

**OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT**

Name and Location of Facility: Cleveland County Juvenile Detention Center
Norman, Oklahoma

Dates of Visit: June 19, 20, and 21, 2007

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: Unannounced Visit, 2007

Date: July 19, 2007

General Information

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on June 19, 2007, at the Cleveland County Juvenile Detention Center, located in Norman, Oklahoma. The OJSO returned on June 20 and 21 to complete the visit. The purpose of the visit was to monitor compliance with established responsibilities. The detention center is operating under a provisional license by the Office of Juvenile Affairs (OJA) for twenty-six juveniles. On the day of the OJSO visit, the census was twenty-four. The OJA contracted with the Cleveland County Board of Commissioners for the management of the detention center, which in turn, contracted with Community Works LLC for the operation of the facility. The facility provides regional detention services to other counties.

Persons Interviewed

- Entry interview and an exit conference with the Facility Director
- Six residents
- Two direct care staff

Documentation Reviewed

- Files on eight residents
- Personnel files and training records of four direct care staff members
- Facility grievance log and grievances for February through June 21, 2007
- Room confinement/room restriction log for May through June 21, 2007
- Therapeutic hold log for 2007
- Inspection report, dated December 4, 2006, issued by the Fire Marshal's office of the Norman Fire Department

- Inspection report, dated June 12, 2007, issued by the Oklahoma State Department of Health, and the facility response, dated June 14, 2007
- Most recent monitoring report issued by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA), dated March 29, 2007, and the facility corrective action plan, dated April 24, 2007
- Incident reports of confinement

Findings

Interviews

The OJSO interviewed six residents. The interview questions were generally regarding the residents' perceptions of safety, detention program services, the rights of residents, discipline practices, and other residential care issues. The OJSO noted:

- Four interviewees stated they heard a staff member cuss at a resident.
- Three interviewees stated they did not feel safe at the facility and attributed those feelings to one staff member. The three residents stated that this staff person had humiliated them, had been verbally and mentally abusive by calling them names, and had been aggressive towards them.
- Four interviewees stated they were placed on room confinement without being given a chance to explain their actions.

Two direct care staff members on-duty were interviewed. No concerns were noted from the staff interviews.

File Reviews

The OJSO reviewed the files on eight residents. The files were essentially complete and well-organized. No concerns were noted from the resident file reviews.

The personnel files and training records of four direct care staff members were reviewed for compliance with detention certification standards. The files were well-organized, and the materials were easy to locate. No issues of concern were noted from the staff file reviews.

Room Confinement Log Review

The OJSO reviewed the room confinement log for May through June 21, 2007. The OJSO noted:

- Incident reports were not in the files regarding eight incidents of room confinement.
- Six of those eight incidents of room confinement were not documented on the room confinement log.

- Fourteen incidents of room confinement did not meet criteria. Examples of the reasons documented for room confinements included:
 - Problems the previous evening
 - Throwing papers
 - Possession of contraband
 - Kicked out of class

Grievance Procedures Review

The OJSO reviewed the facility's grievance policy, log, and resident grievances for February through June 21, 2007. No concerns were noted from the review of the grievance log or the resident grievances.

Observational Tour

The OJSO conducted a tour of the entire facility. The facility was clean and in good repair. No concerns were noted from the tour. The OJSO reviewed the most recent inspection reports by the Norman Fire Department and the Oklahoma State Department of Health. There were no violations noted in the Fire Marshal's report. Minor violations were cited in the health department's report; the facility's response to the health department indicated the minor deficiencies had been corrected. The OJSO reviewed the most recent monitoring report issued by the OJA OPI and the facility's corrective action plan. The facility appeared to have adequately addressed all deficiencies noted in the OPI report.

Summary

An exit conference was held with the facility director and members of the contracting agency's board. The facility director was aware of the residents' concerns regarding staff and had taken action to address the issues. Personnel files, staff training records, and the resident files that were reviewed were in compliance with OJA detention standards. The facility provided both individual and group counseling to the residents.

Violations

1. Four of the six residents interviewed stated they overheard a staff member cuss at a resident. OJA policy OAC 377:3-13-42, Juvenile rights, (7), (B) and (C), states, "Facility staff shall not discipline a juvenile by using humiliation (or) mental abuse."
2. Three of the six residents interviewed stated a staff member had humiliated them, had called them names, and had been aggressive towards them. OJA policy OAC 377:3-13-42, Juvenile rights, (7), (B) and (C), states, "Facility staff shall not discipline a juvenile by using humiliation (or) mental abuse."

