

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

Name and Location of Facility: Enid Adventure Program
Enid, Oklahoma

Dates of Visit: November 29 and 30 and December 3, 2007

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Subject: Second Biannual Visit for 2007

Date: February 14, 2007

Introduction

The Office of Juvenile System Oversight (OJSO) initiated a routine, unannounced visit to the Enid Adventure Program on November 29, 2007. The OJSO returned on November 30 and concluded the visit on December 3, 2007. The Office of Juvenile Affairs (OJA) contracts with Southwestern Oklahoma State University for the operation of the program, which serves OJA-custody males. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The program is licensed for twelve residents by the Division of Child Care of the Department of Human Services (DHS). On the day of the visit, the census was twelve.

Interviews Conducted

- Entry interview and an exit conference with the Program Administrator
- Seven current residents and one former resident
- Two direct care staff members

Documentation Reviewed

- Case records on four residents
- Personnel files of two staff members
- DHS Division of Child Care inspection report, dated September 10, 2007
- Office of the State Fire Marshal inspection report, dated June 29, 2007
- Oklahoma State Department of Health inspection report, dated August 22, 2007

Findings

Interviews Conducted

The OJSO interviewed seven current residents, one former resident, and two direct care staff members. The OJSO noted:

- The majority of juveniles and staff reported that staff used group punishment.
- The majority of juveniles and staff stated that other residents were used in the search for residents who had gone AWOL from the school. Juveniles reported that on one occasion, residents were sent out to try to apprehend a resident who had gone AWOL. Reportedly, the juveniles searched the town and stopped to ask several townspeople if they had seen the resident. According to juveniles and staff, a townspeople climbed up the grain elevator and observed the resident hiding in a field. Reportedly, two juveniles from the facility caught the resident and returned him to staff. Four juveniles reported seeing a staff member grab the resident who had been AWOL and “throw” him into the van.
- The majority of juveniles reported being cursed at by staff or hearing other juveniles being cursed at by staff.
- Four juveniles reported that staff refused to intervene when the juveniles reported to staff that they were being assaulted or were being harassed by other residents. Reportedly, a resident who had reported to staff that another resident was pressuring him for sexual favors was told by staff not to talk about it.
- Three juveniles and staff reported the residents were only allowed three bathroom breaks during school time. The breaks were timed at four minutes, two minutes, and one minute. Reportedly, when a juvenile went over the allotted time, he received a sanction, which was to write a paragraph twenty-five times; the paragraph was approximately ten sentences in length and was due the next day.
- Two juveniles reported that staff had placed a sign in the facility that referred to one resident as the “grievance king.”
- Five juveniles reported being hit or grabbed by staff or observing a staff member improperly grab a resident. Three juveniles reported seeing a staff member throw a football that hit a juvenile and the staff restraining the juvenile when he became upset and used profanity toward the staff member. This incident was not reported to the DHS Office of Client Advocacy, because the resident had already been discharged from the facility.
- The majority of juveniles reported either they did not file grievances because they were afraid of retaliation by staff or they had filed a grievance and had been threatened by staff.

Files Reviewed

The OJSO reviewed four resident files and two direct care staff files. The files were well-organized and complete for the items reviewed. No concerns were noted from the resident and staff files reviewed.

Review of Grievance Log

The OJSO reviewed the facility grievance log for August through November 2007. Twenty-three grievances were filed between August 1 and November 7, 2007; no grievances had been placed in the log after November 7, 2007. The facility later provided the OJSO with copies of eight grievances that were filed between November 8 and December 30, 2007. The OJSO noted:

- Four grievances did not indicate whether the resident accepted or wanted to appeal the resolution.
- One grievance was not signed by the staff who had resolved the grievance.
- One grievance did not recite a resolution.
- Eight grievances did not indicate the staff member assigned to resolve the grievance or the due date.

Review of Incident Reports and Discipline Practices

The OJSO reviewed the incident reports and discipline practices for September 1 through November 6, 2007. The facility provided the OJSO with copies of incident reports from November 6, 2007, through January 1, 2008. The OJSO noted:

