

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

Name and Location of Facility: Northwest Oklahoma Juvenile Detention Center
Woodward, Oklahoma

Date of Visit: March 29, 2010

Oversight Reviewer: Dana S. Holden, Oversight Specialist IV

Focus of Visit: Unannounced Visit, 2010

Date: May 4, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on March 29, 2010, at the Northwest Oklahoma Juvenile Detention Center, located in Woodward, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The facility was certified by the Office of Juvenile Affairs (OJA) for ten juveniles. The OJA contracted with the Woodward County Board of Commissioners to manage the detention center and, in turn, the County Commissioners subcontracted with Eastern Oklahoma Youth Services for the day-to-day operation of the facility. The detention center provides regional services to other counties. On the day of the OJSO visit, the census was nine.

Interviews Conducted

- Entry interview and an exit conference with the superintendent
- Two residents
- One staff member

Documents Reviewed

- Four resident files
- Room Confinement/Room Restriction Log for the period of July 1, 2009, through March 29, 2010
- Office of the Oklahoma State Fire Marshal report dated February 5, 2010
- Oklahoma State Department of Health Food Inspection report dated September 24, 2009
- OJA monitoring report dated January 14, 2010
- Use of Force/Restraint Log from July 1, 2009 through March 29, 2010

Findings

Resident Interviews

The OJSO interviewed two residents. The interview questions pertained to the residents' perceptions of safety, detention program services, resident rights, discipline practices, and other residential care issues. Responses to the interview questions indicated:

- Both interviewees felt safe at the facility.
- Both participated in recreational services.
- Both had access to medical care.
- Both were knowledgeable of the residents' rights.
- Residents received enough to eat.

There were no concerns noted from the interviews of the residents.

Staff Interview

The OJSO interviewed one staff member on duty during this oversight visit. The OJSO noted the following:

- The staff member reported receiving appropriate training for their position.
- The staff member demonstrated familiarity with policies and procedures.

Resident File Review

The OJSO reviewed four resident files. The OJSO noted that one file did not have medical consent/authority to treat the resident. There were no issues of concern noted from the review of the resident files.

Personnel File Review

The OJSO did not review any personnel files. The OJSO has previously reviewed the files on all staff on several occasions.

Room Confinement/Room Restriction Log

The OJSO reviewed the room confinement/room restriction log, and related incident reports from July 1, 2009, through March 29, 2010. Documentation indicates that there were a total of thirteen incidents of room confinement from July 1, 2009, through March 29, 2010. The OJSO noted the following:

- Ten of the thirteen incidents did not meet criteria for room confinement. Some examples of reasons residents were put on room confinement are:
 1. Cursing staff;
 2. Having a negative attitude and speaking sarcastically to staff;
 3. Refusing to come out of his room or participate in program activities;
 4. Refusing to do large muscle exercise; and
 5. Being loud and cursing staff.

- Seven of the thirteen incidents had incomplete documentation.
- Staff did not provide documentation to justify continuing room confinement in eight of the thirteen instances of room confinement.

There were no other concerns noted from the room confinement review.

Use of Force/Restraint Log

The OJSO reviewed the use of force/restraint log and related incident reports from July 1, 2009, through March 29, 2010. There were three restraints documented during this time frame. There were no concerns noted from the three restraints that were reviewed.

Reports Reviewed

The OJSO reviewed the facility's latest inspection report from the State Fire Marshal's Office dated February 5, 2010, and the latest inspection report by the Oklahoma State Department of Health dated September 24, 2009. There were minor violations noted in both reports that had already been corrected prior to the OJSO oversight visit.

The OJSO reviewed the latest inspection report by the OJA Office of Public Integrity (OPI) dated January 14, 2010. There were no concerns noted from this inspection report.

Summary

The OJSO discussed concerns regarding the use of room confinement with the facility superintendent. The OJSO is concerned that the OJA policy concerning room confinement and room restriction is so vague that it does not offer the detention operators an option to deal with residents who are not violent but refuse to cooperate or comply with staff directions. An example of this was a resident who refused to come out of his room and participate in program activities. The resident was not acting violently or threatening but was completely uncooperative. The resident did not meet the criteria for room confinement nor did his actions warrant being placed in a physical restraint in order to remove him from his room. The facility was forced to either leave the resident in his room on confinement or send staff in to forcefully take the resident from his room, thereby placing the resident and the staff members at risk of being injured. The OJSO has noted that this kind of behavior is becoming more common in the detention centers and warrants being formally addressed by OJA.

An exit conference was conducted with the facility superintendent and all of the findings were discussed.

Recommendations

1. The OJSO recommends that the OJA in conjunction with the Detention Operators Association review the current policy regarding room confinement, room restriction, and restraints to address the issue of residents who are being uncooperative or refusing to participate in programming activities.

Areas of Concern

1. One resident file did not have documentation of medical consent/authority to treat the resident.
2. Seven incidents of room confinement reviewed were not properly documented. The reports gave conflicting dates/times of confinement and/or release.

Violations

1. There were ten instances of room confinement reviewed that did not meet criteria. OJA policy, 377:3-13-44, Security and control, (c), (14), Room confinement, (A), (i) through (vi), state, "Room confinement is used with detained juveniles: for self protection; to separate juveniles from fighting; to restrain juveniles in danger of inflicting harm to themselves or others; to restrain juveniles who have escaped or who are in the process of escaping; to prevent destruction of property if reasonably related to (i) through (iv); and 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)."
2. Staff did not document the reason for continuing a resident on room confinement in eight of the thirteen instances reviewed. OJA policy, 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (E), states, in part, "A written record shall be maintained on any juvenile. . . . 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."

DSH/LB