

HB 1140 Survey Form

Instructions

- House Bill 1140 requires sheriffs to submit a report regarding the care of pregnant inmates
- **All sheriffs/wardens are required to complete this survey.** Counties that do not have a jail or that house pregnant inmates elsewhere should indicate the policies of facilities where the majority of pregnant inmates would be housed.
- **Survey is due no later than September 1, 2016**
- Do not include any identifying information of any pregnant inmate in this survey

County \_\_\_\_\_ Date \_\_\_\_\_

Report Prepared by Name and Title	Phone #	Email address

Name of facility, if other than county jail \_\_\_\_\_

Total capacity of facility \_\_\_\_\_ Average Daily Population in FY 2016 (Sept. 1, 2015-Aug. 31, 2016) \_\_\_\_\_

Average length of stay for all offenders in FY 2016 \_\_\_\_\_

# of female beds \_\_\_\_\_ Average Daily Population of females in FY 2016 \_\_\_\_\_

Is your facility routinely able to house pregnant inmates?      Yes      No

If no, please explain why and current arrangement for the housing of pregnant inmates

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pregnant inmates/Birth Demographics

Total # of pregnant inmates in FY 2016 \_\_\_\_\_ Average length of stay of pregnant inmates \_\_\_\_\_

# of pregnant inmates that gave birth September 1, 2015 to report date \_\_\_\_\_

# of live births \_\_\_\_\_ # of stillbirths \_\_\_\_\_ # of premature births\* \_\_\_\_\_

# of low birth weight (less than 2500 grams or 5.5 lbs) \_\_\_\_\_ # of very low birth weight (less than 1500 grams or 3.3 lbs.) \_\_\_\_\_

\*Premature is defined as before the 37<sup>th</sup> week

**1. Please provide a description of the sheriff's actions to comply with the rules and procedures adopted under section 511.009 (a) (18) of the Texas Government Code**

Government Code 511.009 (a) (18) reads as follows:

- (A) Determine if a prisoner is pregnant and;
- (B) Ensure that the jail's health services plan addresses medical and mental health care, including nutritional requirements, and any special housing or work assignment needs for persons who are confined in the jail and are known or determined to be pregnant.

<p>A. Determine if a prisoner is pregnant-describe procedures</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>B. Ensure Health services plan addresses items in letter B above.</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

<p><b>2. Please provide a description of any policies adopted by the sheriff regarding the placement of a pregnant prisoner in solitary confinement or administrative segregation</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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**3. Please answer the following questions regarding Obstetrical or Gynecological Care of pregnant inmates.**

a. Circle the type of provider that supervises the majority of routine health care to a pregnant inmate in your facility.

- |                              |                                |                     |
|------------------------------|--------------------------------|---------------------|
| Obstetrician or gynecologist | General or family practitioner | Physician Assistant |
| Nurse Practitioner           | Midwife                        | Other_____          |

b. Do pregnant inmates in your facility have regular access to a healthcare provider that specializes in obstetrics or gynecology?

1. Yes

2. No

c. If no, identify the reasons or barriers for not having OB/GYN access for pregnant inmates, i.e. no OB/GYN in the county, physicians refuse to see inmates, etc.

d. Does your facility have access to a provider that specializes in high-risk pregnancy?

1. Yes

2. No

e. If no, please provide reasons for not having access to high-risk specialists.

f. Please provide any comments or observation regarding the availability of obstetrical care in your area

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**4. Please answer the following questions regarding prenatal care in your facility.**

a. Counseling on the following issues - Please indicate if the following education/counseling issues are provided at your facility:

Counseling/Education issue	Routinely offered	Available upon request	Not provided
Nutrition			
Exercise			
Labor and Delivery			
Stress Reduction			
Drug or alcohol use			
Domestic Violence			
Parenting			
Mental Health			
Effects of pregnancy			
Other _____			

b. Prenatal Care - Indicate frequency of routine visits by provider and trimester at your facility

\_\_\_ Facility policy does not address this issue (check if applicable)

Provider	1 <sup>st</sup> trimester	2 <sup>nd</sup> trimester	3 <sup>rd</sup> trimester
Nurse			
Nurse Practitioner/PA			
Physician			
Other _____			

c. Indicate if the below procedures are conducted, by whom, and how often

\_\_\_ Facility policy does not address these procedures (check if applicable)

Action	Who Performs	How often
Blood Typing		
Blood Pressure measurement		
Fetal Heart Tone		
Urinalysis		
Abdominal Palpation		
Fetal movement		
Weight		
Symphysis fundus height measurement		
Other tests		

d. Indicate how brassieres (bras) for pregnant inmates are provided in your facility?

