

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Report of a Complaint Investigation
Pottawatomie County Jail

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Introduction

The Office of Juvenile System Oversight (OJSO) received a complaint on September 27, 2007, alleging that a suicide attempt by an incarcerated juvenile was not reported to all of the proper authorities in a timely manner. Specifically, jail personnel did not notify the Office of Juvenile Affairs (OJA) of the custody youth's suicide attempt until two days after the attempted suicide. The OJSO initiated an investigation on October 2, 2007, into the actions of staff in response to the suicide attempt and reviewed the jail's policies and procedures regarding suicide prevention, use-of-force, and restraints. The OJSO returned to the jail on October 3 and October 4 to resume the investigation and concluded the investigation on October 5, 2007. An exit conference was conducted with the facility director on October 16, 2007.

Interviews Conducted

- Facility Director
- Four staff members: three detention officers and a member of the medical unit
- Medical Director
- Two OJA Juvenile Services Unit (JSU) workers
- Four juveniles

Documentation Reviewed

- Six incident reports regarding the suicide attempt
- Files on four juveniles
- Shift notes for September 16 through September 19, 2007
- Jail policies and procedures

Findings

Interviews

The OJSO interviewed three staff members who were present when staff became aware of the suicide attempt. One staff member, who was among the first to respond to the scene, told the OJSO that the towel around the juvenile's neck "wasn't on that tight" and that the staff member believed that the juvenile was "trying to get attention." Another staff member who responded to the scene told the OJSO that the towel appeared "tight around (the juvenile's) neck." It was reported to the OJSO that when the towel was removed from around the juvenile's neck, the juvenile was lying on the floor shaking and "trying to get (his/her) wits about (him/her)."

The three staff members interviewed stated that the juvenile was then placed in the restraint chair, on the authorizing order of the medical director. Each of these three staff members gave a different date and/or time of the juvenile's release from the restraint chair.

The OJSO interviewed three staff members regarding the general operation of the facility. From the staff members' responses, the OJSO noted:

- All three staff members reported that the cameras in the cells that house juveniles allowed jail personnel working the desk to observe the juveniles dressing and toileting.
- One staff member reported that medical treatment provided by the facility for the incarcerated juveniles was allowed only if the juveniles had money in their inmate trust accounts to pay for the services. According to the inmate handbook, inmates were charged \$8.00 for a doctor's visit and \$85.00 for dentist's visit. Incarcerated juveniles in OJA custody were transported by OJA for medical treatment at no cost to the juveniles.
- All three staff members reported that the facility did not provide underwear to incarcerated juveniles, nor were the juveniles allowed to keep their own underwear. In order for the incarcerated juveniles to have underwear, they had to purchase the undergarments from the commissary.
- The facility director and one staff member reported that juveniles housed at the jail were not being provided education services.

The OJSO interviewed the medical director. The medical director stated that she had served in that capacity for the jail and the juvenile detention center for the past two years. When the OJSO asked about her previous work experience with the juvenile population, the medical director stated that prior to hire at this facility, she had not worked in employment that served juveniles. The medical director advised that her medical training consisted of certification as a long-term care aide and a medication aide. She stated that the training she had received regarding suicide recognition and prevention was provided through the facility. According to the medical director, her

duties included preparing and distributing medications and scheduling doctor appointments for the inmates.

The OJSO asked the medical director to describe what took place when staff became aware of the suicide attempt by the incarcerated juvenile on September 16, 2007. From the medical director's statements, the OJSO noted:

- The juvenile attempted to hang himself/herself by tying a towel around the neck.
- The medical director is the only staff person authorized to order a juvenile to be placed in or released from the restraint chair.
- On September 16, 2007, the medical director authorized the staff to place the juvenile in the restraint chair after the suicide attempt.
- The juvenile remained in the restraint chair for approximately sixty hours.
- On September 19, 2007, the medical director authorized the release of the juvenile from the restraint chair; she did not authorize an earlier release because she believed the juvenile would self-harm again.
- An inmate who is placed in a restraint chair is to be released by the detention officers for fifteen minutes every two hours.
- The medical director did not contact the on-call physician at any time regarding the incident.
- The medical director did not attempt to have the juvenile gatekept to establish whether the juvenile was eligible for mental health care.
- The medical director's description of the facility's protocol for when a suicide attempt took place was:
 - Staff, with the approval from the medical director, places the inmate in the padded cell or the restraint chair.
 - The medical director notifies the doctor if there are injuries.
 - The medical director interviews the inmate to determine when it is safe to release the inmate from the padded cell or restraint chair.
- The medical director spoke periodically to the juvenile while the juvenile was in the restraint chair to determine when it would be safe to release the juvenile from the chair.

