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:	October 16, 20, 22, 27, and 29, 2008, and January 13, 2009
OJSO Reviewers:	Dana S. Holden and Harold Jergenson, Oversight Specialists
Focus of Visit:	Unannounced Visit, 2008
Date:	March 9, 2009

Introduction

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on October 16, 2008, at the Oklahoma County Juvenile Detention Center, located in Oklahoma City. The OJSO returned on October 20, 22, and 27 to resume the visit and concluded the oversight on October 29, 2008. An exit conference was held with facility administration on January 13, 2009. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The detention center was certified for seventy-nine juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). The facility's census on the first day of the visit was ninety-one.

Interviews Conducted

- Entry interview with the facility administrator on October 16, 2008
- Exit conference with facility administration on January 13, 2009
- Five direct care staff members
- Thirteen residents

Documents Reviewed

- Eighteen resident files
- Office of the Oklahoma State Fire Marshal report dated March 14, 2008
- Oklahoma State Department of Health Food Inspection report dated April 29, 2008
- OJA OPI annual monitoring report regarding a visit conducted on June 19, 2008
- Incident reports
- Facility room confinement/room restriction logs

Findings

Interviews

The OJSO interviewed thirteen 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:

- Twelve interviewees stated they felt safe at the facility.
- Nine interviewees rated the quality of the food as fair, and four rated it as poor.
- Ten residents reported that they did not receive enough to eat; they also reported that staff were served larger portions of food and were allowed second helpings.
- All thirteen interviewees stated either they had been cursed at by staff or they had witnessed other residents being cursed at by staff.
- Nine interviewees stated they had been locked in their rooms for two hours or more a day for reasons other than shift changes or rule violations.
- Seven interviewees reported that they had been placed on room confinement. Four of these seven residents reported that staff had not explained the reasons for the room confinement and that the residents had not been allowed to explain their behaviors.
- Five of the seven residents who had been placed on room confinement stated that their personal property and bedding were removed from their rooms while they were on room confinement.

No other issues of concern were noted from the residents interviewed.

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. The OJSO noted:

- All five interviewees described appropriate amounts of daily recreation time for the residents.
- Two interviewees stated that a resident's personal property and bedding were removed from the resident's room when the resident was on room confinement.
- All five interviewees reported that staff and residents received the same food and the same portions of food at mealtimes and that staff were not served additional helpings of food.

No other issues of concern were noted from the staff members interviewed.

Resident File Review

The OJSO reviewed eighteen resident files. The files were well organized and were complete for the required documentation. The OJSO noted:

- Documentation in the resident files did not indicate the reasons for locking residents in their rooms. The documented lengths of time the residents were locked in their rooms constituted room confinement. Two examples noted were:

    1. A resident was locked in his room for a total of twenty-nine times between September 28 and October 19, 2008. The lengths of time the resident was locked in his room ranged from one hour, fifteen minutes to seventeen hours, thirty minutes. Resident file documentation did not indicate the reasons the resident was locked in his room for any of the twenty-nine times.
    2. Another resident was locked in his room for a total of twenty-five times between September 28 and October 19, 2008. The lengths of time the resident was locked in his room ranged from one hour, fifteen minutes to seventeen hours, thirty minutes. Resident file documentation did not indicate the reasons the resident was locked in his room for any of the twenty-five times.

Room Confinement/Room Restriction Log Review

The OJSO reviewed the room confinement/room restriction logs for July 1 through September 30, 2008. The facility documented one hundred incidents of room confinement for that time frame, which was an increase in the number of incidents of room confinement from the OJSO's previous visit. The facility had documented a total of two hundred instances of room confinement for the first seven months of 2007, compared to the one hundred instances of room confinement for the three-month period in 2008. From the room confinement log, the OJSO noted:

- In four instances of room confinement, the rule violations documented as the reasons for room confinement did not meet criteria for room confinement.
- Documentation indicated that twelve residents were not released from room confinement after they had regained control of their behaviors, had agreed to cooperate with staff, and could safely return to the general population.
- Reviews were not documented as occurring every three hours to assess the residents' behaviors to determine whether or not to continue room confinement. Documentation was vague and inadequate regarding the behaviors of the residents on room confinement or the need for continued room confinement. Examples of reasons for continued room confinement were: Resident was playing with a juice carton, resident was short on words when asked about how he felt, and resident was looking out his window.
- In twenty-six instances of room confinement, the incident reports, observation check sheets, administrative reviews, and disciplinary hearing reports were not properly completed.

