Distribution Agreement

In presenting this thesis as a partial fulfillment of the requirements for a degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis in whole or in part in all forms of media, now or hereafter now, including display on the World Wide Web. I understand that I may select some access restrictions as part of the online submission of this thesis. I retain all ownership rights to the copyright of the thesis. I also retain the right to use in future works (such as articles or books) all or part of this thesis.

Priya Patel April 9, 2025

Perinatal Shackling in the United States: An Ethics Perspective

by

Priya Patel

Ju Zhang
Adviser

Center for the Study of Human Health

Ju Zhang
Adviser

Dan Benardot

Committee Member

Christina Gavegnano

Committee Member

Victoria Phillips

Committee Member

2025

Perinatal Shackling in the United States: An Ethics Perspective

By

Priya Patel

Ju Zhang
Adviser

An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Center for the Study of Human Health

2025

Abstract

Perinatal Shackling in the United States: An Ethics Perspective
By Priya Patel

Perinatal shackling is the practice of restraining incarcerated women before, during and after labor. While case law has historically affirmed the health rights of incarcerated women, including the right not to be shackled, the United States' legal and regulatory environment still falls short in defending them. This thesis seeks to understand perinatal shackling through a unique two-pronged approach: an empirical review of state-level anti-shackling statutes and a normative, context-based ethical analysis of case studies using moral principles and ethical theories.

This thesis found that as of February 2025, out of the 50 states and the District of Columbia, 9 states do not have any anti-shackling statutes in place. Furthermore, 8 states had no documentation requirements in place for incidents of shackling within their existing anti-shackling statutes. Therefore, 17 states currently do not have documentation requirements for incidents of shackling. Additionally, only 22 states were found to grant medical staff the authority to order the removal of shackles. Out of the remaining states, 7 states were found to grant limited authority, 13 states were found to grant no authority, and 9 states had no legislation in place at all. Hence, 22 states currently do not grant medical staff with the authority to order the removal of shackles.

Based on this data, this thesis argues for the following universal policy recommendations that are backed by ethical theory: 1) extension of authority to health care professionals, especially nurses, 2) implementation of documentation requirements and review protocols during incidents of shackling, and 3) integration of clinical ethics consultations. Firstly, documentation requirements help promote the development of inner virtues within correctional staff. Secondly, the extension of authority to health care staff merges the perspectives of care and justice. Finally, the integration of clinical ethics consultations reduces moral distress within correctional officers and health care staff and promotes ethical and fair decision-making. In conjunction, these policy recommendations are proposed to promote fair and just decision-making on the use of shackles.

Perinatal Shackling in the United States: An Ethics Perspective

By

Priya Patel

Ju Zhang
Adviser

A thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Center for the Study of Human Health

2025

Acknowledgements

I would like to thank my adviser, Dr. Zhang for her continued support and mentorship throughout my research and the thesis-writing process. I would also like to my committee members, Dr. Benardot, Dr. Gavegnano and Dr. Phillips for their feedback, guidance, and time. Additionally, thank you to Dr. Freeman and Dr. Hall-Clifford for their supervision and advising through the Human Health Honors Program. Finally, I would like to give a special thank you to my family and friends for always supporting me and encouraging me throughout this process.

Table of Contents

Chapter 1: Introduction 1

Chapter 2: Methodology 3

Chapter 3: Historical Review of Legal Frameworks 9

Chapter 4: Results 22

Chapter 5: Theoretical Framework: Introduction to Ethical Considerations 26

Chapter 6: Case Studies 40

Chapter 7: Policy Recommendations 56

Chapter 8: Conclusion 60

Chapter 9: Limitations and Future Directions 61

Appendix A 65

Appendix B 68

References 71

Table of Figures

Figure 1: Methods Diagram 8

Figure 2: Existence of Anti-shackling Statutes 25

Figure 3 Documentation Requirements 25

Figure 4: Authority of Medical Staff 25

Chapter 1: Introduction

In 1980, there were 26,326 women incarcerated in the United States (Budd, 2024). By 2022, that number increased to 180,684, a 585% increase. Furthermore, according to the Prison Policy Initiative, 30% of the world's incarcerated female population are in the United States (Kajstura, 2018). In comparison, only 4% of the world's female population reside in the United States. This shows that over the past decades, the United States has emerged as a leader in women's incarceration rates. Furthermore, it is important to note that this incarceration is not proportional to all demographics as the incarceration rate for Black women was 1.6 times that of white women in 2022 (Budd, 2024). Similarly, the incarceration rate for Latina women was 1.2 times the incarceration rate of white women. Finally, incarcerated women experience a higher prevalence of negative health complications including mental illness, addiction, and chronic conditions (Norris et al., 2022). This shows that incarcerated women are a prevalent population in U.S who are vulnerable to a number of negative health outcomes which exemplifies their unique need. Therefore, it is important to understand factors that can act as a barrier to addressing this population's health needs and exacerbate their risk for negative health outcomes.

Dignam and Adashi define perinatal shackling as the use of handcuffs, leg irons, and waist shackles on pregnant inmates before, during and after birth (2014). According to the American College of Obstetricians and Gynecologists (ACOG), the state of pregnancy and postpartum period itself leaves women vulnerable to adverse health outcomes like venous thrombosis, hypertensive disease, and vaginal bleeding (2021). These risks are further exacerbated through shackling as it limits health care professionals' ability to assess, diagnose and treat these negative health outcomes (ACOG, 2021). Specifically, restraints limit mobility

which can increase the risk for falls and impede health professionals' ability to move a patient during labor and delivery related emergencies (ACOG, 2021).

In 2021, ACOG joined the American Medical Association (AMA) and the American Public Health Organization (APHA) when it published a committee opinion opposing the use of shackles on inmates who are pregnant, in labor, or in the postpartum period (ACOG, 2021; APHA, 2023; Clarke, 2013). Despite this, a study exploring the experiences of nurses caring for pregnant inmates found that 82.8% of the nurses interviewed reported that their patients were "shackled sometimes to all of the time" (Goshin et al., 2019, p. 27). Furthermore, a 2024 study found that all state laws restricting perinatal shackling include exception clauses that permit the practice when an inmate poses as a risk of escape or a risk to safety (Brawley & Kurnat-Thoma, 2024).

When the practice of perinatal shackling was first reviewed, what stood out was the legal persistence that allowed it, despite being generally condemned by reputable public health and medical organizations. Perinatal shackling, at initial glance, demonstrates itself as an obvious violation of human rights for which a complete ban can be argued. However, at further glance, the difficult dilemmas that legislators and policymakers face when navigating between the safety and security concerns of prisons and hospitals with optimizing the health and dignity of inmates emerges. Therefore, I am interested to see how an ethical perspective based on data analysis can aid in navigating this moral dilemma. According to philosopher John Harris, a bioethical analysis is the application of moral philosophy and ethical principles to address problems in the field of life sciences, including medicine and health care (Harris, 2001, as cited in Langlois, 2013). This paper seeks to propose policy recommendations on perinatal shackling by 1) gaining an understanding of the current legislative environment related to perinatal shackling through an

empirical collection of state statutes and reviewing the relevant constitutional and federal frameworks and 2) evaluating the ethical conflicts associated with it through an improved theoretical framework. In other words, in this thesis, I seek to answer the question: how can ethical theory be utilized to inform state policy?

In the chapters ahead, Chapter 2 will provide an overview of my methodology that takes a two-faceted empirical and normative approach to analyze perinatal shackling. In Chapter 3, within my empirical approach, I am going to explain the federal and constitutional history that frames today's legislative environment on this practice. I will also review previous legal mapping studies on perinatal shackling to provide a preliminary state framework. In Chapter 4, I will review the results from this thesis's mapping which sought to understand updated findings on how many U.S states have anti-shackling legislation in place, have documentation requirements for incidents of shackling and have clauses that extend the authority to health care staff to order the removal of shackles. Next, in Chapter 5, I will shift the focus to my normative approach which introduces a novel theoretical framework and includes the relevant ethical considerations related to perinatal shackling. I will apply this theoretical framework to two case studies in Chapter 6, *Nelson v. Correctional Medical Services* (2009) and *Villegas v. Metropolitan Government of Nashville* (2013). Based on my normative and empirical conclusions, I will propose policy recommendations in Chapter 7. Finally, in Chapter 8, I will offer concluding statements and in Chapter 9, review my limitations and relevant future directions.

Chapter 2: Methodology

An Empirical & Legal Approach

My thesis conducts a 50-state survey, which compiles findings regarding the "key provisions of law on a particular issue, identifies patterns in the nature and distribution of laws, and defines important questions for evaluation research, legal analysis and policy development" (Burris, 2020, p. 2). Using this methodology, I conducted a legal collection and survey of state statutes related to the use of restraints on inmates who are pregnant, in labor, and/or in the post-partum period for all 50 states and the District of Columbia.

Statues were primarily collected through the legal database, Westlaw. To compile the various statutes, a number of search strings were utilized because legislation related to perinatal shackling considers a number of key words. The search strings included the following terms: "pregnan!", "birth", "labor", "delivery", "postpartum", "restrain!", "inmate", "prison!", "document!", "report!", "writ!", "find!". The truncation on keywords with an exclamation point directs the search to include alternative endings to the word (UC Berkeley Law Library 2025). For example, "pregnan!" will include pregnancy, pregnant, pregnancies, etc. Multiple searches were conducted using search strings created in consultation with Westlaw's research attorneys and a law librarian at Emory Law School. All relevant statutes that resulted from these searches were compiled. Finally, I used Westlaw's AI Jurisdictional Survey tool to further identify relevant statutes related to perinatal shackling and documentation requirements that may have been missed in initial searches. Statues referenced from this survey were cross-checked with statutes previously downloaded and if any additional relevant statutes existed, they were added to the dataset.

After relevant statues were compiled by each state, the data was categorized to answer the following questions: 1) whether a prohibitionary statute related to perinatal shackling in each state exists, 2) whether a state's statute includes any form of documentation requirement for when incidents of shackling occur and 3) whether a state's statute provides health care professionals and staff with the authority to order removal of shackles. These questions were derived from previous legal mapping scholarship in this area, notably, "Use of Shackles on Incarcerated Pregnant Women" by Brawley and Kurnat-Thoma (2024) and the "Anti-Shackling Legislation and Resource Table" created by the organization, Advocacy on Reproductive Wellness of Incarcerated People (ARRWIP) (Thomas et al., 2024). In this thesis, the first two questions were answered as "yes" and "no" and the last question was categorized as: "authority", "limited authority" and "no authority".

Assessing the "restrictiveness" of each statue was extremely difficult to categorize because of the extent of variability, subjective nature of the prohibitionary rules across states, and time and resource limitations. Instead, this thesis includes a table with 10 statutes as examples that summarizes what forms of restraints are permitted, when they are permitted and other guidelines in each state (Appendix A). This structure was inspired by the resource table created by ARRWIP and seeks to show how anti-shackling legislation can vary across the U.S (Thomas et al., 2024).

Furthermore, previously conducted legal mapping studies on perinatal shackling were reviewed as a part of the empirical review and as a resource for deciding what variables to categorize for. This thesis specifically reviews the works: "Use of Shackles on Incarcerated Pregnant Women" by Brawley and Kurnat-Thoma (2024) , "A National Analysis of Shackling Laws and Policies as They Relate to Pregnant Incarcerated Women" by Thomas and Lanterman

(2019) and the "Anti-Shackling Legislation and Resource Table" created by the organization, Advocacy on Reproductive Wellness of Incarcerated People (ARRWIP) (Thomas et al., 2024). Finally, this paper conducted a case analysis of federal court cases, *Nelson v. Correctional Medical Services* (2009) and *Villegas v. Metropolitan Government of Nashville* (2013), to understand how legislation reflects onto real life scenarios.

A Normative Approach through Ethical Analysis

The second aspect of this thesis is a normative ethical review where I considered the questions of "what ought to be done?", "what ought not to be done" and the kind of people we should strive to become (Sugarman & Sulmasy, 2001, p. 3). Through this normative approach, I assessed the moral permissibility of perinatal shackling in U.S prisons. To set the foundation for my ethical analysis, I identified the relevant non-moral empirical facts which included federal law, state statutes, and case narratives. Then, I applied Beauchamp and Childress' principlism and moral theories to evaluate the ethical implications of shackling. This approach allowed me to understand and analyze the competing perspectives of carceral justifications and lived experiences of pregnant individuals. Furthermore, I used this ethical framework to examine the obligations of correctional officers, health care professionals and legislators. Finally, I developed my own moral judgements that were grounded on both theory and evidence to propose policy recommendations aimed at promoting justice, preservation of dignity, and compliance with moral principles when treating pregnant inmates.

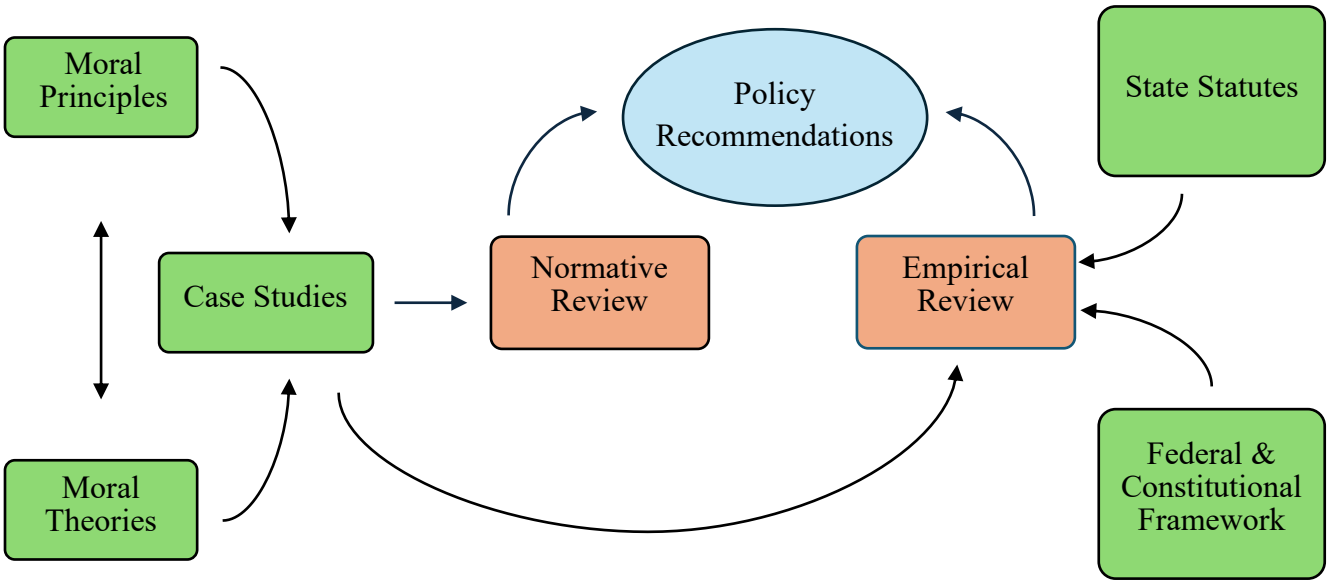
Specifically, the two federal court cases, *Nelson v. Correctional Medical Services* (2009) and *Villegas v. Metropolitan Government of Nashville* (2013) were reviewed. Case studies help us contextualize and assess ethical arguments through real-world examples. In this approach,

moral principles were first established, and then real-life cases were addressed through the "application of (abstract) principles" (Flynn, 2022, Section 5.1). Flynn states that a major advantage of this approach is being able to find agreement between theories to reach a moral judgement.

Philosopher John Rawls explains that "reflective equilibrium" is achieved when we work amongst theoretical frameworks, principles, moral rules and our own personal intuitions to produce a "considered judgment" (Daniels, 2023, Section 1). Through the methodology of achieving reflective equilibrium, this paper utilized the empirical and legal approach as a groundwork to build the normative approach upon with the ultimate goal of proposing policy recommendations (Figure 1). Furthermore, the integration of Beauchamp and Childress' principles of autonomy, nonmaleficence, beneficence, and justice with the notable moral theories like feminist theories, ethics of care, virtue ethics, utilitarianism, and egalitarianism allowed for the consideration of different criteria and perspectives. Combining these perspectives also allowed me to create an improved theoretical framework that is relevant to the context of perinatal shackling.

In conclusion, normative questions on how we should or should not act in the case of perinatal shackling is both complex and contentious. Through a multifaceted approach, this paper ensured that the moral judgments derived, and policy recommendations introduced were evidently supported through this binary approach of both normative and empirical study.

Figure 1: Methods Diagram



Chapter 3: Historical Review of Legal Frameworks

Constitutional Framework

In "Reproductive Healthcare for Incarcerated Women: From Rights to Dignity" (2019), Laufer analyzes the constitutional framework that sets the standard for the current legal environment on the health and reproductive health needs of female inmates. In particular, this work reviewed the landmark cases of *Estelle v. Gamble* and *Turner v. Safely* to make claims about their effectiveness in upholding the constitutional health rights of incarcerated women.

According to Laufer, the 1976 case, *Estelle v. Gamble,* established the constitutional right of incarcerated individuals to medical care (2019). In this case, a prisoner experienced an injury during a work assignment and argued the claim that his prison failed to sufficiently provide him treatment (*Estelle v. Gamble*, 1976, as cited in Laufer, 2019). He argued that this failure was a violation of his Eight Amendment right to be free from cruel and unusual punishment. The Supreme Court found that when a government entity incarcerates an individual, the individual is then reliant on the state for his or her necessary medical treatment. Therefore, a failure to provide this necessary medical treatment, subjects a prisoner to "pain and suffering" that serves no "penological purpose" and thus is "incompatible with the evolving standards of decency that mark the progress of a maturing society" (*Estelle v. Gamble*, 1976, as cited in Laufer, 2019, p. 1787). Hence, in its ruling the Supreme Court established that when a prison fails to meet the medical requirements of a prisoner, the involved parties, including the prison system and correctional staff, are acting in "deliberate indifference" to the inmate's needs. Finally, this act of deliberate indifference is a violation of the inmate's Eight Amendment right (*Estelle v. Gamble*, 1976, as cited in Laufer, 2019).

According to Laufer, the court also introduced a standard to establish this deliberate indifference as a constitutional violation (*Estelle v. Gamble*, 1976, as cited in Laufer, 2019). Within this standard, a medical needs to be defined as *serious* for a prison entity, official, or staff member to be considered as acting in deliberate indifference to it. Later, the case, *Farmer v. Brennan*, added a second standard to establishing deliberate indifference by proposing a "subjective awareness" component towards the *seriousness* of a medical need (*Farmer v. Brennan*, 1994, as cited in Laufer, 2019). The court stated that for a correctional officer to have subjective awareness, they "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" (*Farmer v. Brennan*, 1994, as cited in Laufer, 2019, p. 1787). In other words, correctional officers must have the knowledge of the circumstances that create a harm or risk of harm and also have the ability to reach that conclusion when a risk of harm is present.