In addition, the medical director described another incident, in which a juvenile complained of having a rash in the groin area. The medical director stated that she did not schedule the juvenile for an appointment with the facility doctor, and, therefore, the juvenile's caseworker transported the juvenile for medical care. According to the medical director, the doctor who treated the juvenile prescribed an ointment for the rash. The medical director stated that she (medical director) examined the juvenile approximately four different times to ensure the rash was healing.

The medical director advised the OJSO that the facility's medical unit had only three staff members. According to the medical director, none of the three had received specialized training in suicide precaution or intervention, beyond what the facility offered to all of its employees.

The medical director reported that the cells for the juvenile inmates did not have running cold water for approximately two weeks. Jail personnel and JSU workers reported that the juveniles had to get drinking water from the shower. The medical director further reported that the toilet in the room for female juveniles did not flush properly, causing the toilet to clog. The medical director stated that the toilet was clogged for several days, causing a "terrible stench." A staff member of the jail reported that the medical director, on two different occasions, escorted a male trustee to the room to plunge the toilet when maintenance did not respond to the problem.

On two different occasions during the interview with the OJSO, the medical director stated that she was confused and that she was not sure how to treat juveniles who were incarcerated. The medical director also stated that she had only recently become aware that the juvenile's case worker is to be notified of a suicide attempt by the juvenile.

The OJSO interviewed two OJA JSU workers. One described an event when jail staff responsible for monitoring the intercom for the juvenile inmates did not respond to her intercom call. The JSU worker stated that after visiting a juvenile client at the jail, she pushed the intercom button to request to be let off the locked unit. According to the JSU worker, jail staff did not respond to her call. The JSU worker told the OJSO that she made a collect call on a pay phone to her staff at the OJA office and had them call the jail, so she could be let off the locked unit. During the OJSO's interview with the facility director, he spoke of a similar event when his intercom call went unanswered by jail staff and he could not get off the locked unit.

The OJSO asked the two JSU workers questions regarding their observations of the general operation of the facility. From the JSU workers' responses, the OJSO noted:

- Cleaning supplies were not provided on a regular basis for the juveniles to clean their cells.
- Clean bedding was not provided to the juveniles.
- A privacy curtain in the shower had fallen down. Jail personnel, juveniles, and JSU workers reported that the privacy curtain had been down for approximately three weeks. Reportedly, male and female juveniles were able to observe each other showering, and adults entering the facility through the sally port could observe juveniles showering.
- The cells for juvenile inmates did not have running cold water for approximately two weeks. Jail personnel and JSU workers reported that the juveniles had to get drinking water from the shower.

The OJSO interviewed four incarcerated juveniles. When asked about the general operation of the facility, the juveniles expressed some of the same concerns as the staff personnel and JSU workers. The juveniles stated:

- Cleaning supplies were not provided on a regular basis for the juveniles to clean their cells.

- Cameras in the cells that house juveniles allowed jail personnel working the desk to observe the juveniles dressing and toileting. A female juvenile who was interviewed reported that a male staff member came on the intercom while she was dressing and said, "Get dressed. No one wants to see you naked."
- Medical treatment for non-custody youth was allowed only if the incarcerated juveniles had money in their inmate trust accounts to pay for the services.
- A privacy curtain in the shower had fallen down. Jail personnel, juveniles, and JSU workers reported that the privacy curtain had been down for approximately three weeks. Reportedly, male and female juveniles were able to observe each other showering and adults entering the facility through the sally port could observe juveniles showering.
- The toilet in the room for female juveniles did not flush properly, causing the toilet to clog. Jail personnel confirmed that the toilet was clogged for several days, causing a "terrible stench." A staff member of the jail reported that the medical director, on two different occasions, escorted a male trustee to the room to plunge the toilet when maintenance did not respond to the problem.
- The majority of the juveniles interviewed reported they were not allowed to attend school.

Review of Incident Reports

The OJSO reviewed the incident reports prepared by staff regarding the suicide attempt. According to the incident reports, the juvenile attempted to hang himself/herself by tying a towel around his/her neck, and staff members were alerted to the juvenile's attempted suicide by a youth in an adjoining cell. The incident reports stated that when staff members removed the towel from around the juvenile's neck, the juvenile threatened to try to self-harm again. The reports also stated that staff contacted the facility's medical director, who gave authorization for staff to place the juvenile in the restraint chair. One report stated, "The inmate was not to be released from the (restraint) chair by anyone other than (the medical director) on Monday."

