

**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: July 22 and 23, 2008

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: Unannounced Visit, 2008

Date: October 22, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on July 22, 2008, at the Cleveland County Juvenile Detention Center, located in Norman, Oklahoma. The OJSO returned on July 23 to complete the visit. The purpose of the visit was to monitor compliance with established responsibilities and facility policy and procedures. The detention center is certified for 26 juveniles by the Office of Juvenile Affairs (OJA). 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. On the day of the OJSO visit, the census was 26.

Interviews Conducted

- Entry interview and an exit conference with the Program Director, Program Coordinator, Coordinator of Safety and Operations, and the Administrative Assistant to the Program Director
- Six residents
- Four direct care staff on-duty

Documents Reviewed

- Six resident files
- Four direct care staff member personnel files and training records
- Facility room confinement/room restriction log for January through July 2008
- Facility incident, observation, and restraint reports regarding 18 incidents of confinements involving 13 residents
- Norman Fire Department report dated July 7, 2007
- Oklahoma State Department of Health Food Inspection report dated March 18, 2008
- OJA Office of Public Integrity (OPI) monitoring report dated December 6, 2007

Findings

Interviews

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

- Five residents stated they felt safe at the facility and attributed those feelings to staff; the one resident who did not feel safe attributed those feelings to other residents.
- Three residents stated that the program rules, resident rights, discipline process, and the grievance process were not explained during the intake process. Reportedly, staff gave the residents a copy of the Resident Handbook and instructed the residents to read the handbook.
- Four residents rated the quality and the quantity of the food as good.
- All six residents interviewed reported that staff used appropriate forms of discipline for rule violations by residents.

No other concerns were noted from the resident interviews.

Four direct care staff members were interviewed. No concerns were noted from the staff interviews.

File Reviews

The OJSO reviewed six resident files. The files were well-organized. The OJSO noted:

- Five files contained incomplete daily notes by staff from each shift.
- One file did not contain documentation to indicate medical consent/authority to treat.

No other concerns were noted from the resident files review.

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

Room Confinement/Room Restriction Log Review

The OJSO reviewed the room confinement/room restriction log for January through July 2008. Eighteen incidents involving 13 residents were randomly selected for review. The OJSO requested copies of the incident reports, observation reports, and restraint reports for the 18 incidents. The OJSO noted:

- The documentation for nine incidents of room confinement was incomplete.
- Seventeen incidents of room confinement did not meet criteria. Some of the reasons documented for room confinement were unsafe behavior, profanity, disrespect to staff, inappropriate sexual behavior, possession of contraband, and expulsion.
- The documentation for 17 instances of room confinement did not indicate staff had conducted sight checks of the confined residents every 15 minutes.
- Fifteen incidents of room confinement did not have corresponding incident reports.
- The documentation for sixteen incidents of room confinement indicated the residents remained in room confinement after staff had recorded that the residents were behaving calmly and were not causing disturbances.
- Five incidents of room confinement did not document the dates and times of the confinement and/or release from confinement.
- Documentation regarding four incidents of confinement indicated the residents were placed on room confinement the following morning for incidents that had occurred at or near bedtime the previous night.

Observational Tour

The OJSO did not tour the facility. The OJSO noted that an inspection by the fire marshal's office was overdue. The OJSO reviewed the most recent inspection by the health department. The facility's response to the health department indicated the minor deficiencies cited in the report had been corrected. The OJSO reviewed the most recent monitoring report issued by the OJA OPI; no deficiencies were cited in the report. The OPI report stated, "The [Cleveland County] juvenile detention center has complied with the requirements and standards relating to a juvenile detention center under the provision of Title 10 Oklahoma [Statutes] Annotated Section 7304-1.2."

Summary

The OJSO discussed its findings with the program director and administrative staff members in the exit conference. The facility director agreed to contact the fire marshal's office to request an inspection. On August 20, 2008, the facility director advised the OJSO that the fire marshal's office had inspected the facility on August 6, 2008, and that no deficiencies were cited in its report.

Areas of Concern

1. Five of the six resident files reviewed contained incomplete daily notes by staff from each of the three shifts. The OJSO noted that the incomplete notes occurred more often by staff on the second shift.
2. Fifteen of the 18 incidents of room confinement selected from the room confinement log for review did not have corresponding incident reports. The facility director stated he believed that staff used the observation reports to document to the room confinement/room restriction log rather than to write incident reports.

Violations

1. Three of the six juveniles interviewed reported that policies and procedures regarding program rules, resident rights, discipline process, and the grievance process were not explained to the juveniles at intake, but, rather, residents were given a copy of the Resident Handbook and instructed to read the handbook. OJA policy OAC 377:3-13-39 Admission procedure and criteria, (b), (12), (A)-(E), states, "The facility's written policy and procedure for admitting juveniles includes, but is not limited to, provisions which require the facility to provide an orientation which includes: juvenile rights; program description; program rules; grievance process; and discipline policy."
2. One of the six resident files reviewed did not contain documentation to indicate medical consent/authority to treat. OJA policy OAC 377:3-13-40 Records, (a), (16), in part, states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at the minimum . . . medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent."
3. Documentation on the room confinement/room restriction log regarding 9 of the 18 incidents of room confinement selected for review was incomplete. 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."
4. Seventeen of the 18 incidents of room confinement reviewed did not meet criteria for confinement. Some of the reasons documented for room confinement were unsafe behavior, profanity, disrespect to staff, inappropriate sexual behavior, possession of contraband, and expulsion. OJA policy OAC 377:3-13-44 Security and control, (c), (14) Room restriction, (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).
5. Documentation for 17 of the 18 instances of room confinement reviewed did not indicate staff had conducted sight checks of the confined residents every 15 minutes.
6. Documentation for 16 of the 18 incidents of room confinement reviewed indicated the residents remained in confinement after staff recorded that the residents' behaviors were appropriate. OJA policy OAC 377:3-13-44 Security and control, (c), (15) Procedure for room confinement or room restriction, (D), states, "The juvenile shall be released when staff determines that he or she can safely be returned to the group."

7. Five of the 18 incidents of room confinement reviewed did not document the dates and times of the confinement and/or release from confinement. 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."
8. Documentation regarding four incidents of confinement indicated the residents were placed on room confinement the following morning for incidents that had occurred at or near bedtime the previous night. OJA policy OAC 377:3-13-44 Security and control, (c), (14) Room confinement, in part, states, "Room confinement means locking a juvenile in his/her room when the juvenile has been charged with a major rule violation requiring confinement for his/her safety or the safety of others or to ensure the security of the facility."

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