According to Laufer, historically, the application of this standard has been generally successful in cases that has dealt with incarcerated women's health, but only when the health need is apparent and "egregious", and the claim of deliberate indifference is obvious to the court (Kuhlik, 2017, as cited in Laufer 2019, p. 1787). However, Laufer adds that "courts have been hesitant to classify certain reproductive issues as objectively serious-including pregnancy, elective abortions, or breast pumping" (Laufer, 2019, p. 1788). For example, historically, when courts consider certain reproductive health services like abortion, they determine its *seriousness* and necessity by comparing them to other procedures (*Victoria W. v. Larpenter*, 2004, as cited in Laufer, 2019). Therefore, the necessity of abortion would be determined by comparing it to the need of other elective procedures instead of analyzing abortion "in its own right." (*Victoria W. v. Larpenter*, 2004, as cited in Laufer, 2019, p. 1788). This shows that when courts compare the

reproductive health needs of women to the medical needs of men, they risk under-classifying their *seriousness*. Therefore, while *Estelle v. Gamble* is regarded as a landmark case for protecting the health needs of prisoners and holding prison officials accountable, its standard falls short in protecting the reproductive health needs of female prisoners (Laufer, 2019). In conclusion, this showcases what our legal system fails to do for incarcerated women, as oftentimes, their reproductive health needs like pregnancy-related care or breast pumping fail to be considered *serious* medical needs by courts.

Furthermore, even when the *seriousness* of a health need of a female inmate does get recognized by the court, oftentimes the second standard of establishing *subjective awareness* to prove deliberate indifference fails to be met. This can be exemplified by the 2010 case, *Webb v. Jessamine*, where a pregnant prisoner was forced to deliver her child in her cell because she was ignored by her deputies when she informed them that she was in labor (as cited in Marquis, 2018). In the court's decision, the *seriousness* of this medical need was established but they did not find that her prison guard acted in deliberate indifference on the basis that he did not have the "requisite knowledge" since he was "unaware that the plaintiff's water had broken" (Marquis, 2018, p. 222). This shows that even when a medical need is obvious like active labor and delivery, courts can fail to meet fair judgements through *Farmer v. Brennan's* subjective awareness component.

Drawing attention to perinatal shackling, the standards set by *Farmer v. Brennan* and *Estelle v. Gamble* are used to determine whether a correctional officer is deliberate indifference to the medical needs of the inmate by shackling them during pregnancy, labor, delivery, or postpartum. As perinatal shackling can lead to adverse health consequences to both the pregnant inmate and her child, courts deliberate on whether this risk of harm is outweighed by safety and

security justifications (Ferszt et al., 2018; Nelson v. Correctional Medical Services, 2009). Furthermore, statutory legislation universally contains exception clauses when it restricts the use of restraints to allow it in cases of flight and safety risk (Brawley & Kurnat-Thoma, 2024). Hence, as we have explored the constitutional framework utilized to assess incidents of shackling brought to courts, it is also important to explore frameworks that seek to determine the constitutionality of regulations.

In the 1987 case, *Turney v Safley*, inmates called the court to assess the constitutionality of two prison regulations that sought to interfere with the constitutional rights of inmates, one in regard to familial communication between immediate family members belonging to different correctional institutions and the second about the requirements set by the prison when an inmate intends to marry (*Turner v. Safley,* 1987). In conjunction with establishing that both regulations were unconstitutional, the court also introduced a standard known as the *Turner Test* that assesses the *reasonableness* of a regulation with four criteria (*Turner v. Safley,* 1987, as cited by Laufer, 2019). First, to justify a regulation, there must be a "valid" and "rational" connection between a regulation and a reasonable government need (*Turner v. Safley*, 1987, as cited by Laufer, 2019, p. 1790). Secondly, an "alternative means" must be set for a prisoner to exercise the limited rights. Thirdly, the courts must consider the impact that "accommodating this exercise of the right" has on the prison's resources (*Turner v. Safley*, 1987, as cited by Laufer, 2019, p. 1790). Finally, courts should also consider if there are alternative means available for a prison to achieve its goal. Today, courts are able to utilize this standard to validate a prison regulation that interferes with prisoners' rights.

The constitutionality of statues related to perinatal shackling can be considered within the *Turner Test* to understand if minimizing an inmate's rights is justified in light of public safety

and security concerns. While it can be argued that prison systems should maximize an inmate's health and dignity, *Turner v. Safley* shows that they need to also consider the government's and prison system's needs. Safety and security are integral components to the success of a prison system. Therefore, it can be argued that it may be necessary to infringe upon a prisoner's rights if it is necessary for a prison system's success. This can be especially true, if a prison system experiences serious limitations like lack of resources and staffing shortages that may necessitate the infringement of rights through shackling as the only means available for prisons to maintain public safety and mitigate security risks.

The standards set by *Turner v. Safley*, *Farmer v. Brennan*, and *Estelle v. Gamble* can be looked to for the protection of reproduction health rights of pregnant inmates. However, Laufer argues that the standards set by these cases were, nevertheless, established to cater to a male prison population and therefore lack the comprehensive framework for courts to uphold the health rights of incarcerated women (2019). This failure becomes apparent when we seek to address certain women's reproductive rights including access to abortion, access to menstrual hygiene products and the right to not be shackled while pregnant. This leaves us to question, how can a female prisoner's health needs be protected through constitutional frameworks, which were established principally to meet the needs of men.

The 1994 case, *Women Prisoners of District of Columbia* is known for being the first court case that ruled against the practice of perinatal shackling (Dignam & Adashi, 2014). This case established that the use of restraints during the labor and delivery period of a pregnant inmate is a violation of their Eighth Amendment constitutional rights. The court ruled that between the last trimester of pregnancy and labor or delivery, correctional officers may only restrain an inmate during transportation with leg restraints except if the inmate displayed violent

behavior in the past or has been a flight risk (Hall et al., 2015). Building on, in 2009, *Nelson v. Correctional Medical Services* established that restraining pregnant inmate during labor results in negative health consequences to the mother and her unborn child. The court also found that in their case, no safety or flight risk argument is justified or compelling enough for restraining a pregnant inmate during labor.

Following *Nelson v. Correctional Medical Services,* notable cases were *Brawley v. Washington* in 2010 and *Villegas* v. The *Metropolitan Government Of Nashville And Davidson County* in 2013 (Hall et al., 2015). In *Brawley v. Washington,* the court examined the argument that restraints should be avoided or removed because of the existence of a medical need. In *Villegas v. The Metropolitan Government Of Nashville And Davidson County,* the Sixth Circuit court took an interesting stance when it reversed a summary judgment in the plaintiff or prison's favor. While the court was considerate of the precedent set by *Nelson v. Correctional Medical Services*, it acknowledged that shackling law is not fully developed and contemplated the correctional institution's claim of the plaintiff presenting as a flight risk. These previous cases show us the arguments that incarcerated women and prison systems claim when incidents of shackling occur (Hall et al., 2015). As court systems focus on reviewing legal, health, and safety considerations, it can be valuable to examine these cases through focused ethical considerations. Later in this paper, I will study the cases of *Villegas* v. The *Metropolitan Government of Nashville and Davidson County* and *Nelson v. Correctional Medical Services* in depth through an ethical perspective.

Federal Framework: A Failure to Ban Perinatal Shackling

The First Step Act passed in 2018 includes prohibitory legislation on perinatal shackling for pregnant inmates that are in the custody of the Federal Bureau of Prisons (BOP) and the U.S. Marshals Service (Congressional Research Service 2019). This act prohibits the use of restraints on inmates who are pregnant in labor and the postpartum period. However, the act includes an exception clause where the use of restraint is permitted when the corrections official or U.S. marshal determines that the inmate is either a flight risk or safety risk, and if a treating health care professional finds that the restraints are necessary for the inmate's medical safety. The act also requires that restraints should be used in the least restrictive manner, and prohibits ankle, leg, waist restraints, backwards facing wrist restraints, 4-point restraints, and restraints that attach one inmate to another. The legislation also includes a documentation requirement for when restraints are used and gives medical staff the authority to ask for restraints not to be used or order their removal.

Finally, the legislation calls for the development of a training program for prison staff on the use of restraints for pregnant inmates and their health (Congressional Research Service 2019). Training guidelines must include: 1) how to recognize pregnancy-related symptoms that may require a referral to health care providers 2) what circumstances constitute as exceptions to "the prohibition on the use of restraints" 3) when restraints are used, how to use them in a manner that they do not present harm to the "inmate, the fetus, or the newborn", 4) reporting requirements when the use of restraints occurs and 5) the authority of health care professionals to request the removal of restraints (Congressional Research Service 2019, p. 17).

While the First Step Act attempts to create a general legislative action restricting perinatal shackling, it only applies to pregnant inmates in federal prisons under the BOP and the U.S. Marshals Service (Congressional Research Service 2019). The most recent census of state and

federal adult correctional facilities by the Bureau of Justice Statistics (BJS) in 2019 found that there are 1,677 adult correctional facilities in the United States, 111 of which are operated by the BOP and 1,155 by the state governments and 411 privately (U.S. Department of Justice, 2021). This shows that while there is a federal law in place that restricts perinatal shackling, the majority of correctional institutions in the United States are run by the state or privately. Furthermore, a majority of the United States' women's incarceration population resides in state prisons and local jails with 77,000 in state prisons, 84,000 in local jails, and 16,000 in federal prisons and jails (Sawyer & Wagner, 2025). Therefore, as states have individual jurisdictions on their anti-shackling legislation, it is important to report on how that anti-shackling legislation varies across states.

The First Step Act also requires the BJS to annually collect data from the Federal Bureau of Prisons (FBOP) (U.S. Department of Justice, 2024). The data collected found that in 2023, 123 pregnant inmates were in the custody of federal prisons. Out of the 123 pregnant inmates, 61 had a live birth, 47 were released from custody before giving birth, 9 experienced a miscarriage, and 4 had an abortion. Furthermore, there was 1 incident of ectopic pregnancy, 1 incident of preterm birth, and 1 incident of still birth (U.S. Department of Justice, 2024). Within this data, it is possible for pregnant inmates to experience multiple outcomes.

In 2023, three incidents of restraint usage on two pregnant inmates occurred and were documented (U.S. Department of Justice, 2024). All three incidents of shackling occurred when the inmate was in postpartum recovery and hand restraints were utilized. In 2022, BJS documented 8 incidents of restraint usage among 96 pregnancies. Restraints were used on 1 inmate who was pregnant at the time and 7 inmates who were in postpartum recovery. Finally, within all 8 incidents of shackling, hand restraints were used, and leg restraints were used within

3 of them. Between 2019- 2023, there were 180, 91, 74, 96, and 123 total pregnancies chronologically. Between 2019-2023, there were 1, 1, 2, 8, and 3 incidents of shackling chronologically (U.S. Department of Justice, 2024).

This data shows the prevalence of pregnancies in women's federal prisons, incidents of shackling as well as the maternal health outcomes. Furthermore, this shows that despite restrictive legislation, incidents of restraint-use still occur through the exception clauses. This demonstrates the importance of documentation requirements to account for them and ensure that the justifications under which they are utilized are warranted. We cannot make conclusions based on the effect of anti-shackling legislation on pregnancy outcomes based on this data alone because it was collected after the implementation of anti-shackling legislation. However, this data can be used in the future to compare pregnancy outcomes in prisons that do not have any anti-shackling policies in place to quantitatively explore the impact of restraint-use on pregnancy outcomes.

State Laws, Regulations and Policies

In January of 2000, Illinois was the first state to introduce and pass a state level statute against perinatal shackling (Dignam & Adashi, 2014). Specifically, this statute prohibited the use of restraints during transport to the hospital and the use of leg irons, general shackles and waist shackles during labor (Public Act 91-253, 2000, as cited by Dignam & Adashi, 2014). While the statute only addressed the use of restraints surrounding active labor/delivery and transport, it paved the way for more states to issue statutes related to anti-shackling in the subsequent years. Evidently, 17 more states enacted legislation by mid-2013 (Dignam & Adashi, 2014).

In 2015, Thomas and Lanterman conducted a national analysis on laws and policies related to perinatal shackling in the United States (Thomas & Lanterman, 2019). Their study excluded New Jersey, Michigan, and the District of Columbia. The study identified 9 states with no restrictions on shackling incarcerated pregnant women. Furthermore, the study found that 20 states had documentation requirements in place for when an incarcerated women is shackled "at any point during gestation, labor, delivery, or recovery" (Thomas & Lanterman, 2019, p. 273). Finally, all of the states evaluated permitted the use of shackles when the inmate posed as a safety of flight risk.

This study additionally researched how the states restrict the type of restraint utilized which includes handcuffs, leg irons, and waist chains. They found that the more restrictive a type of restraint becomes, the less likely the legislation is to permit it. According to Thomas and Lanterman, a reason for the second trend can be that a lesser restrictive restraint is perceived as less likely to cause harm to the pregnant inmate and her child by legislators. Therefore, the results showed that handcuffs emerged as "the most common shackling method used on pregnant incarcerated women" (Thomas & Lanterman, 2019, p. 278). Secondly, the study evaluated how shackling restrictions varied by the period of pregnancy which includes the first trimester, second trimester, third trimester, labor, delivery, medical emergencies, and the postpartum period. They found that as the pregnancy stage progresses or becomes more severe, the less likely the legislation was to permit the use of shackles. Therefore, during the first trimester, 39 states permitted shackling during pregnancy, 38 states permitted shackling during the second trimester of pregnancy and 34 states permitted them during the third trimester of pregnancy. Finally, 9 states allowed shackling during active labor, medical emergencies, and delivery, and 28 states

allowed it during postpartum recovery. Hence, the study shows that the closer an inmate is to birth or delivery, the likelihood of shackling being permitted is lower.

Published in 2024, a study by Brawley and Kurnat-Thoma identified 40 states and the District of Columbia with anti-shackling statutes in place as of September 2022. They found that all laws reviewed between these states included exception clauses where the correctional officer was permitted to apply restraints to pregnant inmates when it was determined that they presented as either a flight or safety risk. Similar to Thomas and Lanterman's findings, they found that while states vary on the level of restrictiveness within their legislation, they agree on permitting shackling during the exceptions clauses. (Brawley & Kurnat-Thoma, 2024).

This study also addressed variables of whether each state restricts shackling during pregnancy, birth, and postpartum, whether medical professionals have the authority to remove shackles, what the legislation defines as a medical professional, whether the state restricts waist restraints, and whether documentation is required when shackling occurs (Brawley & Kurnat-Thoma, 2024). Specifically, the study found that, 51% of states do not place restrictions on shackling during pregnancy, 45.1% do not have documentation requirements, 54.9% of states do not authorize nurses to remove shackles, and 41.2% do not prohibit the use of waist shackles.

Finally, the "Anti-Shackling Legislation and Resource Table" by the organization, Advocacy and Research on Reproductive Wellness of Incarcerated People (ARRWIP) affiliated with the Johns Hopkins University School of Medicine Department of Gynecology and Obstetrics details anti-shackling laws, on perinatal shackling as of January 2024 (Thomas et al., 2024). They provide a summary table on the anti-shackling legislation in each state as well as on the federal level. They also categorize the states into 1) whether states restrict restraint-use

during pregnancy, labor, delivery, postpartum, and transportation, 2) whether states restrict restraint-use during labor and delivery, 3) whether states permit medical staff to order the removal of restraints, 4) whether states require documentation and 5) which states have no anti-shackling legislation in place at all. They identified 15 states for the first criteria, 41 states and Washington D.C for the second criteria, 24 states for the third criteria, 32 states for the fourth criteria, and 9 states for the last criteria.

Regulating State Law

Incarceration in the United States umbrellas many different forms of institutions including prisons, halfway houses, and jails (Schlanger et al., 2020). Prisons fall under the jurisdiction of the state and federal government and hold those who are convicted of a felony and sentenced to one or more years of prison. Halfway houses "facilitate reintegration of prisoners into the non-prison world… provide community-based supervision to people deemed low risk" (Schlanger et al., 2020, p. 4). Finally, jails are predominantly operated locally by cities and counties and can hold individuals who 1) are awaiting trial, 2) convicted for short terms, 3) are awaiting transfer 4) are awaiting a hearing and 5) have been confined on the basis of illegal immigration grounds (Schlanger et al., 2020). As established, the majority of the United States' female incarceration population resides in state prisons and local jails (Sawyer & Wagner, 2025).

In the United States, each state's prison system is operated by the state's Department of Corrections (DOC) while the federal prison system is operated by the Bureau of Prisons (BOP) (Dolovich, 2022). According to Dolovich, theoretically, a state's department of corrections' structure is shaped by the "state legislation authorizing their creation, and their ongoing operation is always subject to statutory directives and legislative oversight" (Dolovich, 2022, p.

156). Furthermore, courts are meant to reinforce and "play only a modest role in prison regulation" (Dolovich, 2022, p. 156). Dolovich argues that legislation has largely avoided interfering authoritatively in prisons and leaves the decision-making up to corrections administrators. Hence, "much therefore rides on prison officers being independently motivated to ensure the safety and well-being of the residents they oversee" (Dolovich, 2022, p. 162). Dolovich introduces an important argument of the power delegated to correctional and prison officials and the limitations of policy.

As mapping all of the variables that Thomas and Lanterman, Brawley and Kurnat-Thoma and ARRWIP did in their studies was beyond the scope of my thesis, I have decided to focus on whether state statutes include documentation requirements for shackling and whether they distribute authority over the use of restraints to health care providers. According to Dolovich, the prison environment antagonizes inmates in the eyes of correctional officers as "people sentenced to arrive already labeled as wrongdoers deserving of punishment" (Dolovich, 2022, p. 162). While Dolovich points out an important factor on the existence of bias amongst correctional officers, we can consider how legislation can be used to address these cases of bias and increase accountability. Documentation requirements and review protocols can account for unwarranted incidents of shackling as the correctional officer is required to report on the incident and justify his/her actions. Secondly, authorizing medical professionals to order the removal of shackles divides the formerly, independently distributed power, amongst correctional officers and health care professionals.

