

**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: June 28, 29, 30 and July 1, 2011

Oversight Reviewer: Janice Sharp, Oversight Specialist

Focus of Visit: First Biannual Visit, 2011

Date: August 25, 2011

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit at the Central Oklahoma Juvenile Center (COJC) on June 28, 2011, and returned on June 29, June 30, and July 1, 2011, to complete the oversight visit. The purpose of the visit was to assess the facility's compliance with established responsibilities and facility policy and procedures. 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). On the first day of the OJSO visit, the census was forty-seven male residents and twenty female residents.

Title 10A of the Oklahoma Statutes, Section 2-7-611, effective November 1, 2009, authorized the OJA to certify secure juvenile facilities. The OJA Office of Public Integrity had issued COJC a Permanent Certificate to operate as a 116-bed secure juvenile facility through June 30, 2012. The facility had received the rules pertaining to the OJA certification requirements for secure juvenile facilities.

Interviews Conducted

- Informal entry interview with the facility superintendent and the executive secretary
- Ten residents
- Two youth guidance specialists
- Three juvenile security officers
- Informal exit conference on July 1, 2011, with the facility superintendent
- Telephone exit conference on August 9, 2011, with the facility superintendent; the acting administrator of programs; the administrative programs officer/standards manager; a juvenile justice specialist supervisor; and an administrative technician

Documents Reviewed

- Twelve resident files
- Five personnel files and training records
- Oklahoma State Department of Health Food Inspection report dated May 12, 2011
- Office of the Oklahoma State Fire Marshal report dated May 17, 2011, and the facility response dated May 26, 2011
- OJA Office of Public Integrity (OPI) assessment report dated April 1, 2010, and the facility response dated September 24, 2010
- Facility Crisis Management Center (CMC) log for January 1 through May 30, 2011
- Facility use-of-force log for January 1 through May 30, 2011
- Facility grievance log for January 1 through June 20, 2011
- Facility grievances
- Facility critical incident reports
- Facility OPI investigation log for January 1 through June 30, 2011, regarding reports alleging abuse/neglect
- Facility caretaker conduct review (CCR) log for January 1 through June 30, 2011, regarding reports alleging caretaker misconduct
- Facility daily population report for June 28, 2011
- Facility staff roster
- OJSO report dated December 28, 2010, for the visit conducted on September 8, 9, 14, and 16, 2010, and the facility response dated January 13, 2010 [sic]

Areas Toured

- An observational tour of the facility was not conducted this visit.

Findings

Resident Interviews

The OJSO interviewed ten residents. The focus of the interview questions was to determine the residents' perceptions of safety, treatment, and overall quality of life at the facility. The OJSO noted:

- All ten interviewees reported that they received a resident handbook and a written copy of the resident's rights when they were admitted to the facility.
- Nine interviewees stated that they received written policies regarding visitation, mail, telephone calls, gifts, discipline policies, religious practices, the education program, and the grievance procedures when they were admitted to the facility; the other interviewee stated that he/she received verbal notification of the written policies when he/she was admitted to the facility.
- Seven interviewees reported that they received plenty to eat at the facility; two of the remaining three interviewees stated that they sometimes did not receive enough food, and the other interviewee stated that he/she did not receive enough food.

