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

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| **Name and Location of Facility:** | Pottawatomie County Public Safety Center (Carter Hall) Shawnee, Oklahoma |
| **Date of Visit:** | June 17, 2008 |
| **Oversight Reviewer:** | Dana S. Holden, Oversight Specialist |
| **Focus of Visit:** | Unannounced Visit |
| **Date:** | August 21, 2008 |

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## Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on June 17, 2008, at the Pottawatomie County Public Safety Center (Carter Hall), located in Shawnee, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities. The Office of Juvenile Affairs (OJA) contracts with the Pottawatomie County Jail Trust Authority for operation of the detention center. The facility is certified for fourteen residents by the Office of Juvenile Affairs (OJA). On the day of the OJSO visit, the census was thirteen.

Interviews Conducted

- Entry interview with the Acting Commander
- Four residents
- Three direct care staff members
- Medical Director
- Exit conference with the Executive Director, Detention Commander, and Detention Lieutenant

Documents Reviewed

- Personnel files and training records of three direct care staff members
- Files on five residents
- Office of the Oklahoma State Fire Marshal inspection report, dated March 29, 2007
- Oklahoma State Department of Health Food Inspection report, dated May 6, 2008
- OJA Office of Public Integrity (OPI) monitoring report, dated January 8, 2008
- Facility room confinement logs for February 1 through June 10, 2008
- Facility room restriction logs for February 1 through June 10, 2008

- Facility incident reports for residents who were placed on room restriction/confinement
- Facility Policy 4-1, Use of Force

Area Toured

- Outside recreational area and equipment

**Findings**

Interviews

The OJSO interviewed four residents. The interview questions pertained to the residents' perceptions of safety, detention program services, resident rights, discipline practices, and other detention program issues. The OJSO noted:

- Three interviewees stated that when a resident is absent from school because of assigned room confinement, the resident is also assigned room confinement the following weekend for his/her absenteeism from school.
- Two interviewees stated that when security staff members place a resident on suicide watch, the resident is made to remain on a mat placed in the hallway next to the control room.
- Two interviewees stated that a resident on room confinement must admit wrongdoing before release from confinement is allowed.

No other issues were identified from the resident interviews.

Three direct care staff members, the Medical Director, and the Acting Commander were interviewed. The interview questions pertained to the staff members' perceptions of detention program services, resident rights, discipline policies, and other detention program issues. The OJSO noted:

- Three staff reported that when a resident missed school because of room confinement, the resident is placed on room confinement the following weekend.
- The Medical Director reported she had placed a resident on medical isolation and a full liquid diet for two days, without a physician's order. She also stated that the practice at the facility had never been to obtain a physician's order before placing a resident on medical isolation.
- The Acting Commander stated that the facility frequently did not receive legal documentation or transport orders on juveniles placed in custody. While conducting oversight, the OJSO noted that a juvenile was placed in the facility, without proof of legal authority for the placement. The juvenile was scheduled for an appointment at a medical facility that evening; however, the worker had not provided the facility with a transport order. The Acting Commander stated that the OJA worker had stated that it was the facility's responsibility to get the court orders.

No other issues were identified from the staff interviews.

File Reviews

The OJSO reviewed the files on five residents for compliance with OJA standards. The OJSO noted:

- One file did not contain documentation regarding the authorization of medical treatment or requests for medical consent.
- One file did not contain documentation of legal authority to accept and detain the juvenile.
- One file contained documentation to indicate the Medical Director had placed the resident on medical isolation and had ordered a full liquid diet for two days, without authorization from a physician.

No other concerns were noted from the resident files review.

Three personnel files were reviewed for compliance with OJA detention standards. No concerns were noted from the employee files review.

Review of Other Documents

The OJSO reviewed the logs for use of force, room restrictions, and room confinements and the incidents reports for room confinements for the period of March 1 through June 10, 2008.

***Use of Force Log***

- Documentation indicated a resident was placed in the restraint chair for behaving violently. Facility policy and procedures require staff to:

  - conduct a five-minute observation check to determine status of resident's behavior;
  - have the resident evaluated by medical personnel and the counselor; and
  - conduct a safety check every fifteen minutes to ensure feeling and circulation at the points of restraint.

  The use-of-force log did not document the length of time the resident had remained in the restraint chair, the five-minute observation check of the resident's behavior, or evaluations of the resident by medical personnel and the counselor. It is the OJSO's opinion that the facility's current "medical personnel" do not hold the credentials required to conduct medical assessments. Reportedly, the facility had contacted and received authorization from a judge to place the juvenile in the restraint chair; however, facility documentation did not substantiate this information.

- Documentation indicated a resident was restrained for calling a staff member a derogatory name. The incident report stated that the resident called the staff member a “bitch,” after the staff member removed the Bible the resident was reading while on room confinement.

No other concerns were noted from the use-of-force log review.

### *Room Restriction Log*

- Documentation indicated that residents who were placed on room restriction just prior to bedtime were made to complete the room restriction time the next day, even when the resident cooperated with staff and were ready to return to the general population.
- Documentation indicated that a resident was placed on room restriction for one hour, fifty-five minutes. The length of time on room restriction constituted room confinement.

No other issues were noted from the room restriction log review.

### *Room Confinement Log*

The log documented fifty-two incidents of room confinement occurring from March 1 through June 10, 2008.