Review of the Observation Log

The OJSO reviewed the facility's observation check log for September 16 through September 19, 2007. The OJSO noted:

- Documentation indicated that the juvenile was released from the restraint chair to use the restroom on only three occasions during the timeframe of September 16 through September 18, 2007.
- Documentation did not indicate that staff made visual checks of the juvenile every fifteen minutes, as required by facility policy.
- There was inconsistent documentation regarding the time and date the juvenile was released from the restraint chair.

Review of Facility Policies

The OJSO reviewed jail policy No. 4-1, Use of Force, regarding the guidelines for placing an inmate in a restraint chair. The policy stated, "All subjects who are four pointed should be observed on a continual basis if possible but shall be checked at least every fifteen (15) minutes." The policy did not specify how often an inmate should be released from the chair or the manufacturer's recommendation for duration of time in the chair. The OJSO researched the use of restraint chairs: Manufacturers of restraint chairs recommended that no one should be kept restrained in the chair longer than two hours. The Food and Drug Administration (FDA) issued a letter of warning on July 15, 1992, regarding the use of restraint chairs "because reports of deaths and injuries related to the use of these devices have increased over the last year." The FDA recommended that facilities "allow the use of restraints ONLY under the supervision of a licensed healthcare provider and for a strictly defined period of time."

The OJSO reviewed jail policy No. 11-8-20, Suicide Prevention and Intervention. The policy stated that medical staff at the jail were required to evaluate an inmate within four hours if jail staff believed an inmate was a suicide risk. The policy also stated that medical staff were to make a determination as to what level of intervention was required and what measures were to be taken to ensure the inmate's safety. In addition, the policy stated, "The medical staff conducts facility rounds during which they speak with the inmates previously identified as displaying maladaptive behavior to further assess the inmate's progress."

Observational Tour

The OJSO conducted a tour of the unit that houses juveniles at the jail. The OJSO noted:

- The dayroom flooded when the shower was used. On the day of the tour, a large amount of water had pooled on the dayroom floor.
- The juvenile unit was extremely dirty. Dirt and trash were observed on the floor of the dayroom and in both cells.

Summary

It is concerning that juveniles incarcerated at the Pottawatomie County jail are not being provided medical and dental services as-needed. The jail has a medical doctor that visits the jail and is on-call for emergencies, such as suicide attempts; however, the facility director stated that the facility cannot afford to call the medical doctor regarding every incident. Instead, the facility relies on the judgment of the medical director, who has no formal training in suicide precaution or prevention. Facility staff, incarcerated juveniles, and OJA staff have been led to believe that the medical director is a nurse. One staff introduced the medical director to this investigator as a nurse, and the medical director did not correct the staff member. It is also concerning that the medical director

conducts physical examinations on the juveniles, a procedure that is far above her level of training and expertise.

The OJSO is concerned that the facility used the restraint chair after a juvenile attempted suicide, rather than placing the juvenile under direct observation. Since 1994, across the United States, there have been fifteen documented deaths of people placed in restraint chairs.

Concerns

1. The facility does not issue underwear to the incarcerated juveniles, nor are the juveniles allowed to keep their own undergarments.
2. The cameras in the cells that house juveniles allow personnel, both male and female who are working the desk, to observe the juveniles while they are dressing or toileting.

Violations

1. A juvenile was placed in a restraint chair for approximately sixty hours, contrary to the manufacturer's recommendation for the duration of time in the chair. Oklahoma State Department of Health jail standard OAC 310:670-5-2, Security and control, in part, states, "Instruments of restraint such as handcuffs, leg irons, restraint chairs, restraint beds and straightjackets, shall not be applied longer than authorized by policy and procedure and equipment manufacturers specifications. Prisoners placed in restraints shall not be left without required supervision."
2. Facility staff did not provide the required level of supervision to a juvenile while the juvenile was in the restraint chair. The facility staff did not conduct fifteen-minute-sight checks on the juvenile while the juvenile was restrained. Oklahoma State Department of Health jail standard OAC 310:670-5-2, Security and control, (24), in part, states, "Instruments of restraint such as handcuffs, leg irons, restraint chairs, restraint beds and straightjackets, shall not be applied longer than authorized by policy and procedure and equipment manufacturers specifications. Prisoners placed in restraints shall not be left without required supervision."
3. The facility does not provide the required level of supervision for youth housed on the juvenile unit. An OJA worker was locked on the unit and was unable to get a response from facility staff through the intercom. Oklahoma State Department of Health jail standard OAC 310:670-7-1, Standards for jails holding juvenile offenders, (f), in part, states, "A juvenile prisoner shall be able to communicate with staff members at all times. This can be either by voice or electronic means."
4. The facility houses male and female juvenile inmates on the same unit, which allows for sustained visual contact and verbal communication. Jail personnel, incarcerated juveniles, and JSU workers all stated that the privacy curtain in the shower on the juvenile unit was observed on the floor for approximately three weeks. Without the privacy curtain, juvenile inmates and adults, both male and female, were able to watch a juvenile who was showering. Oklahoma State Department of Health jail