Daily Population Report Review

The OJSO reviewed the facility population reports for the period of November 1 through December 9, 2008. During that time frame, the facility's licensed capacity of seventy-nine residents was exceeded on twenty-six days by as many as nineteen juveniles.

Inspection Reports Review

The OJSO reviewed the most current inspection reports by the fire marshal's office and the health department. The deficiencies noted either had been corrected or the facility had submitted a corrective action plan. The OJA reviewed the facility for the time period of April 8 through June 19, 2008. The non-compliance areas listed in the OJA report were:

- Section 9, Facility Tour: The facility was operating in excess of its licensed maximum number of residents. The report noted that the facility had exceeded its "licensed capacity on twenty-nine of thirty five weekdays (work days) from May 1 through June 19, 2008."
- 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 monitoring report continued to be an issue with the facility.

Violations

1. Incident reports, observation check sheets, administrative reviews, and disciplinary hearing reports were incomplete or contained inaccurate information in ten of the eighteen resident files reviewed. OJA policy, OAC 377:3-13-44, Security and Control, (c), (15), Procedure for room confinement or room restriction, (B) and (E), states, "Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented. 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. 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. Juveniles were locked in their rooms in excess of twelve hours per day. 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."

4. Reviews were not documented as occurring every three hours to assess the residents' behaviors to determine whether or not to continue room confinement. Documentation was vague and inadequate regarding the behaviors of the residents on room confinement or the need for continued room confinement. OJA policy, OAC 377:3-13-44, Security and control, (c), (14) Room confinement, (B), in part, 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."
5. Residents and staff reported that a resident's personal property and bedding were removed from the resident's room when the resident was 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."
6. Four of seven residents who had been placed on room confinement stated that the reasons for the confinement had not been explained and that they were not allowed to explain their behaviors. OJA policy, OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (A), states, "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."
7. Documentation indicated that residents placed on room confinement were not released after they had regained control of their behaviors, had 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."
8. Eight of thirteen residents interviewed reported either they had been cursed at by staff or they had witnessed other residents being cursed at by staff. OJA policy, OAC 377:3-13-42, Juvenile rights, (7), (B) and (C), states, "Facility staff shall not discipline a juvenile by using humiliation [or] mental abuse."
9. Nine of thirteen residents interviewed reported and documentation indicated that residents were kept locked in their rooms in excess of two hours each day for reasons other than shift change or rule violations, constituting 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)."

10. The facility continues to exceed its maximum licensed capacity, which forces the facility to double cell the residents. OJA 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."

Recommendation

To the Office of the Oklahoma State Fire Marshal:

1. Conduct an unannounced inspection of the juvenile detention center and establish a system for monitoring the daily population of the facility. Take appropriate action for non-compliance with state law and building codes.

Summary

The OJSO conducted an exit conference with facility administration on January 13, 2009. All areas of concern were discussed with the facility administrator and the administrative staff. According to the facility administrator, the Oklahoma County Juvenile Detention Center is the receiving facility for the juveniles in Oklahoma County who are court-ordered to detention. The facility administrator explained that because other county detention centers are not used for the placement of the juveniles from Oklahoma County who are court-ordered to detention, the Oklahoma County Juvenile Detention Center continues to exceed its licensed capacity. The facility administrator stated that the problem continued after it was addressed with the juvenile docket judges. On April 29, 2008, the OJA OPI placed the Oklahoma County Juvenile Detention Center on a ninety-day provisional license, due to the facility's consistent over-capacity status; in August 2008, the detention center was granted a full license. An OPI representative with whom the OJSO spoke stated that over-capacity had become a chronic problem at the facility. The facility administrator stated that the Office of the Oklahoma State Fire Marshal was aware of the over-capacity problem, as well.

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