.edu/wellness_clinic/Pregnancy.html (last accessed Jan. 19, 2015) (“[r]ecent studies, however, have shown that up to 20% of women suffer from mood or anxiety disorders during the gestation and postpartum periods), Cheryl Tatano Beck, *Predictors of Postpartum Depression: An Update*, 50 *Nursing Research* 275 (2001) (“[a]pproximately 13% of women experience postpartum depression”), U.S. Department of Health and Human Services, Office on Women's Health, *Depression during and after pregnancy fact sheet*, available at <http://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.html> (last accessed Jan. 19, 2015) (“[a]bout 13 percent of pregnant women and new mothers have depression”).

¹⁰⁶ *Depression during and after pregnancy fact sheet*, *supra* note 105.

¹⁰⁷ *Id.* WebMD Provides the story of Tina Merritt, a woman who suffered from postpartum depression:

When Tina Merritt gave birth to her son Graham six years ago, she expected what all new mothers expect: a joyous experience getting to know her baby. Instead, she found that she was terrified of her own child. “I came home and I cried for hours straight. I was afraid that somebody would leave me alone with this baby that I had no clue how to take care of,” she recalls. Stricken with the fear that she would be an incompetent mother, Merritt went back to work when Graham was 6 weeks old, ceding most of the baby's care to her husband and the grandparents. “It wasn't that I didn't want to take

treated in similar ways as regular cases of depression – with talk therapy and prescription of antidepressants.¹⁰⁸

Occasionally, mothers will suffer from post-traumatic stress disorder (PTSD) as a result of giving birth. Western culture differs from the rest of world – we expect our new parents to respond to childbirth with happiness, joy, and general elation.¹⁰⁹ Other cultures acknowledge that childbirth is a potentially dangerous, sometimes fatal, event.¹¹⁰ As a result, parents and families do not respond to newborns with the same kind of immediate euphoria experience in the west.¹¹¹ Rather, parents and families in these cultures reserve their celebration until the mother and child are judged to be safe and well.¹¹² The perception of birth in other cultures evidences the physical, psychological, and emotional traumas of childbirth. The percentage of women who suffer from PTSD as a result of childbirth varies, depending on country and culture.¹¹³

Childbirth-related PTSD occurs when mothers are “bothered by intrusive thoughts and memories” from birth.¹¹⁴ These “playbacks” of birth inspire feelings of fear, horror, or helplessness, and can interfere with daily life.¹¹⁵ As a result of the PTSD, mothers may avoid routine medical care, subsequent pregnancies, and avoid sex as a means of avoiding their traumatic memories.¹¹⁶ These mothers may feel socially isolated, lonely, angry, and depressed, and these feelings make it more

care of him -- I just thought they were better at it,” she says. “I felt like I couldn’t do it right. My husband knew something was wrong, and he picked up the pieces. He just thought, OK, I need to step up to the plate and be a responsible husband.” Merritt, who now lives in southern California, wouldn’t learn the truth until her son was more than 2 years old: she was suffering from postpartum depression (PPD).

Gina Shaw, *After Baby is Born: Postpartum Depression and Relationships*, available at <http://www.webmd.com/depression/features/postpartum> (last accessed Jan. 19, 2015).

¹⁰⁸ Office on Women’s Health, *supra* note 105.

¹⁰⁹ Gwen Dewar, PhD, *Childbirth trauma and post traumatic stress: What’s wrong with the status quo?*, available at <http://www.parentingscience.com/childbirth-trauma.html> (last accessed Jan. 19, 2015).

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* Dewar posits that the difference in cultural response could be based on the availability of quality medical care in western cultures. *Id.*

¹¹³ *Id.* For example, European studies report childbirth-related PTSD rates around 1-3%, whereas American and Canadian studies report rates between 8-9%. *Id.* A French study purported rates around 13%, and an Iranian study reported rates as high as 20%. *Id.* Dewar states that these statistics are somewhat skewed because the studies only account for full-blown, reported cases of PTSD. Dewar posits that many more women suffer from “subsyndromal” PTSD – where the mother experiences a trauma, but is not traumatized enough to fall within the traditional definition of PTSD. *Id.* Consequently, post-birth trauma is actually more prevalent than studies show. *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

difficult to bond with their babies.¹¹⁷ In certain cases, PTSD sufferers can experience heightened anxiety about their babies, constantly fearing that their child could die.¹¹⁸ Different risk factors increase the likelihood for traumatic birth experiences. These factors include: 1) previous premature births or miscarriages, 2) difficult deliveries that require instrumental interventions, 3) emergency caesarean sections, 4) feelings of fear for well-being of their babies or themselves before and during birth, 5) feelings of helplessness or a lack of control during labor, 6) a history of other traumatic experiences, such as sexual abuse, 7) a history of psychological problems, and 8) insufficient social support from partners or hospital staff.¹¹⁹ Feelings of a lack of control were more likely to produce traumatic experiences and post-birth PTSD symptoms.¹²⁰

Women can also suffer from various other psychological disorders during the postpartum phase. First, some women suffer from “various morbid preoccupations.”¹²¹ These preoccupations can result from distress about the bodily changes that result from pregnancy and childbirth.¹²² Weight gain, stretch marks, and scarring make these women reluctant to undress in front of their partners, avoid looking at themselves naked, and can even keep them from stepping out into public.¹²³ Others develop an overwhelming feeling of conjugal jealousy, where they question their spouse’s fidelity in light of all their physical and emotional changes.¹²⁴

Other women develop obsession of child harm.¹²⁵ “Obsessions of infanticide were one of the first postpartum disorders to be described.”¹²⁶ In such cases, the mother has impulses to attack the child. Rather than acting upon her pathological anger, such as

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* This list is not exclusive. It is reasonable that other risk factors exist.

¹²⁰ *Id.*

¹²¹ Brockington, *supra* note 100, at 307.

¹²² *Id.*

¹²³ *Id.* Brockington presents evidence from a study, showing that roughly 14% of women suffer from similar types of dysmorphophobia. *Id.*

¹²⁴ *Id.* Brockington notes a study showing that roughly 5% of women suffer from this type of conjugal jealousy. *Id.*

¹²⁵ *Id.* See Laura E. Reece, *Mothers Who Kill: Postpartum Disorders and Criminal Infanticide*, 39 UCLA L. Rev. 699 (1991). Miss Reece offers a detailed account of various example cases of women suffering from postpartum issues who took violent action towards their children. She further delves into the perception of these women by society, doctors, and courts. Her article sheds light onto the prevalence of the issue in our society. Doing so allows one to see how traumatic of an experience childbirth can be. See also Deborah W. Denno, *Who is Andrea Yates? A Short Story about Insanity*, 2 Duke Journal of Gender Law & Policy 1 (2003). Miss Denno provides a detailed explanation of Andrea Yates’ highly publicized case. Yates suffered from severe postpartum depression and drowned all five of her children in order to protect them from Satan and her own evil maternal influences. *Id.* at 3. Yates’ case evidences the trauma of childbirth and potentially harmful effects of unmanaged postpartum depression. *Id.*

¹²⁶ Brockington, *supra* note 100, at 307.

child abusers do, these mothers are gentle and devoted to the child.¹²⁷ Often, these mothers experience extravagant infanticidal impulses in combination with fantasies of the family's pain and horror.¹²⁸ This often results in the mother wholly disconnecting with the child, or taking violent action towards the child.¹²⁹ Doctors posit that prescribed antidepressants and therapy can properly alleviate these psychological issues.¹³⁰ Further, physicians note that "[a]voidance of the child should be discouraged, and cuddling and play encouraged, strengthening positive maternal feelings."¹³¹ The various psychological conditions that can result from childbirth evidences the necessity for proper care and monitoring of new mothers by medical professionals.

1. Psychological Impacts of Losing a Child

Losing a child is one of the most traumatic experiences a family could ever be forced to live through. The experience is especially traumatic for the mother, specifically when losing an infant or a child who has not been born yet. Before the end of the Nineteenth Century, nearly one out of every five children in Europe would die in the first year of their life.¹³² The evolution of medical technology and prevalence of ample medical care has since significantly lowered this number.¹³³ As a result, attitudes towards child loss and parental expectations of childbirth have also changed.¹³⁴ Parents now have high expectations of the birthing process. As a result, any issues arising from or during birth are especially crushing to the parents, especially the mother.

