

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

Name of Facility: Oklahoma County Juvenile Detention Center

Dates of Visit: December 15 and December 19, 2005, and January 4, 2006

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Oversight Specialists

Focus of Visit: Oversight Visit

Date: June 22, 2006

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on December 15, 2005, to the Oklahoma County Juvenile Detention Center, located in Oklahoma City. The OJSO made two announced, follow-up visits to the facility on December 19, 2005, and January 4, 2006. The purpose of the oversight was to assess compliance with established responsibilities and facility policy and procedures.

The detention center was certified by the Office of Juvenile Affairs (OJA) for eighty juveniles. On the day of the OJSO visit, the census was eighty-three. The facility has been located at the same site since 1986. Four additional wings were added to the building in 1999. A main control center was located at the front of the facility; seven pods housed the juveniles.

Persons Interviewed

- Entry interview and exit conference with the facility Administrator, facility Assistant Administrator, and the facility Accreditation Manager for accreditation by the American Correctional Association (ACA)
- Subsequent interview with the Administrator (regarding the facility's use of physical restraints)
- Four staff members
- Seven juveniles

Documents Reviewed

- Four personnel files
- Files on eight juveniles

- Inspection reports, dated March 15 and December 16, 2005, by the Office of the Oklahoma State Fire Marshal
- Quarterly referral log, dated October 19, 2005, by the Office of Client Advocacy of the Department of Human Services
- Inspection report, dated January 24, 2005, by the Oklahoma State Department of Health
- Annual assessment report of a visit conducted on June 22, 23, and 24, 2005, by the OJA Office of Public Integrity
- Incident reports
- Disciplinary Hearing Committee records

Areas Toured

- Resident rooms on seven pods
- Bathrooms located on each of the seven pods
- Kitchen and food preparation area
- Nurses' station
- Dining hall
- Holding cells for juveniles waiting to attend court
- Laundry room
- Storage area for chemicals

Overview

Resident Interviews

Seven residents were interviewed. Their responses to the interview questions indicated:

- Six of the seven juveniles reported having been confined to their rooms for a period of three days for rule infractions, they were not given an opportunity to explain their behaviors at the time of the sanctions, and staff did not review with them to determine when return to the general juvenile population was appropriate.
- Two of the seven juveniles stated that staff members had turned off the water to their rooms.

Staff Interviews

Five staff members were interviewed. Their responses to the interview questions indicated:

- All five staff members made positive comments regarding the facility.
- All five believed that the juveniles were treated fairly.

Review of Resident Files

The OJSO reviewed the files on eight juveniles. The review revealed:

- None of the eight files included a statement signed by the juvenile documenting written notification of rights, rules, and range of discipline.
- Four of the eight files did not contain documentation of medical consent and authority to provide medical treatment.
- None of the eight files had documented fifteen-minute room checks of the juveniles on room confinement. The Administrator stated that fifteen-minute room checks were documented on the yellow sheets in the juveniles' files; however, at the time of the OJSO visit, the yellow sheets were not located in the resident files.

Review of Staff Files

The OJSO reviewed four personnel files. The review revealed:

- None of the four files contained documentation to indicate that during orientation training, the staff members received training on the grievance process.
- One file did not contain documentation to indicate the employee received training on cardiopulmonary resuscitation (CPR) and first aid within ninety days of hire.
- One file documented only two personal references.

Review of Room Confinement Practices

The OJSO reviewed documentation regarding the use of room confinement for the months of October, November, and December 2005. The room confinement documentation for October through December indicated:

- Two of the 102 incidents reviewed indicated major rule violations in the use of room confinement. The others were marked minor rule violations or were left blank.
- Sixty-two of the 102 incidents resulted in the residents having been placed in room confinement for 72 hours.
- Thirty-three of the 102 incidents reviewed did not document the residents' opportunities to explain his/her behaviors prior to being placed on room confinement.
- Fifty-three of the 102 recommendations that were reviewed in administrative reviews stated, "Needs to maintain 72 hours confinement" or that the juvenile needed to serve the full confinement. None of the 53 addressed whether the resident could be safely returned to the general population.
- Reportedly, one incident involved a juvenile assaulting another resident. The non-offending resident received room confinement for 72 hours. The juvenile received room confinement for another 72 hours after staff found a spray bottle hidden in his room.
- Reportedly, one incident involved a juvenile having been placed on room confinement for 72 hours after becoming angry and using profanity toward staff when the juvenile was denied telephone privileges.

