OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Name and Location of Facility: Pottawatomie County Public Safety Center (Carter Hall)
Shawnee, Oklahoma

Dates of Visit: November 4, and December 3, 2009

Oversight Reviewers: Dana S. Holden and Janice Sharp, Oversight Specialists

Focus of Visit: Unannounced Visit

Date: February 16, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit at the Pottawatomie County Public Safety Center (Carter Hall) on November 4, 2009, and returned on December 3, 2009, to complete the visit. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The Office of Juvenile Affairs (OJA) contracts with the Pottawatomie County Jail Trust Authority for operation of the detention center. The facility was certified by the OJA for fourteen residents. On the day of the OJSO visit, the census was thirteen.

Interviews Conducted

- Entry interview with the Detention Administrator and the Detention Commander
- Four residents
- Two direct care staff members
- One direct care supervisor
- Exit telephone conference with the Detention Administrator on January 7, 2010

Documents Reviewed

- Four resident files
- Personnel files and training records for two direct care staff members
- Personnel file and training record for one direct care supervisor
- Office of the Oklahoma State Fire Marshal report dated April 28, 2009
- Oklahoma State Department of Health Food Inspection report dated September 22, 2009

- OJA Office of Public Integrity (OPI) monitoring report dated March 25, 2009; facility corrective action plan dated April 23, 2009; OPI correspondence dated July 14, 2009, replying to the corrective action plan; facility re-submitted corrective action plan dated August 21, 2009; and OPI correspondence dated September 4, 2009, replying to the re-submitted corrective action plan
- Facility referrals made to the Office of Client Advocacy (OCA) of the Oklahoma Department of Human Services (OKDHS) regarding allegations of caretaker misconduct
- Facility policy No. 13-8-20, Suicide Prevention and Intervention
- Facility suicide prevention observation log
- OJSO report dated August 21, 2008, regarding the oversight visit conducted on June 17, 2008
- Facility list of residents
- Facility staff roster

Area Toured

An observational tour of the facility was not conducted.

Findings

Resident 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:

- All four interviewees reported that they felt safe.
- All four interviewees stated that they had not been physically restrained at the facility.
- All four interviewees reported that they received enough food to eat.
- All four interviewees stated that they did not know of any resident who had been assaulted or mistreated by a staff member; the four interviewees also stated that they had not been cursed at and had not witnessed other residents having been cursed at by staff members.
- Each of the four interviewees made at least one positive comment regarding staff.
- All four interviewees reported that they understood the facility's grievance process; two of the four interviewees stated they had filed at least one grievance. One of these two interviewees reported knowing the outcome of his/her grievances; the other interviewee reported that the timeframe required for the facility to respond had not expired.

No concerns were identified from the resident interviews.

Staff Interviews

Two direct care staff members and a direct care supervisor 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:

- All three interviewees reported that they were certified in first aid, cardiopulmonary resuscitation, and behavioral management techniques.
- Two of the three interviewees reported that they had restrained a resident in the past year; the other interviewee reported not having restrained a resident in the past year.
- All three interviewees stated that the facility had provided staff with written guidelines on the use of force.
- When asked about training they had received regarding suicide prevention, none of the three interviewees reported that they had received ongoing training in suicide prevention and intervention.
- When asked what was the worst punishment a staff member could give a resident for breaking a rule, two interviewees responded "room restriction", one of these two interviewees also stated "room confinement". The other interviewee stated that a resident could receive a "cooling off" period of less than sixty minutes.
- All three interviewees stated that group punishment was not allowed.
- All three interviewees indicated that residents did not receive daily outdoor recreation.
- When asked to name a part of the program that the interviewees believed most benefited the residents, two interviewees named the school program and the other interviewee named the detention program.

No other concerns were identified from the staff interviews.

Resident File Review

The OJSO reviewed four resident files for compliance with OJA standards. The OJSO noted:

- None of the four resident files reviewed documented that the residents received daily outdoor recreation.
- One resident file indicated that the resident was placed on room confinement after the resident had reported to staff that he/she had been "blacking out and passing out." Documentation indicated that the facility medical personnel had informed staff that the resident was "faking." Documentation stated that facility staff placed the resident on room confinement and that no further medical treatment was provided.
- One resident file indicated that a resident was placed on room restriction for passing a note to another resident. The incident report stated that the facility staff had contacted an administrative staff member on-call to advise of the situation. The administrative staff member ordered that the resident be placed on lockdown until

staff could meet with the resident the next day. Documentation indicated that the resident was placed on lockdown from 6:30 p.m. until the next morning.

No other concerns were noted from the resident file review.

Staff File Review

Three personnel files were reviewed for compliance with OJA detention standards. The OJSO noted:

- One personnel file did not document orientation training for the employee.
- One personnel file did not document CPR and first aid training for the employee.
- Two personnel files did not contain current job performance evaluations for the employees.

Criminal History Log Review

The OJSO reviewed the criminal history log for the three employees whose personnel files were reviewed. Documentation indicated that a criminal history background check had been requested from the Oklahoma State Bureau of Investigation and the report received for one of these three employees; the background history report was filed in a separate file than the employee's personnel file. For the other two employees whose files were reviewed, the OJSO did not find documentation to indicate criminal history reports had been received; documentation of a request for a criminal history background check was documented for one of these two employees.