- When asked to rate the quality of the food served at the facility, on a scale of 1 to 5, with 1 being terrible and 5 being great, one interviewee rated the quality of the food as 1, one interviewee rated the food as 1.5, five interviewees rated the food as 2, one interviewee rated the food as 2.5, and two interviewees rated the food as 3.
- Five interviewees reported that they had been restrained and had been taken to the CMC because of inappropriate behaviors at the facility. When these five interviewees were asked if they had received any injuries when being restrained and/or escorted to the CMC, two interviewees stated that they had gotten red marks on their wrists because the handcuffs were placed too tight, and one interviewee stated that he/she had received a minor eye injury when being restrained. The other two interviewees did not report any injuries. When asked to estimate the length of time they remained in the CMC, some of these five interviewees indicated that the amount of time a resident remained in CMC depended on the staff members and/or the offense.
- Four of the five interviewees who reported having been restrained for inappropriate behaviors stated that they had received a medical evaluation after having been restrained; the other interviewee who reported having been restrained stated that he/she had not always been medically evaluated after having been restrained.
- When asked to give an example of the types of discipline received for a rule infraction, the responses were additional chores, early bedtime, loss of privileges, 250 and 500-word essays, level drop, unit restriction, and last-in-line for all activities.
- All ten interviewees stated that they received individual counseling at the facility; four interviewees reported that their individual counseling had not been on a regular basis lately. Five interviewees stated that they participated in family counseling, eight interviewees stated that they participated in group counseling, and five interviewees stated they had received substance abuse counseling.
- When asked if they received job skills training at the facility, five interviewees described training in food service, office filing, lawn mowing, and painting.
- All ten interviewees indicated that they were familiar with the facility grievance procedures. Seven interviewees reported that they had filed at least one grievance; one of these seven interviewees believed that the grievance process worked, three interviewees believed that the grievance process worked sometimes, and three interviewees did not believe that the grievance process worked.
- Six interviewees reported having been assaulted physically by other residents at the facility.
- All ten interviewees stated that they had not been assaulted sexually at the facility.
- When asked how often unit staff checked on residents when residents were in their dorm areas, five interviewees reported that staff checked on residents every fifteen to thirty minutes. The responses from the remaining five interviewees were that staff checked on residents every thirty minutes; the only time staff came into the dorm area was when something happened, otherwise, staff remained at the staff desk in the dayroom; staff were “always present” in the dorm area; staff were “usually present” in the dorm area; and it depended on the staff person on-duty as to how often checks were made.
- When asked how often security staff conducted walk-throughs on their units, five of the ten interviewees stated that security staff checked the units every one to two hours. The responses from the remaining five interviewees were that security staff

came onto the unit, but the resident did not know the frequency of the walk-throughs; security staff had not been on the unit that week, but they conducted walk-throughs at least once during night hours; security staff came onto the unit, but they did not go into the dorm area; the resident had not seen security staff on the unit; and security staff checked the unit two or three times during day hours and every thirty minutes during night hours. One resident also stated that security staff members were loud when they came onto the unit at night, disturbing the residents' sleep.

- When asked if they felt safe at the facility, five interviewees stated that they did feel safe at the facility; one interviewee stated that he/she "sometimes" felt safe; another interviewee stated that he/she did "not really" feel safe, and three interviewees stated that they did not feel safe. Those interviewees who reported not feeling safe were asked to give their reasons: Peers made him/her feel unsafe; a lot of unit staff and security staff were unaware of happenings among the residents, and therefore, some residents "pick on" other residents; some security staff mistreated the residents when they were not in view of the surveillance cameras; staff were more interested in the residents' behaviors than helping the residents to turn their lives around; and unit staff and security staff did not provide the protection necessary to keep the residents safe.
- When asked if they had suggestions for making the facility a safer place for the residents, the suggestions were that staff could provide closer supervision of the residents; the unit staff could become more informed of what was going on among the residents; a more secure place than the bathrooms was needed for the residents to go during severe weather; and the dorms could be turned into resident rooms with door locks.
- When asked if there were things the interviewees disliked about their quality of life at the facility, the responses were that some residents "bully" other residents; the residents did not have any privacy in the dorms; the quality of food could be better; unit staff should follow the rules in the juvenile handbook and not make up their own rules; male residents were allowed to do more sport activities than female residents; more recreation was needed as the residents spend too much time on the unit; and a resident's unit could be cleaner.
- All ten interviewees reported having received medical and dental examinations subsequent to having been placed at the facility.

No other concerns were identified from the resident interviews

Staff Interviews

The OJSO interviewed five staff members. The OJSO noted:

- All five interviewees reported current certification in first aid, cardiopulmonary resuscitation (CPR), and behavioral management techniques.
- All five interviewees reported that they had restrained residents at the facility. When asked if they had witnessed any injuries during restraints, two interviewees reported that they had witnessed residents having been injured when restrained; three interviewees reported that they themselves had been injured when restraining

residents; and four interviewees reported that they had witnessed other staff members having been injured when restraining residents.