- standard OAC 310:670-5-5, Classification and segregation, (1), states, "Prisoners of opposite sex shall be housed separately. Separation shall be by substantial architectural arrangements which permit no sustained visual contact."
5. The facility allowed untrained staff to conduct medical and mental health screenings of juvenile inmates. Oklahoma State Department of Health jail standard OAC 310:670-5-1, Admission, release and records, (C), in part, states, "The admission process of new prisoners shall include . . . medical/mental health screening by trained facility personnel utilizing a questionnaire approved by the Department of Health, or a screening conducted by a physician or other licensed medical personnel."
 6. The medical director took an adult male trustee into a female juvenile's cell on two different occasions to plunge the clogged toilet. Oklahoma State Department of Health jail standard OAC 310:670-7-1, Standards for jails holding juvenile offenders, (d), in part, states, "An adult prisoner who is assigned trustee status shall not be permitted visual contact with a juvenile prisoner."
 7. The wash basins on the unit for juveniles did not have running cold water for approximately two weeks. The juveniles had to get their drinking water from the shower. Oklahoma State Department of Health jail standard OAC 310:670-5-6, Safety, sanitary and hygiene standards, (18), states, "The potable water supply shall meet all state and local water quality standards. Hot and cold water shall be provided in showers and washbasins."
 8. The facility did not provide cleaning supplies for juvenile inmates to clean their cells. Oklahoma State Department of Health jail standard OAC 310:670-5-6, Safety, sanitary and hygiene standards, (4), states, "Prisoners shall be provided with cleaning materials daily to clean showers, washbasins, and toilets."
 9. The dayroom on the unit for juvenile inmates flooded when the shower on the unit was used. Oklahoma State Department of Health jail standard OAC 310:670-5-6, Safety, sanitary and hygiene standards, (3), states, "Floors shall be kept clean, dry and free of hazardous substances."
 10. Juveniles were not provided with clean bedding on a weekly basis. Oklahoma State Department of Health jail standard OAC 310:670-5-6, Safety, sanitary and hygiene standards, (10), states, "Clean bedding and towels shall be offered at least one (1) time each week."
 11. Juveniles were not provided with clean clothes on a regular basis. Oklahoma State Department of Health jail standard OAC 310:670-5-6, Safety, sanitary and hygiene standards, (9), states, "A prisoner shall be given an opportunity to receive a complete change of clothing at least one (1) time each week."
 12. Incarcerated juveniles were denied services provided by the facility doctor and the facility dentist, if the juveniles did not have sufficient money in their inmate trust accounts to pay for the services. Oklahoma State Department of Health jail standard OAC 310:670-5-8, Medical care and health services, (7), states, "An appointment shall be made with a physician or other licensed medical personnel within forty-eight hours of a valid written request unless more immediate action is dictated by the severity of the current situation."

Title 10 of the Oklahoma Statutes, Section 7303-7.6, Reimbursement for care and maintenance of child and other costs and expenses, in part, states:

A. In any hearing concerning the status of a child, the court, if the court determines the parent is able to pay, shall have authority to adjudge the parent, who has been served with notice of the hearing, liable and accountable for the care and maintenance of any child or children, and to: 2. Pay for the care and maintenance of the child, including, but not limited to, all or some part of placement services, medical care and mental health services, and reasonably monthly expenses, as authorized by law.”

Consequently, 10 O.S. § 7303-7.6 provides a remedy for the jail to recover any costs for medical and dental services provided to juveniles.

13. According to the facility director and one staff member, education services were not provided for the juvenile inmates. Title 10 of the Oklahoma Statutes, Section 7306-3.1, Educational needs during confinement or incarceration, states:

Any child under eighteen (18) year of age who is a legal resident or the child of legal residents of the State of Oklahoma who is detained, held or arrested for any offense pursuant to any provision of the Juvenile Code or Criminal Code of this state, including such persons subject to adult prosecution, youthful offender proceedings, certification as an adult, reverse certification or juvenile proceedings, shall be identified within seventy-two (72) hours of such detention or arrest for educational needs and shall be afforded such educational opportunities by the State Department of Education without delay while in such facility or jail, including city, county and state jails, holding facilities and juvenile or correctional institutions.

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