3. Four of the six residents interviewed stated they had been placed on room confinement without the opportunity to explain their actions. OJA policy OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (A), states, "Prior to room restriction or confinement, facility staff shall explain the reasons for the restriction or confinement to the juvenile and shall give the juvenile an opportunity to explain his or her behavior."
4. Documentation indicated reports were not prepared for eight incidents of room confinement in the two-month period reviewed. OJA policy OAC 377:3-13-44, Security and control, (c), (8), Physical force, (F), states, "A written report is prepared following all uses of force and submitted to the facility administrator by the end of the shift."
5. Six incidents of room confinement were not documented on the room confinement log in the two-month period reviewed. OJA policy OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (E), states, "A written record shall be maintained on any juvenile placed in room restriction or confinement. It includes a log stating who authorized the action, names of persons observing the juvenile and times of observation, the person authorizing release, and the time of release."
6. Documentation indicated fourteen incidents of room confinement did not meet criteria. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), states, "Room confinement is used with detained juveniles:
 - (i) for self protection;
 - (ii) to separate juveniles from fighting;
 - (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
 - (iv) to restrain juveniles who have escaped or who are in the process of escaping;
 - (v) to prevent destruction of property if reasonably related to (i) through (iv); and
 - (vi) [to] stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility and is reasonably related to (i) through (iv)."

DSH:js

Cleveland County Regional Juvenile Detention Center

Operated By

Communityworks, LLC

1650 West Tecumseh Road Norman, OK 73069 405.447.8581 405.447.8585 facsimile

August 1, 2007

Dana S. Holden
Oversight Specialist
OCCY
500 N. Broadway, Suite 150
Oklahoma City, OK 73102

RECEIVED
AUG 10 2007
OCCY

Dear Mr. Holden:

This is in response to the report from the Office of Juvenile System Oversight (OJSO) dated July 19, 2007 pertaining to an oversight visit at the Cleveland County Regional Juvenile Detention Center beginning June 19, 2007 and ending June 21, 2007. This response addresses the violations listed at the end of the OJSO report. Each violation is stated with a response to each concern.

- 1) **Four of the six residents interviewed stated they overheard a staff member cuss at a resident. OJA policy OAC 377:3-13-42, Juvenile Rights, (7), (B) and (C) states "Facility staff shall not discipline a juvenile by using humiliation (or) mental abuse".**

Response: The Program Director is aware that several of the residents had reported that a particular staff member had been verbally aggressive with them. There was no evidence to support the allegation that the staff member had humiliated or mentally abused any resident(s), which if suspected would have been reported to the Office of Client Advocacy (OCA). Regardless, the staff member in question has been counseled regarding appropriate interactions with residents and has been retrained in Managing Aggressive Behavior (MAB). This staff member is particularly strong in holding residents accountable for negative behavior. Sometimes the residents react to being confronted about their negative behavior by complaining about the specific staff member that is holding them accountable. The numbers of grievances were significant enough, however, for the employee to receive additional training and counseling.

- 2) **Three of the six residents interviewed stated a staff member had humiliated them, had called them names, and had been aggressive towards them. OJA policy OAC 377:3-13-42, Juvenile Rights, (7), (B) and (C) states "Facility staff shall not discipline a juvenile by using humiliation (or) mental abuse".**

Response: Upon discussion with OJSO investigator Dana Holden, it was determined that this violation refers to the same staff member as referenced in violation #1. The staff member in question has received additional counseling in appropriate interactions with residents and attended Managing Aggressive Behavior (MAB) for a second session within the past six months.

- 3) **Four of the six residents interviewed stated they had been placed on room confinement without the opportunity to explain their actions. OJA policy OAC 377:3-13-44, Security and Control, (c), (15), Procedure for room confinement or room restriction, (A), states "Prior to room restriction or room confinement, facility staff shall explain the reasons for the restriction or confinement to the juvenile and shall give the juvenile an opportunity to explain his or her behavior".**

Response: Staff has been retrained during staff meetings to discuss the reasons for the restriction/confinement and give the resident an opportunity to explain his/her behavior. Additionally, a revised memorandum regarding room restriction, room confinement and sick days/in room by choice has been issued to staff to address this issue (see attachment #1). It is often the case that the resident is agitated or escalated to the point that they do not listen to staff directives or discussion and might not remember being asked to explain their behavior. It is also a practice to give juveniles warnings and cautions prior to taking action to restrict them to their rooms; therefore, the resident has been given several opportunities to modify their behavior and continues to be non-compliant, resulting in room restriction/confinement.