Review of the Use of Mechanical Restraints

The OJSO reviewed documentation regarding the use of mechanical restraints. Of the thirteen occurrences documented, the OJSO reviewed eight. The OJSO did not note any concerns from the review.

Observational Tour

On December 19, 2005, the OJSO conducted a tour of the facility, hosted by the Administrator. The OJSO noted:

- In three single-occupancy rooms, two juveniles were housed together. In these rooms, each had a bed on the floor for the additional juvenile.
- Psychotropic and unlabeled medications were unsecured on the desk at the nurses' station. The Administrator stated that the nurse was the only one who had access to the clinic and that the door was always kept locked. The OJSO observed a dentist's office and an examination table also in the area.
- The program rules and range of disciplinary actions were not posted.
- Maintenance repairs were needed.

Pod A

- The cold water did not work in the bathroom sinks in three juveniles' rooms.
- Toilet paper was hanging from the ceiling vents in nine juveniles' rooms.
- The spouts in the bathroom sinks were leaking in two juveniles' rooms.
- The drain in a bathroom sink was clogged in one juvenile's room. Reportedly, the drain had been clogged for a few days.
- Writing was found on the fan vents in two juveniles' rooms.
- The hot water did not work in the bathroom sink in one juvenile's room.

Pod B

- The bulbs were burned out in the light fixture in one juvenile's room.
- Pieces of toilet paper were found on the ceiling in one juvenile's room.
- The hot water did not work in the bathroom sink in one juvenile's room.
- Water was leaking from the bathroom sink in one juvenile's room.
- Writing was found on the walls and on the bathroom sinks in four juveniles' rooms.
- A toilet did not flush and there was no running water in one juvenile's room. The juvenile had been admitted the day of the observational tour. The toilet was repaired before the OJSO left the area.
- Window panes were cracked in four juveniles' rooms.

- The lights were flickering in one juvenile's room, and the lights were not working in another juvenile's room.
- The cold water did not work in one juvenile's room.
- Condensation caused water to drip on a bed in one juvenile's room.

Pods C and D

- Gang graffiti was observed throughout both pods.
- Ants were noted in one juvenile's room.
- There was no running water for the bathroom facilities in some of the juveniles' rooms.

During the OJSO's follow-up visit on January 4, 2006, the OJSO noted:

- Medications in three envelopes were unsecured on the desk at the nurses' station. The OJSO spoke with the nurse who stated that the night staff put medications on the desk for her to lock up the following morning.
- A box on the nurses' desk containing syringes was broken. The box was unsecured on the desk in the clinic.
- A medication log had not been maintained.

Summary

The OJSO conducted an exit conference with the Administrator, the Assistant Administrator, and the facility Accreditation Manager for accreditation by the ACA. The Administrator told the OJSO that he wanted to make a recording of the discussion so that he could begin immediately to act on the OJSO's recommendations. The OJSO delineated the violations found. The OJSO received a letter from the facility's Director, dated January 5, 2006, notifying the OJSO of the revised policy changes regarding the storing and distributing of medicines. The OJSO filed a notice with the Oklahoma Board of Nursing regarding the violations found concerning the unlabeled and unsecured medicines, the broken and unsecured sharps box that contained syringes, and the lack of a medication log.

Findings

1. According to the documentation, the requirements for room restriction and room confinement, and the proper procedures taken after juveniles were placed on room confinement, were not followed. Office of Juvenile Affairs policy OAC 377:3-13-44, (c), (13), Room restriction, states, "Room restriction is one means of informally resolving minor juvenile misbehavior. It serves a 'cooling off' purpose and has a short time period (up to 60 minutes) that is specified at the time of the assignment." At the same cite, paragraph (c), (14), (A) and (C), Room confinement, 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. 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 . . . ; and
- (vi) stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility

A juvenile shall not be in room confinement in excess of 24 hours without the opportunity of an administrative review by the administrator or designee who was not involved in the incident.