Chapter 4: Results

My thesis searched for statues related to perinatal shackling in all 50 states and the District of Columbia. For the purposes of this paper, when referring to "states", I include the District of Columbia. I found that there are 42 states with legislative statutes pertaining to perinatal shackling or restricting the use of restraints on pregnant inmates (Figure 2). Furthermore, 34 states had a legislative documentation requirement in place for incidents of shackling (Figure 3). Legislation in 22 states granted health care professionals with the authority to order the removal of restraints, and 7 states were identified as granting limited authority (Figure 4).[1]

Below, Figure 2, maps the existence of legislative prohibitions, limitations, or restrictions on the use of shackles with pregnant inmates across states. States without any prohibitions on shackling are the following: Alaska, Iowa, Kansas, Michigan, Montana, North Dakota, South Dakota, Wisconsin, and Wyoming. Figure 3 maps the existence of legislative documentation requirements on the use of shackles with pregnant inmates across states. The following states have anti-shackling legislation in place but have no documentation requirement within it: California, Indiana, Kentucky, New Mexico, Ohio, Oklahoma, Oregon, and West Virginia. Figure 4 maps the existence of legislative authority to medical staff to influence the use of shackles. The following states with anti-shackling legislation gave "no authority" to medical staff: Alabama, Arizona, Colorado, Georgia, Indiana, Kentucky, Mississippi, Nevada, New Mexico, North Carolina, South Carolina, Utah, and Vermont.

[1] Regulations in addition to statutes were used in the states of New Jersey and Virginia for categorization by error. They are included because the regulations answer research questions that the state's anti-shackling statute does not. For Virginia, 6 VAC 15-40-985 is the regulation and Va. Code Ann § 53.1-40.13 and VA Code Ann. § 53.1-40.12 are the statutes. For New Jersey, N.J.A.C. 10A:31–13.10 is the regulation and N.J. Stat. Ann. § 30:1B-6.9 and N.J. Stat. Ann. § 30:1B-6.8 are the statutes.

The following states were labelled as providing limited authority to health care professionals: Florida, Minnesota, New Hampshire, New Jersey, New York, Oregon, and West Virginia. Appendix B contains the syntax and interpretations for why these 7 states were labeled as limited authority. For example, in Florida's statute, the legislation states that the physician may "request" for restraints not to be used for "documentable medical purposes" and the correctional officer can "consult with the medical staff" over its use (Fla. Stat. Ann. § 944.241, 2024, p. 2). However, the correctional officer still holds the power to place restraints if they make the determination that an "extraordinary public safety risk" exists (Fla. Stat. Ann. § 944.241, 2024, p. 2). In comparison, Arkansas' legislation (which was grants authority) states that "restraints shall be removed if a physician, nurse, or other health professional requests that the inmate or detainee not be restrained" (Ark. Code Ann. § 12-32-102, 2025, p. 1). We can see that Florida's legislative syntax includes words like "consult" and "request". This *limits* the medical staff's authority to influence the removal of restraints while Arkansas' legislation gives them an explicit power to *order* the removal of restraints.

Appendix A includes summaries of the anti-shackling legislation in place for 10 states as examples. This is intended to showcase how legislation varies throughout the states on factors of severity and specificity. For example, Arkansas prohibits the use of restraints on inmates who are pregnant, in labor or the postpartum period except during extraordinary circumstances (Ark. Code Ann. § 12-32-102, 2025). On the other hand, Florida's legislation prohibits restraints only during labor, delivery, and postpartum period with the exception of a special circumstances (Fla. Stat. Ann. § 944.241, 2024). This shows that while Arkansas' legislation includes restrictions on restraints during pregnancy, Florida's legislation is silent. Furthermore, Idaho prohibits restraints "of any kind" during labor and delivery except in extraordinary circumstances (Idaho Code Ann.

§ 20-902, 2025). On the other hand, Connecticut places a complete ban on use of restraints on inmates who are in labor or delivery including during transport without an exception clause (Conn. Gen. Stat. Ann.§ 18-69c, 2024). This shows that legislation can vary across states regarding the types of restraints that are prohibited, when they are prohibited, and when special circumstances apply.

Figure 2: Existence of Anti-shackling Statutes

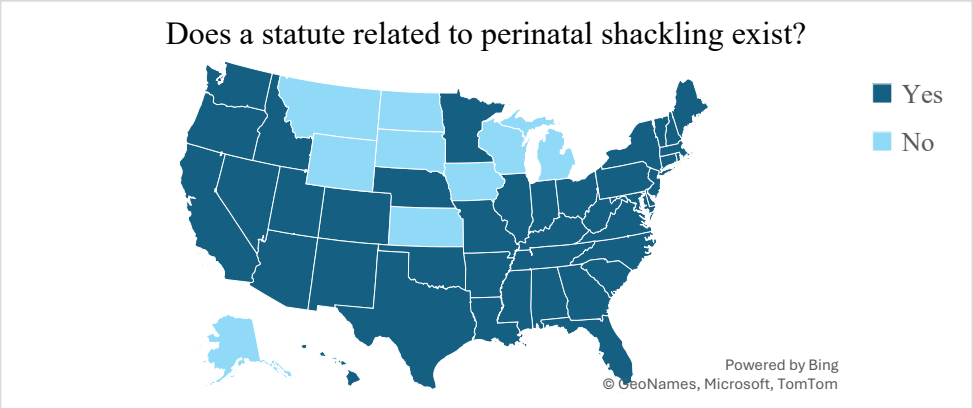


Figure 3: Documentation Requirements

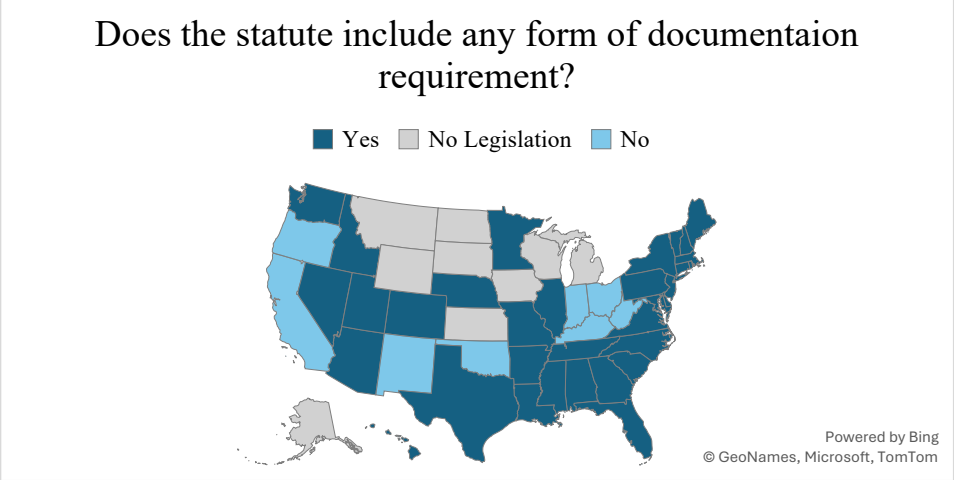
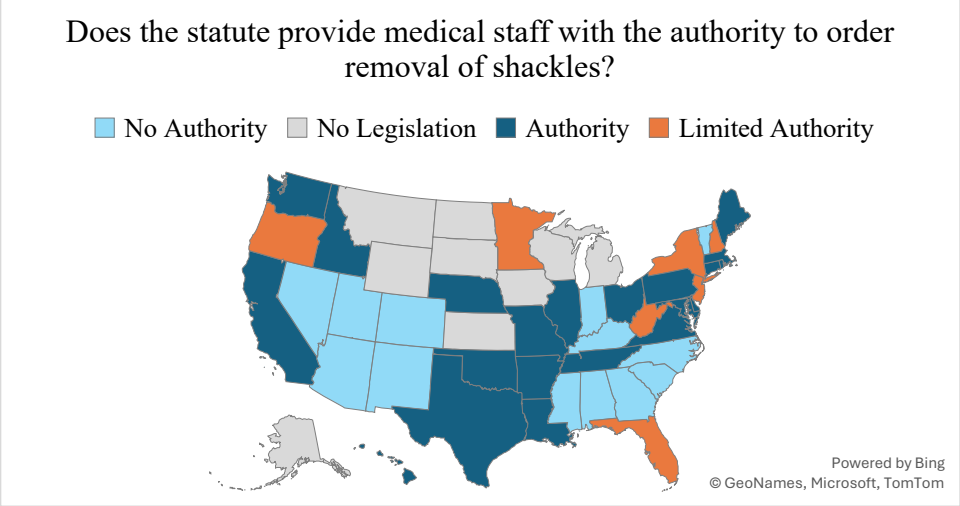


Figure 4: Authority of Medical Staff



Chapter 5: Theoretical Framework: Introduction to Ethical Considerations

Achieving Reflective Equilibrium through the Integration of Moral Principles & Theories

The moral principles of autonomy, nonmaleficence, beneficence, and justice are described in *Principles of Biomedical Ethics* (Beauchamp & Childress, 2013). In their text, the authors establish that these principles are *prima facie* and define them as different from definite obligations as they can conflict with and override with each other. According to Arras, Beauchamp and Childress argue that since real-life scenarios are not straightforward, it is not acceptable to rank principles or give one principal priority over another when conducting an ethical analysis (2017). Instead, we should view principles as equals without a ranking. However, this viewpoint has been controversial as bioethicists have argued that a lack of structure "deprives principles of 'systematicity'" (Gert et al., 2006, as cited in Arras, 2017, pg. 9). In other words, without a clear structure and rank, how these principles should be weighed varies amongst people and different interpretations.

The goal of using principles is to establish a theoretical framework that can be used to produce a moral judgment on perinatal shackling and frame policy. To produce systematicity within the four principles, this paper will view them as Beauchamp and Childress intended and incorporate ethical theories based on the context of the moral issue at hand: perinatal shackling. According to philosopher, John Rawls, by working amongst theoretical frameworks, principles, moral rules and our own personal intuitions, reflective equilibrium can be achieved (Daniels, 2023). Therefore, this paper will combine Beauchamp and Childress's *prima facie* principles with recognized frameworks in bioethics like feminist ethics, ethics of care, virtue ethics, egalitarianism, and utilitarianism.

Autonomy, Principle of Respect for Autonomy, and Feminist Ethics

Beauchamp and Childress define a person's autonomy as their ability to make their own decisions and be the administrators of their own life (2013). This ability is dictated by two factors: liberty and agency. First, to have liberty, one must have freedom from outside, coercive influences. Secondly, to have agency, one must have the rational capacity to act intentionally. The principle of respect for autonomy obligates us to avoid hindering somebody else's ability to act as an autonomous person and to foster autonomous decision-making (Beauchamp & Childress, 2013). Beauchamp and Childress's traditional idea of autonomy has been widely criticized by feminist ethicists (Mackenzie & Stoljar, 2000). Mackenzie and Stolijar identify five major critiques of autonomy which include the idealization and individualization of autonomy. To demonstrate this, they cite the works of notable feminist scholars Lorraine Code and Annette Baier.

Lorraine Code criticizes that the traditional definition of autonomy idealizes its "notion of self-sufficient independence" (Mackenzie & Stoljar, 2000). She describes the traditional autonomous being as "self-sufficient, independent, and self-reliant" which aligns "autonomy with individualism" (Code, 1991, as cited by Mackenzie & Stolijar, 2000, p. 6). Code argues that, symbolically, this view of autonomy is not only unrealistic but it also values "independence" over other values that emerge from "interdependence" like "trust, loyalty, friendship, caring and responsibility" (Mackenzie & Stoljar, 2000, p. 6). Furthermore, Code criticizes that this "character ideal" of autonomy strips away diversity and views institutions and societies that are based on "interdependence" as a threat to autonomy. (Mackenzie & Stoljar, 2000, p. 6).

This ideal autonomous agent can also be weaponized against oppressed demographics in society, notably, people with disabilities and women (Wendell, 1996 as cited by Ells, 2001). An

example of this is when social constructs and stereotypes perpetuate the idea that women have inferior rational capacities for decision-making than men (Donchin, 1995). This stereotype can be perpetuated by physicians and health care providers when they make judgements based on gender and underestimate a female patient's capacity for decision-making.

Secondly, Mackenzie and Stolijar (2000) critique individualism against four different understandings of it, three that stand out are 1) that individuals are secluded from other individuals, 2) that individuals can characterize their sense of self as independent from their relationships, and 3) an individual's identity is inherent. Considering the first understanding of individualism, Annete Baier claims that people are "heirs to other persons who formed and cared for them, and their personality is revealed both in their relations to others and in their response to their own recognized genesis" (Baier, 1985, as cited by Mackenzie & Stolijar, 2000, p. 7). Bair's argument directly falsifies autonomy's focus on individuals as separate beings because they argue that it is impossible for a person to develop without the influence of their environment. The first standard of Beauchamp and Childress's standard for autonomy is liberty or a freedom from outside, coercive influences (Beauchamp & Childress, 2013). However, Baier introduces the convincing argument that meeting this standard is impossible because external influences and relationships are compulsory to personal development.

Human beings live in social environments and therefore it is impossible for their beliefs, choices and actions to not be characterized by their relationships. This idea that individuals are made up of their social context also makes for the arguments that our environment influences how we view ourselves and that our relationships are key characterizers of our identity (Mackenzie & Stoljar, 2000). Both of these claims falsify the second and third understanding of

individualism and proves that identity can be extrinsic and that our social relationships impact how we view ourselves.

To revise and address these critiques of autonomy, feminists introduce the idea of understanding autonomy through relationships, which accounts for the impact of oppressive social institutions and conditions on an individual (Ells, 2001). This reconstruction of Beauchamp and Childress's autonomy seeks to create a definition of autonomy that is in line with the real world and moves away from idealization and individualism. When considering an incarcerated woman, the nature of the incarceration itself disqualifies her from acting as Beauchamp and Childress's independent, autonomous agent. Therefore, even if an incarcerated individual possesses agency, living under a prison system's umbrella is a barrier to their liberty. Hence, when we consider an incarcerated woman, we need to understand the context of her environment and institutional forces at play, highlighting flaws in Beauchamp and Childress' narrowed definition.

Hence, the question arises: if an incarcerated woman's autonomy is predetermined to be infringed, how can her bodily autonomy be preserved? To answer this, we must consider the principle of respect for autonomy. As established earlier, inmates are reliant on the state for their health needs. Similarly, they also look to prison authorities and health care teams for the protection of their autonomy. I argue that when considering the relationship between an inmate and her correctional officer or physician, the latter party holds a greater degree of freedom, control, and power. Decision-making over use of restraints is up to correctional officers and not the inmate herself. Therefore, to prioritize an inmate's bodily autonomy, ideally, a correctional officer should refrain from the use of restraints. However, as autonomy and the principle of respect for autonomy are *prima facie*, they can be overridden by other principles including

beneficence (promotion of good) and nonmaleficence (prevention of harm) (Beauchamp & Childress, 2013). This can include maintaining the safety of other stakeholders like the prison staff, medical staff, and other inmates.

Principle of Beneficence and Dignity

Philosopher William Frankena defines the principle of *beneficence* as an obligation to prevent and remove harm to others while actively promoting good (Beauchamp & Childress, 2013). Therefore, correctional officers, physicians, nurses, and medical staff have an ethical obligation and responsibility to promote the health of pregnant inmates, actively work to promote positive health outcomes, and preserve the dignity of pregnant inmates.

Whether beneficence should be viewed as an obligation is largely dependent on the situation it is being evaluated under (Jacobson & Silva, 2010). This thesis argues that beneficence should be viewed as an obligation in the context of pregnant inmates navigating the carceral institution for care. The *prima facie* nature of respect for autonomy allows correctional officers, health care workers, and the law to act paternalistically, if justified (Vaughn, 2022). In Gerald Dworkin's definition of paternalism, the state coercively interferes with the matters of an individual on the basis that they are acting with that individual's best interest and to protect them from harm (Wicks, 2016). Because incarcerated individuals are dependent on the state for their health and well-being, the state has a responsibility for their care both legally and ethically. Beauchamp and Childress consider health care to be relational in the sense that when we consider the relationship between the patient and physician, the patient is at a subordinate position because they possess a health need or illness (2013). Similarly, when we consider the relationship between an inmate and the correctional officer, the inmate is also at a subordinate

position because of their incarceration in addition to their health need or illness. This power imbalance between the patient or prisoner, the physician, and the correctional officer demonstrates the ethical obligation of both the physician and correctional officer to act in beneficence or in a way that promotes good.

In addition to health and well-being, dignity is a need and right of incarcerated individuals and preserving it also belongs under the umbrella of doing good. While human dignity is an automatic right solely based on being human, social dignity is determined by an individual's interactions with others and society (Jacobson & Silva, 2010). Within social dignity includes individualistic dignity or self-worth and relational dignity or worth that is demonstrated through actions and behavior. While human dignity is intrinsic, social dignity is variable and can be preserved, promoted, and diminished. Incidents of shackling are a violation of both of these forms of dignity. Therefore, both the social and intrinsic forms of dignity need to be upheld. However, social dignity is particularly vulnerable to incarceration because it can be diminished through the direct influence of how correctional officers perceive and treat incarcerated individuals.

When a health care provider or prison staff member interacts or forms a relationship with a patient, they have the opportunity and obligation to act in beneficence. Therefore, as dignity can be established and promoted through action, under the obligation of beneficence, paternalistic parties including medical staff and prison authorities should engage in action that promotes a pregnant inmate’s social and intrinsic dignity.

Principle of Non-maleficence and Harm

Beauchamp and Childress's principle of nonmaleficence is described as an obligation to not cause harm to others (Beauchamp & Childress, 2013). Distinct from the active promotion of good, this principle enforces the intentional action of harm avoidance.

The definition of harm can vary based on context, but in the case of perinatal shackling, I include and consider any physical, emotional, pain, injury, and/or suffering that may be caused to both the pregnant inmate and her unborn child. While the physical negative health outcomes that may arise through perinatal shackling may be more apparent, we must also consider the harm that can be caused to her psychology and dignity. Furthermore, during incidents of perinatal shackling, the pregnant inmate is not the only stakeholder. We must also take into consideration the harm done to others when a correctional officer restrains a pregnant inmate, including the moral distress subjected to other patients in the hospitals, health care staff, and other prison staff.

Chapter 3 of this thesis establishes that courts often determine the legal accountability of a prison official to the medical needs of a prisoner by assessing whether they were acting in deliberate indifference. In other words, if a prison official does not possess the knowledge of the medical and health needs of a person, they are not acting in deliberate indifference and therefore are protected from legal consequences. However, Beauchamp and Childress, hold people ethically accountable for unintentional harm through the principle of nonmaleficence's harm caused by negligence (2013). As harm can be imposed on an individual both intentionally and unintentionally, an ethical lens enforces responsibility for both.

While it is important to establish accountability for quantifiable harm, we must also consider the risk for harm. Shackling a pregnant inmate serves as a physical health risk for both the mother and her unborn child (Ferszt et al., 2018). However, not all cases of perinatal

shackling result in negative health outcomes. According to Beauchamp and Childress (2013) an action imposing the risk of harm does not guarantee that a harmful outcome will occur. Hence, even when a pregnant inmate is not restrained, she may still experience a negative health outcome or harm. Therefore, when we make a moral judgement, we should not just consider the quantifiable harmful outcomes that occur but also consider actions that impose the risk of harm.

