

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

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**Name and Location of Facility:** L. E. Rader Center  
Sand Springs, Oklahoma

**Dates of Visit:** May 20, 21, 22, 26, 27, and June 3, 2009

**Oversight Reviewers:** Harold Jergenson and Anthony Kibble,  
Oversight Specialists

**Focus of Visit:** First Biannual Visit, 2009

**Date:** August 28, 2009

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on May 20, 2009, at the L. E. Rader Center (LERC) located in Sand Springs, Oklahoma. The OJSO resumed the oversight on May 21, 22, 26, 27, and completed the visit on June 3, 2009. The purpose of the visit was to assess compliance with established responsibilities. The facility is a secure rehabilitation program for male juveniles adjudicated Delinquent or Youthful Offender who are in the custody of the Office of Juvenile Affairs (OJA). The LERC was operated by the OJA and was licensed by the division of Oklahoma Child Care Services (OCCS) of the Oklahoma Department of Human Services (OKDHS).

The focus of the visit was to assess the facility's caretaker conduct review (CCR) processes; grievance procedures; use of mechanical restraints; and solitary confinement.

### **Interviews Conducted**

- Seventeen residents
- Informal interview with two administrative programs officers (APO)
- Exit conference with the facility superintendent

### **Documents Reviewed**

- Ten resident files
- LERC Institutional Daily Census Log from July 1, 2008, through May 20, 2009
- OKDHS OCCS Residential Child Care Facility Inspection report dated May 4, 2009
- LERC mechanical restraint report (RC-88) from February 2, 2009, through April 30, 2009
- Seven LERC Use of Mechanical Restraints (RC-86) completed forms
- LERC solitary confinement log from January 5, 2009, through April 30, 2009

- LERC grievance log from January 1, 2009, through May 18, 2009
- Fifteen completed grievance forms
- LERC Caretaker Conduct Review (CCR) log from January 2, 2009 through May 20, 2009
- LERC crisis log from January 2, 2009, through April 30, 2009
- Nineteen completed CCR investigation files

## **Findings**

### Resident Interviews

The OJSO randomly selected twenty one residents for interviewing purposes. Four of these twenty-one residents declined to be interviewed. The interview questions pertained to the residents' perceptions regarding the grievance process, discipline practices, and safety. From the seventeen residents interviewed the OJSO noted:

- Ten out of seventeen residents reported that they did not believe the grievance process worked. Residents reported filing and appealing grievances; however, they reported never receiving a response.
- Four out of seventeen residents reported that the grievance process worked "Sometimes".
- Three out of seventeen residents reported that they believed the grievance process worked.

Residents were asked how often they felt safe at the facility, using a Likert scale (Very Frequently, Frequently, Occasionally, Rarely, Very Rarely, and Never). The OJSO noted:

- Nine out of seventeen residents reported that they felt safe "Very Frequently" at the facility.
- Five out of seventeen residents reported that they felt safe "Occasionally" at the facility.
- Two out of seventeen residents reported that they "Never" felt safe at the facility.
- One out of seventeen residents reported that he "Very Rarely" felt safe at the facility.

### Resident File Review

Ten resident files were reviewed. No concerns were noted from the review.

### Mechanical Restraint Report (RC-88) Review

The OJSO reviewed the mechanical restraint report (RC-88) from February 2, 2009, through April 30, 2009. The OJSO noted:

- There were seven on-campus instances of mechanical restraint during the relevant time frame.
- The mechanical restraint report did not include the reason for the use of the restraints or the person authorizing the use of the restraints.

- The mechanical restraint report indicated that in one incident the restraints had been left on a resident for twenty-three minutes and in another incident the restraints had been left on a resident for sixty-nine minutes.

There were no additional concerns noted from the Mechanical Restraint Report.

#### LERC Solitary Confinement Log Review

The OJSO reviewed the LERC Solitary Confinement Log from January 5, 2009, through April 30, 2009. According to the log, solitary confinement had been used a total of thirty-eight times during the time period reviewed. The OJSO noted:

- The log indicated that there were two incidents in which solitary confinement had exceeded the three hour time frame.
- One incident of solitary confinement indicated that a resident had been placed in confinement seven hours and forty-eight minutes. The resident was placed in solitary confinement due to the belief that the resident had a cellular phone, cigarettes, and a lighter on his person. Reportedly, there was another medical incident that took place at the same time on campus. Consequently, the security officers responded to the medical emergency and the resident remained in solitary confinement under the supervision of one security officer. Upon staff arriving the following morning there were three smoked cigarettes on the floor of the room where the resident had been confined. The staff was also able to retrieve the cellular phone from the resident after the resident had broken the cellular phone into pieces. The items were turned over to the local police department and charges have been filed against the resident. Subsequent to the incident, an internal investigation was conducted by the LERC and a finding of Caretaker Misconduct was confirmed on the staff members involved.

There were no additional concerns noted from the Solitary Confinement Log.

