

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

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

**Date of Visit:** June 30, 2006

**Reviewers:** Sara Vincent-Spain, Oversight Specialist; Mike Heath, director of the OJA Office of Public Integrity; Reeda Thompson, Daryl Fields, Larry Ritchie, Tony Daniels, and Ralph McRenolds, staff members of the OJA Office of Public Integrity

**Focus of Visit:** Unannounced Visit

**Date:** December 20, 2006

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The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on June 30, 2006, at the Cleveland County Regional Juvenile Detention Center, located in Norman, Oklahoma. The OJSO was accompanied by staff members of the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). The purpose of the visit was to assess compliance with established responsibilities, facility policy and procedures, and a facility plan of compliance for deficiencies and policy violations identified by the OJSO and the OJA in an exit conference held on April 17, 2006, with the detention center's Executive Director. The plan of compliance was submitted to the OJSO on May 15, 2006.

On August 2, 2006, the OJSO met with OJA OPI staff members and the OJA Interim Director. The OPI provided a report of the findings from the collaborative visit on June 30. Continuing concerns were:

1. Management of medication was inadequate: Labeled pill cups, identified with the residents' names, were left loose and were unattended on the top surface of the fax machine.
2. Jumpsuits worn by the residents were frayed, ripped, and/or stained.
3. Residents' shoes and socks were badly worn.
4. Personal belongings of residents were not stored in a dedicated storage area.
5. Paint chips were observed on the mattresses of residents' beds.
6. Paint was peeling from the walls and ceilings.
7. The ceiling plaster was cracked.
8. Floor tiles were missing.
9. Graffiti was observed on the walls of the resident rooms.

10. Trash cans were over-flowing.
11. A latex glove (medical type) was found on the hallway floor along side a trash container.
12. Evidence of roaches was observed.
13. Mold was identified in the refrigerator of the control room.
14. An exit door to the control room was blocked by clutter.
15. Confinement rooms did not have running water.

In a letter, dated August 17, 2006, the OJA informed the Cleveland County Board of Commissioners of the deficiencies at the detention center. The letter stated that the deficiencies listed placed the certification of the facility in jeopardy.

The Commissioners informed the OJA in a letter, dated September 11, 2006, that the deficiencies had been corrected and an interim consultant would oversee the operations of the facility until November 1, 2006, when a new facility director was to be hired. In a letter, dated September 13, 2006, the OJA notified the Commissioners a stay was granted until November 1, 2006, regarding the final decision of certification.

On October 31, 2006, the OJA revoked the certification of the detention center. The facility was closed, and the OJA arranged transfers of all residents to other placements. The OJA reported that the detention center was closed due to continuous noncompliance with contractual mandates.

The Cleveland County Commissioners have notified the OJA of their intent to re-open the facility under new management, pending OJA certification.

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