- When the five interviewees were asked if there were areas in which they would like to receive additional training, the suggestions made were: time management training, so that staff could complete the paperwork that was required without sacrificing time that could be spent interacting with the residents; advanced training for supervisors; leadership skills training for staff; and continuous training on policy and procedures.
- All five interviewees stated that staff ate the same food as the residents when they dined together.
- All five interviewees stated that residents had access to grievance boxes on the units.
- When asked to name their most important responsibilities at the facility, three interviewees stated that their main responsibilities were to ensure the safety of the residents, staff, and facility; one interviewee stated that his/her main responsibilities were to ensure the health and safety of the residents and consistency among staff members regarding the care of the residents; and the other interviewee stated that his/her main responsibilities were to ensure that the residents were not sexually inappropriate, to know the whereabouts of the residents at all times, and to ensure bedtimes.
- When asked to name the most severe consequence a resident could receive for a rule infraction, four interviewees stated that restriction to the unit for seventy-two hours was the most severe consequence; the other interviewee stated that loss of privileges for twenty-four hours was the most severe consequence.
- All five interviewees stated that residents received recreation daily.
- Four interviewees reported that security staff conducted walk-throughs of the units at least hourly; the other interviewee stated that security staff conducted walk-throughs every hour, unless a crisis occurred that prevented a walk-through.
- When asked to name what they believed to be a strength of the facility for the population of residents served, the responses were: The facility did a good job to meet the needs of residents and to protect the residents; the current staff were a strength to the facility; the program rewarded the residents' good behaviors; and the treatment program helped the residents.
- When asked if there were any changes that could be made to improve the program for the residents, one interviewee stated that there needed to be more hands-on activities for the residents; the other four interviewees did not suggest any changes.

No concerns were identified from the staff interviews.

Resident File Review

The OJSO reviewed twelve resident files. The OJSO noted:

- Two resident files reviewed did not contain copies of legal documents verifying authority to accept the juveniles into the facility.
- Two resident files reviewed did not document that these newly admitted juveniles had received orientation materials.

- Two resident files reviewed did not document that the grievance policies and procedures had been explained when these residents were admitted to the facility.
- Two resident files reviewed did not document the signatures required on the grievance notification form.
- One resident file reviewed did not contain an individualized treatment and service plan.
- One resident file reviewed did not document that a review was performed monthly of the resident's treatment plan.
- Three resident files reviewed did not document counseling sessions as occurring in accordance with the residents' individualized treatment plans. (This finding was based on the counseling sessions documented for April, May and June 2011.)

No other concerns were identified from the resident files reviewed.

Personnel File and Training Record Review

The OJSO reviewed five personnel files and training records. All five personnel files were complete for the items reviewed. The training records documented that these five staff members had received the required training hours for 2010. In addition, documentation indicated that these staff members were current in CPR certification and first aid training. Documentation also indicated that four of the five staff members whose training records were reviewed had recently received a behavior management refresher course, and the other staff member whose training record was reviewed had recently received behavior management orientation. No concerns were identified from the personnel files and training records reviewed.

Grievance Log and Grievances Review

The OJSO reviewed the grievance log for January 1 through June 20, 2011. Documentation indicated that 669 grievances were filed during the reporting period. Of those 669 grievances, the issues in 74 grievances had not been resolved at the time of the oversight visit. Of the 595 grievances that processed through the informal grievance resolution process, 100 resolutions were appealed for final resolution at the formal grievance level. The OJSO noted the specific dates documented for 5 resolved grievances. In all five instances, the grievance log documentation indicated that the issues of the grievances were resolved before the grievances were filed. For example, the log documented that a grievance was filed on the 23rd day of the month; received for processing and possible resolution and assigned to a staff member the following day, the 24th; set for possible resolution on the 27th; and resolved on the 15th of the month that the grievance was filed. The OJSO also noted that 6 of the 595 completed grievances were not resolved within the required timeframe.