Principle of Justice

According to Beauchamp and Childress, the principle of justice formally states that everybody should be treated equally (2013). However, they find that this simplistic definition lacks a nuanced approached when applied to health care settings. To address this, they introduce material principles of justice which are based on notable moral theories like utilitarianism, libertarianism, communitarianism, and egalitarianism.

Utilitarians believe that one must act by maximizing utility or producing the maximum amount of good with the minimum amount of bad (Beauchamp & Childress, 2013)[2]. Libertarian theories believe that all members of society are obligated to one another to consider and uphold individual liberty rights through coercive powers and fair procedures. Libertarian philosophers also believe in a limited state interference and argue against a public health care system (Häyry, 2022). Communitarianism theories emphasize community, common good, and general welfare as opposed to individual rights (Beauchamp & Childress, 2013). Additionally, communitarians argue for a government that has naturally developed and reject societies based on rights contracts or utility (Häyry, 2022). Egalitarianism's idea of justice promotes the idea of treating people

[2] This idea of maximizing utility has different interpretations within Utilitarianism. While one form is the maximization of good and minimalization of bad, an example of another form is by achieving the minimum harm or negative utilitarianism (Smart, 1958)

equally because all humans are born with equal status. (Beauchamp & Childress, 2013). Egalitarians believe that the “important constituents of well-being” should be included in this equal treatment (Häyry, 2022, p. 16). When considering the practice of perinatal shackling through a policy perspective and the point of view of correctional officers, the utilitarian perspective of balancing the harms with benefits and the egalitarian perspective promoting the fair distribution of “constituents” of well-being are relevant and valuable. These perspectives allow us to deliberate between the well-being of inmates and safety concerns for the public as well as security concerns of correctional officers.

As established earlier in Chapter 3, the United States’ legal framework obligates prisons to the health care of inmates. Unlike inmates, a non-incarcerated individual or a *free citizen* enjoys the liberty to act strategically for their health care services (Kipnis, 2012). This includes having the ability to change doctors or care providers, express dissatisfaction to management or administrators, sue providers, or choose to pay out-of-pocket for services that are not covered by their insurance. In comparison, the options available to incarcerated individuals is drastically limited as they do not have the liberty to engage in any of the preceding concepts and must accept what is available.

Distributive justice calls for a fair distribution of goods and services that is consistent with the necessities of society (Creary, 2021). As seen in the previous paragraph, the environment of care for an incarcerated individual is not and can never be homogeneous to that of a *free citizen.* However, because inmates do not have the freedom to strategize and optimize it for themselves, prisons are bound legally and morally to provide them substantive and fair health care (Kipnis, 2012). Focusing on Häyry’s definition of egalitarianism, quality health care is an integral and a defining "constituent of well-being” and a right established at birth (Häyry, 2022,

p. 16). In other words, while incarceration serves to delegate a punishment, the withholding of health services should not be included in that punishment. As seen earlier, courts agree with this philosophy when they establish that a deliberate indifference to the serious health needs of inmates is a form of cruel and unusual punishment in violation to the Eight Amendment. Incarcerated individuals are entitled to a fair distribution of health care goods and services and deserve to have their health care be given equal priority. This includes freedom from coercive shackling that can lead to negative health outcomes.

One method of achieving this fairness is through utilitarianism's attempt to optimize the maximization of utility or balance of the most "good" with the least "bad" (Beauchamp & Childress, 2013). Utilitarians believe that this act of maximization requires an impartial perspective that "that gives equal weight to the legitimate interests of each affected party" (Beauchamp & Childress, 2013, p. 355).

As we have established, the First Step Act (2018) and statutes related to perinatal shackling permit the use of restraints during flight and safety risk (Brawley & Kurnat-Thoma, 2024; Congressional Research Service, 2019; Thomas & Lanterman, 2019). Legislators make a valid argument where they seek to protect the safety of the public and medical staff through exception clauses. On the other hand, certain policies that give health care professionals explicit power to order the removal of restraints exemplifies their attempt to protect the health and well-being of pregnant inmates. When considering anti-shackling legislation, by navigating between two risks of harm, policymakers deliberate on who's "good", or benefit should be prioritized. When considering the "bad", legislators, health staff, and prison staff should consider the harms of shackling to the incarcerated individual and her unborn child, and a risk of safety by the incarcerated individual to herself and her unborn child in the absence of shackling. They also

consider the risk to safety of the prison staff, public, health staff, and the concern for flight risk in the absence of shackling.

Within these policies, the decision-making is usually left entirely up to the correctional officer and sometimes includes the health care staff. Utilitarians can argue that by allowing one group to be "prioritized" over another, the interests of the "the affected parties" are not given equal weight. However, correctional officers and health care workers take on paternalistic roles who have special obligations to the health and safety of those they are responsible. However, as social beings, our beliefs, choices and actions are often impacted by our environment and relationships. Therefore, bias against certain racial groups, gender, and incarcerated populations can also pave the way for impartial decision-making. Secondly, correctional officers also have non-paternalistic obligations to the prison's interests and security. Therefore, it is impossible for these personal biases and special obligations to not influence their decision-making on which prevention of "harm" is optimal. However, instead, it is necessary to ensure that the selection of which harm to prevent is fair and just.

Moral Theories: Aristotle's Virtue Ethics and Ethics of Care

In Book II of *Nicomachean Ethics*, Aristotle describes inner virtue as two-fold: intellectual and moral. While intellectual virtue is taught through "instruction", moral virtue is developed through "habit" (Aristotle, ca. 350 B.C.E./1926, p. 71). Aristotle further states "Virtue then is a settled disposition of the mind determining the choice of actions and emotions, consisting essentially in the observance of the mean relative to us, this being determined by principle, that is as the prudent man would determine it" (Aristotle, ca. 350 B.C.E./1926, p. 95). Therefore, as Aristotle dives deeper into the definition of virtue, he describes it as the inherent

inner qualities that drive an individual's "actions and emotions". In Book III, he further states, "If then whereas we wish for our end, the means to our end are matters of deliberation and choice… But the activities in which the virtues are exercised deal with means. Therefore, virtue also depends on ourselves. And so also does vice" (Aristotle, ca. 350 B.C.E./1926, pp. 143-145).

According to Aristotle, when we seek to achieve an "end", the "means" to achieve so is a choice between "virtue" and "vice". Therefore, virtue is developed, either through instruction or habit. However, Aristotle states that regardless, a virtuous action is a choice that is dependent on the individual. In other words, as individuals, we choose to either engage in or refrain from a certain virtuous behavior (moral or immoral action). Hence, Aristotle states, "if therefore we are responsible for doing a thing when to do it is right, we are also responsible for not doing it when not to do it is wrong, and if we are responsible for rightly not doing a thing, we are also responsible for wrongly doing it" (Aristotle, ca. 350 B.C.E./1926, pp. 143-145). Aristotle's virtue ethics advocates for the individualistic choice of the inner development of virtuous character. This choice between "virtue" and "vice" dictates whether an action performed is moral or immoral.

Health care providers and correctional staff are held to certain standards of behaviors and actions or "virtues". The International Corrections & Prisons Association (ICPA) guidelines virtues and standards of ethical conduct to correctional officers and individuals working in correctional facilities (ICPA, n.d.). Key virtues highlighted within their code are honesty, integrity, duty of obedience, duty to report, duty of care, transparency, and professional conduct. Within duty of care, ICPA highlights that correctional officers should recognize the "inherent dignity" within inmates and the worth they are granted with the status of being human (ICPA, n.d., Section 3). Furthermore, the duty of care calls to correctional officers to view each inmate

with the “potential” of becoming “a law-abiding citizen” (ICPA, n.d., Section 3). As discussed in the principle of justice, the nature of incarceration blurs the line of what rights and liberties inmates are entitled to. The perception of correctional officers of prisoners impacts their decision-making on whether it is appropriate to restrain inmates or perceptions of what standard of care inmates are deserving of.

Because engaging in virtuous behavior promotes moral action, it is integral for correctional officials to possess these inner virtues. The duty to report obliges correctional officers to report situations where they witness unethical behavior or when a correctional official may witness another officer shackling a pregnant inmate when it is not warranted (ICPA, n.d.). Furthermore, the virtues of integrity and honesty requires correctional officers to possess accountability and transparency when shackling occurs. Professionalism includes the attributes for collaboration and consultation with health care professionals on the health and safety needs of pregnant inmates. While on one hand, Aristotle tells use to choose “virtue” over “vice”, he excludes women from virtue, claiming them not to be “perfect deliberators” because they do not “generate as much heat as men do” granting men a superior status (Superson, 2024, p. 3). Hence, feminist’s ethicist often criticizes Aristotle's view of women being inferior to men in their capacity to “deliberate” and his view that women do not have the power to choose virtue.

Similarly, Feminists criticize traditional moral theories and principles by claiming that they do not include the “moral experience” of women (Vaughn, 2022, p. 51). This includes extracting out assumptions that women are inferior, less mature, or less rational than men or that their moral conflicts and concerns are inferior to men’s. Because of these concerns and critiques of traditional moral theory that excludes women, feminist scholars propose an entirely new theory, the ethics of care. This theory is valuable because it considers the unique moral

experiences of women which includes the experience of pregnancy that is assigned to women at birth.

This theory of ethics of care was introduced by Carol Gilligan who found that women often embody the perspective of care, and men rely on the perspective of justice (Held, 2005). This idea has been criticized for stereotyping women as emotional and men as rational. However, Gilligan expresses that attributes of care and rationality are both essential for men and women to possess and that men should work to build virtues of care and women should consider justice (Held, 2005). I believe that this integration of the care and justice perspective manifests well into moral conflicts of perinatal shackling. As health care providers and correctional officers are responsible for inmates, they must possess virtues of both care like empathy and compassion as well as of rationality and justice like having the ability to reason, think critically, and balance risks. In other words, they must have the ability to empathize with pregnant inmates on their situation as well as be able to balance between factors like the health needs of the pregnant inmate and the safety and security of the hospital staff. Furthermore, it is important to note that while health care professionals are responsible for the care of their patients, the have an unequal distribution of power when they are not granted the authority to remove shackling.

Chapter 6: Case Studies

Overview of *Nelson v. Correctional Medical Services*

At 29 years old, Shawwana Nelson was incarcerated by the Arkansas Department of Corrections' (ADC) McPherson Unit at six months pregnant (*Nelson v. Correctional Medical Services*, 2009) for "credit card fraud and hot checks" (*Nelson v. Correctional Medical Services, 2008*, p. 4). On September 20, 2003, Nelson arrived at her prison infirmary after going into labor (*Nelson v. Correctional Medical Services*, 2009). As she was in extreme pain and her contractions measured at five to six minutes apart, her infirmary nurses prepared to transport her to a contracted civilian hospital for birth. To be transported, Nelson needed to walk from the prison infirmary to the sally port down a hallway that was approximately the distance of a football field. While walking, Nelson was in so much pain that she had to stop twice and rely on the wall for support. At the sally port, Nelson met Officer Patricia Turensky who was instructed by Lieutenant Williams to rush Nelson to the hospital and not delay with handcuffs. Despite this, she restrained Nelson using handcuffs. (Nelson v. Correctional Medical Services, 2009).

At 3:50 pm, they arrived at the hospital and Officer Turensky shackled Nelson's legs to a wheelchair to take her to the maternity ward (*Nelson v. Correctional Medical Services*, 2009). At the maternity ward, both of her ankles were restrained to the opposite sides of her hospital bed. At this point, Nelson had dilated to 7 centimeters and was in labor. She could not move her legs or stretch and was experiencing extreme physical and mental pain. Every time a nurse needed to check her dilation, they would ask Officer Turensky to remove her shackles. After they were done, Officer Turensky would shackle her again. Nelson also requested an epidural, but was informed that she would have to wait for her physician, Dr. Herberger, who arrived at 5:00 pm. At this point, because Nelson was too close to delivery, Dr. Herberger only prescribed her

Tylenol. He also requested that her shackles to be removed before she went to the delivery room. At 6:15 pm, Nelson was taken to the delivery room where she gave birth to a baby boy.

According to Alexander in "Unshackling Shawanna: The Battle Over Chaining Women Prisoners during Labor and Delivery" (2009), a law review on this case, after the delivery, Nelson was re-shackled to her hospital bed by Officer Turensky who shortly after went off-duty and left the hospital. Because she was shackled postpartum, Nelson had soiled herself during the night. This led the correctional officer who took over for Officer Turensky to refrain from restraining Nelson her second night at the hospital (Alexander, 2009).

According to Nelson, the incidents of shackling caused her mental distress, pain, injury to her hip, tear to her stomach muscles, an umbilical hernia, and damage to the sciatica nerve (*Nelson v. Correctional Medical Services*, 2009). Hence, she needed to undergo a surgery for her hernia and a have a hip replacement. Nelson's orthopedist also stated that the shackling caused her hip deformation due to which she will experience "lifelong" pain (*Nelson v. Correctional Medical Services, 2009*, p. 8). Finally, Nelson claimed that this pain has hindered her ability to perform everyday activities, and she has been advised not to engage in future childbirth (*Nelson v. Correctional Medical Services*, 2009).

According to Alexander, Nelson filed a lawsuit against ADC and Correctional Medical Services (CMS) - a for-profit company contracted by ADC to provide medical care to prisoners on April 15, 2004 (Alexander, 2009). She later added ADC's medical director, Larry Norris, and the correctional officer who restrained her, Officer Turensky, as well as unnamed nurses to her complaint as additional defendants. This led the state defendants and Officer Turensky to file a motion for summary judgment based on qualified immunity (Alexander, 2009). A summary

judgment occurs in a case where the court enters a judgment prior to allowing the case to continue to a comprehensive trial (Cornell Legal Information Institute, 2024). Qualified immunity provides legal immunity to government officials when they are being sued because the plaintiff claims a violation to their "statutory or constitutional right" (Cornell Legal Information Institute, 2023).

Alexander notes that the district court dismissed Nelson's claim against the nurses due to pre-trial conflicts and the claim against CMS and the medical director on the basis that "no evidence demonstrating the unconstitutionality of the CMS policy" was provided (Alexander, 2009, p. 445). However, notably, the court did not dismiss Nelson's claim against Officer Turensky and ADC Director Norris and denied their claim for qualified immunity. This led the defendants to file an appeal to the Eighth Circuit Court of Appeals.

The Eight Circuit Court of Appeals panel reversed the district court's decision and granted qualified immunity to the defendants (Alexander, 2009). According to "Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners" by Ocen, this panel of three judges concluded that because the prison officials took Nelson to the hospital when she expressed her pain and removed the restraints prior to delivery, they were not acting deliberate indifference (2012). This led Nelson to request a rehearing petition to the Court of Appeals which was granted (Alexander, 2009).

The major question at the rehearing en banc was whether Nelson was entitled to proceed to trial for her claim that Officer Turensky and Director Norris violated her Eighth Amendment rights by shackling her during labor and postpartum (Nelson v. Correctional Medical Services, 2009). A 6-5 opinion yielded that the use of shackles on Nelson during labor was a violation to

her Eighth Amendment rights and that her pregnancy did constitute as a "serious medical need" (Ocen, 2012). However, the court affirmed the panel's granting of qualified immunity to Director Norris and only reached the conclusions in favor of Nelson in regard to Officer Turensky (Nelson v. Correctional Medical Services, 2009; Ocen, 2012). Furthermore, in Judge Murphy's opinion on the rehearing, he determined that Nelson established the right not to be shackled and provided that she was not a security or flight risk (Nelson v. Correctional Medical Services, 2009). Hence, the case against Officer Turensky was allowed to continue to a jury trial.

In the final jury trial against Officer Turensky, the jury ruled in favor of Nelson and awarded her a nominal, $1.00 in damages (Nelson v. Turnesky, 2010). This outcome was based on Nelson's only remaining claim of deliberate indifference shown by the correctional officer to her medical needs (Nelson v. Turnesky, 2010). Therefore, the court's decision was backed by the constitutional frameworks and precedents of *Farmer v. Brennan* and *Estelle v. Gamble* (Dignam & Adashi, 2014). Furthermore, in regard to the negligent, nominal charges awarded by the jury, Ocen states that it is "certainly plausible that the ideological constructions of female prisoners generally and Black women in particular as bad mothers who are deviant, dangerous, and sexually promiscuous, impacted how the jury viewed the physical and dignitary harms Nelson suffered" (Ocen, 2012, p. 1283). While this case ultimately ruled in favor of Nelson, Ocen asserts that social bias on incarceration, race and gender may have played a role as to why Nelson was only given a nominal award of $1.00 for damages.

Ethical Analysis

From this case, what stands out is the initial shackling of Nelson through the use of handcuffs at the sally port by Officer Turensky. At this point Nelson was in so much pain by her

contractions that she had to use the wall as support. This is something that Officer Turensky was a witness too. Aristotle attributes moral action to virtuous behavior, which he describes as an individual choice (Aristotle, ca. 350 B.C.E./1926). One of the virtues set by the ICPA includes the duty of care which requires correctional officers to recognize the "inherent dignity" of inmates (ICPA, n.d., Section 3) The immediate shackling of Nelson by Officer Turensky despite receiving instructions from her superiors to refrain from doing so and being witness to her pain and suffering exemplifies a lack of concern to Nelson's health, dignity and the health of her unborn child. This lack of care is further demonstrated when Nelson was shackled at the hospital in labor and during postpartum. This is especially apparent when Nelson was repeatedly shackled and unshackled every time a nurse requested to check her dilations. This action of being subjected to continuous shackling and unshackling further dehumanizes Nelson's experience as she is left facing extreme emotional and mental pain while already experiencing the pain of labor. This dehumanization and infliction of emotional and mental pain is a threat to Nelson's social and intrinsic dignity.

Secondly, Officer Turesnky's actions conflicted with the regulations in place and the orders of her superiors. At the time, Ark. Dep't of Corr. Admin. Reg. 403 § V (1992) or Regulation 403, an administrative regulation by the ADC required that restraints be used "only when circumstances require the protection of inmates, staff, or other individuals from potential harm or to deter the possibility of escape" (Nelson v. Correctional Medical Services, 2009, p. 8). Furthermore, the regulation specifies that during transport for medical emergencies, an officer should "use good judgment in balancing security concerns with the wishes of treatment staff and the medicine needs of the inmate" and to consult with a superior when an officer has reason to believe that a security risk exists (Nelson v. Correctional Medical Services, 2009, p. 8).

