

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

Name and Location of Facility: Pittsburg County Regional Juvenile Detention Center
McAlester, Oklahoma

Dates of Visit: August 10 and 11, 2010

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: Announced Visit, 2010

Date: November 10, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an announced visit on August 10 and 11, 2010, to the Pittsburg County Regional Juvenile Detention Center, located in McAlester, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities. The detention center is certified for ten juveniles by the Office of Public Integrity of the Office of Juvenile Affairs (OJA). The OJA contracted with the Pittsburg County Board of Commissioners for regional juvenile detention services, and the Eastern Oklahoma Youth Services, Inc. contracted for the operation of the facility with the Pittsburg County Board of Commissioners. On the day of the OJSO visit, the census was ten.

Interviews Conducted

- Entry interview and an exit conference with the program coordinator
- Three residents
- Two detention staff members

Documents Reviewed

- Case records on six residents
- Facility room confinement log for January 1, 2010, through February 14, 2010
- Facility wing restriction log for January 1, 2010, through August 3, 2010
- OJA annual assessment report regarding a visit on February 18, 2010
- Office of the Oklahoma State Fire Marshal inspection report dated March 15, 2010
- Oklahoma State Department of Health inspection report dated November 19, 2009
- Facility incident reports for January 1, 2010, through August 3, 2010

Findings

Resident Interviews

The OJSO interviewed three residents regarding their perceptions of safety, detention program services, resident rights, discipline practices, and other detention care issues. The OJSO noted the following:

- Two of the three residents reported that once a resident was released from room confinement, they were placed on wing confinement for a period of time to be determined by the superintendent.
- One resident reported a staff member made inappropriate comments about his sexual orientation in front of other residents. This information was confirmed by a staff member.

There were no other concerns regarding the resident interviews.

Staff Interviews

Two detention staff members were interviewed. One staff member confirmed that a staff member had made inappropriate remarks to a resident regarding his sexual orientation. The superintendent stated this incident was addressed with the staff member. The superintendent stated the resident had made inappropriate comments to some of the female residents and the staff member was trying to address that behavior. No other issues of concern were identified from the staff interviews.

Resident File Review

The OJSO reviewed the case records on six residents for compliance with detention certification standards. The OJSO noted:

- The review of incident reports and shift notes located in the resident files documented that residents were placed on room confinement after February 14, 2010. These incidents were not noted on the room confinement log.

No other issues of concern were identified from the resident file reviews.

Personnel File Review

The OJSO did not review personnel files during this assessment. The personnel files and training records are kept at another location and they had been recently reviewed by the Office of Public Integrity (OPI).

Room Confinement Log

The OJSO reviewed the facility's room confinement log for January 1, 2010, through February 14, 2010. The log did not document any uses of room confinement after February 14, 2010. The OJSO noted the following from the room confinement log review:

- The room confinement log was not maintained after February 14, 2010. There were no entries made on the log after February 14, 2010, even though documentation indicated there were twenty-one incidents where residents were placed on room confinement after that date.
- There were eighteen incidents of room confinement that did not meet criteria. Some examples of violations are, "refusing to take medication," "talking too loosely," "acting up," and "cursing."
- Staff did not properly document incidents of room confinement. There were incidents where staff did not complete an incident report, three hour review, or fifteen minute sight check sheet.

- When residents were released from room confinement they were immediately placed on wing restriction rather than being returned to the general population.
- Residents were locked in their rooms on “administrative lockdown” for periods of time that would normally constitute room confinement.
- All residents were locked in their rooms for approximately seventy minutes because of a “medical incident with another resident.” Documentation indicated the only medical incident at that time was a resident who complained of his side hurting.

Wing Restriction Log

The OJSO reviewed the wing restriction log from January 1, 2010, through August 3, 2010. The OJSO noted the following:

- Residents were kept on wing restriction or room restriction in excess of sixty minutes without documentation justifying the extension of time.

Facility Inspection Reports

The OJSO reviewed the most current OJA annual assessment report dated February 18, 2010. OPI cited the facility for minor violations of detention certification standards. The facility submitted a corrective action plan which was accepted by OJA. The OJSO reviewed the latest inspection reports by the Oklahoma State Department of Health dated November 19, 2009, and the Oklahoma State Fire Marshal dated March 15, 2010. There were no deficiencies noted.

Areas of Concern

1. Residents were placed on administrative lockdown without any documentation.
2. Residents were placed on lockdown due to staff shortages.
3. When residents were placed on room restriction or room confinement, staff removed all of their property. This was addressed with the superintendent and it was recommended that the residents be given some form of activity such as reading to occupy their time while on confinement.
4. All residents were locked in their rooms for approximately seventy minutes due to a medical incident involving a resident. Documentation indicated a resident complained of his side hurting and he was allowed to lie on the sofa on the wing.

Violations

1. Twenty-one incidents of room confinement were not documented on the room confinement log. OJA policy, OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (E), states, “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. Documentation indicated that residents placed on wing confinement were kept in their room in excess of the one hour time limit allowed by policy. OJA policy, OAC 377:3-13-44, Security and control, (c), (12), Procedures for separation from general population and/or general activities for disciplinary reasons, in part, states, “The following procedure shall be utilized as an intermediary level of intervention, which requires the continual line of sight

and sound observation of the juvenile. If a juvenile is separated from the general population, the reasons for the separation and length of time shall be documented in the written daily observation of the juvenile. The separation should not be in excess of 60 minutes.”

3. Residents were placed on room confinement without proper documentation. OJA policy, OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (B), states, “Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented” and, (E), states, “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”.
4. Residents were put 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), 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).”

Summary

The OJSO noted that there were incidents of room confinement not documented on the room confinement log and the facility continues to exceed the sixty minute time frame for wing restriction. These problems were addressed in the OJSO’s previous report in 2009. It is concerning that violations found in previous visits continue even though the facilities corrective action plan dated September 30, 2009, stated, “Staff will ensure the reports are placed in the log in a timely manner,” and “the facility will no longer allow wing restriction to exceed sixty minutes.”

The OJSO recognized that the strengths of the facility are the organization and completeness of the resident files and the staff interactions with the residents. All residents interviewed gave positive responses when asked about the staff.