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:	July 26, 27, and 29, 2010
Oversight Reviewers:	Dana S. Holden, Oversight Specialist IV, Janice Sharp, Oversight Specialist III, and Harold Jergenson, Oversight Specialist III
Focus of Visit:	Announced Visit, 2010
Date:	November 17, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) began an announced visit on July 26, 2010, at the Oklahoma County Juvenile Detention Center, located in Oklahoma City. The OJSO returned on July 27, 2010, and concluded the oversight on July 29, 2010. 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 fifty-nine.

Interviews Conducted

- Entry interview with the facility administrator, assistant facility administrator, and the quality assurance manager on July 26, 2010
- Exit conference with facility administration on August 5, 2010
- Five direct care staff members
- Eleven residents

Documents Reviewed

- Eleven resident files
- Five direct care staff personnel and training files
- Office of the Oklahoma State Fire Marshal inspection report dated March 2, 2009
- Oklahoma State Department of Health inspection report, dated December 14, 2009
- OJA Office of Public Integrity (OPI) annual assessment report regarding a visit conducted on June 22, 2010
- Incident reports from January 1, 2010, through July 26, 2010
- Facility logs on room confinement and room restriction for January 1, 2010, through July 26, 2010
- Use of force/restraint log for January 1, 2010, through July 26, 2010
- Grievance log from January 1, 2010, through July 26, 2010
- Resident handbook revised June 2009

- Dayroom manual 2009
- Room confinement policy 8.4-6 revised March 2009
- Office of Client Advocacy (OCA) investigations for January 1, 2010, through July 26, 2010
- Medical files for two residents

Findings

Resident Interviews
The OJSO interviewed eleven 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:

- Three residents interviewed stated they were not allowed to attend school while they were housed on B pod.

There were no other concerns noted from the resident interviews.

Staff Interviews
Five 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. There were no concerns noted from the staff interviews.

Resident File Review
The OJSO reviewed eleven resident files. The OJSO noted the following:

- Two files did not have documentation of authority or medical consent to treat the juvenile. The names of the residents were provided to the quality assurance manager by e-mail on august 23, 2010.

There were no other concerns noted from the resident file review.

Personnel File Review
The OJSO reviewed five personnel files. There were no concerns noted from the personnel file review.

Room Confinement and Room Restriction Logs
The OJSO reviewed the room confinement log for January 1, 2010, through July 26, 2010. There were a total of one hundred seven incidents of room confinement documented for that time frame. Of these one hundred seven incidents of room confinement, fifty-eight were chosen for further review. The names of the residents involved in incidents of room confinement where the OJSO found a violation or an area of concern were provided to the facility staff during the exit conference. On August 20, 2010, the OJSO received an e-mail from the quality assurance manager requesting the names of the residents who were placed on room confinement for incidents that did not meet criteria and the names of residents who did not have documentation of authorization for medical treatment. The quality assurance manager requested a two week extension of time and advised that she would be responding to the information

provided to her by the OJSO. On August 23, 2010, the OJSO provided the facility quality assurance manager by e-mail with the specific names of residents involved in incidents of room confinement that did not meet criteria and the two residents that did not have documentation of authority to provide medical treatment. The OJSO did not receive any additional information prior to the two week deadline of September 6, 2010. The OJSO noted the following from the room confinement log:

- Documentation indicated that the disciplinary review committee used room confinement as a form of punishment. The committee documented that residents were kept on room confinement for "not showing remorse" or for "showing no sympathy for peers." The committee did not document why a resident couldn't be safely returned to the general population in their reviews.
- Documentation indicated facility staff used minor rule infractions such as looking out the door window to keep a resident on room confinement. The staff did not document how looking out the window posed a threat to the safety of the facility, staff, or residents.
- Documentation indicated there were five instances where an administrative assessment was not conducted of the resident's behavior every three hours to determine whether or not to continue room confinement. Staff did not wake residents who were sleeping during day time hours and in one instance did not document any three hour reviews. The OJSO noted that this number was an improvement over the assessment conducted by the OJSO in 2009.
- There were six instances of room confinement that did not meet criteria. Residents were placed on room confinement for being in possession of contraband such as cell phones, ink pens, or for writing gang graffiti on the inside of their door. The names of these residents were provided to the quality assurance manager by e-mail on August 23, 2010.
- Documentation indicated residents were not released from room confinement when it was safe or staff did not adequately document why it was not safe to return a resident to the general population. Staff used reasons such as the resident was "looking out their window," "refused to apologize," or the resident "wasn't remorseful."
- Staff threatened to place a resident on a twenty-four hour blue sheet (illness request) for refusing to take their medication. As a result of staff's actions, the resident became upset that they were placed in their room and attempted to assault a staff member. The name of this resident was provided to the facility at the exit conference.

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

Room Restriction Log

The OJSO reviewed the room restriction log for the period of January 1, 2010, through July 26, 2010. There were no concerns noted from the room restriction log.

Restraint Log Review

The OJSO reviewed the restraint log for the period of January 1, 2010, through July 26, 2010. During this time period there were five incidents documented where mechanical restraints were used. The OJSO noted the following:

- The facility administrator ordered a resident placed in mechanical restraints and put on room confinement for being in possession of a cell phone. The staff did not document any violent or dangerous behavior by the resident.

There were no other concerns noted from the restraint log review.

Grievance Log Review

The OJSO reviewed the facility grievance log for the period of January 1, 2010, through July 26, 2010. There were no concerns noted from the grievance log review.

Other documentation reviewed

The OJSO reviewed the latest inspection report from the OJA Office of Public Integrity (OPI) dated June 22, 2010. The facility addressed all concerns noted in the OPI report in a written plan of correction. There were no concerns noted from the OJA OPI report.

The OJSO reviewed the latest inspection reports from the state Fire Marshal's office dated March 2, 2009. The OJSO was advised that the facility had been requesting the Fire Marshal's office to come inspect the facility however, they had been unsuccessful. The OJSO contacted the State Fire Marshal's office on July 26, 2010 and requested the inspector contact the quality assurance manager to schedule an inspection. The inspector advised he would contact the facility and schedule an inspection. The OJSO reviewed the State Health Department inspection report dated December 14, 2009. There were no violations noted in the report.

Summary

During the entry conference the facility administrator requested that he not be required to respond to areas of concern listed in the OJSO report. The administrator stated that since the areas of concern were based on this investigators opinion, he felt it wasn't necessary to respond. I advised the administrator I would note that in my report. The OJSO provided the quality assurance manager with a list of names and materials the OJSO would review following the entry conference.

During the exit conference the facility administrator was provided with a copy of the facility exit checklist. The OJSO recognized the facility strengths as the actual physical security of the facility and the medical care provided to the residents. The OJSO appreciates the cooperation of the facility staff in providing the materials requested and their participation in the entry and exit conferences.

Areas of Concern

1. Documentation indicated that the disciplinary review committee used room confinement as a form of punishment.
2. Documentation indicated facility staff used minor rule infractions to keep a resident on room confinement.
3. The OJSO noted that there were several instances where cell phones were brought into the facility by residents, stolen from staff, or given to a resident by a staff member. The OJSO was advised that in one incident the staff member who gave

the cell phone to a resident was terminated from employment and the incident was referred to law enforcement.

Violations

1. 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), (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 [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. Documentation indicated instances where staff did not conduct a three hour assessment of the juvenile's behavior for continuing a juvenile on room confinement. OJA policy, OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (B), states, in part, "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 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."
4. Two resident files did not have documentation of authority to treat or medical consent. OJA policy, 377:3-13-40, Records, (a), (16), states, in part, "Facility staff shall complete a confidential record . . . and include, at the minimum, the following: medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent."
5. Staff threatened to place a resident on a twenty-four hour blue sheet (illness request) for refusing to take their medication. As a result of staff's actions, the resident became upset that they were placed in their room and attempted to assault a staff member. OJA policy, 377:3-13-42, Juvenile rights, (7), (A), states, "Facility staff shall not discipline a juvenile by using: corporal or <u>unusual punishment</u>." (emphasis added)
6. The facility administrator ordered a resident placed in mechanical restraints and put on room confinement for being in possession of a cell phone which did not meet criteria. OJA policy, 377:3-13-44, Security and control, (c), (9), Use of mechanical restraints, (A), (i) through (v), state, "Restraints are used only: 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; and [to] prevent destruction of property if reasonably related to (i) through (iv)."