According to Circuit Judge Murphy's opinion, Officer Turensky would have been aware of these regulations and received training on them during her orientation (Nelson v. Correctional Medical Services, 2009). ICPA's duty of obedience requires correctional officers to adhere to rules, regulations and ethical guidelines. Furthermore, ICPA's virtue of professional conduct requires that correctional officers apply "sound judgement, which is fair, reasonable, and just" (ICPA, n.d., Section 6). Along with ICPA's duty of care, Officer Turensky also demonstrates a violation of these virtues. This is exemplified through the following facts: 1) Nelson was arrested as a non-violent offender 2) Officer Turensky testified that "she did not ever feel threatened by Nelson at any time" and 3) Nelson did not pose as a flight risk (Nelson v. Correctional Medical Services, 2008; Nelson v. Correctional Medical Services, 2008). Therefore, Officer Turensky shackled Nelson in the absence of a flight risk or security risk and against the regulations in place. This stands as a clear violation of the virtues: duty of obedience and professional conduct.

In her defense, when asked about her reasoning for shackling Nelson, Officer Turensky testified that "because if I don't and the Warden shows up at the hospital —which she has done on occasion—she would write me up" (Nelson v. Correctional Medical Services, 2009, p. 18). While Officer Turensky may be suggesting a broader institutional failure, it is still important to note that she was still advised earlier by her superior upon meeting Nelson to not delay with the use of handcuffs. Additionally, it has been established that her own personal judgment did not suggest that Nelson posed as either a safety or security risk.

Despite testifying "no" when asked if Nelson said or did anything that would suggest that she is a flight risk, Officer Turensky also testified "Because I did not know what [Nelson's] crime was and the way she was talking about how she should not be considered an inmate because she was in the free world in a free-world hospital, that made me a tad nervous." (Nelson v.

Correctional Medical Services, 2009, p. 18). While Officer Turensky's statements contradict, a reasonable factfinder in the court's rehearing procedure found that when viewed in the "light most favorable to Nelson", Nelson's statement could be interpreted as simply that she was expressing a "wish to be able to give birth in the normal manner without being shackled to the bed" (Nelson v. Correctional Medical Services, 2009, pg. 18). Regardless, the final jury trial ruled in favor of Nelson on her deliberate indifference claim. Furthermore, ICPA's duty of obedience "entails no obligation to follow orders to do anything illegal or unethical" (ICPA, n.d., Section 2). Therefore, while it can be argued that the fear of being written up by a warden may have placed Officer Turensky in a difficult position when deciding whether or not Nelson should be shackled, she was under no ethical or moral obligation to do so.

We have considered the failure of Officer Turesnky to recognize Nelson's "inherent dignity" and to treat her in a manner that upheld it. However, it is important to note that the shackling also caused Nelson considerable physical harm. Nelson claimed a hip injury and umbilical hernia that required surgical treatment along with other negative health outcomes from the shackling (Nelson v. Correctional Medical Services, 2009). She described the long-term consequences of this which includes medical advice to refrain from future childbirth and chronic pain. Hence in this context, harm not only consisted of emotional injury and suffering but also quantifiable physical injury. Additionally, referring to shackle-use, Officer Turensky stated that she "imagine[d] they hurt the ankles when you're lying in bed" (Nelson v. Correctional Medical Services, 2009, p. 10). Hence, Officer Turensky demonstrates an awareness of the pain that she may be infliction on Nelson. In conclusion, through the infliction of these forms of harm, Officer Turensky acts in violation to the principle of nonmaleficence.

Through her testimony, we can also establish that Officer Turesnky acted in violation to the principle of beneficence which dictates the active promotion of well-being and dignity. One could argue that Officer Turensky did remove restraints on Nelson when she was specifically asked to, first by the nurses and then by Dr. Herberger and therefore fulfilled the obligation of harm avoidance. However, Officer Turensky had directly witnessed Nelson's suffering and was told by a nurse on duty that "she wished that Nelson was not being restrained by shackles" (Nelson v. Correctional Medical Services, 2009, p. 10). Furthermore, through her most recent testimony quoted, we can see that she had an awareness of the harm and suffering that can be caused through shackling. Hence, it can be established that Officer Turesnky had compelling reason to refrain from shackle-use and no compelling reason to justify them. Therefore, Officer Turensky's lack of concern demonstrates a violation to the principle of beneficence.

Focusing on the possession of certain virtues like care and obedience and the relationship between Officer Turensky and Nelson, it has been established that through her actions, Officer Turensky acted in violation of the principle of nonmaleficence, beneficence, and ICPA's duty of care and duty of obedience. In Chapter 5, I established that an incarcerated individual's liberty is reduced by their prison system which makes them dependent on their prison system for the preservation of their bodily autonomy. Furthermore, due to its *prima facie* nature, an incarcerated individual's autonomy can be infringed upon if justified by the principles of beneficence and non-maleficence. In this case when Officer Turensky, infringed upon Nelson's bodily autonomy through the use of shackles, I demonstrated that she had acted in violation of these two principles. As Officer Turensky had both paternalistic obligations to the well-being of the inmate and her child and non-paternalistic obligations to the prison staff, just decision-making would have resulted if Officer Turensky gave fair weight to both obligations. However, I have

established that, instead, Officer Turensky was indifferent to the rights and needs of Nelson by shackling her with no rational justification for it. Therefore, through the violations of virtue ethics, the principle of beneficence and the principle of non-maleficence, Officer Turensky violated the principle of justice and subjected Nelson to an unfair distribution of harm.

Case Study 2: *Villegas v. Metropolitan Government of Nashville*

On July 3, 2008, Juana Villegas was arrested by police officer, Tim Coleman. in Tennessee at nine months pregnant (*Villegas v. Metropolitan Government of Nashville,* 2013). After failure to provide a valid driver's license, she was arrested and brought to a jail operated by the Davidson County Sherriff's office. There, her illegal immigration status was established, and she was placed on a detainer which meant that no federal action would be taken until are charges were resolved. Due to her detainer and failure to post bond, Villegas was classified as a "medium-security inmate". On her third day in jail, Juana Villegas' water broke, and she went into labor (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). After informing the jail guard, she was placed in an ambulance to go to Nashville General Hospital. On the ambulance, her wrists were handcuffed together in front of her body and her legs were shackled together while she was on a stretcher. She rode to the hospital in this state with two male officers, Officer Barshaw and Officer Farragher. During the ride, Officer Barshaw asked his supervisor, "what if all of a sudden the baby started [and it] took more time to unrestrain these restraints in the back of the ambulance" (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). At the hospital, the staff requests for her shackles to be removed so Villegas can change into her hospital gown. As she changed, Officer Barshaw and Officer Farragher were in the room with their backs turned and she was re-restrained after she finished.

Shortly after this, Officer Moore arrived at the hospital to take over for Officer Barshaw and Officer Farragher. Officer Farragher informed Officer Moore of Villegas' medium security status and provided her with Villegas' charge sheet. Under her supervision, Officer Moore removed Villegas' shackles but kept one of her legs restrained to the hospital bed. Officer Moore also overheard the hospital staff and a doctor discussing a "No Restraint Order" and a nurse informed Moore that she 'shouldn't put leg irons on [Plaintiff]'" (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). At 11:00 PM, Officer David Peralta takes over for Officer Moore who then leaves the hospital. At 11:20 pm, a hospital doctor signs a physician's order requesting the removal of restraints and shackles which is placed into Villegas hospital file. However, this order is not given to any officer. Shortly after Officer Peralta arrives at the hospital, he removes Villegas' restraints. At this time Villegas requests pain medication and receives an epidural. At around 1:00 AM, Villegas gives birth to her child. At 7:00 AM, when Officer Peralta's shift ends, he re-restrains one of Villegas' ankles to her hospital bed. When Villegas is discharged, the hospital staff provides her with a breast pump, but Officer Peralta does not allow Villegas to take it with her because he does not consider it to be a "critical medical device". (Villegas v. Metropolitan Government of Nashville, 2013).

These events caused Villegas to file a suit in the United States District Court for the Middle District of Tennessee against the Metropolitan Government of Nashville and Davidson County in March 2009 (Villegas v. Metropolitan Government of Nashville, 2013). She claimed that the shackling during labor and postpartum as well denial of a breast pump by the Defendant was an act of deliberate indifference to her health and medical needs (Villegas v. Metropolitan Government of Nashville, 2013). The district court granted Villegas partial summary judgment and ruled that the Defendant was deliberately indifferent to her medical needs through the

shackling during labor and postpartum and denial of breast pump. The case went on to trial for damages and she was awarded $200,000 by a jury. This led the Defendant to submit an appeal to the United States Court of Appeals, Sixth Circuit. The Court of Appeals reversed the district court's summary judgment on both claims and determined that Villegas' claim was not warranted, and the case needs to be remanded for further proceedings. Eventually the Metropolitan Government of Nashville and Davidson County entered a settlement with Villegas for a total of $490,000, $390,000 of which accounted for legal fees (Nashville Metropolitan Council, 2013).

When reviewing the appeal, the court viewed the "facts and all inferences…in the light most favorable to the party against whom summary judgment was entered" or the Metropolitan Government of Nashville and Davidson County (Villegas v. Metropolitan Government of Nashville, 2013, p.3). Because the court of appeals had not previously decided on a shackling claim, they looked to previous courts and cases on deliberate indifference and medical needs claims. In Chapter 3 of this paper, I discussed how the *Farmer v. Brennan* established that in order to be indifferent to an incarcerated individual's medical needs, a correctional officer must have a subjective awareness of that need (Farmer v. Brennan, 1994). The court also identified a second component along with standard: objectivity. This assesses whether society considers the risks claimed as something that "violates the contemporary standards of decency" (Helling v. McKinney, 1993, as cited by Villegas v. Metropolitan Government of Nashville, 2013, p. 3). The court also looked to previous shackling cases that declared shackling as a violation to the inmate's Eight Amendment rights, the United Nations' Standard Minimum Ruled for the Treatment of Prisoners which states that restraints should only be used to mitigate flight risk, for health and safety reasons in the absence of alternative means and the American Medical

Association's resolution that advocated for similar sentiments (Villegas v. Metropolitan Government of Nashville, 2013).

Concerning the objective component, the court found that, while shackling is condemned and qualifies as a violation of "contemporary standards of decency" by society, there are exceptions where it is accepted by society like flight or safety risk (Villegas v. Metropolitan Government of Nashville, 2013). Similarly, when establishing the Eight Amendment right, the court found that they must consider whether Villegas was truly flight risk as the Metropolitan Government had claimed. The court found that Villegas' classification as a medium security inmate and her state of pregnancy and labor complicates whether her shackling was warranted under a flight risk claim. This conflict makes the district court's summary judgment inappropriate. In other words, the court found that, while a reasonable factfinder would have concluded that Villegas was likely not a flight risk due to her pregnancy, "material factual disputes" existed in the district court's case on whether Villegas was adequately "shown to be a flight risk" (Villegas v. Metropolitan Government of Nashville, 2013, p. 10).

In regard to the *subjective* component, the court explored whether the officers were aware of the risk of harm caused by shackling. In her defense, Villegas provided testimony of Officer Bradshaw who, as shown earlier, stated "what if all of a sudden the baby started [and it] took more time to unrestraint these restraints in the back of the ambulance" (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). Furthermore, Villegas argued that the fact that the hospital ordered the officers to remove the shackles establishes *subjective* awareness. However, the court felt that this evidence is not enough because there was no record of the order and no evidence that the officers were aware of it.

Furthermore, both sides presented medical experts who gave contradictory statements (Villegas v. Metropolitan Government of Nashville, 2013).Villegas presented an assistant professor of Obstetrics and Gynecology at Meharry Medical College who stated that the use of leg irons and shackles during pregnancy increases the risk for blood clots which can be life-threatening. Furthermore, she stated that a pregnant inmate is most at risk to this during the postpartum. Finally, she explained that restraints can cause, impede the pregnant woman's ability to "safely handle a newborn child", increase the risk for falls, and be a major problem if the patient experiences umbilical cord relapse (Villegas v. Metropolitan Government of Nashville, 2013, p. 10). Villegas also brought forward a psychiatrist who spoke about the psychological risks caused by shackling. On the other hand, the Metropolitan Government of Nashville and Davidson Country also brought a gynecologist who contradicted with "there is no significant risk to the patient with a leg restrained up to the time of delivery and immediately postpartum and none in this case" (Villegas v. Metropolitan Government of Nashville, 2013, p. 9). Hence, these conflicting testimonies further inclined the court to reverse the district court's summary judgment.

In conclusion, due to disputes on establishing the objective and subjective component to justify a deliberate indifference, conflictive expert testimonies on the negative outcomes, the court ruled to reverse the district court's summary judgment. They found that on remand, a jury needs to determine whether Villegas posed as a flight risk and whether the officers had subjective knowledge.

Ethical Analysis

A major difference between *Nelson v. Correctional Medical Services* (2009) and V*illegas v. Metropolitan Government of Nashville* (2013) is that the latter considers the additional inequity that Villegas faced due to her illegal immigration status. As established, distributive justice focuses on the fair distribution of benefits and risks. Villegas was arrested for failing to provide a valid driver's license and was identified as an illegal immigrant. This, along with an inability to post bond, resulted in her classification as a medium security inmate. This classification was a major component to the decision-making process that resulted in her placement in restraints. According to the Metropolitan Government of Nashville and Davidson County because hospitals are "'conducive to security breaches including escape,' medium-security inmates at hospitals remain shackled until they return to jail" (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). However, according Judge Clay's opinion on the matter, "Villegas was not being held for a crime of violence and had not been convicted of any crime. She was not individually assessed for flight risk or risk of harm to herself or others, and she had not engaged in any conduct evidencing such" (Villegas v. Metropolitan Government of Nashville, 2013, p. 13). Furthermore, the opinion states that a reasonable factfinder would deem Villegas as not a flight risk (Villegas v. Metropolitan Government of Nashville, 2013). Therefore, it is clear that the correctional officers did not make a circumstance-based judgment when deciding to use restraints but rather based on her non-citizenship status.

I argue that Villegas' non-citizenship status is not a morally relevant when deciding on the use of shackles. Instead, the decision-making should have been based on whether or not she posed as a flight or safety risk, which we established earlier is not the case. Through the principle of justice, Villegas' should be granted equal status and receive equal treatment that is not

influenced by her immigration status. Therefore, this is a violation of the principle of justice because her classification subjected her to unnecessary and unfair harm.

In *Nelson v. Correctional Medical Services* (2009), we focused on the harms subjected by the correctional officer to the inmate. Here, I would like to focus on the harm that Villegas' nurses and care team were also subjected to. However, it is still important to acknowledge the emotional and dignitary harm and risk of physical harm that Villegas' correctional officers imposed onto her and its violations to the principles of beneficence, non-maleficence, and ICPA's virtues. The shackling of Villegas's prior to and after birth also resulted in significant moral distress to her nurses. Officer Moore overheard the hospital discussing a "No Restraint Order" and a nurse informed Moore of their opposition against the restraints (Villegas v. Metropolitan Government of Nashville, 2013, p. 2). Furthermore, while there was record of a physician order in Villegas' file, there was no evidence that it was directly given to any officers. However, Officer Moore was aware of the disapproval on the use of restraints by the nurses which established her subjective awareness of the risk of harm associated with the shackling. Despite this, she remained restrained. This demonstrates that despite communicating against the use of restraints, the nurses were put in a powerless position over the care of their patient. Therefore, the correctional officer's subjected moral distress onto Villegas' care team in violation of the principles of beneficence and non-maleficence.

Furthermore, as we have established that Villegas did not pose as a flight risk or safety concern, we can conclude that the correctional officers did not properly weigh the risks of harm fairly and justly. By only basing their decision-making on Villegas's medium security inmate status and not by the actual circumstances in place, the correctional officers did not adequately balance the risks and benefits of this case. Therefore, the correctional officers unfairly and

unjustly favored mitigating the risk of harm to public safety and security rather than protecting the risk of harm to Villegas' health, wellbeing and dignity and the health of her child. Furthermore, it can be argued that we must also acknowledge the failure of the nurses and care team. While they expressed to the correctional officers of their disapproval on the use of shackles and the physician signed a no restraint order, the care team failed to officially and effectively communicate this to the prison staff, subjecting Villegas to unnecessary harm. A potential reason for this could be the lack of authority by the prison or state regulation.

Chapter 7: Policy Recommendations

A major policy recommendation that stands out from my data and ethical insights is the implementation of universal documentation requirements throughout statutes and review protocols. My legal mapping showed that there are only 34 statutes in place that require documentation after shackling takes place. As correctional officers make decisions based on individual judgment, we have established that the just balancing of safety and security risks with the health and dignity of the patient is integral to moral decision-making. Documentation requirements can pose as an added measure of accountability for fair decision-making. Additionally, they encourage correctional officer to critically think about the justifications for the decision to shackle and if they are reasonable and valid.

In both *Nelson v. Correctional Medical Services* (2009) and V*illegas v. Metropolitan Government of Nashville* (2013), the courts did not find any convincing reason for the correctional officers to justify that the pregnant inmates had posed as either a flight risk or a safety risk. Ethically, correctional officers should fairly weigh the risk of harm to the pregnant inmate and her child against the risk of harm by safety and security concerns. They should also consider the obligation that they have to the health of the inmates under their care and minimize bias. In the two case studies, we saw that this did not happen. Hence, documentation requirements can encourage fair decision-making through which the harm to pregnant inmates is minimized and prevented.

Furthermore, quality documentation on the use of shackles and its justification can provide insights for the prison system on the prevalence of the practice and presents as an opportunity for further research and education. For example, through documentation review

protocols, the correctional facility can conduct a review session on the incidents of shackling and give correctional officers an opportunity to evaluate the harms of shackling and how to navigate public safety and security concerns with the health of the inmates. This is also an opportunity to bring together key stakeholders like the medical staff, doctors, nurses and clinical ethicists to collaborate and discuss how the harms of shackling can be minimized. Furthermore, this strategy can cultivate virtues like competence and trustworthiness within correctional officers and key stakeholders. This is important because the implementation and enforcement of the anti-shackling laws largely depends on frontline correctional officers.

A second policy recommendation that I proposed is the extension of authority over the use and removal of shackles to medical staff, especially nurses. As we saw in *Nelson v. Correctional Medical Services* (2009), while the physician on duty was able to order the removal of restraints when Nelson went into the delivery room, the nurses did not make such an order despite showing their opposition to the shackles while Nelson was in labor prior to delivery. Furthermore, my research found that only 29 states' legislation currently involve health care staff into the decision-making process over the use of restraints (22 states providing authority and 7 states providing limited authority). In *Jailcare*, Carolyn Sufrin states, "As an obstetrician in Pennsylvania in 2004, six years before the state passed an anti-shackling law, I delivered the baby of a woman who was shackled and felt powerless to ask an armed guard to remove the restraints" (2017, p. 148) This shows that a lack of legal authority to remove restraints can leave health care staff "powerless" over making decisions in favor of their patients' health. Hence, through universal laws granting them this authority, we can mitigate the moral distress caused by this "powerlessness", empower health care staff and professionals, and foster more just decision-making.

