

AMENDED

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH OFFICE OF JUVENILE SYSTEM OVERSIGHT

Name and Location of Facility:	Central Oklahoma Juvenile Center Tecumseh, Oklahoma
Dates of Visit:	February 11, 12, 13, 14, and 19, 2008
Oversight Reviewer:	Dana S. Holden, Oversight Specialist Anthony Kibble, Intern
Focus of Visit:	First Biannual Visit, 2008
Date:	June 4, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) initiated a routine, unannounced visit at the Central Oklahoma Juvenile Center (COJC) on February 11, 2008. The OJSO resumed the oversight on February 12, 13, and 14, and completed the visit on February 19, 2008. The facility is a medium-secure rehabilitation program for juveniles adjudicated Delinquent or Youthful Offender who are in the custody of the Office of Juvenile Affairs (OJA). The facility is licensed for 119 residents by the division of Oklahoma Child Care Services (OCCS) of the Department of Human Services. On the first day of the OJSO visit, the census was 108.

The focus of the visit was to assess the facility's investigations of caretaker conduct reviews (CCRs); responses to resident grievances; and reports of incidents of alleged abuse, neglect, or misconduct to the DHS Office of Client Advocacy (OCA), in accordance with DHS policy OAC 340:2-3-37 regarding caretaker conduct review.

Interviews Conducted

- Entry interview and an exit conference with the Institutional Superintendent
- Thirty-seven residents

Documents Reviewed

- CCRs for July 2007 through January 28, 2008
- Grievance logs for November 2007 through January 2008

Findings

The OJSO interviewed twenty-four residents regarding their perceptions of safety, program services, resident rights, discipline practices, and other residential care issues. Thirteen additional residents were interviewed regarding grievances filed that were resolved through internal investigations by the facility (CCRs).

Findings from the interviews with the twenty-four residents regarding residential care issues were:

- Thirteen residents rated the quality of the food as poor, and ten residents rated the food as fair.
- Sixteen residents stated that group punishment was used. Reportedly, the sanctions imposed ranged from restricted television viewing to lowered points on each resident's point cards.
- Ten residents stated they did not believe that the grievance process worked, and eight residents stated that the grievance process worked only some of the time.
- Twenty-one residents stated that staff cursed at the residents on a regular basis.

Safety

The twenty-four residents interviewed were asked about physical and sexual assaults and the presence of dangerous contraband at the facility. The OJSO noted:

- Fifty percent (12 of 24) reported seeing residents in possession of dangerous contraband. Items included shanks, cigarettes, tobacco for dipping, lighters, and money.
- Seventy-nine percent (19 of 24) reported being physically assaulted by other residents, and 63% (15 of 24) reported being physically assaulted by staff members.
- Twenty-five percent (6 of 24) reported being sexually assaulted by other residents, and 17% (4 of 24) reported being sexually assaulted by a staff member.

Seventeen female residents of the twenty-four resident interviewees were interviewed regarding a specific male staff member, who, allegedly, had been observed watching female residents shower and change clothes. The OJSO noted:

- Thirteen of the seventeen female resident interviewees reported they had observed the specific staff member watching other female residents while those females showered or bathed, or that the interviewees had observed him watching them while they themselves showered or bathed. One female resident had filed a grievance against the staff member for making an inappropriate sexual remark to her, and another female resident had filed a grievance after she had seen the staff member watching her as she was getting out of the shower. The facility conducted CCR inquiries of both allegations and made findings of not confirmed. Both of these female residents were interviewed; however, the investigating officer did not interview any other female residents. The two staff members who were interviewed

as witnesses to these two incidents did not work on the units for female residents and would not have had knowledge of allegations made by any female residents concerning incidents that had allegedly occurred on their female unit.

- Nine residents stated they had reported incidents regarding this specific staff member watching female residents while they showered and dressed, and that the allegations had never been addressed.

The twenty-four resident interviewees were asked how often they felt safe at the facility. A six-point Likert scale was used in recording their responses. The results of the responses were: Very Frequently, 4% (1 of 24); Frequently, 29% (7 of 24); Occasionally, 33% (8 of 24); Rarely, 4% (1 of 24), Very Rarely, 13% (3 of 24); and Never, 17% (4 of 24).