As carriers of the child, mothers are especially affected by the loss of a child. In the weeks following the child's death, mothers experience sadness, irritability, and somatic symptoms,¹³⁵ where the mental anguish causes the mother to feel physical pain.¹³⁶ The severity of these symptoms diminishes over the first year, but can continue for longer.¹³⁷ At least 20% of women suffer from continued anguish beyond

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² William Badenhorst and Patricia Hughes, *Psychological aspects of perinatal loss*, 21 *Best Practice & Research Clinical Obstetrics and Gynecology* 249, 250 (2007).

¹³³ *Id.*

¹³⁴ *Id.* "Children were valued in previous generations, but where poor families barely subsisted, a birth was also another mouth to feed. Conditions for many people in the industrializing world of the 19th century were similar to those experienced in the developing world today, with most income spent on food, long, hard hours of work, and precarious survival." *Id.*

¹³⁵ WebMD, *Somatoform Disorders*, available at <http://www.webmd.com/mental-health/somatoform-disorders-symptoms-types-treatment> (last accessed Jan. 19, 2015).

¹³⁶ Badenhorst & Hughes, *supra* note 132, at 251.

¹³⁷ *Id.*

the first year.¹³⁸ Roughly 20% of mothers in Badenhorst and Hughes' study were found to suffer from PTSD as a result of their child's death.¹³⁹

It is impossible to quantify a mother's grief over a lost child, let alone extrapolate it into data. Beyond scientific data, our instincts as human beings allow us to see the vicious pain a mother goes through after losing a child. One can barely even imagine the pain a mother goes through after losing a child, nor would one speak to such a traumatic event without ever experiencing it. These humanistic given points provide even more ample basis for providing mothers with additional care.

2. Psychological Impacts in the Context of Jails and Prisons

Psychological issues are more prevalent amongst prisoners than in the rest of society. As recently as 2005, roughly 75% of female prisoners suffered from a mental health problem.¹⁴⁰ Roughly 75% of inmates and prisoners that qualified under the mental health criteria also met criteria for substance dependence or abuse.¹⁴¹ Further, one-in-three state prisoners and one-in-six jail inmates had received treatment for a mental health problem during their incarceration.¹⁴² Female prisoners are also more likely to report extensive histories of emotional, physical, and sexual abuse.¹⁴³

These statistics show the prevalence of mental issues among the female jail and prison population. Preexisting psychological conditions put pregnant and expectant mothers at an increased risk for additional psychological issues.¹⁴⁴ Failing to provide adequate prenatal care and education not only disadvantages the incarcerated mothers, but also the medical staffs. Different psychological issues may have gone

¹³⁸ *Id.* See Kaniz Gausia, Allisyn C. Moran, Mohammed Ali, David Ryder, Colleen Fisher, and Marge Koblinsky, *Psychological and social consequences among mothers suffering from perinatal loss: perspective from a low income country*, 11 BMC Public Health 1 (2011) available at <http://www.biomedcentral.com/content/pdf/1471-2458-11-451.pdf> (last accessed Jan. 19, 2015) (finding that 43% of women suffered from depression six months after their child's perinatal death).

¹³⁹ Badenhorst & Hughes, *supra* note 132, at 251. These numbers were amplified when considering mothers who gave birth to a stillborn baby. *Id.* The study also noted an increased prevalence of PTSD when the mother held her dead baby. *Id.* at 252. Interestingly enough, fathers also experienced PTSD symptoms when they were given the opportunity to hold the deceased child. *Id.*

¹⁴⁰ Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates*, available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (last accessed Jan. 19, 2015). Here, "mental health problems" were defined by two measures: 1) recent history, including clinical diagnosis or treatment by a mental health professional, or 2) symptoms of a mental health problem, as prescribed in the DSM-IV. *Id.* at 1. The problem must have occurred within the twelve months prior to the interview. *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ Nena Messina and Christine Grella, *Childhood Trauma and Women's Health Outcomes in a California Prison Population*, 96 Am. J. Pub. Health 1842, 1842 (2006).

¹⁴⁴ See generally *infra* § (III)(B)(3) (discussing the impact and prevalence of preexisting psychological conditions on the likelihood of recurring psychological conditions or new psychological conditions as a result of pregnancy, childbirth, or events following birth).

undiagnosed or unnoticed during their admission. Without knowledge of potential issues, the proper type of care cannot truly be provided to these women. Consequently, failing to provide individualized care for these incarcerated mothers puts all actors in jeopardy: the mother, the child, and the medical and prison staffs. This provides further ample justification for requiring statutorily mandated prenatal care for incarcerated mothers and their innocent children.

IV. STATUTORY SCHEMES

Prison standards are generally mandated and enforced by state authorities. State standards across the U.S., however, frequently fail to provide basic care for incarcerated pregnant women. For example, 41 states do not require prenatal nutrition counseling for incarcerated women, and 34 states do not require screening and treatment for women with high-risk pregnancies.¹⁴⁵ These inadequacies are not present throughout all states. For example, Pennsylvania's statutory regime is hallowed as one of the best.¹⁴⁶

A. Pennsylvania Statutory Scheme

In 1971, Pennsylvania took proactive steps to reform its prisoner care system by enacting the Prison Medical Services Program. The program has evolved into one of the most comprehensive prisoner care programs in the United States. The legislation provides the basic framework for inmates – access to health care, treatment for serious needs, nutrition, exercise, and personal hygiene items.¹⁴⁷ The program also provides a list of medical treatments the inmates receive free of charge.¹⁴⁸ “Prenatal care” is specifically enumerated within this list.¹⁴⁹ Pennsylvania's statute revolutionizes modern views of female inmates by providing a legitimate basis for showing that this type of care and treatment cannot be denied.

In addition to its statutory scheme, the Pennsylvania Maternity Care Coalition began the use of a “MOMobile” program.¹⁵⁰ The MOMobile began working with the Riverside Correctional Facility in 2006. It delivers education and support for incarcerated expecting mothers, and is coupled with individual attention for up to one

¹⁴⁵ See *Mothers Behind Bars*, *supra* note 10, at 6. The article establishes a rating system and assigns grades to each state based on prenatal care, shackling, and family-based treatment as an alternative to incarceration. *Id.* at 6. For the purposes of this article, the grades for prenatal care will be examined, separate from grades for shackling and alternative treatment. Other examples of lackluster statutory provisions include: (1) 43 states do not require medical examinations as a component of prenatal care, (2) 48 states do not offer pregnant women screening for HIV, (3) 45 states do not offer pregnant women advice on activity levels and safety during their pregnancy, (4) 44 states do not make advance arrangements for deliveries with particular hospitals, and (5) 49 states fail to report all incarcerated women's pregnancies and their outcomes. *Id.* at 6.

¹⁴⁶ *Id.* at 15.

¹⁴⁷ 37 PA. CODE § 93.12(a).

¹⁴⁸ 37 PA. CODE § 93.12(d).

¹⁴⁹ 37 PA. CODE § 93.12(d)(14).

¹⁵⁰ See *Mothers Behind Bars*, *supra* note 10, at 24.

year after the mother is released.¹⁵¹ More than two-thirds of MOMobile participants improved their knowledge of prenatal, postpartum, and child-related issues as a result of the program.¹⁵² Over four years, MOMobile achieved great success by helping more than 300 women.¹⁵³ However, the program's funding was cut in 2010, and has not been able to flourish since. MOMobile still provides as much care as it can to the women of the Riverside Correctional Facility.¹⁵⁴ The presence of progressive programs, such as MOMobile, undoubtedly has an immense impact on the lives of incarcerated expectant mothers.

Despite being well drafted, the Pennsylvania statutory scheme faces its own issues. The statute does not provide any explicit means for correctional institutes to provide care for the prisoners. Nor does it provide explicit penalties for institutions failing to follow guidelines, or recourse for prisoners who have been denied care.¹⁵⁵ Rather, it acts merely as a theoretical guideline for these institutions to follow. The simple existence of statutory requirements does not guarantee practical application and favorable results. The Pennsylvania model is an excellent benchmark, but surely can be improved.

B. Ohio's Statutory Scheme

The Ohio Revised Code denotes that the Director of Rehabilitation and Coordination must promulgate minimum standards for Ohio correctional facilities.¹⁵⁶ These standards ("jail standards") are published yearly, and outline the specific provisions that Ohio correctional facilities must follow.¹⁵⁷ The jail standards provide that no inmate shall be denied necessary health care¹⁵⁸ and denote that inmates' special health needs will be screened and considered at the time the inmates are admitted.¹⁵⁹ The standards also state that pregnant inmates shall receive appropriate and timely prenatal care, delivery, and postpartum care.¹⁶⁰ In a 2013 memorandum, the Department of Rehabilitation and Correction states that female inmates are subject to

¹⁵¹ *Id.*

¹⁵² *Id.* The educational aspects of the MOMobile program have impacts beyond the health of the mother and child. Mothers exhibit stronger relationships, better parenting and community skills, and recidivism rates are low (roughly 23%). *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ The statute provides explicit language on payment procedures, but omits any implementation procedure for available medical procedures and care. 37 Pa. STAT. AND CONS. STAT. ANN. §§ (e) – (h) (West 1971).

¹⁵⁶ OHIO REV. CODE ANN. § 5120.10(A)(1) (West 2015).

¹⁵⁷ See STANDARDS FOR JAILS IN OHIO, available at <http://www.drc.ohio.gov/web/2014JailStandards.pdf> (last accessed Dec. 3, 2014).

¹⁵⁸ *Id.* at § 5120:1-8-09(1)(5). There is a misprint within the statutory text – this section is labeled incorrectly. It should instead be labeled as (A)(5) instead of (1)(5).

¹⁵⁹ *Id.* at § 5120:1-8-09(C)(3)(g).

¹⁶⁰ *Id.* at § 5120:1-8-09(Q).

different medical needs, and specific services shall be provided to them.¹⁶¹ The memorandum later specifically addresses pregnancy management. It acknowledges that each inmate will be given a prenatal evaluation, counseling, and medical support.¹⁶²

While it may seem comprehensive at face value, Ohio's statutory regime lacks the requisite precautions to ensure statutorily mandated care. The types, amount, frequency, and degree of prenatal care and education are never defined.¹⁶³ This gives the facilities opportunity to enforce the requirements arbitrarily and in discriminatory fashions. In an arena where women have already been demonized, preventing them from accessing mandated care is an atrocity.

Further, there are no penalties prescribed by the statutory regime. Female prisoners certainly can pursue civil remedies against the facility and its staff;¹⁶⁴ however, the redress provided by this route is insufficient. The facility and its staff may be subject to monetary demands, but this is no possible, let alone reasonable, redress for a mother who has lost her child as a result of the neglect, negligence, or discrimination by a correctional facility.

The Ohio Legislature set up a quality system of basic principles for the correctional facilities in the state to adhere by. However, by not providing restrictions to prevent arbitrary and discriminatory enforcement, or penalties for failing to adhere to standards, the Ohio Legislature continues to gamble with the lives of innocent children. Nowhere in principles of punishment is threatening the health and livelihood of an unborn, innocent child justified.¹⁶⁵ Therefore, Ohio needs to reform its statutory regime to prevent these various injustices.

V. ESTABLISHING MANDATORY CARE FOR INCARCERATED WOMEN IN OHIO JAILS AND PRISONS

Mandatory care is a necessity under this proposed statutory regime. The available prenatal care in the free world gives women the opportunity to have not only regular checkups on their health and the health of their child, but also to become educated on various aspects of the pregnancy that are not common knowledge.¹⁶⁶ These efforts to provide adequate care and education to the incarcerated mothers is the cornerstone of this proposed legislation.

A. Historical Prisoner Care in American Correctional Facilities

Prisoners already have an established array of rights pertaining to care during their incarceration. The Eighth Amendment prohibits cruel and unusual punishment of

¹⁶¹ See Memorandum from ODRC on Policies Specific to Women, at 1 (Sept. 6, 2013) (available at http://www.drc.ohio.gov/web/drc_policies/documents/68-MED-23.pdf).

¹⁶² *Id.* at 2.

¹⁶³ See generally Standards for Jails in Ohio, *supra* note 157.

¹⁶⁴ Prisoners can seek relief under 18 U.S.C. § 3626 – Appropriate remedies with respect to prison conditions. 18 U.S.C.A. § 3626 (West 2105). § 3626 allows for prospective relief, preliminary injunctive relief, prisoner release orders, and settlement. *Id.* at §§ (a)(1) – (3), (c).

¹⁶⁵ See Dressler, *supra* note 14 (discussing principles and justifications for punishment in the American Criminal Justice System).

¹⁶⁶ See Prenatal Care and Tests, *supra* note 23, Staying Healthy and Safe, *supra* note 28.

prisoners during the course of their sentence.¹⁶⁷ Prisoners claiming improper treatment by prison officials assert a Civil Action for the Deprivation of Rights for relief.¹⁶⁸ Over time, caselaw has expanded the scope of available care for prisoners. In 1976 the Supreme Court handed down its decision in *Estelle v. Gamble*, which became the benchmark case for prisoner's § 1983 claims.¹⁶⁹ The Court in *Estelle* held that deliberate indifference to a prisoner's serious illness or injury constitutes cruel and unusual punishment.¹⁷⁰ The standard not only provides prisoners with a basis for their claims, but also acts as a safeguard against frivolous filings by subjecting each claim to the strict scrutiny of the standard.¹⁷¹ The Supreme Court also expanded the *Estelle* doctrine in 1993 to include alleged future harms to prisoners.¹⁷²

Suits filed by prisoners are traditionally filed against the prison itself. The Supreme Court has held that local governments, acting as the controlling agency of prisons, can be sued in their official capacity.¹⁷³ This rationale has also been applied in Ohio.¹⁷⁴ State of mind of the prison officials has also been taken into account.¹⁷⁵ The Supreme Court in *Wilson* stated that there is no significant distinction between

¹⁶⁷ U.S. Const. amend. VIII. "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." *Id.*

¹⁶⁸ 42 U.S.C.A. § 1983 (West 2015):

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable."

Id.

¹⁶⁹ *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹⁷⁰ *Id.* at 104.

¹⁷¹ *Id.*

¹⁷² See *Helling v. McKinney*, 509 U.S. 25 (1993) (Supreme Court allowed the § 1983 claim of an inmate whose cellmate smoked roughly five packs of cigarettes each day). "It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them." *Id.* at 33.

¹⁷³ See *Monell v. Dept. of Social Services of City of New York*, 436 U.S. 658, 690 (1978). ("...Congress *did* intend municipalities and other local government units to be included among those persons to whom § 1983 applies").

¹⁷⁴ See *Stack v. Karnes*, 750 F.Supp.2d 892, 897 (S.D.O.H. 2010) (holding that a prisoner *could* have a legitimate suit against a local government for failure to provide care in prisons). However, in Ohio, the local sheriff is responsible for maintaining prison and jail standards. Therefore, the proposed legislation will name the sheriff, alongside the correctional facility, in the prisoner's complaint.

¹⁷⁵ See *Wilson v. Seiter*, 501 U.S. 294, 303 (1991).

claims of inadequate confinement conditions and inadequate medical care.¹⁷⁶ Both types of claims are subject to the same deliberate indifference standard purported in *Estelle*.¹⁷⁷

B. Role of Due Process Pertaining to Prisoners' Rights

The Due Process Clause of the Fourteenth Amendment provides that no state shall “deprive any person of life, liberty, or property without due process of law.”¹⁷⁸ Due process assures individuals’ rights and interests pertaining to life, liberty, and property will not be deprived or violated without first assuring adequate process.¹⁷⁹ Adequate process includes: 1) unrestricted right to travel,¹⁸⁰ 2) uninhibited right to vote,¹⁸¹ and 3) access to courts.¹⁸² Lawful imprisonment makes many ordinary rights and privileges

¹⁷⁶ *Id.* “Indeed, the medical care a prisoner receives is just as much a “condition” of his confinement as the food he is fed, the clothes he is issued, the temperature he is subjected to in his cell, and the protection he is afforded against other inmates.” *Id.*

¹⁷⁷ See *Wilson*, *supra* note 175, at 303; see generally *Estelle*, *supra* note 169.

¹⁷⁸ U.S. Const. amend. XIV.

¹⁷⁹ “[T]he guaranty of due process, as has often been held, demands only that the law shall not be unreasonable, arbitrary, or capricious, and that the means selected shall have a real and substantial relation to the object sought to be attained.” *Nebbia v. People of New York*, 291 U.S. 502, 510-511 (1934). Justice Roberts’ statement evidences the general principle underlying due process – assuring individuals’ rights protection from unreasonable, arbitrary, or capricious governmental actions.

“The touchstone of due process is protection of the individual against the arbitrary action of government.” *Wolff v. McDonnell*, 418 U.S. 539, 588 (1974) (citing *Dent v. West Virginia*, 129 U.S. 114, 123 (1899)).

The Supreme Court has stated that a hearing is not required in “every conceivable case of government impairment of private interest.” *Cafeteria & Rest, Workers v. McElroy*, 367 U.S. 886, 894 (1961). Rather, individuals are entitled to adequate process when a fundamental right or identified liberty interest, pursuant to the Fourteenth Amendment, is involved. See *Palko v. State of Connecticut*, 302 U.S. 319 (1937), *overruled by Benton v. Maryland*, 395 U.S. 784 (1969) on a separate issue than the purpose it is cited to in this note (holding that identified individuals’ liberty interests are protected against state action, pursuant to the Fourteenth Amendment).

¹⁸⁰ See *Kent v. Dulles*, 357 U.S. 116, 125 (1958). “The right to travel is a part of the ‘liberty’ of which the citizen cannot be deprived without the due process of law under the Fifth Amendment.” *Id.*

¹⁸¹ See *Harper v. Virginia State Bd. Of Elections*, 383 U.S. 663, 665 (1966).

For it is enough to say that once the franchise is granted to the electorate, lines may not be drawn which are inconsistent with the Equal Protection Clause of the Fourteenth Amendment. That is to say, the right of suffrage “is subject to the imposition of state standards which are not discriminatory and which do not contravene any restriction that Congress, acting pursuant to its constitutional powers, has imposed.

Id. at 666 (citing *Lassiter v. Northampton County Board of Elections*, 360 U.S. 45, 51 (1959)).

¹⁸² See *Griffin v. Illinois*, 351 U.S. 12 (1956) (holding that states must provide a trial transcript or its equivalent to an indigent criminal defendant on his or her first appeal); *Douglas v. California*, 372 U.S. 353 (1963) (holding that states must appoint counsel for indigent

unavailable to prisoners, but doing so is justified by the considerations underlying our penal system.¹⁸³ However, “a prisoner is not wholly stripped of constitutional protections when he is imprisoned for a crime.”¹⁸⁴ There is no “iron curtain” drawn between prisoners and constitutional protections afforded in the United States.¹⁸⁵ Prisoners retain substantial constitutional rights, such as: 1) religious freedoms,¹⁸⁶ 2) access to the courts,¹⁸⁷ and 3) property rights.¹⁸⁸ Ultimately, there must be “mutual

defendants’ first appeal following a criminal conviction); *but see Ross v. Moffitt*, 417 U.S. 600 (1974) (refusing to extend the Griffin-Douglas line of cases to discretionary appeals).

The Court has typically made these decisions, especially those pertaining to voting rights and access to the courts, under the guise of Equal Protection. However, especially in cases addressing access to courts, dissenting justices wrote to advocate for a due process application instead of equal protection. *See Griffin v. Illinois*, 351 U.S. 12 (1956) (Harlan, J., dissenting) (asserting that the type of fundamental fairness being addressed by the majority is better analyzed under due process); *Douglas v. California*, 372 U.S. 353 (1963) (Harlan, J., dissenting) (asserting the issue is better addressed under due process); *Ross v. Moffitt*, 417 U.S. 600 (1974) (Douglas, J., dissenting) (considering both equal protection and due process in the analysis).

Equal protection requires that the defendant be part of an identified and acknowledged class of individuals and show discrimination on the basis of being a member of that class. *See* DAVID RUDOVSKY ET AL., *Rights of Prisoners* § 5:1 Generally (4th ed. 1988). “The Fourteenth Amendment prohibits the government from denying any person within its jurisdiction the equal protection of the laws” (internal citation omitted). *Id.* Justice Stone famously stated in Footnote Four of *Carolene Products*: “whether prejudice against discreet and insular minorities may be a special condition, which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry.” *U.S. v. Carolene Products Co.*, 304 U.S. 144 (1938). Ohio law, however, has declined to acknowledge prisoners as a classification warranting protection under equal protection. *See Dotson v. Wilkinson*, 477 F.Supp.2d 838, 851 (N.D. Ohio 2007) (“[t]he Sixth Circuit holds that prisoners are not a protected class for equal protection purposes.” (citing *Hampton v. Hobbs*, 106 F.3d 1281, 1286 (6th Cir. 1997))). The Supreme Court has also held that pregnancy does not constitute grounds for gender classification, and did not qualify as a proper classification for equal protection purposes. *See Geduldig v. Aiello*, 417 U.S. 484 (1974). Instead, pregnancy is treated as another physical issue, free from gender specification. *Id.* at 494. These lines of cases seemingly undercut an incarcerated mother’s equal protection claim. However, claims may still be sought with fervor under due process.

¹⁸³ *Wolff v. McDonnell*, 418 U.S. 539, 555 (1974).

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 555-56.

¹⁸⁶ *Id.* at 556. *See Cruz v. Beto*, 405 U.S. 319, 322 (1972) (sustaining a prisoner’s 18 U.S.C. § 1983 challenge to a Texas prison action that prohibited him from practicing Buddhism during incarceration); *Cooper v. Pate*, 378 U.S. 546, 546 (1964) (sustaining a prisoner’s 18 U.S.C. § 1983 claim that his First Amendment rights were violated when he was prohibited from practicing his religion of choice).

¹⁸⁷ *See Younger v. Gilmore*, 404 U.S. 15, 15 (1971); *Johnson v. Averi*, 393 U.S. 483 (1969) (state prison regulation barring inmates from assisting other prisoners in preparation of petitions for post-conviction relief was invalid as in conflict with federal right of habeas corpus).

¹⁸⁸ *See Hudson v. Palmer*, 468 U.S. 517 (1984) (Stevens, J., concurring in part, dissenting in part).

accommodation between institutional needs and objectives and the provisions of the constitution that are of general application.”¹⁸⁹

Through substantive due process,¹⁹⁰ the Supreme Court has established a doctrinal approach to establish protection for incarcerated individuals’ medical needs. The “deliberate indifference” standard purported by *Estelle* acts as the substantive benchmark analysis for addressing prisoners’ medical rights.¹⁹¹ More recent decisions have expanded the availability of *Estelle*’s “deliberate indifference” standard beyond the Eighth Amendment pursuant to classification of the prisoner’s liberty interest in obtaining adequate medical treatment.¹⁹² For example, the Sixth Circuit recently expanded *Estelle* to include medical care to “individuals in police custody prior to a criminal conviction.”¹⁹³ The Sixth Circuit reasoned that because the defendant had

Once it is agreed that random searches of a prisoner’s cell are reasonable to ensure that the cell contains no contraband, there can be no need for seizure and destruction of noncontraband items found during such searches. To accord prisoners any less protection is to declare that the prisoners are entitled to no measure of human dignity or individuality – not a photo, a letter, no anything except standard-issue prison clothing would be free from arbitrary seizure and destruction. *Id.* at 555.

¹⁸⁹ *Wolff*, 418 U.S. at 556.

¹⁹⁰ Substantive due process allows the Court to look beyond the enumerated powers of the Constitution, *see* U.S. Const. art. I, §. 8, to derive other protections. Each of the concepts of life, liberty, and property have spawned various areas of jurisprudence affording people additional rights not specifically mentioned within the four corners of the Constitution.

Substantive due process has become a bedrock component of modern constitutional law. If one includes cases decided on the basis of incorporated Bill of Rights provisions – which, since incorporation is but a subspecies of substantive due process, one seeking to understand the doctrine must – substantive due process has led to the invalidation of more legislation by the Supreme Court than any other doctrine.

Peter J. Rubin, *Square Pegs and Round Holes: Substantive Due Process, Procedural Due Process, and the Bill of Rights*, 103 COLUM. L. REV. 833, 835 (2003).

¹⁹¹ The “deliberate indifference” standard is especially applied within Ohio courts’ jurisdiction. *See Brown v. Mohr*, 2015 WL 1476761, No. 2:13-CV-006 (S.D. Ohio 2015) (slip copy); *Lyons v. Heyd*, 2015 WL 892375, No. 1:12-CV-324 (S.D. Ohio 2015) (both cases applying the “deliberate indifference” standard provided by the Court in *Estelle*).

¹⁹² *See Washington v. Harper*, 494 U.S. 210 (1990) (acknowledging a prisoner’s liberty interest in preventing arbitrary administration of antipsychotic drugs; Supreme Court acknowledged the state does not violate due process by administering antipsychotic drugs to an unwilling prisoner who poses a danger of violence to himself and other inmates); *Pabon v. Wright*, 459 F.3d 241, 246 (2nd Cir. 2006) (holding that prisoners have a liberty interest in refusing medical treatment when not provided adequate information to give informed consent to the treatment).

See also Dotson v. Wilkinson, 477 F.Supp.2d 838, 851 (N.D. Ohio 2007). “As Circuits have recognized, a pretrial detainee’s claim for a lack of medical care is properly brought under the Fourteenth Amendment but analyzed under the same Eighth Amendment standards.” *Id.*

¹⁹³ *Smith v. Erie County Sheriff’s Dept.*, 603 Fed. Appx. 414, 11 (6th Cir. 2015). “A person’s right to adequate medical care is violated if the police acted with “deliberate indifference to serious medical needs.” *Id.* Police failure to respond to a person’s medical needs, deliberate indifference means the unnecessary and wanton infliction of pain proscribed by the Eighth

not yet been convicted the Eighth Amendment did not protect her, but she was still entitled to medical protection under the Fourteenth Amendment.¹⁹⁴ This expansion of protection evidences a general judicial movement to afford additional protections to those affected by custody within the criminal justice system.

This expansion of protection is also evidenced by the Supreme Court's approach to prison officials' *mens rea* in deliberate indifference claims.¹⁹⁵ The Court has stated that purposeful or knowing conduct is not necessary to satisfy the *mens rea* requirement for deliberate indifference claims challenging conditions of confinement.¹⁹⁶ Rather, the Court has equated deliberate indifference with recklessness.¹⁹⁷ The Court in *Farmer* held:

[A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.¹⁹⁸

The Court continued to say: "...an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment."¹⁹⁹ This standard has been further refined within Ohio law. The Sixth Circuit has held that prisoners who ask for, and need, medical care must be provided with the requisite care.²⁰⁰ Further, the Sixth Circuit stated: "Failure to provide medical treatment when circumstances

Amendment (internal citations omitted). *Id.* (citing *Burgess v. Fischer*, 735 F.3d 462, 476 (6th Cir. 2013)).

¹⁹⁴ *Id.* "Because she had not been convicted, and thus was not covered by the Eighth Amendment, that same standard of deliberate indifference applies to Stallart through the Fourteenth Amendment." *Id.*

¹⁹⁵ See, *Farmer v. Brennan*, 511 U.S. 825, 836 (1994).

¹⁹⁶ *Id.*

¹⁹⁷ *Id.* "With deliberate indifference lying somewhere between the poles of negligence at one end and purpose or knowledge at the other, the Courts of Appeals have routinely equated deliberate indifference with recklessness." *Id.* The Court in *Farmer* discussed the competing differences between recklessness in civil and criminal law. *Id.* at 836-37. Civil recklessness "generally calls a person reckless who acts or (if the person has a duty to act) fails to act in the face of an unjustifiably high risk of harm that is known or so obvious that it should be known." *Id.* at 836. Criminal law, however, "generally permits a finding of recklessness only when a person disregards a risk of harm of which he is aware." *Id.* at 837.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.* at 838.

²⁰⁰ *Stefan v. Olson*, 497 Fed. Appx. 568, 576 (6th Cir. 2012) (sustaining defendant's deliberate indifference challenge against the jail nurse after: 1) she was informed of his alcoholism, 2) was made aware of his .349 blood-alcohol content, 3) was aware of his racing pulse and dehydration, and 4) was verbally warned of his propensity to seize when sobering up).

clearly evince a need amounts to a deprivation of constitutional due process.”²⁰¹ The Sixth Circuit’s embracing and extension of *Estelle*’s principles evidences continued aspirations of providing clearer, more thorough guidance and standards to govern adequate prisoner care. This standard needs to be extended further to encompass the unique needs of incarcerated mothers.

VI. IMPORTANCE OF ASSURING INCARCERATED MOTHERS’ DUE PROCESS RIGHTS IN THE PROPOSED LEGISLATION

Assuring these incarcerated mothers’ due process rights are protected is one of the most vital concerns of this proposed legislation. Constitutional and precedential protections have been previously established addressing prisoners’ current and future medical issues.²⁰² However, despite these protections, incarcerated women like Pamela Clifton still live through physical, mental, and emotional torture of losing children at the hands of their correctional facilities. This tragic reality affirms the notion that additional safeguards, other than Constitutional and precedential standards, must be implemented to assure the protection of these mothers’ rights. A safeguard such as codifying mandatory care for these mothers would, in theory, circumvent abuses of discretion by both prison officials and courts. At absolute worst, in the most tragic of implementations, mandating care and codifying additional procedural protections would provide a remedy for these mothers who have been wronged by their controlling institution.

A. Necessity of Mandatory Care in this Proposed Statutory Scheme

Prisoner care is already afforded and mandated pursuant to Supreme Court ruling.²⁰³ However, the umbrella of mandatory care has not yet been statutorily concept of mandating prenatal care, but has yet to make real, substantive progress towards the goal.²⁰⁴

Ohio has not yet had its own Pamela Clifton case. However, this is not an opportunity for solace. Rather, this is an opportunity to proactively provide mandatory prenatal care for women in need. The lack of prenatal care has already been shown to have a negative impact on both fetal and birth health.²⁰⁵ Mandating prenatal care would surely impact the neonatal death rates, especially for incarcerated women.²⁰⁶

²⁰¹ *Id.*

²⁰² See U.S. Const. amend. XIII, *supra* note 167 (preventing excessive fines, excessive bail, and cruel and unusual punishment); *Estelle*, *supra* note 169 (establishing the “deliberate indifference” standard for prisoner medical claims); *Helling*, *supra* note 172 (providing protection for prisoners’ future medical issues while incarcerated).

²⁰³ See generally *Estelle* *supra* note 169; *Helling* *supra* note 172; *Wilson* *supra* note 175.

²⁰⁴ See generally ODRC MEMORANDUM, *supra* note 161; O.R.C. §5210, *supra* note 156; 2014 OHIO JAIL STANDARDS, *supra* note 157.

²⁰⁵ CHILD TRENDS DATA BANK, *Late or No Prenatal Care*, *supra* note 44.

²⁰⁶ See Rosenberg, *supra* note 48.

B. Proposed Mandatory Care

The proposed mandatory care would provide incarcerated women the care recommended by doctors and other healthcare professionals. The number of visits,²⁰⁷ expected treatments,²⁰⁸ educational opportunities,²⁰⁹ and treatment facility should all be comparable to typical prenatal care for other women.²¹⁰ Transportation to outside facilities may be necessary to effectuate the policy in full. However, each facility that admits a pregnant prisoner should also be outfitted with a medical center able to handle any emergency complications that may arise during the pregnancy.²¹¹ Further, each member of the medical staff should be trained, certified, and proficient in handling emergency complications. Mandating not only the level of care, but quality from those who provide it will surely have a positive, substantive effect on combatting issues pregnant women face during their incarceration. These steps move society closer to a world where the American Prison system no longer gambles with the lives of innocent children.

