

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

Name and Location of Facility: Oklahoma County Juvenile Detention Center
Oklahoma City, Oklahoma

Dates of Visit: August 7, 8, 9, 10, 13, 14, and 15, 2007
Exit conference: August 27, 2007

OJSO Reviewers: Dana S. Holden and Sara Vincent-Spain, Oversight
Specialists

Focus of Visit: Oversight Visit

Date: January 24, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on August 7, 2007, at the Oklahoma County Juvenile Detention Center, located in Oklahoma City. The OJSO returned on August 8, 2007, and continued the oversight on August 9, 10, 13, 14, and 15, 2007. The purpose of the visit was to assess compliance with established responsibilities. The detention center was certified by the Office of Juvenile Affairs (OJA) for seventy-nine juveniles. The facility's census on the first day of the visit was sixty-five.

Interviews Conducted

- Entry interview with the Facility Administrator on August 7, 2007
- Exit conference with facility administration on August 27, 2007
- Eleven direct care staff members
- Twenty residents

Documents Reviewed

- Six personnel files
- Files on fourteen residents
- Office of the State Fire Marshal inspection report, dated April 16, 2007
- Oklahoma State Department of Health inspection report, dated November 29, 2006
- OJA Office of Public Integrity annual assessment report regarding a visit conducted on April 24 and 25, 2007
- Incident reports
- Facility logs on room confinement, room restriction, illnesses, and suicide attempts
- Resident Handbook

- Daily schedule for residents
- Facility policy concerning Special Management Program

Areas Toured

- Entire facility

Findings

Interviews

The OJSO interviewed twenty residents. The interview questions pertained to the residents' perceptions of safety, program services, resident rights, discipline practices, and other detention program issues. The OJSO noted:

- Six of the twenty residents interviewed stated they did not feel safe at the facility. When the OJSO asked each of those six residents to state the reason for not feeling safe, three stated that staff did not protect them, two said because of the other residents, and one did not give a reason.
- Five of the twenty residents interviewed stated they either had been cursed at by staff or had witnessed other residents being cursed at by staff.
- Because of comments made during interviews with staff, residents were asked if staff showed favoritism toward some of the residents. Three of six residents stated that staff had provided special treats to some residents or had allowed some residents outside of their rooms to walk around with staff.

The OJSO interviewed eight residents who had been placed on a special management program and/or room confinement. The OJSO noted:

Special Management Program

- Five of the eight residents interviewed stated that the residents were kept locked in their rooms.
- Five interviewees stated that the residents received thirty to ninety minutes of recreation time per day.
- Five stated that all meals were eaten in their rooms.
- Three stated that residents were not allowed to attend school or church.
- Four interviewees stated that residents were allowed to have reading materials.

Room Confinement

- All eight of the residents interviewed stated that the residents were kept locked in their rooms.
- All eight stated that all meals were eaten in their rooms.

- Four of the eight interviewees stated that staff removed the bedding from the residents' rooms until bedtime.
- Two stated that residents were placed on room confinement for a predetermined amount of time.
- Five interviewees stated that residents were only allowed fifteen to thirty minutes of recreation per day. According to the interviewees, recreational activities consisted of going to the dayroom to write letters or watch television.

Eleven direct care staff members were interviewed. The interview questions pertained to the staff members' perceptions of program services, resident rights, discipline policies, and other detention program issues. The OJSO noted:

- All eleven staff members interviewed described placing residents on a special management program.
- Eight of the eleven interviewees stated that residents placed on a special management program were kept locked in their rooms.
- Five stated the residents on a special management program ate meals in their rooms.
- Two stated that residents could eat in the cafeteria but only if their behaviors were appropriate.
- Four stated residents received one hour of recreation time daily.
- Five stated that recreation time depended on the resident's behavior.
- Three interviewees stated that behavior contracts were developed for the residents.
- None of the eleven interviewees could explain what a resident needed to accomplish to be released from a special management program.
- None could describe the daily schedule, the restrictions, or the activities for the residents.
- None of the interviewees demonstrated a clear understanding of the difference between room confinement and a special management program.

Incident at Facility

The OJSO became aware of an alleged rioting incident that had occurred on the facility's B unit on August 10, 2007. The OJSO interviewed four residents regarding the incident. The interview questions pertained to the four residents' perceptions of what had caused the incident. The OJSO noted:

- All four interviewees stated that the residents were angry because they were locked down all of the time with nothing to do.
- Two interviewees stated that staff antagonized the residents.