Facility Referral Report Review

The OJSO reviewed the reports the facility had referred to the OKDHS OCA regarding allegations of caretaker misconduct. The OJSO did not note any concerns for the information reviewed.

Visitation Log Review

The OJSO reviewed the visitation log. Documentation did not indicate that the residents were receiving visits by their OJA workers.

Suicide Prevention Observation Log Review

The OJSO reviewed the facility's suicide prevention observation log. The OJSO did not note any concerns for the information reviewed.

Other Inspection Reports Review

The OJSO reviewed the most recent reports by the fire marshal's office, the health department, and the OJA monitoring unit. The fire marshal's office had not cited any

violations; its report documented that the deficiencies and the violations cited from the fire marshal office's previous inspection had been corrected. The health department had cited one violation; the facility provided a copy of a work order to the health department as verification that the process for the repairs had begun. Violations cited in the most recent OJA OPI monitoring report were:

- Section 5, Personnel Records: The pre-employment examinations for two employees were dated after the date of hire, and an employee's file did not contain documentation to verify the education requirement for the employee's position.
- Section 9. Facility Tour: The courtyard perimeter fence needed to be repaired.

The facility submitted a corrective action plan that the OJA accepted, except for the part of the plan regarding an employee's education qualification for a position. The facility re-submitted a corrective action plan regarding the employee's qualification for the position that was accepted by the OJA. The OPI monitoring report documented that the facility had corrected the twelve findings from its last assessment prior to the OJA's most recent assessment.

Area of Concern

1. Documentation did not indicate that the residents were receiving visits from their OJA workers.

Violations

1. Resident files indicated and staff reported that outdoor recreation did not occur daily. OJA policy, OAC 377:3-13-42, Juvenile rights, (5), specifically states that residents "shall have access to on-site recreational opportunities, including daily outdoor exercise, weather permitting."
2. One of the three personnel files reviewed did not document orientation training for the employee. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (A), states, "Each direct-care staff member shall be provided orientation before being allowed to work independently."
3. One of the three personnel files reviewed did not document first aid training for the employee. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (E), in part, states, "Within 90 days of employment, by a detention facility, all direct-care staff shall have successfully completed a specific course of instruction in first aid as established by the Red Cross, American Safety and Health Institute (ASHI), American Heart Association (AHA), and presented by a certified instructor, or by a certified instructor in an equivalent professionally recognized first aid training program."
4. The same personnel file as above did not document CPR certification. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (F), in part, states, "Within 90 days of employment by a detention facility, all direct-care staff shall be certified in [sic] have successfully completed a specific course of

instruction in cardiopulmonary resuscitation (CPR) as established by the Red Cross, American Safety and Health Institute (ASHI), American Heart Association (AHA), or its equivalent. This training must be presented by a certified instructor, or by a certified instructor in an equivalent professionally recognized CPR training program."

5. Two of the three personnel files reviewed did not contain current job performance evaluations for the employees. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (7), Personnel records, (A), (iv), states, "The facility shall keep on file a written personnel record available for review for every staff person employed by the facility. The personnel record includes . . . any reports and notes relating to the individual's employment with the facility and an annual job performance evaluations [sic]."
6. At the time of the OJSO visit, a criminal record background report was not found for two of the three staff members whose criminal record background reports were checked. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (6), Criminal history investigation, states, "The facility shall comply with statutory requirements mandating a criminal history investigation for each applicant for employment [10 O.S. Section 404.1]. The facility shall not employ or retain any person for whom there is documented evidence that the employee would endanger the health, safety, and/or well-being of juveniles."
7. Documentation indicated that two residents were placed in their rooms for more than sixty minutes for reasons that did not meet criteria for room confinement. One resident had allegedly faked a medical condition, and the other had passed a note to another resident. OJA policy, OAC 377:3-13-44, Security and control, (c), (14), Room Confinement, (A), states, "Room confinement means locking a juvenile in his/her room when the juvenile has been charged with a major rule violation requiring confinement for his/her safety or the safety of others or to ensure the security of the facility. 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)."
8. None of the three staff members interviewed reported having received ongoing training in suicide prevention and intervention. Facility policy, 13-8-20, Suicide Prevention and Intervention, states, "Detention center staff identifies suicide-prone residents and closely supervise those identified as such. Ongoing staff training in the implementation of suicide prevention and intervention is required."

Summary

Staff interviewees reported that residents did not receive daily outdoor recreation. The four resident files reviewed did not document that the residents received daily outdoor recreation. The staff members reported that inclement weather and staff shortages were the reasons the residents did not receive daily outdoor recreation time. OJA policy

allows a facility to forego outdoor recreation during inclement weather, but OJA policy does not state that understaffing at a facility is reason not to provide outdoor recreation. The facility needs to ensure that residents receive daily outdoor recreation, weather permitting.

One resident file reviewed indicated that the resident was placed on room confinement after the resident had reported to staff that he/she had fainted. Documentation indicated that the facility medical personnel had informed staff that the resident was "faking." Documentation indicated that no further medical treatment was provided. According to documentation, facility staff placed the resident on room confinement for faking a medical condition.

The OJSO noted that the facility medical staff member who determined that the resident was "faking" did not have formal medical training. In prior OJSO reports, the OJSO has expressed its concerns about non-medical personnel at the facility making determinations of whether medical treatment was needed when a resident reported a potential serious medical problem.

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