Of the 74 unresolved grievances, 35 grievances were still within the required timeframe to process through the informal grievance level. According to the grievance log documentation, the remaining 40 unresolved grievances had not been resolved by the due dates assigned and within the required timeframes set out in OJA policy.

The OJSO reviewed 144 grievances. The OJSO noted:

- Nine of the 144 grievances reviewed did not document the proposed resolution and final resolution information; however, the grievance log recorded the resolution dates.
- One of the 144 grievances reviewed did not propose a resolution to an issue in which a resident might have been at-risk for injury.
- Two of the 144 grievances reviewed did not document the residents' signatures in the Statement of Grievance section.
- Two of the 144 grievances reviewed did not document staff signatures.
- Four of the 144 grievances reviewed recorded that the residents had rejected the proposed resolutions to their issues, but no appeal information was documented on the grievance forms; the grievance log recorded that three of these four resolutions were appealed.

In addition, the OJSO reviewed grievances to follow-up on statements made by resident interviewees who alleged that staff members had cursed at residents. Fifteen of the 144 grievances alleged that staff members had cursed at residents, and three other grievances alleged that staff members had called residents derogatory names.

No other concerns were noted from the grievance log and grievances review.

Use-of-Force Log Review

The OJSO reviewed the use-of-force log for January 1 through May 31, 2011. Documentation recorded 146 incidents of use of physical force involving one or more residents during the reporting period. Mechanical restraints were used on a total of 185 residents in 143 of the 146 incidents. The reasons indicated for the use of physical force were: self-protection/self-harm, 64 incidents; fighting, 21 incidents; assault on staff, 26 incidents; and assault on peers, 39 incidents. Five incidents documented more than one reason for the use of physical force. No concerns were noted from the use-of-force log review.

CMC Log Review

The OJSO reviewed the CMC log for January 1 through May 31, 2011. Documentation recorded 106 instances in which residents were placed in the CMC. In those 106 instances, 41 residents were involved. During this reporting period, 16 residents each were placed in the CMC one time; 8 residents each were placed in the CMC two times, 8 residents each were placed in the CMC three times, 3 residents each were placed in the CMC four times, 3 residents each were placed in the CMC five times, one resident was placed in the CMC seven times, and 2 residents each were placed in the CMC eight times. Twenty minutes was the shortest length of time that a resident remained in the CMC during this reporting period; 23 hours 59 minutes was the longest length of time that a resident remained in the CMC during this reporting period. No concerns were noted from the CMC log review.

Referral Log Review

The OJSO requested to review the facility referral log for January 1 through June 30, 2011. At the time of the OJSO visit, the facility did not maintain a referral log regarding reports of alleged abuse, neglect, and caretaker misconduct made to the OJA Advocate General. On July 25, 2011, the facility provided copies of a referral log regarding OJA OPI investigations and a referral log regarding facility CCRs. The log documentation indicated that the facility made thirty-six reports to the Advocate General during the reporting period for determination as to whether or not investigations were warranted. Twelve of the thirty-six reports were accepted for investigations to be conducted by the OPI, and twenty-four reports were assigned to the facility for caretaker conduct reviews. The allegations were confirmed against staff members in five OPI investigations; the allegations were not confirmed against staff members in two OPI investigations; and the five remaining OPI investigations were still in open status. The findings in five of the twenty-four CCRs were ruled Confirmed Caretaker Misconduct, and the findings of ten CCRs were ruled Not Confirmed Caretaker Misconduct. In each of three other CCRs, the finding was ruled Confirmed Caretaker Misconduct regarding the actions of one staff member and Not Confirmed Caretaker Misconduct regarding the actions of another staff member. The finding in another CCR was ruled Confirmed Caretaker Misconduct regarding the actions of the staff member regarding two residents and Not Confirmed Caretaker Misconduct regarding the actions of the same staff member regarding two other residents, all pertaining to the same incident. The allegation in one CCR was referred to law enforcement for investigation. The CCR referral log indicated that the four remaining CCRs were still in open status. No concerns were noted from the referral log review.

