

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

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

**Date of Visit:** August 17, 2009

**Oversight Reviewer:** Dana S. Holden, Oversight Specialist IV

**Subject:** Unannounced Visit, 2009

**Date:** August 31, 2009

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**General Information**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on August 17, 2009, at the Pittsburg County Regional Juvenile Detention Center, located in McAlester, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The detention center was certified for ten juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). The OJA contracted with the Pittsburg County Board of Commissioners for regional juvenile detention services, and 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 eight.

**Persons Interviewed**

- Entry interview and an exit conference with the facility administrator
- Four residents
- Two direct care detention workers

**Documentation Reviewed**

- Four resident case records
- Facility room confinement log for May 1, 2009, through August 2009
- Facility wing restriction log for May 1, 2009, through August 2009
- OJA annual assessment report for April 7, 2009, visit
- Office of the Oklahoma State Fire Marshal report dated February 20, 2009
- Oklahoma State Department of Health Food Inspection report dated June 4, 2009

**Areas Toured**

An observational tour was not conducted during this oversight visit.

## **Findings**

### Interviews

The OJSO interviewed four residents regarding their perceptions of safety, detention program services, resident rights, discipline practices, and other detention care issues. Two interviewees stated that they were not allowed outside for recreation because they had been absent without leave (AWOL) from a facility prior to coming to the detention center. One interviewee reported having been placed on room confinement for threatening staff. Two interviewees reported they had been placed on room confinement for talking about the staff's keys. According to the two interviewees, staff had considered the juveniles' comments about the staff's keys as a security violation. No other issues of concern were identified from the resident interviews.

Two detention workers were interviewed. No issues of concern were identified from the staff interviews.

### File Review

The OJSO reviewed four resident case records for compliance with detention certification standards. Three of the four files reviewed were on the resident interviewees who reported having been assigned room confinement. Two of these three files did not contain incident reports for the events described by the residents that had resulted in room confinement, i.e., threatening staff and talking about staff's keys. Facility staff did provide the OJSO with a copy of a disciplinary action report that indicated the third resident had been placed on room confinement on July 15, 2009, for seventeen hours, because the resident had asked a staff member if a key "went to all the doors". The facility staff were unable to provide documentation pertaining to the other resident who had reported having been involved in a similar incident. No other issues of concern were identified from the resident file review.

The OJSO did not review employee files during this oversight. The personnel files and training records were kept at another location and had been recently reviewed by the OJA OPI.

### Room Confinement Log Review

The OJSO reviewed the facility's room confinement log for May 1, 2009, through August 17, 2009, and noted that the log did not document any uses of room confinement after April 23, 2009. However, the OJSO had noted from the resident file review and the resident interviews that one resident had been placed on room confinement for seventeen hours on July 15, 2009. This incident was not documented in the room confinement log. In addition, the OJSO noted that documentation in a resident's file had indicated the resident had been placed on room confinement on August 8, 2009. This incident also was not documented in the room confinement log.

### Wing Restriction Log Review

The OJSO reviewed the wing restriction log from May 1, 2009, through August 17, 2009. The OJSO noted there were five instances between June 14, 2009, and July 15, 2009, where residents placed on wing confinement were not released after the sixty-minute time limit allowed for separation from the general population. The OJSO noted that the facility's corrective action plan submitted to the OJA on May 20, 2009, had stated, "We will look at our practice of wing confinement or room restriction, and will no longer allow separation to exceed sixty minutes."

### Facility Inspection Reports Review

The OJSO reviewed the most current OJA annual assessment report. The OPI had cited the facility for violations of detention certification standards in Section 3, Institutional Operations; Section 5, Personnel Records; Section 9, Facility Tour; and Section 10, Corrections. The facility had submitted a corrective action plan on May 20, 2009, that was accepted by the OJA.

The OJSO also reviewed the most current inspection reports by the health department and the fire marshal's office. The two reports documented minor deficiencies, which the facility had corrected prior to the OJSO's visit.

### **Summary**

The OJSO discussed its findings with the facility administrator in the exit conference. The facility continues to exceed the sixty-minute time allowance for wing confinement. The facility administrator stated that she believed it was a matter of staff training. The administrator ensured the OJSO that the issue would be addressed with staff members.

Two residents were not allowed outdoor recreation time. According to the facility administrator, she considered the two juveniles to be an escape risk because they had gone AWOL from previous placements. The OJSO commented that documentation reviewed had not indicated that the residents had attempted to escape from the detention center or that the two residents had made any remarks to indicate they posed an escape risk. In addition, according to facility policy and procedures, staff were to be present with the residents during outdoor recreation time. The facility administrator stated that she would review the situation to determine if the residents could be allowed outdoor recreation without creating a safety risk.

### **Areas of Concern**

1. Two residents were not allowed outdoor recreation due to past AWOL history from prior placements.
2. Facility staff did not prepare incident reports for two residents who were placed in room confinement.

## Violations

1. Three 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 sixty-minute 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, 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. . . ."

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