The OJSO inquired of the four interviewees what actions had taken place at the facility as a result of the incident. The interviewees informed the OJSO that four of the residents who were housed on B unit on the day of the incident had complied with staff instructions and had gone to their rooms when the incident began. The residents stated they had been on lock-down status since the incident.

The OJSO interviewed five of the staff members who were on-duty at the time of the rioting incident on August 10, 2007. The interview questions pertained to the staff members' accounts of the incident and their perceptions of what had caused the incident. The OJSO noted:

- Three of the five staff members interviewed stated that inexperienced personnel were assigned to work on B unit on the day of the incident. Reportedly, the two staff members assigned to B unit on August 10, 2007, had a total of five months' experience and neither staff member was normally assigned to B unit.
- The staff supervisor left the unit after the rioting had begun to get a camera and shackles and to call the facility administrator.
- All five interviewees stated there appeared to be a total breakdown in communication among staff members.
- The staff supervisor did not call for all available staff to assist when the residents' behaviors began to escalate.
- Three staff stated they believed there was enough staff to handle the situation, but reportedly because of the staff's hesitation to take action, the residents became emboldened and staff lost the initiative to gain control of the unit.
- Three interviewees stated there were conflicting instructions given to staff from the staff supervisor and the Detention Officer III.
- Three interviewees reported they believed that some of the newly hired staff were afraid of the residents.
- Four interviewees reported they had witnessed incidents of staff favoritism toward residents. Examples given were:
 - Additional food or candy was given to some residents.
 - Some residents were allowed out of their rooms after hours to walk around with staff or sit in the staff supervisor's office.
 - The staff supervisor had taken a resident off the unit prior to the head count, causing the need for an additional head count on one shift.
 - Some residents were allowed additional telephone calls.

The OJSO inquired of the five staff what actions had taken place at the facility as a result of the incident. The OJSO was told that the facility director had instructed that all residents on B unit were to be kept on lock down indefinitely.

File Reviews

The OJSO reviewed the files on fourteen residents. The OJSO noted:

- Information contained in the progress notes and incident reports did not accurately reflect information documented on the room confinement log.
- Documentation indicated that residents who repeatedly violated rules were placed on a special management program.

- Documentation did not indicate that residents placed on a special management program were provided with an individualized behavioral program, in accordance with facility policy.

Six staff files were reviewed. No concerns were noted from the staff files reviewed.

Room Confinement/Restriction Logs

The OJSO reviewed the room confinement/restriction logs for January 1 through July 31, 2007. Two hundred incidents of room confinement were documented for that time frame. The average amount of time that a resident remained on room confinement was forty hours. Documentation indicated that residents were confined to their rooms as part of the special management program. The logs indicated:

- Thirty incidents of room confinement for rule violations did not meet criteria.
- The room confinement log occasionally contained entries that were out of chronological order; there were several completed pages that had been duplicated, and then information was changed or corrected, without adequate explanation, and both pages were in the log.
- Documentation indicated six residents were not released from room confinement after they regained control of their behaviors, agreed to cooperate with staff, and could safely return to the general population.
- Documentation did not indicate that a review was conducted of the resident's behavior every three hours to determine whether or not to continue room confinement.
- The behaviors of the residents on room confinement or the need for continued room confinement were vague and were not adequately documented in the log. Examples of why residents were continued on room confinement status were: "pacing" in the resident's room, "resident is negative toward staff about being moved," and "standing in his window."
- Documentation indicated one resident on room confinement was not served breakfast because the resident had refused to give his bedding to staff.
- Documentation indicated that on August 10, 2007, two residents requested to be put in their rooms. The confinements lasted in excess of three hours. Staff members and the residents, however, stated that the room confinements were for rule violations, not at the request of the two residents.
- Documentation indicated that twenty-four residents were placed on room confinement "at their request"; however, in eighteen of those instances, documentation revealed the residents had been restrained and/or had committed "rule violations."
- In sixteen instances of "voluntary request," the residents remained on room confinement for three days.
- The amount of time residents remained in their rooms when on a special management program was not consistently documented in the room confinement log.