Other Inspection Reports Review

The OJSO reviewed the most current inspection reports by the health department and the fire marshal's office and the most current assessment report by the OJA OPI. No violations were indicated in the health department report. The fire marshal office's report indicated four non-compliant items; the facility corrective action documentation indicated that three items were corrected immediately and that the facility was working to correct the remaining item. The OJA OPI assessment report provided by the facility was the same report that the OJSO had reviewed during the oversight in winter 2010. No concerns were noted from the inspection reports review.

Area of Concern

1. Most of the twelve resident files reviewed were not complete, as there was missing documentation.

Violations

1. Two of the twelve resident files reviewed did not contain copies of legal documents verifying authority to accept the juveniles into the facility. OJA policy OAC 377:3-13-

136, Juvenile case records, (b), (1), in part, states, “[E]ach juveniles [sic] record shall include, at a minimum . . . documented legal authority to accept the juvenile.”

2. Two of the twelve resident files reviewed did not document that the residents had received orientation materials when admitted into the facility. OJA policy OAC 377:3-13-136, Juvenile case records, (b), (6), states, “[E]ach juveniles [sic] record shall include, at a minimum . . . signed statement(s) by the juvenile acknowledging participation in an orientation that includes the presentation of juvenile rights, program rules, grievance procedures, disciplinary processes and the issuance of the juvenile handbook.”
3. Two of the twelve resident files reviewed did not document that the grievance policies and procedures had been explained to the residents when they were admitted into the facility, and two of the twelve files reviewed did not document required signatures on the grievance notification form. OJA policy, OAC 377:3-13-136, Juvenile case records, (b), (6), states, “[E]ach juveniles [sic] record shall include, at a minimum . . . signed statement(s) by the juvenile acknowledging participation in an orientation that includes the presentation of . . . grievance procedures. . . .” In addition, OJA policy OAC 377:3-1-27, OJA grievance policy, (h), states, “Each OJA and contracted facility shall explain OJA grievance policies and procedures to every resident during intake at the facility.”
4. One of the twelve resident files reviewed did not contain an individualized treatment and service plan. According to facility staff, the OJA Juvenile Services Unit worker had not provided the resident’s individualized treatment and service plan to the facility; however, the resident file contained an institutional treatment plan. OJA policy OAC 377:35-1-3, Purpose, (c), in part, states, “The institution [COJC] shall provide or procure programs and services necessary to implement the juvenile’s individual treatment and service plan (ITSP).” OJA policy OAC 377:3-13-140, Treatment programs, (c), states, “A final treatment plan shall be completed for each juvenile within thirty (30) days of admission to the secure facility.”
5. One of the twelve resident files reviewed did not document that a review was performed monthly of the resident’s treatment plan. OJA policy OAC 377:3-13-140, Treatment programs, (e), states, “Treatment plan reviews shall be completed and documented on a monthly basis.”
6. Four of the resident files reviewed did not document counseling sessions as occurring in accordance with the residents’ individualized treatment plans.” OJA policy OAC 377:3-13-140, Treatment programs, (a), (1)-(3), states, “Each secure facility shall provide professional services necessary to meet the identified needs of juveniles. At a minimum [sic] services shall include: individual, group and family counseling; family planning and parent education; and programs for juveniles with drug and alcohol problems.”
7. The grievance log and grievance forms reviewed indicated non-compliance with OJA grievance policy OAC 377:3-1-28, General Grievance Procedure.

Recommendation to COJC

1. Maintain a log(s) regarding reports of alleged abuse, neglect, and/or caretaker misconduct referred to the OJA Advocate General.

Summary

At the conclusion of the OJSO visit, the OJSO had requested copies of materials from the facility for further review: grievances, training records for the five staff members whose personnel files were reviewed, documentation from the five personnel files reviewed and documentation from nine of the twelve resident files reviewed. The OJSO received the copied materials on July 25, 2011.