- Dates and times of release from confinement were not documented.
- Documentation indicated that residents on room confinement, who were absent from school because of the room confinement, were assigned additional room confinement.
- Documentation indicated that residents remained on room confinement for excessive amounts of time, without documentation to indicate how the resident continued to pose as a threat to self, other residents, or the facility. Staff re-authorizing room confinement during three-hour reviews did not adequately document the reason for continued confinement.
- Documentation indicated that residents were placed on room confinement for reasons that did not meet the criteria for room confinement.
    - The two-day room confinement for one resident was based solely on the word of a juvenile who was being discharged from the facility. The juvenile reported that the resident had planned to escape from the facility.
    - Room confinement was assigned because the resident “blew a piece of toilet paper under the door” of his room.
    - Room confinement was assigned for “destruction of property” when staff noticed “a screw was loosened in the light cover (of the resident’s room).”
- Documentation indicated residents remained on room confinement when they refused to admit their guilt in incidents.
- Documentation for room confinement was incomplete or missing from the log or resident files.

***Fire Marshal and Health Department Inspection Reports and OJA Monitoring Report***

The OJSO reviewed the most current inspection reports by the fire marshal's office and the health department. An inspection by the fire marshal's office was overdue. The facility Acting Commander advised that the fire marshal's office had been contacted to schedule an inspection, and that the inspection was scheduled for July 22, 2008. No concerns were noted regarding the health department inspection report.

Violations cited in the most recent OJA Office of Public Integrity (OPI) monitoring report were:

- Section 1, Policy and Procedure: using a "strike system" that did not comply with OJA policy;
- Section 3, Institutional Operations: assigning room confinement for incidents that did not meet criteria;
- Section 7, Juvenile Interviews: not providing outdoor recreation time for residents; and
- Section 9, Facility Tour: inoperable control panel and dangerous basketball court surface.

<u>Observational Tour</u>

The OJSO conducted a tour of the outdoor recreation area. The concrete was cracked and broken in many areas, rendering the area unsafe for the residents. The Acting Commander advised that the facility had made arrangements to have the outdoor recreation area repaired in the near future. Although juveniles were not being afforded outdoor recreation time, the facility was providing recreation indoors.

**Areas of Concern**

1. Juvenile Services Unit (JSU) workers did not provide the facility with the proper documentation that gave the facility legal authority to accept juveniles for admittance and to provide medical treatment.
2. JSU workers scheduled appointments for juveniles but did not provide the facility with transport orders from the court.
3. Residents were kept on room confinement when they refused to admit their guilt or responsibility in an incident.

**Violations**

1. Residents were placed on suicide watch by security staff without documented authorization of the counselor or medical personnel. OJA policy OAC 377:3-13-45 Program and services, (a), (6) Medical and health care, (B), states, "Medical, mental health, and dental care involving medical judgment are the sole province of the designated physician, mental health professional or dentist."

2. One resident file did not contain a medical consent form or authorization to seek medical care. OJA policy OAC 377:3-13-40 Records, (a), (16), in part, states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at the minimum . . . medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent."
3. One resident file did not contain documented legal authority to accept the juvenile for admittance. OJA policy OAC 377:3-13-40 Records, (b), (1), in part, states, "Facility staff shall maintain a confidential record on each juvenile and ensure that the record is safeguarded from unauthorized and improper disclosure. The case record includes, at a minimum . . . documented legal authority to accept juvenile."
4. The "Medical Director" placed a juvenile on medical isolation and a full liquid diet regime without authorization from a qualified medical professional. OJA policy OAC 377:3-13-45 Programs and services, (a), (6) Medical and health care, (B), states, "Medical, mental health, and dental care involving medical judgment are the sole province of the designated physician, mental health professional or dentist."
5. The facility did not properly document an incident regarding a juvenile placed in a restraint chair. Facility Policy 4-1 states, "While resident is in the four/five point restraint (Mobile Humane Restraint Chair) they will be under constant staff visual supervision. The resident will never be left unattended or unsupervised. A five (5) minute observation will be completed by staff for the behaviors exhibited by said resident. In reference to five (5) minute behavior observation, refer to Use of Force Policy and Procedure; residents must be evaluated by medical personnel and counselor after being in the four/five point restraint (Mobile Humane Restraint Chair). A fifteen minute safety check shall be completed by staff for all of the resident's points of restraint. This observation should include a check for feeling and circulation of the juvenile's points of restraint."
6. Staff restrained a resident for calling a staff member a derogatory name, a rule violation that did not meet criteria for use of force. OJA policy OAC 377:3-13-44 Security and control, (c), (8) Physical force, (A), (i)-(iv), states, "Written policy and procedure limit the use of physical force: for self protection; to separate juveniles from fighting; to restrain juveniles in danger of inflicting harm to themselves or others; and to restrain juveniles who have escaped or who are in the process of escaping."
7. Residents remained on room restriction, without staff documenting why it was unsafe to return the juveniles 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. A resident remained on room restriction for one hour, fifty-five minutes; the length of time of the confinement constituted room confinement. OJA policy OAC 377:3-13-44 Security and control, (c), (13) Room restriction, states, "Room restriction is one means of informally resolving minor juvenile misbehavior. It serves a 'cooling off' purpose and has a short time period (up to 60 minutes) that is specified at the time of the assignment."
9. The room confinement log did not document the dates and times the residents were released from confinement. 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 off persons observing the juvenile and times of observation, the person authorizing release, and the time of release.”

10. Residents were placed in room confinement for rule violations that did not meet the criteria for 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; and (iv) to restrain juveniles who have escaped or who are in the process of escaping; (v) 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).”
11. Staff kept residents on room confinement for excessive amounts of time without properly documenting the reason necessitating continued 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.”

**Summary**

The OJSO discussed the OJSO’s findings during the exit conference with the Executive Director, the newly appointed Detention Commander, and the Detention Lieutenant. The lack of proper documentation regarding residents placed on room confinement is concerning.  The OJSO is also concerned that the facility is not receiving the proper documentation from the OJA workers when juveniles are placed at the facility.

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