The legal debate of whether a prison official is accountable to the health outcomes of a pregnant inmate is based upon whether they had a subjective awareness of the harms to be held in deliberate indifference. When discussing the medical risk and harms to a pregnant woman by shackling, her care team is best qualified to make these decisions. In Chapter 5, the idea that health care providers and correctional officers should both possess virtues of care and justice was discussed. Through documentation and review protocols, we are able to encourage correctional officials to embody traits of justice, rationality, and critical thinking on balancing the risks and harms when making the decision to shackle. Furthermore, by extending this authority to care providers, we are also encouraging them to bring in the care perspective and join the correctional officers in making this difficult decision. In other words, through establishing the authority of the healthcare workers we are merging the care and justice perspective to foster equitable decision - making.

While I did not map if the legislation specified which type of health professional has the authority to order removal of shackles or consult with correctional officers on their use, Appendix B shows how this aspect is also varied. For example, while Rhode Island extends this authority to a "doctor, nurse, or other health professional", Florida extends limited authority only to a physician (6 R.I. Gen. Laws Ann. § 42-56.3-3, 2024, p. 1; Fla. Stat. Ann.§ 944.241, 2024). In the case studies, we found that nurses were the primary contact between a pregnant inmate and the correctional officer and the frequency of contact with the physician was limited. Furthermore, in Brawley and Kurnat-Thoma mapping study, which is current to September 2022, they found that 54.9% of states do not authorize nurses or advanced practiced nurses to order removal of shackles (Brawley & Kurnat-Thoma, 2024) Hence, this thesis recommends universal extension of authority requirements to health care professionals, including nurses.

Finally, I propose the integration of an ethics consultation into the decision-making process of perinatal shackling. A clinical ethics consultation is defined as a service or intervention by a consultant, committee or team to provide ethical insights and help address the ethical issues of a case (Dubler et al., 2009). The decision to shackle a pregnant inmate is a difficult one that bears moral distress on care teams and prison staff. While the need for structured legal guidelines and authorizations of power is important, there must also be a proposal for ethics-based resources. Clinical ethics consultants can "interview relevant medical stakeholders", "review the patient's medical record", review the "social, psychological, and spiritual issues that are often at play", and identify "the ethical issues at play and any sources of conflict" (Dubler et al., 2009, p. 25) The addition of the ethical perspective is valuable to both policy-making process and the decision-making process in practice. Perinatal shackling is moral dilemma; therefore, ethical experts are necessary to help solve it, act as an education resource and provide moral support. Through the actions above, we can ensure that the decision-making on perinatal shackling is undertaken through a multifaceted approach that considers not only safety, security, and health needs but also ethical needs.

Chapter 8: Conclusion

This thesis concludes that perinatal shackling is an unfairly retributive and dehumanizing practice. However, as bioethics permits us to infringe upon these *prima facie* principles when valid flight or safety risk arguments are in play, policies must effectively balance between safety, health and dignity. Furthermore, the United States' overall regulatory environment must strive for the fair distribution of equitable policies. 33% of states (including the District of Columbia) have either no legislation related to perinatal shackling at all, or no legislation related to documentation requirements within their anti-shackling legislation (Figure 3). Furthermore, 43% of states either have no legislation related to perinatal shackling at all or do not provide legal authority to any medical staff to order the removal of shackles (Figure 4). This demonstrates a serious need for universal statutes to be in place and articulates how the protection of inmates' health in certain states with no legislation is disproportionate to states with these protections in place.

In conclusion, I propose the policy recommendations of universal state-wide anti-shackling legislation that includes documentation, reporting requirements, implementation of review protocols, and extension of decision-making authority to nurses and other health care professionals. The implementation of these laws will encourage correctional officers and medical staff to take on and merge their care and justice perspectives. They will also foster and cultivate necessary virtues within correctional officers to promote fair decision-making. Furthermore, the implementation of ethics consultations in hospitals that care for pregnant inmates will allow for 3rd party ethical perspectives that optimize the decision-making process and reduce moral distress from the prison the medical staff.

Chapter 9: Limitations and Future Directions

When comparing my mapping results to Brawley and Kurnat-Thoma's "Use of Shackles on Incarcerated Pregnant Women" (2024), I identified two additional states that enacted anti-shackling legislation: Oregan and West Virgina. Oregon's statute does not include a documentation requirement and provides limited authority to health care professionals over the use of shackles. West Virgina's statute also does not include a documentation requirement and provides limited authority to health care professionals over the use of shackles. While West Virgina was not included in Brawley and Kurnat-Thoma's dataset, they acknowledged this addition in their article. Secondly, I identified the state of Wisconsin as without any statutes related to perinatal shackling while Brawley and Kurnat-Thoma did not. Upon further inquiry, I found that the statute they referenced was the 2017 Senate BILL 393 that sought to enact a statute titled, "302.085 Treatment of a pregnant or postpartum person. According to the Wisconsin State Legislature", this bill failed to pass which may explain why it did not come up in my search (2017 Senate Bill 393, 2017). Furthermore, my findings of anti-shackling statutes are consistent with the research group, ARRWIP's resource table on anti-shackling legislation that is current to January 2024 (Thomas et al., 2024).

Furthermore, I identified 6 additional states with documentation requirements while Brawley and Kurnat-Thoma did not (Brawley & Kurnat-Thoma, 2024). These states were Maine, Mississippi, Missouri, Nevada, Virginia and the District of Columbia. Secondly, Brawley and Kurnat-Thoma identified that Arizona provided health care providers with authority over the removal of shackles while I identified it as "No Authority" (Appendix B). Additionally, I labelled 3 states (Florida, Minnesota, and New Hampshire) with limited authority over the use of shackles while Brawley and Kurnat-Thoma identified them as providing authority. Lastly, I identified 2

states with limited authority (New Jersey and New York) while Brawley and Kurnat-Thoma identified them as no authority. The explanations for why each state was labelled as limited authority can be found in Appendix B.

When comparing my results and ARRWIP's resource tables, minor discrepancies were also identified (Thomas et al., 2024). I found that the states of Nevada and New Jersey had documentation requirements in place, but they were not identified by ARRWIP. Secondly, ARRWIP categorized the state of Oklahoma with documentation requirements in place while my mapping did not. For authority to medical providers, I identified Arizona as "No Authority" while ARRWIP identified it as providing authority to health care providers to order the removal of restraints. Secondly, I identified Virginia with "Full Authority" while ARRWIP did not. I also identified Florida, Oregon, New Jersey and Minnesota with "Limited Authority" while ARRWIP identified them as without authority. Finally, I identified the states of New Hampshire, New York, and West Virginia as "Limited Authority" while ARRWIP designated them as with authority.

There are many reasons for these differences in findings between legal mapping studies including the fact that statutes get amended and change over time (NYU, 2024). I collected and analyzed the statutes present current as of February 2025 and there could have been amendments to statutes since Brawley and Kurnat-Thoma's research in 2022. Additional reasons that account for the difference in findings include the subjective and interpretive nature of laws and regulations and human error. However, these limitations also demonstrate the necessity for multiple legal mapping studies and the constant watching and monitoring of case law to ensure the most accurate and updated overview.

Another key limitation is that I only reviewed and mapped statutes related to perinatal shackling and does not include individual jail and prison policies. State-level statutes cannot inform us of the requirements that are imposed at the county and municipal level (Klieger et al., 2017). Therefore, a future direction of study for this thesis is to study if these translate into individual jail and prison policies at the local level and whether they are more or less restrictive. As mentioned earlier, a second limitation I faced that in mapping the individual state statutes into categories is that laws are extremely interpretive and subjective. This mainly pertains to Figure 4, which reviewed the level of authority the legislation has given to medical staff. Appendix B includes summaries of each of the states that were given limited authority and exemplifies how one could have also argued another classification. An example of this is the state of Oregon, which does not explicitly say that restraints must be removed if a medical staff member requests it but, instead, limits shackling to two excepted clauses, the second of which states: "the attending physician determines that use of the mechanical restraints does not present a medical risk to the adult in custody" (Or. Rev. Stat. Ann. § 421.175, 2024, p. 1). While this legislation involves physicians in the decision-making, my interpretation is that granting of authority is still limited because it does not explicitly require the correctional officer to remove the restraints if the medical staff requests it. However, another person can argue that because the correctional officer determines the risk of flight and safety, the correctional officer should be given equal decision-making power.

A third limitation that arose in the empirical collection is that I did not map or categorize additional categories like the types of restraints the legislation permits, under what circumstances is the placement of restraints restricted to (e.g. safety or flight risk), as well as during what periods of pregnancy are restraints restricted to. This is because, the subjective nature of

legislation made it extremely difficult to map these ideas in an accurate and organized way within the limited amount of time. While some legislations are extremely detailed, others are shorter and vaguer. Additionally, while some states prohibit shackling during pregnancy, labor, and delivery, others may only restrict it during labor and delivery (Appendix A). Furthermore, some states restrict shackling from the point that an inmate is confirmed to be pregnant while others specify certain trimesters of pregnancy. Finally, some states have a total prohibition on restraints during labor while other allow only certain forms of restraints under certain circumstances. While mapping this variability was beyond the scope of this thesis, it also marks a potential future direction.

Lastly, this project did not conduct survey or interview-based research to collect narratives on perinatal shackling from key stakeholders. Through this we can gain deeper insights on the ethical violations related to perinatal shackling by studying the lived experiences of pregnant inmates. Narrative research can also include interviewing correctional officers and health care staff working with pregnant inmates to further understand the moral conflicts they face when tasked with conducting fair decision-making. Hence, another future direction of study is to gain understanding of the lived experiences of incarcerated women, health care staff and correctional officers on the practice of perinatal shackling.

Appendix A

10 examples of summaries on the type of restraints permitted and circumstances of when restraints are permitted

Alabama

This legislation prohibits the use of any leg restraints and waist restraints on women who are pregnant, in labor, in delivery, and the immediate postpartum period (Ala. Code § 14-6-19.1, 2024). However, the legislation permits the use of forward-facing wrist and leg handcuffs on women who are either pregnant or in the post-partum period if they pose as a flight risk or a safety risk that is not able to be addressed through alternative methods. Legislation states that the assessment of this extraordinary circumstance is made by the custodian. (Ala. Code § 14-6-19.1, 2024)

Arizona

This legislation prohibits the use of restraints on women who are pregnant, in labor, in delivery, during transport, the immediate postpartum period, and for 30 days since postpartum (Ariz. Rev. Stat. § 31-601, 2024). However, the legislation permits the use of restraints on women when they pose as a flight risk or safety risk. Legislation states that the assessment of this extraordinary circumstance is made by the correctional officer. Furthermore, legislation permits the use of restraints when requested by the attending health care staff. Legislation includes a notwithstanding section that permits the use of a tether chain which connects the inmate's ankle to the bed frame during postpartum recovery. Finally, legislation calls for the type of restraints and its application to be in the manner that is the least restrictive (Ariz. Rev. Stat. § 31-601, 2024).

Arkansas

Legislation prohibits restraints on an inmate who is pregnant, in labor or the postpartum period except during extraordinary circumstances as determined by the correctional or detention facility (Ark. Code Ann. § 12-32-102, 2025). An extraordinary circumstance is outlined as when an inmate poses as a flight risk or a safety risk to herself, her unborn child, correctional and medical staff, other inmates or to the public. Legislation states that when restraints are applied during a flight risk, they must be done in circumstances that cannot be mitigated through safer means. Legislation states that the restrictiveness of the type and manner of restraints used on pregnant inmates within the previously outlined guidelines should be minimized. Further, legislation prohibits the use of leg or waist restraints during labor and prohibits leg restraints when a pregnant inmate is not in a "wheelchair, bed or gurney" (Ark. Code Ann. § 12-32-102, 2025, p. 2). Finally, legislation states that when used, restraints must be soft, forward-facing hand restraints.

Colorado

Colo. Rev. Stat. Ann. § 17-1-113.7 requires that restraints used on pregnant inmates in a correctional facility or private contract prison should be the least restrictive to ensure the safety of a pregnant inmate (2024). Legislation orders staff to comply with the "Protection of Individuals from Restraint and Seclusion Act", in article 20 of title 26, regarding use of restraints on inmates during labor or delivery and/or postpartum recovery (Colo. Rev. Stat. Ann. § 17-1-113.7, 2024, p. 1)

Colo. Rev. Stat. Ann. § 17-26-104.7 requires that restraints used on pregnant inmates in a county jail should be the least restrictive to ensure the safety of a pregnant inmate (2025). Legislation orders staff to comply with "Protection of Individuals from Restraint and Seclusion Act" regarding use of restraints on inmates during labor or delivery and/or postpartum recovery (Colo. Rev. Stat. Ann. § 17-26-104.7, 2025, pg. 1).

Colo. Rev. Stat. Ann. 26-20-104 requires an agency that uses restraints to monitor them at least every 15 minutes (2024). Legislation prohibits physical or mechanical restraints that place pressure on the chest or impede an individual's ability to breathe. Chemical restraints are only permitted by order of a physician or an advanced practice nurse during emergencies. When an individual is restrained with a mechanical restraint, they must be given "relief periods" of at least 10 minutes every 2 hours except for when they are asleep. (Colo. Rev. Stat. Ann. § 17-26-104.7, 2025, pg. 1). Legislation states that during relief periods, staff should assist the individual with movement, positioning, and toileting methods as necessary. Finally, legislation states that staff should maintain the individual's "dignity and safety" (Colo. Rev. Stat. Ann. § 17-26-104.7, 2025, pg. 1).

Connecticut

Legislation includes a notwithstanding clause where it prohibits use of restraints on inmates who are in labor or delivery including during transport (Conn. Gen. Stat. Ann § 18-69c, 2024). Legislation prohibits correctional staff from York Correctional Institution from using leg and waist restraints on inmates who are pregnant or in the postpartum period. Legislation only permits forward-facing handcuffs to be used on pregnant inmates unless there is extraordinary circumstance in which a pregnant inmate is permitted to be restrained using leg, wrist, and waist restraints. A special circumstance is defined as a safety risk or "threat of harm" to the inmate, staff, and others, or a flight risk that "cannot be reasonably contained by other means" (Conn. Gen. Stat. Ann § 18-69c, 2024, p. 1). In these circumstances, approval must be obtained from the "unit administrator" unless there are "exigent circumstances" present (Conn. Gen. Stat. Ann § 18-69c, 2024, p. 1). Furthermore, legislation states that restraints should be "the least restrictive kind of restraints considering the circumstances" (Conn. Gen. Stat. Ann § 18-69c, 2024, p. 2).

District of Columbia

This legislation prohibits the use of restraints on women who are in the 3rd trimester of pregnancy or post-partum recovery including transport, and labor (D.C. Code Ann. § 24-276.02,

2025, p. 1). However, legislation permits the use of restraints on women who are in the 3rd trimester of pregnancy or post-partum recovery if there is an "extraordinary circumstance" that necessitates the use of restraints to "prevent the confined person from injuring themselves or others" or security risk (D.C. Code Ann. § 24-276.02, 2025, p. 1). Legislation states that the assessment of this extraordinary circumstance is made by the "administrator" (D.C. Code Ann. § 24-276.02, 2025, p. 1).

Georgia

Legislation prohibits the use of handcuffs, waist restraints, leg restraints or "restraints of any kind" during pregnancy (2nd and 3rd trimester), labor, delivery, or the immediate postpartum period (Ga. Code Ann. § 42-1-11.3, 2024, p. 1). Permits shackling during the immediate postpartum period if an extraordinary circumstance of flight risk that "cannot be reasonably contained by other means" or safety risk ("immediate and serious threat of harm") to the inmate herself, the staff or others is present (Ga. Code Ann. § 42-1-11.3, 2024, p. 2). When restraints are permitted, they should be only forward-facing wrist restraints.

Idaho

Legislation prohibits restraints "of any kind" during labor and delivery except in extraordinary circumstances which is defined as when the correctional officer determines that the prisoner is a flight risk or safety ("injuring") risk to herself, the prison staff, or the medical staff (Idaho Code Ann. § 20-902, 2025, p. 1). In this case, leg or waist restraints are prohibited. When restraints are used they must be in the "least restrictive manner necessary" (Idaho Code Ann. § 20-902, 2025, p. 1).

West Virginia

Legislation instructs "superintendent of the facility" to take "reasonable measures" to ensure that inmates are not restrained from the 2nd trimester of pregnancy to when the pregnancy ends (W. Va. Code Ann. § 15A-4-5, 2024, p. 1). However, if there is a flight risk or safety risk present, the inmate can be "reasonably" restrained (W. Va. Code Ann. § 15A-4-5, 2024, p. 1).

Rhode Island

Legislation states that restraints on inmates who are in the 2nd or 3rd trimester of pregnancy should only be those that are "medically appropriate" (6 R.I. Gen. Laws Ann § 42-56.3-3, 2024, p. 1). Legislation prohibits handcuffs, shackles, and restraints on inmates who are pregnant during transport, in labor, in delivery, or in postpartum recovery. However, restraints are permitted if there is a flight risk that "cannot be reasonably contained by other means" or a safety risk ("immediate and serious threat of physical harm") to the inmate, staff or others (6 R.I. Gen. Laws Ann § 42-56.3-3, 2024, p. 1). Legislation prohibits leg and waist restraints on inmates who are in labor/delivery and waist restraints on inmates who are in postpartum recovery.

Appendix B

Explanations for the 7 states given "Limited Authority" status in Figure 3

Florida

Legislation states that the physician "may request that restraints not be used for documentable medical purposes and the "correctional officer" or "correctional institution employee" may "consult with the medical staff" (Fla. Stat. Ann.§ 944.241, 2024, p. 2). Although, if the determination of an "extraordinary public safety risk" is made, the correctional officer is given the authority for restraint application (Fla. Stat. Ann.§ 944.241, 2024, p. 2).

Minnesota

This legislation does not explicitly state that the correctional facility must remove restraints at the request of medical staff, but states that a woman who is in labor or is up to 3 days postpartum can only be restrained within a set of criteria, one of which includes "there is no objection from treating medical care provider" (Minn. Stat. Ann. § 241.88, 2024, p. 1).

New Hampshire

When the inmate is in the first, second or third trimester of pregnancy, legislation states that if the "doctor, nurse or other health professional" requests against the use of restraints, they must be removed unless the correctional officer makes the determination of an "extraordinary risk to the public" and receives approval from the county's superintendent or designee (N.H. Rev. Stat. Ann. § 623-C:1-a, 2024, p. 1). During transportation for labor, delivery, and postpartum, legislation states that restraints are only permitted when there is an "extraordinary medical or security circumstance" and approval is received from the county correctional facility's chief medical officer (N.H. Rev. Stat. Ann. § 623-C:1-a, 2024, p. 1). In this case, if a "doctor, nurse, or other health professional" requests that restraints be removed, they must be immediately. Additionally, they should not be reapplied until approved by medical staff and professionals after they have determined that the risk of harm to the pregnant inmate and her child has ended.

