

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

Name of Facility: Southwest Oklahoma Juvenile Center

Date of Visit: December 6, 2005

Oversight Team: Ellen Harwell and Tina Pendergraft, Oversight Specialists, and Mark James, Post Adjudication Review Board Coordinator

Subject: Unannounced Visit, 2005

Date: May 25, 2006

Introduction

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit of the Southwest Oklahoma Juvenile Center (SWOJC) on December 6, 2005. The focus of the visit was to assess compliance with established responsibilities and facility policy and procedures.

Persons Interviewed

- Six staff
- Fifteen residents

Documentation Reviewed

- Facility policy and procedures
- Office of Juvenile Affairs Rules
- American Correctional Association (ACA) Standards
- Most recent inspection reports by the Oklahoma State Department of Health, the Division of Child Care of the Department of Human Services, and the Office of the Oklahoma State Fire Marshal
- Five staff files
- Files on five residents

Areas Toured

- Entire facility

Overview

The average age of the interviewees was 16.5. The youngest interviewee was thirteen, and two of the interviewees were fifteen. All reported having been at the facility for a year or less.

Resident Interviews

Fifteen residents were interviewed. All stated:

- they had received a copy of the Resident's Rights upon admission;
- they had received written notification upon admission of policies on visitation, mail, telephone calls, gifts, discipline policies, religious practices, the education program, and grievance procedures.
- the teachers were helpful to the residents.
- they could state the treatment issues listed in their treatment plans.
- they had received dental and medical examinations after arriving at the facility.

The residents' responses to the interview questions indicated:

- Eighty-seven percent (13 of 15) believed they received plenty to eat at mealtime.
- Eighty percent (12 of 15) had received additional servings of food.
- Seventy-three percent (11 of 15) believed that group punishment had occurred at the facility.
- Twenty percent (3 of 15) had been handcuffed for reasons other than to transport.
- Forty percent (6 of 15) had regular meetings with a counselor or therapist.
- Eighty percent (12 of 15) had received treatment for their substance-abusing behaviors.
- Forty percent (6 of 15) had been assaulted by either staff members or other residents.
- Sixty-seven percent (10 of 15) felt safe at the facility.
- There were no reports of sexual assaults occurring while at the facility.

Staff Interviews

Six staff members were interviewed. Their responses to the interview questions indicated:

- Four had received injuries or had witnessed injuries to other staff members or residents during the execution of restraints.
- All believed that group punishment was not used at the facility.
- All believed they were to make reports of suspected abuse to the DHS Office of Client Advocacy, a supervisor, or the proper authorities.
- All believed that residents received an hour of mandatory recreation daily.
- Staff shortage had caused an increased need for twelve-hour work days.

Review of Resident Files

The files on five residents were reviewed. The OJSO noted:

- Two files did not contain immunization records.
- The form documenting the resident's receipt of the Juvenile Handbook included a signature line indicating the information was explained but did not indicate the resident had received a copy of the handbook.
- The initial treatment plans in two files were not developed in the required timeframe.
- All files reviewed lacked documentation that the parents or custodians had participated in the development of the juveniles' treatment plans.
- In the five files reviewed, the signature lines for the individualized treatment plans were signed but not dated by all participants.
- In the five files, the treatment plan reviews did not include parent or guardian signatures.

Review of Staff Files

Five staff files were reviewed. No concerns were noted.

Observational Tour

The OJSO conducted a tour of the facility. The OJSO noted minor cosmetic damage with administrative staff. The following concerns were identified:

North Unit

1. A bottle without a label, containing an unknown chemical, was found on the unit.

East Unit

1. The staff room and the cabinet in the staff room used to store chemicals were unlocked.

Summary

Notable improvements were reported by the residents regarding the food. At the time of the oversight visit in June 2005, seventeen of twenty residents reported not having received additional servings of food. During this visit, the majority of the residents interviewed reported having received enough food and having been given the opportunities for additional servings. The resident interviewees believed that the teachers were helpful, and they were able to identify the issues listed in their treatment plans. All stated that they had received the proper information upon admission and had received medical and dental examinations while at the facility.

Findings

1. Immunization records were not found in two resident files reviewed. Department of Human Services licensing standards, Section 154.3, Health and medical services, (d), Immunizations, states, "Each resident is immunized against communicable diseases in accordance with the rules and regulations of the State Department of Health." Immunization could not be verified without presence of the record.
2. Residents did not sign a statement acknowledging receipt of the Juvenile Handbook. The signature line provided on the form is for the staff member. Facility procedures, No. SW50100.02 I, (A), (1), states, "General orientation will include issuance of the facility's rules, regulations, Juvenile Handbook, and services to include visitation. If the juvenile does not understand English, a staff member will assist the juvenile in understanding the material, either by supplying him with written material or providing translation in their own language. The juvenile will sign that he has received and understands the above."
3. The initial treatment plans for two residents were not completed within twenty-four hours of the residents' admittance. Facility procedures, No. SW50100.02I, (B), states, "An initial treatment plan will be completed by the Psychological Department within 24-hours of admission."
4. Individualized treatment plans that were completed within thirty days of admission did not document participation, or the reasons for lack of participation, by the parents or guardians, nor were the plans signed by the parents or custodians and all the signatures dated, in any of the resident files reviewed. Department of Human Services licensing standards, Section 154, Social services, (b), Service planning, (1), Comprehensive service plan, (A), states, "The facility involves the resident and parents or custodian in the development of the service plan. If the parents or custodian do not participate in the development of the service plan, the reason for non-participation is documented in the service plan." