

**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: December 16, 17, and 18, 2009

Oversight Reviewers: Dana S. Holden and Janice Sharp, Oversight Specialists

Focus of Visit: Unannounced Visit, 2009

Date: March 18, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit on December 16, 2009, at the Oklahoma County Juvenile Detention Center, located in Oklahoma City. The OJSO returned on December 17 to resume the oversight, and the OJSO concluded the visit on December 18, 2009. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures and to conduct a complaint investigation. In addition, the information from this oversight visit was obtained for reporting in the OJSO systemic review regarding room confinement at Office of Juvenile Affairs (OJA) facilities. The OJA contracts with the Oklahoma County Juvenile Bureau for operation of the detention center. The facility was certified by the OJA for eighty residents. On the first day of the OJSO visit, the census was eighty-one residents, seventy-four male and seven female residents.

The complaint received by the OJSO alleged that a resident's prescription for medication had not been refilled by the facility, resulting in the resident not receiving his/her medication for a month. Allegedly, the facility had not notified the resident's custodians of the missed dosages. The OJSO determined that the resident had been admitted into the facility without documentation of a diagnosis, and that the facility had not been aware of the juvenile's medication prescription. Reportedly, the resident missed four days of medication after having been admitted into the facility. When the facility became aware of the prescription for the resident, the facility took action to obtain the medication.

Interviews Conducted

- Entry interview with the facility administrator
- Five residents

- Four direct care staff members
- Informal interview with the Quality Assurance manager
- Informal interview with the facility nurse
- Exit conference on January 19, 2010, with the facility administrator and administrative staff members

Documents Reviewed

- Sixteen resident files
- Facility staffing notes regarding residents on Unit B
- Personnel files and training records for four direct care staff
- Personnel file and training record for one facility administrator
- Office of the Oklahoma State Fire Marshal report dated February 27, 2009
- Oklahoma State Department of Health Food Inspection reports dated February 25, 2009, and December 14, 2009
- OJA Office of Public Integrity (OPI) monitoring report dated April 17, 2009; facility corrective action plan dated May 20, 2009; and OPI correspondence dated July 14, 2009, replying to the corrective action plan
- Facility grievance log review for July 1, 2009, through December 15, 2009
- Facility room confinement log for July 1, 2009, through December 15, 2009
- Facility use-of-force/restraint log for January 1, 2009, through December 15, 2009
- Facility policy 8.4-6: Room confinement
- Facility reports of residents receiving psychotropic medications for June through November 2009
- Facility incident reports for July 1, 2009, through December 15, 2009
- Facility daily activity and program schedule for December 18, 2009
- Facility school year schedule for 2009-2010
- Facility daily room chart
- Facility daily detention population report
- Facility staff roster

Areas Toured

- Walk-through of entire facility

Findings

Resident Interviews

The OJSO interviewed five residents on Unit B. The interview questions pertained to the residents' perceptions of safety, detention program services, resident rights, discipline practices, and other detention program issues. The OJSO noted that three of the five interviewees stated that residents on Unit B were not allowed to attend school, and another interviewee stated that residents on Unit B attended school only when the resident population on Unit D was not at full capacity; the other interviewee did not provide a response. No other concerns were identified from the resident interviews.

Staff Interviews

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

- All four interviewees reported current certifications in first aid, cardiopulmonary resuscitation (CPR), and behavioral management techniques.
- Two interviewees reported having restrained a resident in the past year. One of these two interviewees reported that a resident had received an injury during the restraint and that a referral was made to the Office of Client Advocacy (OCA) of the Oklahoma Department of Human Services (OKDHS) to request review of the incident to determine whether or not the resident had been injured due to caretaker misconduct. According to the interviewee, the resident had possibly bit his/her tongue during the restraint.
- All four interviewees stated that they had received written guidelines on the use of force.
- All four interviewees stated that sight checks were conducted every fifteen minutes when residents were in their rooms; all four interviewees also stated that sight checks were conducted every ten minutes or direct observation occurred when a resident was on suicide watch.
- All four interviewees stated that grievance forms were available to the residents.
- When asked to rate the quality of the food served, with 1 being the worst and 10 being the best, one interviewee rated the food quality as 5, another interviewee rated it as 7, one interviewee rated it as 9, and the other interviewee rated it as 10.
- When asked to rate the quantity of the food served, with 1 being the worst and 10 being the best, one interviewee rated the food quantity as 5, two interviewees rated it as 7, and the other interviewee rated it as 10.
- Three of the four interviewees stated that room confinement was the worst punishment a resident could receive for a rule infraction; the other interviewee stated that loss of points from the point system was the worst punishment a resident could receive for a rule infraction.
- Three of the four interviewees stated that residents received thirty minutes of outdoor recreation during the weekdays; the other interviewee stated that a schedule had been prepared for outdoor recreation time. Examples of outdoor recreation were playing non-defensive basketball, shooting hoops, and walking around the outdoor recreation area.
- When asked to name what the interviewees believed was the most beneficial part of the program for the residents, one interviewee named the group therapy sessions, another interviewee stated the self-discipline instilled in the residents, one interviewee stated the positive interactions that occurred between the residents and staff, and the other interviewee stated the care the residents received.
- When asked if the interviewees had any concerns for the residents at the facility, one interviewee stated that a special diet was not provided to residents with diabetes and another interviewee stated that more therapeutic intervention and improved

monitoring of medication reactions were needed for residents with behavioral health conditions such as Attention Deficit Hyperactivity Disorder.

The OJSO asked the four interviewees questions specific to Unit B. The OJSO noted:

- All four interviewees reported that male residents assigned to room confinement were placed on Unit B.
- Three of the four interviewees stated that the resident population and resident behavior determined when a resident was moved from Unit B. Interviewees stated that when a bed on another unit became available and/or a resident's behavior was appropriate, then the resident could be moved to another unit. The other interviewee did not provide a response.
- All four interviewees stated that residents on Unit B on confinement were not allowed to attend school.
- All four interviewees reported that residents on all units, except for the residents on confinement, received the same activities and privileges.
- One of the four interviewees stated that a resident was released from confinement when the resident became calm, and two interviewees stated that behavior determined when a resident was released from confinement. The other interviewee did not provide a response.
- Two of the four interviewees stated that bedding and personal property were removed from the resident room when a resident was placed on confinement and that the bedding was returned to the resident at bedtime. One of these two interviewees stated that a blanket was left in the room during the day for the resident. Another interviewee stated that it was not routine to remove bedding and personal property from the resident's room when a resident was placed on confinement. The other interviewee did not provide a response.

No other concerns were identified from the staff interviews.

Resident File Review

The OJSO reviewed sixteen resident files for compliance with OJA standards. Seven of the sixteen files reviewed did not contain medical consent or authority to treat the residents.

The OJSO also reviewed the unit binders for the residents on Unit B. The forms in the binders were the Resident Telephone Log, Resident Medication Log, Resident Mail Log, Staffing Notes, Unit Placement Form, Room/Bed Check Sheet, and Phone Call Authorization Form. On the forms in several places, the OJSO noted that requested information was not provided or the requested information was incomplete.

No other concerns were noted from the resident file review.

Staff File Review

The personnel files for four direct care staff members and a facility administrator were reviewed for compliance with OJA detention standards. No concerns were identified from the staff file review.

Facility Room Confinement Log Review

The OJSO reviewed the facility room confinement log for July 1 through December 15, 2009. For that time period, 178 incidents of room confinement were documented. The number of room confinements appeared to have increased from the last oversight visit; in 2008, the facility had a total of 100 instances of room confinement for the first seven months. From the most recent visit, the OJSO noted:

- Residents were placed on room confinement for rule infractions that did not meet criteria for room confinement.
- Documentation indicated that bedding and personal property were removed routinely from the resident room when a resident was placed on room confinement. Staff interviews and resident file documentation corroborated this finding. Subsequent to the visit at the facility, the OJSO contacted the OJA Office of Public Integrity to inquire if it was a valid practice for a facility to remove the bedding and personal property of residents on room confinement. The OJA Office of Public Integrity advised that the facility would need to document a valid reason for removing the bedding and personal property from the resident room during room confinement.
- In thirty-eight instances of room confinement, documentation indicated that a three-hour assessment was not conducted to determine whether or not the resident could return to the general population. Documentation on the room confinement log was vague or inadequate regarding the behaviors of residents on room confinement or the reasons for continued room confinement. Examples of reasons for continued room confinement were: “resident was inciting” and “looking out his window”.
- Documentation indicated that a resident remained on room confinement from December 7, 2009, through December 11, 2009, without any documentation of rule violations, administrative reviews, three-hour administrative assessments, observation reports, or incident reports.
- Documentation indicated that one resident was denied meals for a “prolonged period of time” because the resident refused to comply with staff directives. The incident report stated that the resident refused to give his/her bedding and personal property to staff when he/she was placed on room confinement.

No other concerns were identified from the room confinement log review.

Facility Restraint Log Review

The OJSO reviewed the facility restraint log review for January 1, 2009, through December 15, 2009. The log documented twelve instances during this review period when restraints were used. Documentation did not indicate that staff remained with the

resident while the resident was being mechanically restrained. No other concerns were identified from the restraint log review.