New Jersey

This regulation involves medical professionals but does not provide them with the explicit authority to order the removal of restraints. Legislation states that a pregnant inmate should not be restrained without medical approval unless the inmate poses as a flight risk or safety risk. If an inmate poses as a risk, medical staff can review the "placement of restraints as soon as practicable" (N.J.A.C. 10A:31–13.10, 2025, p. 2). Furthermore, legislation states that "Health Services personnel must prescribe the necessary precautions, including decisions about the manner in which the inmate is to be restrained… whether medical personnel should be present during the application of restraints, whether the inmate should be restrained at the institutional hospital or a local medical facility, etc." (N.J.A.C. 10A:31–13.10, 2025, p. 3)

New York

Legislation states that a superintendent, sheriff, or designee is allowed to apply restraints when the determination is made that a safety risk exists, in "consultation with the medical professional" (N.Y. U.C.C. Law § 611, 2024, p. 1). Hence, while the legislation involves medical staff, it does not give them explicit power.

Oregon

Legislation states that a woman who is in labor, birth, or postpartum cannot be restrained unless two criteria are met. The second criterion states that "the attending physician determines that use of the mechanical restraints does not present a medical risk to the adult in custody" (Or. Rev. Stat. Ann § 421.175, 2024, p. 1)

West Virginia

Legislation states that before applying restraints in cases where there is no safety threat, they must consult with "an appropriate health care professional" to certify that the use of restraints does not pose as a "risk of harm to the inmate or the fetus" (W. Va. Code Ann. § 15A-4-5, 2024, p. 1)

Explanations for 4 examples of states given authority status in Figure 4

Arkansas

"If the correctional or detention facility determines that the inmate or detainee is required to be restrained under subsection (a) of this section, the restraints shall be removed if a physician, nurse, or other health professional requests that the inmate or detainee not be restrained" (Ark. Code Ann. § 12-32-102, 2025, p. 1)

District of Columbia

"Notwithstanding the authorization by the Administrator under paragraph (1) of this subsection, if the doctor, nurse, or other health professional treating the confined person determines that the removal of the restraints is medically necessary to protect the health or safety of the confined person, or the baby, the restraints shall be removed immediately." (D.C. Code Ann. § 24-276.02, 2025, p. 1)

Hawaii

"If the doctor, nurse, or other health professional treating the pregnant female requests that restraints not be used, the corrections officer accompanying the pregnant female shall immediately remove all restraints." (Haw. Rev. Stat. Ann § 353-122, 2024, p. 1)

Rhode Island

If a "doctor, nurse, or other health professional treating the prisoner or detainee requests" against restraints, legislation orders the correctional officer to remove them "immediately" (6 R.I. Gen.

Laws Ann § 42-56.3-3, 2024, p. 1). When there are no "exigent circumstances" which is determined by the health care professional, the correctional officer should consult first with "the medical director of the department of corrections" (6 R.I. Gen. Laws Ann § 42-56.3-3, 2024, p. 1). If the "medical director of the department of corrections" confirms the necessity for restraints, the correctional officer must determine whether leg restraints or hand restraints should be utilized "in consultation" with the "health professional" (6 R.I. Gen. Laws Ann § 42-56.3-3, 2024, p. 1).

References

2017 Senate Bill 393, Wisconsin State Legislature (2017).

Alexander, E. (2009). Unshackling Shawanna: The Battle over Chaining Women Prisoners during Labor and Delivery The Ben J. Altheimer Symposium: Prisoners' Rights: The Rights of the Convicted and Forgotten. *UALR L. Rev.*, *32*, 435.

American College of Obstetricians and Gynecologists (2021). *Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals*. American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/reproductive-health-care-for-incarcerated-pregnant-postpartum-and-nonpregnant-individuals

American Public Health Association (2023). *A Call to Stop Shackling Incarcerated Patients Seeking Health Care*. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2024/01/16/shackling-incarcerated-patients

Aristotle. (ca. 350 B.C.E./1926). *Nicomachean Ethics*. Harvard University Press. https://www.loebclassics.com/view/LCL073/1926/volume.xml

Arras, J. (2017). *Methods in Bioethics: The Way We Reason Now*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780190665982.001.0001

Beauchamp, T. L., & Childress, J. F. (2013). Principles of biomedical ethics. In (7th edition. ed.). New York: [Oxford University Press].

Brawley, V., & Kurnat-Thoma, E. (2024). Use of Shackles on Incarcerated Pregnant Women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *53*(1), 79-91. https://doi.org/10.1016/j.jogn.2023.09.005

Budd, K. M. (2024). *Incarcerated Women and Girls*. The Sentencing Project. https://www.sentencingproject.org/fact-sheet/incarcerated-women-and-girls/

Burris, S. C. (2020). How to Write a Legal Mapping Paper *Temple University Legal Studies Research Paper*. https://doi.org/ http://dx.doi.org/10.2139/ssrn.3133065

Clarke, J. G. (2013). *Shackling and Separation: Motherhood in Prison*. AMA Journal of Ethics. https://journalofethics.ama-assn.org/article/shackling-and-separation-motherhood-prison/2013-09

Congressional Research Service (2019). *The First Step Act of 2018: An Overview*. https://www.congress.gov/crs-product/R45558

Creary, M. S. (2021). Bounded Justice and the Limits of Health Equity. *Journal of Law, Medicine & Ethics*, *49*(2), 241-256. https://doi.org/10.1017/jme.2021.34

Daniels, N. (2023). Reflective Equilibrium. In E. N. Zaltam & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Fall 2023 ed.): Metaphysics Research Lab, Stanford University.

Dignam, B., & Adashi, E. Y. (2014). Health Rights in the Balance: The Case against Perinatal Shackling of Women behind Bars Special Issue on Health Rights Litigation: Papers. *Health & Hum. Rts. J.*, *16*, 13.

Dolovich, S. (2022). The Failed Regulation and Oversight of American Prisons. *Annual Review of Criminology*, *5*(Volume 5, 2022), 153-177. https://doi.org/https://doi.org/10.1146/annurev-criminol-011518-024445

Donchin, A. (1995). Reworking Autonomy: Toward a Feminist Perspective Special Section: Beyond Autonomy. *Cambridge Quarterly of Healthcare Ethics*, *4*(1), 44-55. doi:10.1017/S0963180100005636

Dubler, N. N., Webber, M. P., & Swiderski, D. M. (2009). Charting the future. Credentialing, privileging, quality, and evaluation in clinical ethics consultation. *Hastings Cent Rep*, *39*(6), 23-33. https://doi.org/10.1353/hcr.0.0208

Ells, C. (2001). Shifting the Autonomy Debate to Theory as Ideology1. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *26*(4), 417-430. https://doi.org/10.1076/jmep.26.4.417.3009

Farmer v. Brennan, 511 U.S. 825, 114 S. Ct. 1970, 128 L. Ed. 2d 811, 1994 U.S. LEXIS 4274, 62 U.S.L.W. 4446, 94 Cal. Daily Op. Service 4103, 94 Daily Journal DAR 7626, 8 Fla. L. Weekly Fed. S 209 (Supreme Court of the United States June 6, 1994, Decided).

Ferszt, G. G., Palmer, M., & McGrane, C. (2018). Where Does Your State Stand on Shackling of Pregnant Incarcerated Women? *Nursing for Women's Health*, *22*(1), 17-23. https://doi.org/10.1016/j.nwh.2017.12.005

Flynn, J. (2022). Theory and Bioethics. In E. N. Zaltaand & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Winter 2022 ed.). Metaphysics Research Lab, Stanford University. <https://plato.stanford.edu/archives/win2022/entries/theory-bioethics/>.

Goshin, L. S., Sissoko, D. R. G., Neumann, G., Sufrin, C., & Byrnes, L. (2019). Perinatal Nurses' Experiences With and Knowledge of the Care of Incarcerated Women During Pregnancy and the Postpartum Period. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *48*(1), 27-36. https://doi.org/10.1016/j.jogn.2018.11.002

Hall, R. C. H., Friedman, S. H., & Jain, A. (2015). Pregnant Women and the Use of Corrections Restraints and Substance Use Commitment. *Journal of the American Academy of Psychiatry and the Law Online*, *43*(3), 359. http://jaapl.org/content/43/3/359.abstract

Häyry, M. (2022). *Roles of Justice in Bioethics*. Cambridge University Press. https://doi.org/DOI: 10.1017/9781009104364

Held, V. (2005). *The Ethics of Care: Personal, Political, and Global*. Oxford University Press. https://doi.org/10.1093/0195180992.001.0001

Jacobson, N., & Silva, D. S. (2010). Dignity Promotion and Beneficence. *Journal of Bioethical Inquiry*, *7*(4), 365-372. https://doi.org/10.1007/s11673-010-9258-y

Kajstura, A. (2018). *States of Women's Incarceration: The Global Context 2018*. Prison Policy Initiative. https://www.prisonpolicy.org/global/women/2018.html

Kipnis, K. (2012). 373Social Justice and Correctional Health Services. In R. Rhodes, M. Battin, & A. Silvers (Eds.), *Medicine and Social Justice: Essays on the Distribution of Health Care* (pp. 0). Oxford University Press. https://doi.org/10.1093/acprof:osobl/9780199744206.003.0032

Klieger, S. B., Gutman, A., Allen, L., Pacula, R. L., Ibrahim, J. K., & Burris, S. (2017). Mapping medical marijuana: state laws regulating patients, product safety, supply chains and dispensaries, 2017. *Addiction*, *112*(12), 2206-2216. https://doi.org/https://doi.org/10.1111/add.13910

Langlois, A. (2013). *Negotiating Bioethics: The governance of UNESCO's Bioethics Programme*. https://doi.org/10.4324/9780203101797

Laufer, S. (2019). Reproductive Healthcare for Incarcerated Women: From Rights to Dignity Notes. *American Criminal Law Review*, *56*(4), 1785-1810.

Legal Information Institute. (2024). *Summary judgment*. Legal Information Institute. https://www.law.cornell.edu/wex/summary_judgment

Legal Information Institute. (2023). *Qualified immunity*. Legal Information Institute. https://www.law.cornell.edu/wex/qualified_immunity

Mackenzie, C., & Stoljar, N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford University Press, Incorporated.

Marquis, E. (2018). "Nothing Less Than the Dignity of Man": Women Prisoners, Reproductive Health, and Unequal Access to Justice Under the Eighth Amendment. *California Law Review*, *106*(1), 203-230. http://www.jstor.org/stable/44630789

Nashville Metropolitan Council. (2013). Resolution No. RS2013-878: A resolution authorizing the Metropolitan Department of Law to compromise and settle the claims of Juana Villegas against the Metropolitan Government of Nashville and Davidson County for $490,000.00, and that said amount be paid out of the Judgments and Losses Fund. Nashville Metropolitan Council Budget and Finance Committee.

Nelson v. Corr. Med. Servs., 583 F.3d 522, 2009 U.S. App. LEXIS 21730 (United States Court of Appeals for the Eighth Circuit October 2, 2009, Filed)

Nelson v. Corr. Med. Servs., 533 F.3d 958, 2008 U.S. App. LEXIS 15270 (United States Court of Appeals for the Eighth CircuitJuly 18, 2008, Filed)

Nelson v. Turnesky, 2010 U.S. Dist. LEXIS 101926, 2010 WL 3655565 (United States District Court for the Eastern District of Arkansas, Batesville Division September 13, 2010, Filed)

New York University Law Library (2024). *Statutes and Constitutions Research: Updating Statutes*. https://nyulaw.libguides.com/c.php?g=773844

Norris, W. K., Allison, M. K., Fradley, M. F., & Zielinski, M. J. (2022). 'You're setting a lot of people up for failure': what formerly incarcerated women would tell healthcare decision makers. *Health & Justice*, *10*(1), 4. https://doi.org/10.1186/s40352-022-00166-w

Ocen, P. A. (2012). Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners. *California Law Review*, *100*(5), 1239-1311. https://www.jstor.org/stable/23408737

Sawyer, W., & Wagner, P. (2025). *Mass Incarceration: The Whole Pie 2025*. https://www.prisonpolicy.org/reports/pie2025.html

Schlanger, M., Bedi, S., & Shapiro, D. (2020). *Incarceration and the Law: Cases and Materials* (10 ed.). https://ssrn.com/abstract=3635053

Smart, R. N. (1958). Negative Utilitarianism. Mind, 67(268), 542-543. https://www.jstor.org/stable/2251207

Sufrin, C. a. (2017). Jailcare : finding the safety net for women behind bars. In. Oakland, California: [University of California Press].

Sugarman, J., & Sulmasy, D. P. (2001). Methods in medical ethics. In J. Sugarman & D. P. Sulmasy (Eds.). Washington, D.C.: [Georgetown University Press].

Superson, A. M. (2024). Feminist Ethics. Cambridge University Press. https://doi.org/DOI: 10.1017/9781108587839

The International Corrections and Prisons Association for the Advancement of Professional Corrections. (n.d.). *ICPA's Code of Ethical Conduct*. The International Corrections and

Prisons Association for the Advancement of Professional Corrections https://icpa.org/icpa-about/icpa-s-code-of-ethical-conduct.html

Thomas, K., Kao, L., Parayil, T., Sommers, E., Lulseged, B., Moss, A., Kramer, C., Shlafer, R., & Sufrin, C. (2024). *Anti-Shackling Legislation and Resource Table*. A. a. R. o. R. W. o. I. P. (ARRWIP). https://arrwip.org/wp-content/uploads/2024/02/ARRWIP-Anti-shackling-legislation-and-resource-table_-Jan2024-.pdf

Thomas, S. Y., & Lanterman, J. L. (2019). A National Analysis of Shackling Laws and Policies as They Relate to Pregnant Incarcerated Women. *Feminist Criminology*, *14*(2), 263-284.

Turner v. Safley, 482 U.S. 78, 107 S. Ct. 2254, 96 L. Ed. 2d 64, 1987 U.S. LEXIS 2362, 55 U.S.L.W. 4719 (Supreme Court of the United States June 1, 1987, Decided).

U.S. Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics. (2021). Census of State and Federal Adult Correctional Facilities, 2019 – Statistical Tables. https://doi.org/https://bjs.ojp.gov/content/pub/pdf/csfacf19st.pdf

U.S. Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics. (2024). Federal Prisoner Statistics Collected Under the First Step Act, 2024. https://bjs.ojp.gov/document/fpscufsa24.pdf

UC Berkeley Law Library (2025). *Lexis & Westlaw Search Tips & Tricks: Power Searching -- All You Need to Know*. https://libguides.law.berkeley.edu/c.php?g=848033

Vaughn, L. (2022). *Bioethics Principles, Issues, and Cases*. Oxford University Press.

Villegas v. Metro. Gov't of Nashville, 709 F.3d 563, 2013 U.S. App. LEXIS 4382, 2013 FED App. 0059P (6th Cir.), 2013 WL 776798 (United States Court of Appeals for the Sixth Circuit March 4, 2013, Filed).

Wicks, E. (2016). *The State and the Body : Legal Regulation of Bodily Autonomy* [Book]. Hart Publishing. https://doi.org/10.5040/9781509909988

Legislative References

Code of Alabama (2024) § 14-6-19.1. Treatment of female inmates who are pregnant or in immediate postpartum period. In *Title 14. Criminal Correctional and Detention Facilities, Chapter 6. Jails, Article 1. General Provisions.* Retrieved from Thomson Reuters.

Arizona Revised Statutes Annotated (2024) § 31-601. Pregnant prisoners; restraints; written findings; rules; appropriate food and dietary supplements; restrictive housing; bed placement; training; reporting; definitions. In *Title 31. Prisons and Prisoners, Chapter 5. Limited Restrictions for Pregnant Prisoners and Prisoners with Children, Article 1. General Provisions.* Retrieved from Thomson Reuters.

West's Arkansas Code Annotated (2025) § 12-32-102. Restraint of pregnant inmate or detainee. In *Title 12. Law Enforcement, Emergency Management, and Military Affairs, Subtitle 3. Correctional Facilities and Programs (Chapters 25 to 59). Chapter 32. Treatment of Female Inmates or Detainees.* Retrieved from Thomson Reuters.

West's Annotated California Codes (2024) § 3407. Prohibition on use of restraints on pregnant or recovering inmates; advisement on policies. *In Penal Code, Part 3. Of Imprisonment and the Death Penalty*, *Title 2. Imprisonment of Female Prisoners in State Institutions, Chapter 3. Prisoners.* Retrieved from Thomson Reuters.

West's Annotated California Codes (2024) § 4023.8. Rights of incarcerated pregnant person; treatment. *In Penal Code, Part 3. Of Imprisonment and the Death Penalty, Title 4.*

County Jails, Farms and Camps, Chapter 1. County Jails. Retrieved from Thomson Reuters.

West's Annotated California Codes (2024) § 3408. Pregnancy test; counseling; examination; prenatal care; community services; hospitalization; postpartum care; disclosure of information. *In Penal Code, Part 3. Of Imprisonment and the Death Penalty, Title 2. Imprisonment of Female Prisoners in State Institutions, Chapter 3. Prisoners.* Retrieved from Thomson Reuters.

West's Colorado Revised Statutes Annotated (2025) § 17-26-104.7. Prohibition against the use of restraints on pregnant persons in custody. *In Title 17. Corrections, Correctional Facilities and Programs, Facilities, Article 26. Jails, Part 1. General Provisions.* Retrieved from Thomson Reuters.

West's Colorado Revised Statutes Annotated (2024) § 17-1-113.7. Prohibition against the use of restraints on pregnant inmates in the custody of correctional facilities and private contract prisons—report. *In Title 17. Corrections, Department of Corrections, Organization, Article 1 Department of Corrections, Part 1. Corrections Administration*. Retrieved from Thomson Reuters.

Colorado Revised Statutes Annotated (2024) 26-20-104. General duties relating to use of restraint on individuals. *Title 26. Human Services Code (Arts. 1 — 24), Article 20. Protection of Persons from Restraint (§§ 26-20-101 —26-20-111).* Retrieved from LexisNexis.

Connecticut General Statutes Annotated (2024) § 18-69c. Assessment of inmates for pregnancy. Care and treatment of pregnant inmates. Restrictions on the use of leg or waist restraints. *In Title 18. Correctional Institutions and Department of Correction, Chapter 323. York Correctional Institution.* Retrieved from Thomson Reuters.

West's Delaware Code Annotated (2024) § 6603.Use of restraints on pregnant prisoners; other prohibitions. *In Title 11. Crimes and Criminal Procedure, Part IV. Prisons and Prisoners, Chapter 66. Restraint of Pregnant Persons in Custody.* Retrieved from Thomson Reuters.

West's Delaware Code Annotated (2025) § 6602. Definitions. *In Title 11. Crimes and Criminal Procedure, Part IV. Prisons and Prisoners, Chapter 66. Restraint of Pregnant Persons in Custody*. Retrieved from Thomson Reuters.