Example statutory language could include:

Care covered under this statute [includes]: number of visits to a proper overseeing doctor, expected treatments during visits, educational opportunities for the expectant mothers. Upon admission, each inmate will be subject to an HIV/AIDS test, pregnancy test, and psychological evaluation to provide an adequate medical profile. If an inmate tests positive as pregnant, or enters the facility pregnant, they will be subject to an in-depth psychological evaluation to determine the proper scope and requirements of their prenatal care.

Each correctional facility will be outfitted with at least a medical center that can provide adequate care in cases of emergency. Not every jail and prison is expected to have a full-fledged medical center. However, each facility must be able to handle emergency situations. Correctional facilities that do not have a full-functioning medical center must have a proper transportation plan and agreement with a local medical center that can provide the requisite adequate prenatal care.

Members of the jail or prison medical staffs must be trained, certified, and proficient in handling emergency complications associated with prenatal care. It is acknowledged that these medical professionals are subject to licensing and regulation from other entities. These licensing requirements will be considered when evaluating the staff.”²¹²

²⁰⁷ See Prenatal Care and Tests, *supra* note 23, at 5.

²⁰⁸ *Id.*

²⁰⁹ See Staying Healthy and Safe, *supra* note 28.

²¹⁰ It is key to note that this is not an exclusive list. Surely other individual complications will arise that require the expansion of categories, types, and methods of treatment. This article does not propose limiting the possibilities to that within the author's sphere of creativity.

²¹¹ See *Lanzetta v. State of N.J.*, 306 U.S. 451 (1939) (criminal statute invalidated because of an ambiguous definition within the element defining a “gang”). Justice Butler stated: “[t]he challenged provision condemns no act or omission; the terms it employs to indicate what it purports to denounce are so vague, indefinite and uncertain that it must be condemned as repugnant to the due process clause of the 14th Amendment.” *Id.* at 458.

²¹² See *infra* § VII – “Proposed Statute.”

VII. PREVENTION OF ARBITRARY AND DISCRIMINATORY ENFORCEMENT OF POLICIES

Prevention of arbitrary and discriminatory enforcement of statutes and polices is governed by the void for vagueness doctrine. Void for vagueness establishes three values: 1) providing fair notice or warning to the public, 2) preventing of arbitrary, capricious, and discriminatory enforcement, and 3) ensuring fundamental constitutional protections are not unreasonably impinged upon or inhibited.²¹³ The doctrine is broken into two prongs: notice and prevention of arbitrary and discriminatory enforcement. Satisfaction of both prongs will prevent pregnant inmates from being subjected to additional injustice.

A. Notice & Fair Warning

Criminal statutes must give persons of ordinary intelligence fair notice of what conduct is prohibited.²¹⁴ A line must be drawn for the public to know what the consequences of violation of a law will result in. In order for warning to be fair, that line must be drawn clearly.²¹⁵ Ohio caselaw has also embodied this principle.²¹⁶ Ohio law has also adopted three ancillary precepts: 1) a statute will not be declared void merely because it could have been worded more precisely,²¹⁷ 2) not every word must be defined; undefined words are accorded their common, everyday meaning,²¹⁸ and 3) Notice is aimed at the conduct of the accused for things such as alerting them to elements of the crime.²¹⁹

²¹³ See generally *State v. Cephus*, 830 N.E.2d 422 (2d Dist. Montgomery County 2005); *State v. Schwab*, 695 N.E.2d 801 (12th Dist. Butler County 1997).

²¹⁴ See *Lanzetta v. State of N.J.*, 306 U.S. 451 (1939) (criminal statute invalidated because of an ambiguous definition within the element defining a “gang”). Justice Butler stated: “[t]he challenged provision condemns no act or omission; the terms it employs to indicate what it purports to denounce are so vague, indefinite and uncertain that it must be condemned as repugnant to the due process clause of the 14th Amendment.” *Id.* at 458. Justice Butler’s comments evidence the point that criminal statutes must give notice of the illegal conduct to average individuals.

²¹⁵ See *McBoyle v U.S.*, 283 U.S. 25, 27, 51 (1939); Justice Holmes famously said:

Although it is not likely that a criminal will carefully consider the text of the law before he murders or steals, it is responsible that a fair warning should be given to the world in language that the common world will understand, of what the law intends to do if a certain line is passed. To make the warning fair, so far as possible the line should be clear. *Id.*

²¹⁶ See *State v. Collier*, 581 N.E.2d 552, 555 (1991).

To successfully meet the standard for void for vagueness, it must be demonstrated that the statute is vague not in the sense that it requires a person to conform his conduct to an imprecise but comprehensive normative standard, but rather in the sense that no standard of conduct is specified at all. *Id.* at 555.

²¹⁷ *State v. Williams*, 728 N.E.2d 342, 361 (2000).

²¹⁸ *State v. Davidson*, 723 N.E.2d 172, 173 (7th Dist. Mahoning County 1998).

²¹⁹ See also *State v. Mushrush*, 733 N.E.2d 252, 259 (1st Dist. 1999) (1st Dist. Court contrasting sentencing guidelines from sentencing provisions in terms of providing notice to potential violators of statutory provisions).

B. Preventing Arbitrary and Discriminatory Enforcement

Prevention of arbitrary and discriminatory enforcement is regarded as the more important of the two prongs.²²⁰ A statute is unconstitutionally vague “when it leaves judges and jurors free to decide, without any legal fixed standards, what is prohibited and what is not in each particular case.”²²¹ The effect of the arbitrary enforcement is that the people to be protected by the statute are actually harmed by its application.

Construction of the proposed statute will be vital in assuring proper application and enforcement. It must be written properly to prevent giving undue discretion to the staff at the jails and prisons.²²² Providing requirements and penalties with specificity will eliminate the need for interpretation. Further, the legislation should include a substantial definition section. Rules of statutory construction do not require every term to be defined,²²³ however, this will provide empirical grounds for jails and prisons, courts, legislators, and incarcerated mothers to quickly understand the available rights and remedies.

Specific actions should be mandated within the statutory language. For example, if a pregnant inmate complains of any pregnancy-related issue, she should be immediately transported to the infirmary for examination. Example statutory language could provide:

Upon request, any incarcerated mother will be taken to the medical center within the correctional facility. Prisoner requests must be honored, regardless of subjective perception of intent or potential for lying by the prisoners. The risk of abuse of this privilege is heavily outweighed by the interest in protecting the health of both the expectant mother and her child.²²⁴

Providing such explicit language will eliminate any potential gray areas for individuals and courts to debate over, and will prevent the assertion of any vagueness

²²⁰ See *Kolender v. Lawson*, 461 U.S. 352, 357, 360 (1983) (statute requiring persons who are lawfully stopped to provide “credible and reliable” information was struck down because it gave the police unlimited discretion); see also *Smith v. Gougen*, 415 U.S. 566, 574 (1974) (Massachusetts flag-misuse statute invalidated for vaguely addressing non-ceremonial uses of flags resulting in criminal charges).

²²¹ See 1 LaFare, *SUBSTANTIVE CRIMINAL LAW* § 2.3(c), at 151 (2d ed. 2003); see also *Grayned v. City of Rockford*, 408 U.S. 104, 108-109 (1972) (a vague law impermissibly delegates basic policy matters to policemen, judges, and juries for solution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application), *Papachristou v. City of Jacksonville*, 405 U.S. 156, 168 (1972) (examines the effect of unfettered discretion being put in the hands of police officers); See also *Connally v. General Const. Co.*, 269 U.S. 385, 395 (1926) (a law becomes arbitrary when its application depends on the “probably varying impressions of juries”).

²²² See *City of Chicago v. Morales*, 527 U.S. 41 (1999) (Chicago gang loitering ordinance ruled unconstitutional under void for vagueness; ordinance gave police undue discretion, which lead to improper application of the law).

²²³ See *State v. Davidson*, *supra* note 218.

²²⁴ See *infra* § VII – “Proposed Statute.”

claims. Ultimately, this will prevent arbitrary and discriminatory enforcement of the statutory requirements.

VIII. MANDATED PUNISHMENTS

A. Basis for Punishment

The Ohio Revised Code provides statutory provisions that create criminal punishments for acts affecting the livelihood of children. The Revised Code specifically makes it a crime to endanger the life of a child.²²⁵ Penalties range from misdemeanors to felonies depending on the seriousness of the endangerment.²²⁶ The presence of such a statute evidences the Ohio Legislature's intention to preserve the sanctity of the lives of our children.