At the same cite, paragraph (c), (15), Procedure for room confinement or room restriction, states,

When room restriction or confinement is used, the (following) procedure . . . is followed.

- (A) Prior to room restriction or confinement, facility staff shall explain the reasons for the restriction or confinement to the juvenile and shall give the juvenile an opportunity to explain his or her behavior.
 - (B) Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented.
 - (C) Juveniles placed in room confinement shall be afforded living conditions and essential services approximating those available to the general juvenile population. Exceptions shall be justified in writing by clear and substantial evidence.
 - (D) The juvenile shall be released when staff determines that he or she can safely be returned to the group.
 - (E) A written record shall be maintained on any juvenile placed in room restriction or confinement. 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.
2. Written notification as documented by a statement signed by the juvenile that he/she had been advised of juvenile rights, program rules, grievance process, and discipline policy was not found in eight files. Office of Juvenile Affairs policy OAC 377:3-13-39, Admission procedure and criteria, (b), (12), states, "The facility's written policy and procedure for admitting juveniles includes . . . provisions which require the facility to provide an orientation which includes juvenile rights, program description, program rules, grievance process, and discipline." Office of Juvenile Affairs policy OAC 377:3-13-40, Records, (a), (19), states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include . . . statement signed by the juvenile that he/she has been advised of juvenile rights, program rules, grievance process, and discipline policy."

3. Sinks and toilets in the juveniles' rooms noted above were not operational. Office of Juvenile Affairs policy OAC 377:3-13-46, Physical plant or facility, (c), (2) and (4), states, "Every lavatory basin, bathtub or shower is supplied with hot and cold water under pressure at all times. All fixtures must be maintained in good working condition."
4. More than one juvenile was housed in rooms constructed for single occupancy. Office of Juvenile Affairs policy OAC 377:3-13-46, Physical plant or facility, (b), Space, (1), (A), in part, states, "There shall be no double-celling of juveniles unless the room has been specifically constructed to house two juveniles." When more than one juvenile was housed in a single-occupancy room, a bed was placed on the floor for the additional juvenile. American Correctional Association standards, 3-JDF-2B-06, states, "The number of juveniles does not exceed the facility's rated bed capacity."
5. One staff file did not have documentation of CPR and first aid training within ninety days of hire. Office of Juvenile Affairs policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (E) and (F), in part, states, "Within 90 days after employment, all direct-care staff shall have successfully completed first aid training. . . . All direct-care staff shall be certified in cardiopulmonary resuscitation (CPR) within 90 days after employment. . . ."
6. One personnel file reviewed documented only two of the three required references. Office of Juvenile Affairs policy OAC 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."
7. Four resident files reviewed did not contain documentation of medical consent and the authority to treat. Office of Juvenile Affairs policy OAC 377:3-13-40, Records, (16), in part, states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include . . . medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent."
8. One resident file reviewed did not contain documented participation in recreational activities. Office of Juvenile Affairs policy OAC 377:3-13-42, Juvenile rights, (5), states, "A juvenile shall have access to on-site recreational opportunities, including daily outdoor exercise, weather permitting." Office of Juvenile Affairs policy OAC 377:3-13-45, Program and services, (a), (4), Recreation, 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."
9. The rules and range of disciplinary actions were not posted. Office of Juvenile Affairs policy OAC 377:3-13-44, Security and control, (b), states, "A list of in-house rules, outlining acts prohibited in the facility and the range of disciplinary procedures . . . is posted in a conspicuous and accessible area."
10. Medications were not properly labeled and were not stored under lock. A sharps box, containing syringes, was broken and was unsecured. Office of Juvenile Affairs policy OAC 377:3-13-45, Program and services, (a), (6), Medical and health care, (E), (iii), states, "The secure juvenile detention facility shall develop and maintain written policy and procedure which accounts for receiving, storing, dispensing, administering and distributing all medications and first aid supplies." At the same cite, paragraph (7), Medication, (B) and (D), states, "Medication is administered by

persons properly trained in medical administration and under supervision of the physician and facility administrator. 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. Any adverse reaction to the medication is documented. All medications, syringes, and needles are protected by maximum security storage and are under the supervision of staff on duty."

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