1. Facility provides      2. Available for purchase on commissary      3. Family/Inmate provided  
 4. Not allowed in facility      5. Other \_\_\_\_\_

e. Please provide any comments regarding your facility's prenatal care of pregnant inmates.

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**5. Indicate which of the following mental health services are available for pregnant inmates.**

Mental Health Service	Routinely Offered	Available upon request	Not Available
Psychiatric Assessment (other than intake)			
Suicide Prevention			
Crisis Intervention			
In-house Mental health Care			
Off-site mental health care			
Therapy/counseling			
Discharge planning			
Other _____			

**6. Drug abuse or chemical dependency treatment-Indicate your facility's availability of drug abuse or chemical dependence treatment of pregnant inmates.**

Service	Routinely Offered	Available upon request	Not Available
Chemical Dependency treatment			
Detox protocol			
Detox support			
Methadone access			
Other _____			

Please provide any comments regarding your facility availability of drug abuse or chemical dependence treatment of pregnant inmates at your facility.

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**7. Nutritional Standards**

Average daily caloric intake of pregnant inmate's \_\_\_\_\_ calories (Consult with licensed dietician for caloric intake)

Please indicate whether the items below are offered:

Item	Routinely provided	Available Upon request	Not available
Supplemental Snack			
Prenatal Vitamins			
Fresh Fruits/Vegetables			
Nutritional beverages (Ensure) etc.			
Fresh Water			

If a supplemental snack is routinely offered, please describe a typical snack item \_\_\_\_\_

**8. Work assignments-describe if your facility is able to provide work opportunities for pregnant prisoners. If able to provide work assignments, please describe the types of work assignments, the working conditions, and any issues with providing work opportunities.**

_____ _____ _____ _____ _____ _____
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**9 a. Housing Conditions-Please describe typical housing assignments for pregnant prisoners, such as single or multiple occupancy cells, frequency of using medical/infirmiry cells, and any issues prisoners may experience in their housing units.**

_____ _____ _____ _____ _____
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b. Pregnant Inmates are typically held in what type of cell in your facility?

Cell Type	Routinely Housed	Physician Order Required	Inmate Request	Not Available to Pregnant Inmates
Medical Cell				
General Population-Single Occupancy Cell				
General Population-Multiple Occupancy Cell				
Administrative Segregation (because of pregnancy)				

c. Indicate whether the following items are provided:

Item	Routinely Provided	Physician Order Required	Available upon request	Not available
Lower bunk				
Double mattress				
Double pillows (if pillows are allowed in facility)				

10. Please describe situations in which a pregnant prisoner has been restrained, including the reason a determination to use restraints was made under Section 361.062, Local Government Code in FY 2016. In the description, please include the following:

1. Whether the pregnant inmate was in labor, delivery or recovery
2. Event leading up to the use of restraints
3. The justification for use of restraints
4. Title of person authorizing restraints
5. Length of time in restraints
6. Observations of the inmate's behavior and condition
7. During transport in vehicle

**DO NOT PROVIDE ANY IDENTIFYING INFORMATION OF THE INMATE ON THIS FORM**

**Add additional sheets as necessary**

**Situation # 1 DO NOT PROVIDE ANY IDENTIFYING INFORMATION OF THE INMATE ON THIS FORM**

1.

2.

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5.

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**Situation #2 DO NOT PROVIDE ANY IDENTIFYING INFORMATION OF THE INMATE ON THIS FORM**

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**Situation #3 DO NOT PROVIDE ANY IDENTIFYING INFORMATION OF THE INMATE ON THIS FORM**

1.

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**Situation # 4**

1.

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**RETURN SURVEY BY FAX, EMAIL, OR MAIL NO LATER THAN SEPTEMBER 1, 2016**

**TEXAS COMMISSION ON JAIL STANDARDS**

**Attn: Diana Spiller**

**P.O. Box 12985**

**Austin, TX 78711**

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**Email [diana.spiller@tcjs.state.tx.us](mailto:diana.spiller@tcjs.state.tx.us)**

**If you have any questions, please contact: Diana Spiller at (512) 463-2690**