#### Grievance Log Review

The OJSO reviewed the LERC grievance logs from January 1, 2009, through May 18, 2009. The OJSO also reviewed fifteen grievance forms submitted during the same time period. The OJSO noted:

- According to the grievance logs, there were seventy-seven grievances that had not been resolved.
- Seven of the fifteen grievance forms reviewed had been appealed at the first level, but they had not been resolved, and they were past the five day time frame.

The OJSO inquired of the advocates on campus in regard to the current grievance process. The advocates reported that each day, they gather the grievances submitted on that day, and then they assign the grievances to be resolved by a staff member on the unit corresponding with the grievance. The advocates reported that they did not have any means to ensure that the grievances get resolved and given back from the staff members who were originally assigned.

### LERC Caretaker Conduct Review (CCR) Log

The OJSO reviewed the LERC CCR log from January 2, 2009, through May 20, 2009. There were a total of forty-four CCRs assigned to the facility during the time period that was reviewed. The OJSO selected nineteen completed CCRs from the log to review. The OJSO noted:

- According to the log, sixteen of the nineteen CCRs reviewed were not completed within the thirty-day time frame.
- One CCR investigation involving injury to the resident indicated that the incident took place on December 29, 2008; however, it was not reported to the OCA until January 7, 2009.

There were no additional concerns noted from the CCR log review.

### **Areas of Concern**

1. Ten out of seventeen residents reported that they did not believe the grievance process worked. Residents reported filing or appealing grievances, but never receiving a response to the grievance.
2. One CCR investigation involving injury to the resident indicated that the incident took place on December 29, 2008; however, it was not reported to the OCA until January 7, 2009, or three days after the holiday weekend.
3. One incident of solitary confinement indicated that a resident had been placed in confinement seven hours and forty-eight minutes. The resident was placed in solitary confinement due to the belief that the resident had a cellular phone, cigarettes, and a lighter on his person. Reportedly, there was another medical incident that took place at the same time on campus. Consequently, the security officers responded to the medical emergency and the resident remained in solitary confinement under the supervision of one security officer. Upon staff arriving the following morning there were three smoked cigarettes on the floor of the room where the resident had been confined. The staff was also able to retrieve the cellular phone from the resident after the resident had broken the cellular phone into pieces. The items were turned over to the local police department and charges have been filed against the resident. Subsequent to the incident, an internal investigation was conducted by the LERC and a finding of Caretaker Misconduct was confirmed on the staff members involved.

### **Violations**

1. The mechanical restraint report (RC-88) did not include the reason restraints were used or who authorized the use of the restraints when the restraints had been applied for on campus transport. OKDHS Licensing Requirements for Residential Child Care Facilities, 340:110-3-169, Requirements for secure care facilities, (4), Seclusion and mechanical restraint log, (B), states, in part, "The log includes: . . . the name of the person authorizing the use of seclusion or mechanical restraint. . . ." LERC policy RC30100.11, Mechanical Restraints, II,

Documentation, (B), 1 through 3, states, in part, "All uses of mechanical restraints are recorded on the Use of Mechanical Restraints Report (RC-88). [This] [r]eport will include conditions under which restraints may be used; [the] [t]ypes of restraints to be applied for specific conditions; [and the] [p]erson authorizing the use of restraints. . . ."

2. The solitary confinement log indicated that there were two incidents in which a resident had been confined for more than three hours. OJA policy, OAC 377:35-11-4, Solitary confinement, (b), states, in part, "Solitary confinement shall not be used for punishment at any OJA institution. No juvenile shall remain in solitary confinement in excess of three hours . . . ." LERC policy, Procedure Number: RC30500.04, I, Solitary Confinement, (E), states, in part, "Placement in Solitary Confinement will not exceed three hours as in accordance with OJA Standard 377:35-11-4. **3-JTS-3E-03**. . . ."
3. According to the grievance logs, there were seventy-seven grievances that had not been resolved. In addition, seven out of fifteen grievance forms reviewed had been appealed at the first level, but had not been resolved within the five day time frame. OJA policy, OAC 377:3-1-30, Grievance procedures for institutions, group homes, and contract facilities, (b), Institutions, states, in part:

The assigned staff shall review each grievance and attempt to resolve the grievance with the juvenile. If the grievance is not resolved in three working days, the juvenile may appeal to the supervisor or facility administrator who will have an additional five working days in which to attempt resolution. The grievance shall be resolved within seven working days.

4. According to the Caretaker Conduct Review log, there were sixteen CCRs that were not completed within the thirty day time frame. OKDHS policy, OAC 340:2-3-37, Caretaker conduct review (CCR), (f), Time for completion of report, states, "The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR."

## Summary

During the exit conference, the OJSO discussed with the superintendent the areas of concern and violations listed above. The OJSO acknowledges that there has been a recent change in administration and the new administration is in the process of implementing new policy and procedures.