- 4) **Documentation indicated reports were not prepared for eight incidents of room confinement in the two-month period reviewed. OJA policy OAC 377:3-13-44, Security and Control, (c), (8), Physical Force, (F), states "A written report is prepared following all uses of force and submitted to the facility administrator by the end of the shift".**

Response: Staff has been retrained in writing (see attachment #1) and during staff meetings to properly document incidents of room confinement (see attachment #2). It is possible that some, if not all, of the incident reports in question were under supervisory review; therefore, the reports were not contained in the case file at the time of the oversight visit. Regardless, it is acknowledged that staff needs to improve in the area of report writing and properly documenting incidents. Supervisory staff has been reviewing all incident reports and not approving them until needed revisions are made. This is a staff development and ongoing training issue that we are addressing through active supervisory involvement.

One other issue of note is that item #4 references preparing a written report following all uses of force. Communityworks policy and procedure does not mandate that a therapeutic hold report be completed if the resident willingly goes to his/her room. Under circumstances where the resident willingly complies to go to his/her room, staff would complete an incident report and an observation report which outlines the reason(s) for room confinement and the observation checks every 15 minutes during the confinement.

- 5) Six incidents of room confinement were not documented on the room confinement log in the two month period reviewed. OJA policy OAC 377:3-13-44, Security and Control, (c), (15), Procedure for room confinement or room restriction, (E), states "A written record shall be maintained on any juvenile placed in room restriction or confinement. It includes a log stating who authorized the action, names of persons observing the juvenile and times of observation, the person authorizing release and the time of release.

Response: As stated in response #4, staff has been reminded through additional training and through written directives to properly document all incidents of room restriction/confinement and maintain all such incidents on the respective log. Training will be ongoing to address this issue.

- 6) Documentation indicated fourteen incidents of room confinement did not meet criteria. OJA policy OAC 377:3-13-44, Security and Control, (c), (14), Room confinement, (A), states "Room confinement is used with detained juveniles:

- (i) for self protection;
- (ii) to separate juveniles from fighting;
- (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
- (iv) to restrain juveniles who have escaped or are in the process of escaping;
- (v) to prevent destruction of property if reasonably related to (i) through (iv); and
- (vi) to stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility and is reasonably related to (i) through (iv).

Response: It is acknowledged that incidents of room restriction and confinement need to be more effectively documented to demonstrate that the circumstances warrant the restriction/confinement. The examples given in the body of the oversight report for not meeting criteria for confinement were as follows: **problems the previous evening**- we discussed this issue with Oversight Specialist Holden regarding how to document incidents of confinement that occur at the end of the day and before an assessment is made at the beginning of the next day. It was decided that the confinement log should remain open at the end of the day until the resident is assessed at the beginning of the next day and removed from room confinement when the behavior warrants.

Throwing papers, possession of contraband and being kicked out of class-documentation needs to more specifically identify behavior that places residents and staff at risk from thrown objects and/or destroys property and/or incites other juveniles. Although throwing papers, possessing contraband and being kicked out of class as such may not justify confinement, the behavior that accompanies these incidents needs to be thoroughly explained to indicate safety concerns. I am confident that incidents of confinement are justified but staff need to better document the reasons for confinement. Ongoing staff training and written directives will emphasize documenting incidents more appropriately.

In summary, there were no concerns during the oversight visit with staff interviews, resident files, personnel files/training records, or the facility tour. Two general areas of concern were documentation of room restriction/room confinement and issues pertaining to a particular staff member. Both the documentation issues and the personnel issues have been addressed and will continue to be monitored. I appreciate the opportunity to respond to the issues identified during the oversight visit. If there should be additional areas of concern or a need for discussion, please contact me.

Sincerely,



Tony Sardis
Program Director

Cc: Robert E. Christian
Mike Heath
Donna Glandon
Kim Sardis
Keith Goodwin
Shelly Waller