Ohio's statutory scheme also implements a broad view of fetal homicide laws. Ohio is among 38 states that have fetal homicide laws, and 23 states that apply fetal homicide laws to the early stages of pregnancy.²²⁷ The Revised Code acknowledges viability beginning at the point "at which there is a realistic possibility of maintaining and nourishing of a life outside the womb with or without temporary artificial life-sustaining support."²²⁸ Ohio imposes additional criminal punishment for various crimes that result in the termination of a woman's pregnancy. Involuntary manslaughter,²²⁹ reckless homicide,²³⁰ and negligent homicide²³¹ all have additional

²²⁵ Ohio Rev. Code Ann. § 2919.22(A) (West 2014);

No person, who is the parent, guardian, custodian, person having custody or control, or person in loco parentis of a child under eighteen years of age or a mentally or physically handicapped child under twenty-one years of age, shall create a substantial risk to the health or safety of the child, by violating a duty of care, protection, or support. *Id.*

See also Ohio Rev. Code Ann. § 2903.15 (makes permitting child abuse a crime); However, a person having responsibility of a child will be exonerated if they can show they did not have "Readily available means to prevent the harm to the child or the death of the child and the defendant took timely and reasonable steps to summon aid." *Id.* at § 2919.22(B).

²²⁶ *Id.* at § 2919.22(E)(1), (E)(2)(a) – (e) (West 2014).

²²⁷ NAT'L CONFERENCE OF STATE LEGISLATURES, *Fetal Homicide Laws*, available at <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> (last accessed Dec. 3, 2014).

²²⁸ Ohio Rev. Code Ann. § 2901.01(B)(1)(C)(i) (West 2014).

²²⁹ Ohio Rev. Code Ann. § 2903.04 (A) – (B) (West 2014) (makes it criminal to unlawfully terminate another's pregnancy as a proximate result of the offender committing or attempting to commit a felony or misdemeanor).

²³⁰ Ohio Rev. Code Ann. § 2903.041; "No person shall recklessly cause the death of another or the unlawful termination of another's pregnancy." *Id.* at § (A).

²³¹ Ohio Rev. Code Ann. § 2903.05(A) (West 2014);

No person shall negligently cause the death of another or the unlawful termination of another's pregnancy by means of a deadly weapon or dangerous ordinance as defined in section 2923.11 of the Revised Code. *Id.* at § (A).

Deadly weapon is defined as "any instrument, device, or thing capable of inflicting death, and designed or specifically adapted for use as a weapon, or possessed, carried, or used as a weapon. Ohio Rev. Code. Ann. § 2923.11(A) (West 2014). Dangerous ordinance encompasses various

penalties written within when the result of defendant's actions is the termination of a pregnancy. The Ohio Legislature expressed its intent to extend additional protection for pregnant mothers and their unborn children by including such additional penalties. This is the type of protection that needs to be extended to pregnant mothers within Ohio correctional facilities.

B. Extending Punishment to Correctional Facilities

The proposed statutory scheme institutes both mandatory care standards for pregnant prisoners,²³² and a punishment system for both correctional facilities and their individual actors for failure to provide care. Punishment is justified by the Ohio Legislature's intent to extend protection to the mother and her unborn child, evidenced in the explicit writing of the Ohio Revised Code.²³³ It is inhumane to deny mothers this type of protection during incarceration simply because these women lack proper recourse against the correctional facility.

Wagering punishment against correctional facilities and their individual actors presents a critical issue: punishing the people in charge can ultimately affect the prisoners. It is easily conceivable that decreased funding and levying personal punishment against individuals within the facilities could lead to further denial of care, or worse, complete abrogation of standards.²³⁴ However, a proper statutory and regulatory scheme can alleviate these issues and prevent any blatant downstream effects on these incarcerated mothers.

1. Punishing Individual Actors within the Facility

Individual actors within the facility would be subject to punishment when their actions fail to conform to the statutory standards. Similar to criminal defendants, the facility's actors should be punished when their actions have an adverse impact on the woman's pregnancy.²³⁵ Unlike criminal defendants, however, punishment should be levied before there is a detrimental impact on the mother or unborn child. In light of the detailed, statutorily mandated care for these women, failure to comply with such standards should result in an immediate penalty. For example, if a guard fails to escort a female prisoner to the infirmary upon her request for care, the guard would be subject

definitions. However, all deal with obsolete firearms and weapons that employ outdated firing mechanisms, such as those that employ the use of black powder, rather than gunpowder. *See* Ohio Rev. Code Ann. § 2923.11(L)(1) – (6)(2014).

²³² *See* Discussion, *supra*, §(V)(C).

²³³ *See* Ohio Rev. Code Ann. §§ 2901.01, 2903.04, 2903.041, *supra* notes 228-231 (all sections include additional punishment if defendant causes a termination of the mother's pregnancy).

²³⁴ Distribution of jail and prison funds will certainly affect the means of punishment. This issue was subjected to in-depth research, however, no constructive results could be obtained. Much of the information being sought fell within the bounds of "red tape," and was consequently not available through traditional research methods. A call was placed to the Ohio Department of Corrections, and a message was left for the director. However, as of February 16, 2015, there has been no reply.

²³⁵ *See* Ohio Revised Code sections, *supra* notes 228-231.

to a form of reprimand or punishment.²³⁶ Or if a nurse failed to properly assess the seriousness of the woman's claim, the nurse would be subject to sanctions.²³⁷ Example statutory language could posit:

Each individual actor's conduct will be examined and evaluated independently. More egregious denials of care will warrant harsher penalty. For example, a prison guard who dismisses an inmate complaining of a headache back to her cell will not be punished as harshly as a guard who dismissed an inmate who claimed to be having contractions, or suffering from vaginal bleeding."²³⁸

Punishments available to individuals would include monetary fines, work suspension, or potential termination. Penalties would depend on the severity of the offense. For example, a guard that disregards a woman's request to be taken to the infirmary for experiencing heartburn could have his pay suspended for a period of time. If the woman complained of vaginal bleeding after the guard sent her back to her cell, punishment would be more severe. Under these circumstances, the guard could be subject to more severe wage garnishment, or possibly termination. Seriousness of punishment is dependent upon the actor's knowledge of the woman's situation at the time of her request. The statute does not require facility actors to be trained in the medical field; however it does require the actors to be cognizant of the circumstances, the statutory requirements, and to take the prescribed actions.

2. Punishing the Correctional Facility

The actual correctional facilities differ from the individual actors because the facility and its controlling officers lack the typical interpersonal interaction with the inmates. The proposed statutory scheme must, therefore, be more proactive in preventing breaches of mandatory care. Proactive steps include: 1) implementation of extensive training for all staff members, 2) routine evaluations of staff and their exercise of mandatory statutory provisions, 3) developing a rapport²³⁹ with the

²³⁶ This article acknowledges the possibility of female prisoners attempting to take advantage of the system by making requests at various times and places that may burden the prison staff. However, this issue is minimized because it is limited to pregnant prisoners. Further, it is within the interests of the health of the mother and child to honor each request. Prison officials are urged to show deference to caution in these situations.

See also Stefan v. Olson, supra note 200, at 576 ("If a prisoner asks for and needs medical care, it must be supplied).

²³⁷ It is noted that prison doctors and nurses are subject to medical standards in addition to these statutorily mandated provisions. There may be situations where medical standards would usurp these regulations in light of their ethical duties as medical practitioners, and that is fully acknowledged by this article. However, the interplay between statutory duties and medical duties is not a topic that will be discussed in this article.

²³⁸ *See infra* § VII – "Proposed Statute."

²³⁹ Development of a rapport between guards and prisoners is more of a goal than a requirement. Development of proper relationships between guards and inmates facilitates proper conduct within correctional facilities. *See* S. Alexander Haslam and Stephen D. Reicher, *When Prisoners Take Over the Prison: A Social Psychology of Resistance*, 16 PERS. SOC. PSYCHOL. REV. 154, 154-55 (2012). Haslam and Reicher use the famous Stanford Prison

pregnant inmates to assure that standards are being maintained, and that they are receiving their entitled care, and 4) maintaining detailed documentation of all pregnant prisoner requests to establish an empirical system of assuring appropriate care.

