

**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: September 18, 2007

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: Unannounced Visit, 2007

Date: October 4, 2007

General Information

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit on September 18, 2007, to the Northwest Oklahoma Juvenile Detention Center, located in Woodward, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities. 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 eight.

Persons Interviewed

- Entry interview and an exit conference with the Superintendent
- Three direct care staff members
- Three residents

Documents Reviewed

- Personnel files and training records of the three direct care staff members interviewed
- Files on eight residents
- Office of the State Fire Marshal inspection report, dated January 11, 2007
- Oklahoma State Department of Health inspection report, dated September 17, 2007
- OJA monitoring report, dated May 3, 2007

Findings

Interviews

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

- they felt safe at the facility;
- education services were provided at the facility;
- they participated in recreational services;
- appropriate consequences were received for rule violations;
- they had access to medical care;
- they were knowledgeable of the resident's rights;
- they received enough to eat; and
- the food tasted good.

Two of the three residents interviewed stated that they were kept locked in their rooms from one evening until the next afternoon, because of staff shortage at the facility.

Three direct care staff members were interviewed. The OJSO noted:

- All three interviewees reported receiving appropriate training for their positions.
- All three demonstrated familiarity with policies and procedures.
- The three interviewees could not clearly explain the difference between room confinement and room restriction.

File Reviews

The OJSO reviewed the files on eight residents. The OJSO reviewed the medication administration log regarding four juveniles. The OJSO's concerns noted from the review of the medication administration log were:

- Three instances of improper documentation regarding the number of doses of medication that was given or that remained.
- One instance of the administration of the wrong dosage of medication.
- One instance of lack of documentation regarding the reason for not administering the prescribed medication.

The personnel files and training records of the three direct care staff members interviewed were reviewed for compliance with detention certification standards. The files were well-organized, and the materials were easy to locate. Two staff members' training records reviewed documented the required hours of annual training, and the other staff member's training record reviewed documented 7.5 hours of training for

2007. One of the three files reviewed contained documentation of one of the three required reference checks and another file did not contain documentation of any reference checks.

Room Confinement/Room Restriction Log

The OJSO reviewed the room confinement/room restriction log for April 2007 through September 18, 2007. Six instances of room confinement did not meet criteria. The infractions of rules and the amounts of time of confinement documented for those six instances were:

1. A resident gave a new staff member incorrect information regarding the types of exercises for large muscle activity at the facility. The resident was placed on room confinement for 4 hours, 45 minutes.
2. A resident fell asleep in class. The resident was placed on room confinement for 23 hours, 45 minutes.
3. A resident made a remark that contained an offensive word. The resident was placed on room confinement for 22 hours, 33 minutes.
4. A resident pretended to shoot a make-believe gun and held his hands under a table. The resident was placed on room confinement for 16 hours, 25 minutes.
5. A resident displayed "aggressive body language." The resident was placed on room confinement for 1 hour, 45 minutes.
6. A resident was observed whispering. The resident was placed on room confinement for 20 hours, 25 minutes.

Documents Reviewed

The OJSO reviewed the facility's most recent inspection reports by the Office of the State Fire Marshal and the Oklahoma State Department of Health. No violations were noted in either report. The most recent inspection report by the OJA Office of Public Integrity cited the facility for non-compliance of Section 5, Personnel Records; Section 9, Facility Tour; and Section 10, Corrections. The facility had submitted a corrective action plan or had corrected the deficiencies, prior to the OJSO's visit.

Summary

Overall, the facility appeared to be meeting the needs of the residents. The OJSO's findings were discussed with the facility's Superintendent in an exit conference. When asked about residents being kept locked down when there was a staff shortage at the facility, the facility director stated that there were times when a staff shortage occurred and residents were kept locked down until sufficient staff could arrive at the facility.

Violations

1. Residents were kept locked in their rooms, due to staff shortage. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (3), Supervision, states,

“Sufficient staff shall be available to provide continuous day and night supervision of the residents and protection of the facility as well as to allow staff relief from duty.”

2. Staff members interviewed could not adequately explain the difference between room restriction and room confinement. The facility’s policies specify the difference, in accordance with OJA policy. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8) Staff training, in part, states, “All staff shall be trained on facility policy and procedures.”
3. Staff did not maintain an accurate record of medications administered to four residents. OJA policy OAC 377:3-13-45, Program and services, (a), (7), Medication, (B), in part, states, “When any medication is administered, a precise record is kept of the juvenile’s name, reason for dosage, route, date and time given, and signature of the person who administered it.”
4. Two of the three staff files reviewed did not contain documentation of the required reference checks. OJA policy 377:3-13-43, Staff requirements, (a), General provisions, (7), Personnel records, (A), (iii), states, “The personnel record includes three written references and/or documentation of telephone interviews.”
5. Residents were placed on room confinement for incidents that did not meet criteria. 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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