- Residents' privileges were taken away for behavior management. The residents' description of loss of privileges (LOP) was sitting on the ledge in front of the fireplace. Residents were not allowed to speak without permission and could only ask for permission to use the bathroom, request medical care, or request a grievance form. If the residents asked or requested anything other than those three things, they received a sanction. Juveniles could work off the amount of time they were given for restricted privileges at a rate of twelve hours per day on weekdays and fifteen hours per day on weekends. Juveniles did not receive any LOP credit time while attending school.
- Different amounts of LOP time were assigned for the same offense. Incident reports indicated that one staff had given four hours of LOP time and other staff had given eight, sixteen, and twenty-four hours for the same offense.
- Documentation indicated staff had given multiple blocks of LOP time. One resident received LOP time three times on October 26, 2007, totaling 50 hours. The same resident received 48 hours of LOP for four infractions on October 29, 2007; 36 hours for three rule infractions on November 1, 2007; and 229 hours for six rule infractions on November 2, 2007. This resident had received a total of 630 hours of LOP time since his arrival at the facility on October 19, 2007. Another resident was given 361 hours of LOP time.
- Incident reports dating from November 6 to December 3, 2007, indicated that staff routinely assigned LOP time for what appeared to be minor rule infractions. The following are examples of rule infractions where juveniles were given LOP time:
 - Throwing a leaf in another juvenile's face.
 - Giving partial effort while participating in physical therapy.

- Talking without permission.
- Communicating non-verbally.
- Grabbing a resident by the foot in a playful manner.
- Sleeping in the van.

One resident was given a total of 630 hours of LOP time between October 26 and December 3, 2007. Assigning a resident to continuous loss of privileges has the effect of separating the juvenile from the rest of the population. Another juvenile was given a written sanction of 200 sentences for not putting his socks in the washer.

Observational Tour

The OJSO did not conduct a tour of the facility. The facility had been visited by the DHS licensing unit on September 10, 2007, the health department on August 22, 2007, and the fire marshal's office on June 29, 2007, and none had noted any deficiencies in their inspection reports.

Concerns

1. Staff did not intervene when four juveniles told staff that they were being harassed or assaulted by other juveniles and one juvenile reported to staff he was being pressured for sexual favors by another resident.
2. Juveniles are only allowed three bathroom breaks while attending school: a four minute break, a two minute break, and a one minute break. Reportedly, a staff member stated that juveniles needed to "learn to train their bowels."
3. A staff member placed a sign in the facility that referred to one of the residents as the "grievance king," because the resident had filed a large number of grievances.
4. Juveniles reported they did not file grievances, because they were afraid of retaliation by staff or they had been threatened by staff for filing grievances.
5. Grievance forms were not filled out completely by the staff.
6. A review of facility incident reports revealed that staff primarily used loss of privileges for behavior management. Several incidents indicated that staff assigned large blocks of LOP time to juveniles within a few hours. The assigning of large amounts of LOP time could have the effect of making the juvenile feel hopeless or remove any motivation he might have to improve his conduct.
7. The amounts of LOP time assigned were inconsistent. One staff might give a juvenile four hours of LOP time, and another staff might give the same juvenile twenty-four hours of LOP time, for the same offense, during the same shift.
8. Large blocks of LOP time were assigned for minor rule infractions. Two examples are: One juvenile received seventy-two hours of LOP time for "throwing a leaf into a resident's face" and one resident received twenty-four hours of LOP time for "drawing a long line on his desk."

Violations

1. Staff used group punishment. DHS licensing standards, Section 154.2, Behavior management, (b), Prohibitions, (12), states, "Facility policies prohibit group punishment."
2. Juveniles searched for and apprehended a resident who had gone AWOL from the facility. DHS licensing standards, Section 154.2, Behavior management, (b), Prohibitions, states, "Facility policy prohibits one resident punishing another resident."
3. Juveniles reported being cursed at by staff. DHS licensing standards, Section 154.2, Behavior management, (b), Prohibitions, (2), states, "Facility policy prohibits harsh, humiliating, cruel, abusive or degrading language."
4. Juveniles reported being hit or grabbed or seeing a staff member improperly grab a resident. DHS licensing standards, Section 154.2, Behavior management, (b) Prohibitions, (1), states, "Facility policy prohibits shaking, striking, spanking, or other cruel treatment."
5. A juvenile was given 630 hours of restricted privileges from October 26 through December 3, 2007. The juvenile was not allowed to communicate with other juveniles and could only ask staff three specific questions. DHS licensing standards, Section 154.2, Behavior management, (c), Separation, states. "A resident may be removed from the group or group activity as a method of behavior management. The resident remains within hearing of an adult in an unlocked, safe, clean, well-lighted, well-ventilated area. The separation does not exceed one hour in duration."

Summary

The OJSO conducted three days of oversight at the facility. It is concerning that the facility staff allowed juveniles to participate in the search and apprehension of a resident who had gone AWOL from the facility. In addition, the liberal use of LOP time seems to be a disproportionate consequence for the offense(s) committed. The OJSO is encouraged by the program's team management approach for correcting the concerns.

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