West's Delaware Code Annotated (2024) § 6605. Annual report. *In Title 11. Crimes and Criminal Procedure, Part IV. Prisons and Prisoners, Chapter 66. Restraint of Pregnant Persons in Custody*. Retrieved from Thomson Reuters.

West's District of Columbia Code Annotated 2001 Edition (2025). § 24-276.03. Reporting requirements. *In, Division IV. Criminal Law and Procedure and Prisoners, Title 24. Prisoners and Their Treatment, Chapter 2. Prisons and Prisoners, Subchapter VIII-A. Limitations on the Use of Restraints on Certain Confined [Persons].* Retrieved from Thomson Reuters

West's District of Columbia Code Annotated 2001 Edition (2025) § 24-276.02. Use of restraints by places of confinement. *In, Division IV. Criminal Law and Procedure and Prisoners, Title 24. Prisoners and Their Treatment, Chapter 2. Prisons and Prisoners, Subchapter*

VIII-A. Limitations on the Use of Restraints on Certain Confined [Persons]. Retrieved from Thomson Reuters.

West's Florida Statutes Annotated (2024) § 944.241. Incarcerated pregnant women. *In, Title XLVII. Criminal Procedure and Corrections (Chapters 900-999), Chapter 944. State Correctional System*. Retrieved from Thomson Reuters.

West's Code of Georgia Annotated (2024) § 42-1-11.3. Women who are pregnant or in the immediate postpartum period. *In Title 42. Penal Institutions, Chapter 1. General Provisions, Article 1. Inmate Policies.* Retrieved from Thomson Reuters.

West's Hawai'i Revised Statutes Annotated (2024) § 353-122. Limitation on use of restraints. *In Division 1. Government, Title 20. Social Services, Chapter 353. Corrections and Rehabilitation, [Part VI]. Pregnant Offenders; Restraints*. Retrieved from Thomson Reuters.

West's Idaho Code Annotated (2025) § 20-902. Restrictions on restraint of pregnant prisoners--Extraordinary circumstance. *In Title 20. State Prison and County Jails. Chapter 9. Restraint of Pregnant Prisoners.* Retrieved from Thomson Reuters.

West's Smith-Hurd Illinois Compiled Statutes Annotated (2024) 5/3-6-7. Pregnant committed persons, *In Chapter 730. Corrections, Act 5. Unified Code of Corrections, Chapter III. Department of Corrections, Article 6. Institutions; Facilities; and Programs*. Retrieved from Thomson Reuters.

West's Smith-Hurd Illinois Compiled Statutes Annotated (2024) 5/3-15003.6 Pregnant committed persons. *In Chapter 55. Counties, Act 5. Counties Code, Article 3. Officers*

and Employees, Division 3-15. County Department of Corrections. Retrieved from Thomson Reuters.

West's Smith-Hurd Illinois Compiled Statutes Annotated (2024) 160/30. Medical care for committed persons. *In Chapter 210. Health Facilities and Regulation, Act 160. Health Care Violence Prevention Act.* Retrieved from Thomson Reuters.

West's Annotated Indiana Code (2024) 11-10-3.5-3. Restraining inmate. *In Title 11. Corrections, Article 10. Correctional Services and Programs, Chapter 3.5. Pregnant Inmates.* Retrieved from Thomson Reuters.

West's Annotated Indiana Code (2024) 11-10-3.5-1. Definitions. *In Title 11. Corrections, Article 10. Correctional Services and Programs, Chapter 3.5.* Pregnant Inmates. Retrieved from Thomson Reuters.

West's Annotated Indiana Code (2024) 11-12-4-1. Adoption of minimum standards; requirements of standards; committee of sheriffs; views and suggestions of sheriffs and county commissioners*. In Title 11. Corrections, Article 12. Community Corrections, Chapter 4. Standard Rules, Construction of County Jails.* Retrieved from Thomson Reuters.

Baldwin's Kentucky Revised Statutes Annotated (2024) 196.173. Pregnant inmates housed in jail, penitentiary, local or state correctional or detention facility, residential center, or reentry center; permissible and impermissible restraints. *In Title XVII. Economic Security and Public Welfare, Chapter 196. Corrections, General Provisions.*. Retrieved from Thomson Reuters.

West's Louisiana Statutes Annotated (2024) § 744.3. Restraint during childbirth . *In Louisiana Revised Statutes, Title 15. Criminal Procedure, Chapter 7. Prisons and Correctional*

Institutions, Part I-D. Safe Pregnancy for Incarcerated Women. Retrieved from Thomson Reuters.

West's Louisiana Statutes Annotated (2024) §744.7. Recordkeeping and retention. *In Louisiana Revised Statutes, Title 15. Criminal Procedure, Chapter 7. Prisons and Correctional Institutions, Part I-D. Safe Pregnancy for Incarcerated Women.* Retrieved from Thomson Reuters.

West's Louisiana Statutes Annotated (2024) § 744.5. Definitions. *In Louisiana Revised Statutes Title 15. Criminal Procedure, Chapter 7. Prisons and Correctional Institutions, Part I-D. Safe Pregnancy for Incarcerated Women*. Retrieved from Thomson Reuters.

Maine Revised Statutes Annotated (2023) § 1582. Restraint of pregnant prisoners and pregnant juveniles. *In Title 30-a. Municipalities and Counties, Part 1. Counties, Chapter 13. County Jails and Jailers, Subchapter 2-a. Pregnant Prisoners and Pregnant Juveniles.* Retrieved from Thomson Reuters.

Maine Revised Statutes Annotated (2023) § 1660. Report. *In . In Title 30-a. Municipalities and Counties, Part 1. Counties, Chapter 13. County Jails and Jailers, Subchapter 4 Miscellaneous Provisions.* Retrieved from Thomson Reuters.

Maine Revised Statutes Annotated (2023). § 3102. Restraint of pregnant prisoners and pregnant juveniles. *In Title 34-a. Corrections, Chapter 3. Correctional Facilities Subchapter 1. General Provisions, Article 4. Pregnant Prisoners and Pregnant Juveniles*. Retrieved from Thomson Reuters.

West's Annotated Code of Maryland (2024) § 9-601. Pregnant incarcerated individuals. *In Correctional Services, Title 9. State and Local Correctional System--Incarcerated Individuals, Subtitle 6. Miscellaneous.* Retrieved from Thomson Reuters.

Massachusetts General Laws Annotated (2024) § 118. Pregnant and postpartum inmates; standards of care; use of restraints. *In Part I. Administration of the Government (Ch. 1-182), Title XVIII. Prisons, Imprisonment, Paroles and Pardons (Ch. 124-127), Chapter 127. Officers and Inmates of Penal and Reformatory Institutions. Paroles and Pardons*. Retrieved from Thomson Reuters.

Minnesota Statutes Annotated (2024) § 241.88. Restraining an incarcerated pregnant woman. *In Corrections (Ch. 241-244 App.), Chapter 241. Corrections; Department; Facilities Incarcerated Pregnant Women.* Retrieved from Thomson Reuters.

West's Annotated Mississippi Code (2024) § 47-5-1507. Care for incarcerated women related to pregnancy and childbirth, *In Title 47. Prisons and Prisoners; Probation and Parole, Chapter 5. Correctional System, Dignity for Incarcerated Women Act*. Retrieved from Thomson Reuters.

West's Annotated Mississippi Code (2024) § 47-5-1509. Inmate postpartum recovery. *In Title 47. Prisons and Prisoners; Probation and Parole, Chapter 5. Correctional System, Dignity for Incarcerated Women Act.* Retrieved from Thomson Reuters.

Vernon's Annotated Missouri Statutes (2024) 217.151. Restraints, use of on pregnant offenders--definitions--extraordinary circumstances—requirements. *In Title XIII. Correctional and Penal Institutions [Chs. 216-221], Chapter 217. Department of Corrections, Department, Organization, Powers and Responsibilities.* Retrieved from Thomson Reuters.

West's Revised Statutes of Nebraska Annotated (2024) § 47-1007. Report; contents. *In Chapter 47. Jails and Correctional Facilities, Article 10. Health of Incarcerated Women, (a) Healthy Pregnancies for Incarcerated Women Act.* Retrieved from Thomson Reuters.

West's Revised Statutes of Nebraska Annotated (2024) § 47-1004. Detention facility; use of restraints prohibited; exception; detention facility employee; presence in room during labor or childbirth; administrator of detention facility; duties. *In Chapter 47. Jails and Correctional Facilities, Article 10. Health of Incarcerated Women, (a) Healthy Pregnancies for Incarcerated Women Act.* Retrieved from Thomson Reuters.

West's Revised Statutes of Nebraska Annotated (2025) § 47-1003. Terms, defined. *In Chapter 47. Jails and Correctional Facilities, Article 10. Health of Incarcerated Women, (a) Healthy Pregnancies for Incarcerated Women Act.* Retrieved from Thomson Reuters.

West's Nevada Revised Statutes Annotated (2023) 209.376. Care of offender who is pregnant: Limitations on use of restraints on offender who is in labor, delivering her baby or in the postpartum period; report. *In Title 16. Correctional Institutions; Aid to Victims of Crime (Chapters 208-217), Chapter 209. Department of Corrections, Custody, Care and Education of Offenders.* Retrieved from Thomson Reuters

West's Nevada Revised Statutes Annotated (2025) 211.155. Limitations on use of restraints on prisoner who is in labor, delivering her baby or recuperating from delivery. *In Title 16. Correctional Institutions; Aid to Victims of Crime (Chapters 208-217), Chapter 211. Local Facilities for Detention, Management of Prisoners.* Retrieved from Thomson Reuters

Revised Statutes Annotated of the State of New Hampshire (2024) § 623-C:1-a. 623-C:1-a. Use of Restraints on Pregnant Women in County Correctional Custody. *In Title LX.*

Correction and Punishment (Ch. 615 to 623-C), Chapter 623-C. Medical Services for Prisoners. Retrieved from Thomson Reuters

Revised Statutes Annotated of the State of New Hampshire (2024) § 623-C:2-a. Use of Restraints on Pregnant Women in State Correctional Custody. *In Title LX. Correction and Punishment (Ch. 615 to 623-C), Chapter 623-C. Medical Services for Prisoners.* Retrieved from Thomson Reuters

New Jersey Administrative Code (2025) 10A:31–13.10. Care of pregnant inmates. *In Title 10a. Corrections, Chapter 31. Adult County Correctional Facilities, Subchapter 13. Medical, Dental, and Health Services* . Retrieved from Thomson Reuters

New Jersey Statutes Annotated (2024) 30:1B-6.8. Promoting visitation for inmates who are primary caretaker parents; duties of commissioner; conditions. *In Title 30. Institutions and Agencies, Subtitle 1. State Department and Institutions Governed Thereby, Chapter 1B. Department of Corrections.* Retrieved from Thomson Reuters

New Jersey Statutes Annotated (2024) 30:1B-6.9. Establishment of policies that promote visitation for inmates who are primary caretaker parents; duties of chief executive officer or warden; conditions. *In Title 30. Institutions and Agencies, Subtitle 1. State Department and Institutions Governed Thereby, Chapter 1B. Department of Corrections.* Retrieved from Thomson Reuters

West's New Mexico Statutes Annotated (2024) § 33-1-4.2. Restraints on pregnant prisoners. *In Chapter 33. Correctional Institutions Article 1. Corrections Department.* Retrieved from Thomson Reuters

McKinney's Consolidated Laws of New York Annotated (2024) § 611. Births to incarcerated individuals of correctional institutions and care of children of incarcerated individuals of

correctional institutions. *In Correction Law, Chapter 43. Of the Consolidated Laws, Article 22. Miscellaneous Provisions.* Retrieved from Thomson Reuters.

West's North Carolina General Statutes Annotated (2024) § 153A-229.2 Care for female incarcerated persons related to pregnancy, childbirth, and postpartum recovery. *In Chapter 153A. Counties, Article 10. Law Enforcement and Confinement Facilities, Part 2b. Dignity for Women Incarcerated in Local Confinement Facilities.* Retrieved from Thomson Reuters.

West's North Carolina General Statutes Annotated (2024) § 148-25.2 Care for female incarcerated persons related to pregnancy, childbirth, and postpartum recovery. *In Chapter 148. State Prison System, Article 2b. Dignity for Women Incarcerated in Prison Facilities*. Retrieved from Thomson Reuters.

Baldwin's Ohio Revised Code Annotated (2024) § 2901.10. Restraint of pregnant woman. In Title XXIX. Crimes—Procedure, Chapter 2901. General Provisions General Provisions. Retrieved from Thomson Reuters.

Oklahoma Statutes Annotated (2024) § 4.2 Restraints on pregnant inmates--Access to certain persons during delivery. In Title 57. Prisons and Reformatories, Chapter 1. General Provisions. Retrieved from Thomson Reuters.

West's Oregon Revised Statutes Annotated (2024) § 421.175 Use of restraints during labor prohibited; exceptions. *In Title 34. Human Services; Juvenile Code; Corrections, Chapter 421. Department of Corrections Institutions; Compacts, Custody Generally.* Retrieved from Thomson Reuters.

Purdon's Pennsylvania Statutes and Consolidated Statutes (2025) 61 § 5911 Postpartum recovery *In Title 61 Pa.C.S.A. Prisons and Parole, Part III. Inmate Confinement, Chapter 59. Miscellaneous Provisions. Retrieved from Thomson Reuters.*

Purdon's Pennsylvania Statutes and Consolidated Statutes (2025) § 1104 State recording system relating to pregnant and postpartum incarcerated individuals or detainees. *In Title 61 Pa.C.S.A. Prisons and Parole, Part II. Correctional Institutions, Chapter 11. General Administration, Subchapter A. Penal Operations and Procedures.* Retrieved from Thomson Reuters.

Purdon's Pennsylvania Statutes and Consolidated Statutes (2025) § 1758 County recording system for pregnant and postpartum incarcerated individuals or detainees. *In Title 61 Pa.C.S.A. Prisons and Parole, Part II. Correctional Institutions, Chapter 17. County Correctional Institutions, Subchapter E. Penal Operations and Procedures.* Retrieved from Thomson Reuters.

Purdon's Pennsylvania Statutes and Consolidated Statutes (2025) § 5905 Healthy birth for incarcerated women. *In Title 61 Pa.C.S.A. Prisons and Parole, Part III. Inmate Confinement, Chapter 59. Miscellaneous Provisions.* Retrieved from Thomson Reuters.

West's General Laws of Rhode Island Annotated (2024) § 42-56.3-3 Restraint of prisoners and detainees. *In Title 42. State Affairs and Government, Chapter 56.3. The Healthy Pregnancies for Incarcerated Women Act*. Retrieved from Thomson Reuters.

Code of Laws of South Carolina 1976 Annotated (2024) § 24-13-35 Treatment of female inmates; visits with minor dependents. *In Title 24. Corrections, Jails, Probations,*

Paroles and Pardons, Chapter 13. Prisoners Generally, Article 1. General Provisions. Retrieved from Thomson Reuters.

West's Tennessee Code Annotated (2024) § 41-51-202. Pregnant inmates; use of restraints. *In Title 41. Correctional Institutions and Inmates, Chapter 51. Correctional Institutions and Inmates--General Provisions, Part 2. Pregnant Inmates.* Retrieved from Thomson Reuters.

Vernon's Texas Statutes and Codes Annotated (2023) § 511.0105 Report Regarding Restraint of Pregnant Prisoner. *In Government Code, Title 4. Executive Branch, Subtitle G. Corrections, Chapter 511. Commission on Jail Standards.* Retrieved from Thomson Reuters.

Vernon's Texas Statutes and Codes Annotated (2023) § 511.0104. Rules Regarding Restraint of Pregnant Prisoner. *In Government Code, Title 4. Executive Branch, Subtitle G. Corrections, Chapter 511. Commission on Jail Standards*. Retrieved from Thomson Reuters.

Vernon's Texas Statutes and Codes Annotated (2023) § 361.082. *In Local Government Code, Title 11. Public Safety, Subtitle C. Public Safety Provisions Applying to More than One Type of Local Government, Chapter 361. Municipal and County Authority Relating to Jails, Subchapter F. . Disciplinary Matters Relating to Municipal and County Jails.* Retrieved from Thomson Reuters.

Vernon's Texas Statutes and Codes Annotated (2023) § 501.066. Restraint of Pregnant Inmate or Defendant. *In Government Code, Title 4. Executive Branch, Subtitle G. Corrections, Chapter 501. Inmate Welfare, Subchapter B. General Medical and Mental Health Care Provisions.* Retrieved from Thomson Reuters.

West's Utah Code Annotated (2024) § 64-13-46. Pregnant inmates. *In Title 64. State Institutions, Chapter 13. Department of Corrections--State Prison*. Retrieved from Thomson Reuters.

West's Vermont Statutes Annotated (2024) § 801a. Pregnant inmates. In Title Twenty-Eight. Public Institutions and Corrections, Chapter 11. Supervision of Adult Inmates at the Correctional Facilities, Subchapter 3. Care of Inmates. Retrieved from Thomson Reuters.

Virginia Administrative Code (2025) 6 VAC 15-40-985 Restraint of pregnant offenders. I*n Title 6. Criminal Justice and Corrections, Vac Agency NO. 15. Department of Corrections, Chapter 40. Minimum Standards for Jails and Lockups, Part V. Jail Operations.* Retrieved from Thomson Reuters.

West's Annotated Code of Virginia (2024) § 53.1-40.12 Treatment of prisoners known to be pregnant*. In Title 53.1. Prisons and Other Methods of Correction, Chapter 2. State Correctional Facilities, Article 2.2. Treatment and Control of Prisoners Known to be Pregnant.* Retrieved from Thomson Reuters.

West's Annotated Code of Virginia (2024) § 53.1-40.13 Treatment of prisoners during postpartum recovery. *In Title 53.1. Prisons and Other Methods of Correction, Chapter 2. State Correctional Facilities, Article 2.2. Treatment and Control of Prisoners Known to be Pregnant.* Retrieved from Thomson Reuters.

West's Revised Code of Washington Annotated (2024) 72.09.651 Use of restraints on pregnant women or youth in custody--Allowed in extraordinary circumstances. *In Title 72. State Institutions, Chapter 72.09. Department of Corrections.* Retrieved from Thomson Reuters.

West's Revised Code of Washington Annotated (2024) 70.48.500 Use of restraints on pregnant women or youth in custody--Allowed in extraordinary *circumstances In Title 70. Public*

Health and Safety, Chapter 70.48. City and County Jails Act. Retrieved from Thomson Reuters.

West's Annotated Code of West Virginia (2024) § 15A-4-5 Transfer of inmates of state institutions or facilities. *In Chapter 15A. Department of Homeland Security, Article 4. Corrections Management.* Retrieved from Thomson Reuters.