Facility Resident Grievance Log Review

The OJSO reviewed the resident grievances filed from July 1, 2009, through December 15, 2009. The OJSO noted:

- Two grievances did not document resolutions.
- The resolutions documented for nine grievances did not specifically address the residents' issues.
- Four grievances indicated that the residents wanted to appeal the resolution; however, documentation did not indicate that the appeals were filed.
- Documentation regarding thirteen grievances did not indicate that these grievances alleging abuse or neglect by staff were reported to the OKDHS OCA.

No other concerns were identified from the grievance log review.

Inspection Reports Review

The OJSO reviewed the most recent reports by the fire marshal's office, the health department, and the OJA monitoring unit. The fire marshal's office report noted that the facility had "exhibited a history of non-compliance" in exceeding its certified capacity. On the day of the OJSO visit, the facility census was one more than its certified capacity. The health department had not cited any violations. The most recent OJA OPI monitoring report cited:

- Section 5, Personnel Records: One file did not document a pre-employment physical, one file did not document a tuberculin skin test upon employment, and one file did not document a chest x-ray for a positive tuberculin skin test.

The OPI report recommended that food portion sizes be upgraded to better meet the nutritional needs of the residents. The facility submitted a corrective action plan that the OJA accepted.

Areas of Concern

1. Nine instances of room confinement were not properly documented. The date and time of confinement and the date and time of release from confinement were identical.
2. Documentation indicated that when a resident committed another rule infraction while on room confinement that staff restarted the resident's time to remain on room confinement; the resident was not given credit for time already completed in room confinement. Documentation indicated that one resident remained 100 hours on room confinement because staff repeatedly restarted the resident's time.

3. Grievance forms submitted by residents were not properly filled out by the residents or the grievance coordinator. Two grievances did not document resolutions, two grievances were not signed by the residents, two grievances were not signed by staff, and the resolutions on nine grievances did not specifically address the residents' issues.
4. The facility had exceeded its licensed capacity on the first day of the OJSO visit.

Violations

1. Residents were placed on room confinement for incidents that did not meet criteria for room confinement. 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)."
2. Thirty-eight instances of room confinement did not document a three-hour assessment of the juveniles' behaviors to determine whether or not the juveniles could be returned to the general population. OJA policy, OAC 377:3-13-44, Security and control, (c), (14) Room confinement, (B), states, "Room confinement of juveniles shall be re-authorized every 3 hours, except during normal sleeping hours, by a supervisor/administrator who was not involved in the original incident. . . . Reasons for continued room confinement shall be documented."
3. Documentation indicated and residents and staff reported that staff removed all of the resident's personal property and bedding from the resident room when a resident was placed on room confinement. OJA policy, OAC 377:3-13-44, Security and control, (c), (15) Procedure for room confinement or room restriction, (C), states, "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."
4. Documentation indicated that residents on room confinement were not released from room confinement after the residents regained control of his/her behavior, 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."
5. Documentation indicated that Unit B residents were not allowed to attend school when the facility exceeded its licensed capacity. OJA policy, OAC 377:3-13-42, Juvenile Rights, (14), states, "A juvenile shall receive educational instruction to which the juvenile is entitled under provisions of state education laws and regulations."
6. Seven of the sixteen resident files reviewed did not contain documentation regarding authority to treat or medical consent. OJA policy, OAC 377:3-13-40, Records, (a),

(16), in part, states, "Facility staff shall complete a confidential record . . . and include, at the minimum . . . medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent."

7. Documentation did not indicate that staff remained with a resident while the resident was being mechanically restrained. OJA policy, OAC 377:3-13-44, Security and Control, (c), (9), Use of mechanical restraints, (I), states, "A juvenile placed in [mechanical] restraints shall not be left unattended."
8. Documentation did not indicate that when residents alleged staff abuse or neglect on grievance forms that staff reported the allegations to the OKDHS OCA. OJA policy, OAC 377:3-1-25, Abuse, neglect, and caretaker misconduct, (a), Requirements for reporting incidents of abuse, neglect, or caretaker misconduct, in part, states, "State law requires every person with reason to believe that a child or juvenile is or has been abused or neglected to report the condition or incident to the appropriate office for investigation. Title 10 §7004-3.4(B)(2)* confers on OCA the responsibility of investigating allegations of caretaker abuse and neglect of juveniles, regardless of custody, residing outside their own homes, other than the foster care level."

Summary

During the oversight visit, the OJSO provided a list of names of residents whose files would be reviewed, and facility staff accompanied the OJSO to Unit B where the OJSO conducted resident interviews in the residents' rooms. The OJSO conducted an exit conference on January 19, 2010, with the facility administrator and administrative staff. The OJSO's findings, including all concerns and violations, were discussed during the exit conference. The OJSO provided the facility staff with specific examples of the violations found. The OJSO appreciated the assistance and cooperation of the facility staff during the oversight visit and the exit conference.

DSH:JKS

* Renumbered as 10A O.S. §1-9-112 by Laws 2009, HB 2028.