Suicide Attempts Log

The OJSO reviewed the suicide attempts log for January 1 through July 31, 2007. The OJSO noted:

- A suicide attempt by a resident was recorded in the log by each shift, which gave the appearance that the resident made several suicide attempts within a twenty-four-hour period, resulting in inaccurate data of the actual number of suicide attempts, threats of suicide, and self-mutilations made by residents.
- Documentation indicated one resident was found unconscious, lying on the floor with a sheet around the resident's neck. Staff reported that the resident was placed on direct supervision for twenty-four hours and that the nurse was contacted. The nursing notes indicated the resident was not seen by the nurse until the next day. Reportedly, the resident was discharged to the resident's home; however, documentation did not indicate that the facility provided the family with information regarding the youth's suicide attempt, in order to seek further treatment.
- Documentation indicated a resident was found with a plastic bag over the resident's face and a sheet tied around the resident's neck. Documentation did not explain how the resident had obtained a plastic bag.

Observational Tour

The OJSO conducted an observational tour of the entire facility. The low census allowed the facility to move residents to different units so that units could receive a fresh coat of paint. The entire facility appeared clean and well-maintained.

The OJSO reviewed the most current inspection reports by the Office of the State Fire Marshal and the Oklahoma State Department of Health. The deficiencies noted on the reports were either corrected or a corrective action plan had been submitted by the facility. The OJA reviewed the facility for the time period of April 30, 2006, through April 25, 2007. The non-compliance areas listed in the OJA report were:

- Section 5, Personnel records: One staff member did not have documentation of a pre-employment physical.
- Section 9, Facility Tour: The facility was operating within its licensed maximum number of residents. The cold water button in two rooms was not functioning.
- Section 10, Corrections from previous OJA visit: The facility had not corrected the problem of operating over capacity.

The OJSO noted that the violations cited in the OJA had been corrected, prior to the OJSO's visit.

In addition, the OJA report noted that the facility had made twenty-one referrals to the Office of Client Advocacy (OCA) of the Department of Human Services for the assessment period. The facility made confirmed findings of caretaker misconduct in six of the twenty-one referrals. The OJA report stated, "It appears there were eleven (11)

attempted suicides. Most of the attempts were made by the resident tying a sheet around the neck.”

Areas of Concerns

1. Six of the twenty residents interviewed reported they did not feel safe at the facility.
2. A resident who made a suicide attempt and was found unconscious with a sheet tied around the neck was not seen by medical personnel until the next day. The incident occurred when medical personnel were routinely at the facility. According to documentation, no effort was made to have the youth assessed for mental health treatment.
3. The special management program appeared to be used as an unrestricted alternative to room confinement. Without the safety criteria and documentation requirements of room confinement, its use was subject to punitive abuse by the staff.

Violations

1. Progress notes, incident reports, and the room confinement log were incomplete or contained inaccurate information in ten of the fourteen resident files reviewed. Office of Juvenile Affairs policy OAC 377:3-13-40, Records, (b), (10) and (12), in part, states, “Facility staff shall maintain a confidential record on each juvenile and ensure that the record is safeguarded from unauthorized and improper disclosure. The case record includes, at a minimum, progress reports on program involvement and grievance and disciplinary record, if any.”
2. 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, (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).
3. Residents were placed on a special management program to separate chronic rule violators from the general population. OJA policy OAC 377:3-13-44, Security and control, (12), Procedures for separation from general population and/or general activities for disciplinary reasons, states the procedures for separation of a juvenile “requires continual line of sight and sound observation of the juvenile” and “the separation should not be in excess of 60 minutes.”
4. Residents placed on a special management program were not allowed the required amounts of recreation and leisure time. OJA policy OAC 377:3-13-45, Program and services, (a), states, “Activities and services are available to juveniles outside their rooms at least 12 hours a day. The facility shall provide or make available the minimum services and programs given in (1)–(7) of this subsection to detained

juveniles.” At the same cite, paragraph (a), (4), Recreation, in part, states, “Written policy and procedure provide a recreation schedule that includes at least one hour per day of large muscle activity and one hour of structured recreational activities.”

5. Residents placed in room confinement were not released after they regained control of their behaviors, agreed to cooperate with staff, and could safely return to the general population. 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.”
6. One resident on room confinement was denied food when he refused to give his bedding to staff. OJA policy OAC 377:3-13-42, Juvenile rights, (7), (D), states, “Facility staff shall not discipline a juvenile by using punitive interference with the daily functions of living such as eating or sleeping.”

Summary

An exit conference was conducted with the administrative staff of the facility on August 27, 2007, at the Oklahoma Commission on Children and Youth office. All areas of concern were discussed with the director and the administrative staff. The director assured the OJSO that the findings would be corrected prior to the next oversight visit.

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