The twenty-four resident interviewees were asked what contributed to their feelings of safety. The options given for the responses were staff, facility police officers, peers, and self (ability to keep themselves safe), and the residents could choose more than one option. The results of the responses were: Staff, 17% (4 of 24); Police Officers, 8% (2 of 24); Peers, 21% (5 of 24); and Self, 50% (12 of 24). Thirteen percent (3 of 24) of the resident interviewees stated they were not sure what contributed to their sense of safety.

The twenty-four residents were also asked what contributed to feeling unsafe. The options given were staff, facility police officers, and peers, and the residents could choose more than one option. The results of the responses were: Staff, 42% (10 of 24); Police Officers, 17% (4 of 24); and Peers, 63% (15 of 24).

Grievances

The OJSO reviewed the grievance log and the grievances filed for the period of November 2007 through January 2008. From a total of 177 grievances, the OJSO noted:

- Eighteen grievances that were listed on the grievance log sheet had no grievance documentation contained in the grievance book. No explanation for the missing documentation appeared in the grievance book.
- Thirteen grievances did not document resolutions.
- Thirteen grievances did not document that the residents had accepted the resolutions.
- Sixteen grievances did not document whether or not the residents wanted to appeal the resolutions.
- Eleven grievances were not signed by the residents, and twelve were not signed by the staff members.
- Fifty-two grievances were not resolved in the required time frame.

Caretaker Conduct Review (CCR) Inquiries

The OJSO requested the CCR files from July 2007 through January 28, 2008. The facility conducted seventy-six CCR inquiries during this time frame; the OJSO reviewed the files of seventy-two to determine compliance with OAC 340:2-3-37 sections (c) through (f). In these seventy-two files, the OJSO noted:

- Eleven inquiries had findings of Confirmed.
- Twenty-two inquiries had findings of “Did not confirm.”
- Twelve of these residents indicated they were not interviewed regarding the incidents.
- Sixteen were listed as pending investigations at the facility.
- Six had been referred back to the OCA for investigations at OCA.
- Seventeen facility reports had not been turned in to the OCA by the due date.

The OJSO was advised that the facility officers did not record the staff and resident interviews in the twenty-two CCR inquiries that resulted in findings of “Did not confirm.” The OJSO noted that twelve CCRs had handwritten notes containing alleged statements made by residents to the facility investigator. When the OJSO spoke with the residents and read the handwritten statements to them, all denied ever making the statements to the officers and denied knowing that inquiries had been initiated. The OJSO interviewed 25 residents who were listed as victim(s) or as witness(es) on CCRs. Sixty percent (15 of 25) reported that they had not been interviewed by a staff member regarding a CCR inquiry involving a resident in a physical or sexual assault.

Case specific findings and information concerning these CCRs are attached to this report in a confidential attachment to be reviewed by the facility. The attachment is not electronically published because the case specific information is not public record. General concerns and violations are noted below.

Areas of Concern

1. When asked if the grievance process worked, 25% (6 of 24) of the residents interviewed said it did. Forty-two percent (10 of 24) of the residents interviewed stated that the grievance process did not work. The remaining eight residents interviewed stated that the grievance process worked sometimes.
2. Eighty-eight percent (21 of 24) of the residents interviewed stated that staff members had used curse words when speaking to them.
3. Residents were asked what contributed to feeling unsafe at the facility. Forty-two percent (10 of 24) of the residents interviewed reported that staff members were the reason for feeling unsafe, 63% (15 of 24) reported that peers were the reason, 17% (4 of 24) stated that facility police officers were the reason, and 4% (1 of 24) of the residents interviewed stated that the absence of cameras for all areas of the campus was the reason for feeling unsafe at the facility.
4. An incident was not completely described in the original referral to the OCA, resulting in the OCA referring the grievance back to the facility for a CCR.

Photographs of the resident's injuries revealed that the left eye was swollen almost shut and that the face, head, and neck areas were bruised. It did not appear that the photographs had been provided to the OCA, or that the facility had advised the OCA of the extent of the resident's injuries.