The OJSO conducted a telephone exit conference with facility administration on August 9, 2011. Earlier that day, the OJSO had facsimiled a facility exit checklist that identified the files reviewed and the areas of concern and the violations listed, with the files identified in which the deficiencies were found. The OJSO and the facility administration discussed each item listed. On August 10, 2011, via facsimile, and August 12, 2011, via courier, the facility provided documentation for the items that could be resolved. Items resolved were verification of medical screenings for five residents, immunization records for three residents, initial treatment plans for two newly admitted residents, and monthly treatment plan reviews for eight residents, all of whose files had been reviewed. In addition, the facility provided photographic verification of written grievance policy posted on the female unit and medical documentation verification that a resident was medically evaluated after having been restrained.

During the telephone exit conference, the OJSO discussed with the facility administration that nine of the twelve resident interviewees reported that they had not participated or they were uncertain that they had participated in the development of their treatment plans; six resident interviewees were unable to identify any treatment issues listed on their treatment plans; some of the resident interviewees reported that they had been cursed at by staff and/or had witnessed other residents having been cursed at by staff; some of the resident interviewees reported that they had witnessed residents with contraband (tobacco, medication, and a needle); staff interviewees did not believe that they had a way to report anonymously their concerns of abuse and/or neglect of residents; and some staff interviewees reported that they did not receive rest breaks during their shifts. During this discussion, the OJSO expressed concern that even though the residents signed their treatment plans, an acknowledgement that the resident had participated in the development of his/her treatment plan, the consensus of the nine residents reporting no participation or minimal participation was that the goals and objectives of the treatment plans were not fully explained to the residents and that the residents believed that staff were more concerned with obtaining the residents' signatures. Resident interviewees had explained that that they were given their treatment plan reviews without any discussion from staff regarding treatment issues. In regard to the other items discussed, the facility superintendent advised that the cursing and contraband issues had been reported, addressed, and documented and that the hotline number for reporting abuse and neglect was posted in the facility, but that the superintendent would ensure that staff were aware that they could anonymously report allegations of abuse and neglect. Further, the facility superintendent agreed to address the rest break issue.

The OJSO followed-up on statements made by some resident interviewees that residents were not always released from the CMC or the Crisis Counseling Center (CCC) after the residents became calm. The OJSO reviewed documentation regarding incidents in which residents were taken to the CMC or CCC due to the residents' behaviors. The OJSO and the facility administration discussed three specific incidents in the telephone exit conference. Items discussed were the offenses cited; documentation that authorization was obtained for a disrobement search; documentation indicating required staff were present during the disrobement search; staff documenting the clock time a resident was released from the CCC; residents remaining in the CCC when documentation indicated the residents had become calm; documentation stating that a resident remained in handcuffs "quietly", and a video recording not occurring because the batteries were not charged in a handheld camera. The facility superintendent was adamant that the residents did not remain in the CMC or CCC for longer lengths of time than was needed to ensure the safety of all residents and staff. It appeared that the facility superintendent worked to ensure that residents were released from the CMC and CCC when their release did not jeopardize the safety of the residents and staff and the operation of the facility.

In addition, items discussed during the telephone exit conference in which the facility superintendent agreed to address with staff were:

- obtaining the transporting officer information requested on the juvenile intake tracking form;
- obtaining the family contact information requested on the juvenile intake tracking form, or if obtaining the information is not applicable, noting so on the form;
- documenting required signatures on forms, i.e., treatment plans, treatment goal agreements, monthly treatment plan reviews, and therapy progress sheets;
- performing treatment plan reviews on a current basis (for example, one file documentation indicated that the treatment plan reviews for October, November, and December 2010 all occurred on the same date in February 2011);
- completing forms with correct information (for example, on one form, a youth guidance specialist signed off as a facilitator and a juvenile justice specialist signed off as the supervisor, while on another form, the same youth guidance specialist signed off as the supervisor and the same juvenile justice specialist signed off as the facilitator); and
- maintaining appropriate materials/documentation in the resident files (for example, one file appeared to contain information regarding another resident).

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