Punishing the correctional facilities presents a unique challenge. Wagering monetary penalties against the institution would have dire ramifications upon the prisoners. For example, reducing the amount of state funding would affect the facility's ability to provide the requisite care for the prisoners. Doing so would create a vicious circle, where a facility is penalized but lacks the requisite means to reconcile the penalties.

Instead, the proposed legislation would establish a system of penalties imposed against the individuals within prison management. The individuals would be punished for lacking the requisite oversight to prevent statutory violations. Penalties would vary depending on the egregious nature of the offense. For example, a blatant disregard to take action to prevent their guards and nurses from providing the prescribed care would warrant a harsh penalty. Penalties would include garnishment of wages, personal fines, suspension, and ultimately termination for the most egregious offenses.

Statutory provisions would also subject the facility management to penalty for the actions of their employees and staff. For example, if a nurse was turning pregnant prisoners away and denying their care, and the prison officials knew of the nurse's actions but failed to take action to stop her from acting in such a way, the officials would also be subject to penalty. This system of vicarious liability would prevent prison officials from scapegoating their employees to avoid punishments against themselves. This would also create a degree of regulation within the walls of the prison by the staff because no single party could look to protect itself by deferring liability to someone else. This would, in theory, foster an environment of compliance with the proposed statutory scheme.

Example statutory language could include:

The correctional facility's liability will be examined and evaluated on a case-by-case basis. The correctional facility's liability will depend on its

Experiment ("SPE") as the basis for their examination. *Id.* at 155. The SPE took nine college students and divided them as guards and prisoners. *Id.* The results were horrific.

In its first 6 days, five of the original prisoners had broken down and been released as a result of the humiliation, degradation, and abuse that they had suffered at the hands of the guards. At this point in the study – which was scheduled to last 2 weeks – was called off because of concerns for the welfare of those who had been imprisoned. Significantly, though, the guards who had meted out this vicious punishment, were, like the prisoners, simply "normal" college students who had been randomly assigned to play a role as prisoners or guards in the study. *Id.*

The findings and results of the SPE are evidence of the potential negative ramifications of allowing correctional facilities to harbor negative, even abusive, relationships between inmates and guards. Advising and encouraging guards to attempt to develop positive relationships with these incarcerated mothers would, in theory, prevent the negative ramifications shown in the SPE. Not every single guard will get along with each inmate. This statutory construction fully accounts for this type of "human factor." The purpose of this sort of provision is a means to facilitate positive results within the correctional facility, but also acknowledge that relationships cannot be forced upon individuals.

knowledge of the individual actors' conduct and the prisoners' claims of needing care. More egregious denials of care warrant harsher punishment. Scierter will be examined when determining facility liability. For example, if the warden were aware that his/her guards were deliberately ignoring a particular prisoner's calls for help, but failed to circumvent the action, this facility would be subject to harsher punishment. Further, punishment includes garnishing of the warden's wage, redistribution of benefits to incarcerated mothers, and termination in the most egregious cases.²⁴⁰

There is no form of punishment or retribution that could possibly ease a mother's pain of losing a child, or a family's pain of losing a mother – especially when the death is the result of negligence or recklessness of an organization designed to protect them. Penalizing prison staff and officials will never take such pain away. Therefore, a duty falls upon the state to ensure that it takes proper action to establish guidelines to prevent any injurious consequences resulting from inadequate prisoner care.

IX. CONCLUSION

Chances to act proactively and prevent harm are rarely presented in our society. Remedial measures are put in place long after lives have been endangered and people have been harmed. Ohio has the rare opportunity to be proactive and prevent harm to pregnant inmates and their children. Ohio can assure the safety and health of these expectant mothers and children through the implementation of an adequate statutory scheme. Instituting statutes that require mandatory prenatal and post-birth care for incarcerated women would be a leap forward not only for prisoner's and women's rights, but also for human rights. These statutes would no longer allow the state to gamble with the lives of its incarcerated mothers and their children. Instead, safety and peace of mind could be delivered to these mothers and their children.

²⁴⁰ See *infra* § VII – “Proposed Statute.”

X. PROPOSED STATUTE

1. Definitions:

- a. "Adequate prenatal care" means prenatal care equivalent to the amount, type, quality, and frequency of care as prescribed by medical professionals.
 - i. Adequate prenatal care includes providing proper educational opportunities for the expectant incarcerated mothers.
 - ii. Quality of care provided at these visits, during these appointments, or during educational sessions will be the same as offered to non-incarcerated women.

2. Purpose:

- a. The purpose of this statute is to protect the health of expectant mothers and their children by providing mandatory, adequate prenatal care for all incarcerated mothers.
- b. These incarcerated mothers will not be treated differently as patients because of their current incarceration. The focus of this particular statute is to protect both the children and mothers, and discrimination against the mother ultimately harms the child.

3. Mandatory Care:

- a. Care covered under this statute:
 - i. Number of visits to a proper overseeing doctor
 - ii. Expected treatments during visits
 - iii. Educational opportunities for the expectant mothers
 1. The significant or an immediate family member may accompany the mother to these appointments.
 2. However, the individual, not the state, will fund expenses incurred, including travel to and from the location of the appointments.
- b. Upon admission, each inmate will be subject to an HIV/AIDS test, pregnancy test, and psychological evaluation to provide an adequate medical profile.
 - i. If an inmate tests positive as pregnant, or enters the facility pregnant, they will be subject to an in-depth psychological evaluation to determine the proper scope and requirements of their prenatal care.
- c. If the particular correctional facility is not properly outfitted with the medical facility or technology, the pregnant prisoners at that location will be transported to a hospital or medical center that is able to provide the adequate prenatal care.
- d. Each correctional facility will be outfitted with at least a medical center that can provide adequate care in cases of emergency. Not every jail and prison is expected to have a full-fledged medical center. However, each facility must be able to handle emergency situations.

- e. Correctional facilities that do not have a full-functioning medical center must have a proper transportation plan and agreement with a local medical center that can provide the requisite adequate prenatal care.
 - f. Members of the jail or prison medical staffs must be trained, certified, and proficient in handling emergency complications associated with prenatal care.
 - i. It is acknowledged that these medical professionals are subject to licensing and regulation from other entities. These licensing requirements will be considered when evaluating the staff.
4. Inmates' Requests for Care:
- a. Upon request, any incarcerated mother will be taken to the medical center within the correctional facility.
 - b. Prisoner requests must be honored, regardless of subjective perception of intent or potential for lying by the prisoners.
 - i. The risk of abuse of this privilege is heavily outweighed by the interest in protecting the health of both the expectant mother and her child.
5. Providing Adequate Notice:
- a. Pregnant inmates will be notified, in writing, of their rights afforded under this statute.
 - b. Inmates will be read their afforded rights aloud, and will be required to provide a signature acknowledging their understanding of these rights.
6. Punishment:
- a. Each prisoner's claim of failure to provide care will be examined on a case-by-case basis.
 - b. Punishing the Individual Actors:
 - i. Each individual actor's conduct will be examined and evaluated independently.
 - 1. More egregious denials of care will warrant harsher penalty.
 - a. For example, a prison guard who dismisses an inmate complaining of a headache back to her cell will not be punished as harshly as a guard who dismissed an inmate who claimed to be having contractions, or suffering from vaginal bleeding.
 - ii. Punishment can range from wage garnishment to termination depending on the severity of the conduct.
 - c. Punishing the Correctional Facility:
 - i. The correctional facility's liability will be examined and evaluated on a case-by-case basis.

- ii. The correctional facility's liability will depend on its knowledge of the individual actors' conduct and the prisoners' claims of needing care.
 - 1. More egregious denials of care warrant harsher punishment.
 - 2. Scierter will be examined when determining facility liability.
 - a. For example, if the warden were aware that his/her guards were deliberately ignoring a particular prisoner's calls for help, but failed to act to circumvent the action, this facility would be subject to harsher punishment.
- iii. Punishment includes garnishing of the warden's wage, redistribution of benefits to incarcerated mothers, and termination in the most egregious cases.