5. Seventy grievances either were not filled out completely or were not properly logged in the grievance log.
6. Some concerns identified during the second biannual visit in 2007 had not been adequately addressed by the facility. Concerns listed in the previous oversight report that were still noted in this oversight visit were Item 3, the residents' perceptions of the grievance process; Item 4, staff cursing at the residents; and Item 5, the residents' perceptions of safety at the facility.

Violations

1. Residents (16 of 24) reported that staff used group punishment. DHS licensing standards, Section 154.2, Behavior management, (b), Prohibitions, in part, states, "Facility policy prohibits: . . . (12) group punishment."
2. Residents (21 of 24) reported that staff cursed at the residents on a regular basis. OJA policy OAC 377:10-1-3, Discipline, (b), states, "OJA staff and contractors shall adhere to OJA rules regarding discipline of juveniles. Prohibited disciplinary actions include, but are not limited to: (6) use of profanity by OJA or contract staff."
3. Residents (15 of 24) reported being physically assaulted by staff members. COJC policy "C030400.01, (IV), Protection From Harm, (A), states, "Juveniles have the right to not be subjected to personal abuse, corporal punishment, personal injury, disease, property damage, and harassment."
4. Seventeen residents reported they had not been interviewed by a staff member in reference to CCR inquiries involving those residents. COJC policy C030400.03, (II), Internal Investigative Process—CCR, (E), states, "All juveniles and staff identified will be interviewed."
5. The staff assigned to conduct the CCR inquiries did not initiate the investigations within the required twenty-four-hour time frame. COJC policy C030400.03, (II), Internal Investigative Process—CCR, (C), states, "The Superintendent/designee shall begin the investigation within 24 hours of the OCA referral."
6. The staff assigned to conduct the CCR inquiries did not complete the investigation within the required thirty-day time frame. DHS policy OAC 340:2-3-37,(f), states "[t]he final written report is submitted to the advocate general within 30 calendar days from the date the OCA intake notified the administrator that an allegation is referred for CCR."
7. The staff conducting CCR inquiries did not obtain written statements from the alleged victims or witnesses. OJA policy OAC 377:3-1-25, Abuse, neglect and caretaker misconduct, (c), Preliminary assessment procedures, (3), (A), in part, states, "A facility employee designated to conduct a caretaker misconduct review shall: (iii) obtain written statements and conduct interviews with: (I) each alleged victim; (II) each eyewitness; (III) other persons with knowledge relevant to the allegation."

8. Three staff members failed to report restraining a female resident when she refused to allow a staff member to conduct a pat search of her person. The juvenile reported that she had been injured during the restraint. The restraint and injury were confirmed by medical reports. COJC policy C030100.10, Use of Force, (IX), Multi-purpose Reports, (A), states, "Every employee involved in a use of force will prepare a written report to the Superintendent before leaving the institution."
9. The facility did not maintain copies of video recordings of incidents involving restraints of residents. When the OJSO asked for copies of the video recordings, facility staff advised there were no recordings even though the CCR inquiries specifically referenced those recording. COJC policy C030100.10, (VI), Audiovisual Cameras, (3), states, "After each use of force, the recorded incident will be downloaded and transferred to a DVD. This DVD will be labeled, logged, and stored. DVD's will be maintained for a period of 1 year or upon completion of any investigation or court action."
10. The staff writing Multi-purpose reports did not list the juveniles' injuries on the reports. COJC policy C030100.10, Use of Force, (IX), Multi-purpose Reports, (C), in part, states, "All Multi-Purpose Reports will contain the following: (6) Any resulting personal injury or property damage."
11. Fifty-two grievances were not resolved within the required time frame. OJA policy OAC 377:3-1-30, Grievance procedures for institutions, group homes, and contract facilities, (b), in part, states, "If the grievance is not resolved in three working days, the juvenile may appeal to the supervisor or facility administrator who will have an additional five working days in which to attempt resolution."

OJSO Recommendation

1. The Oklahoma Administrative Code 340:2-3-37, (f), and COJC internal policy C030400.03 should be studied, because existing provisions could be interpreted inconsistently causing confusion for responsible staff.

COJC policy C030400.03, (II), Internal Investigative Process–CCR, (D), states:

The CCR report must be completed within seven (7) working days to include a written report of the findings and a resolution from the Superintendent/designee in writing.

OAC 340:2-3-37, (f), states:

Time for completion of report. The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR.

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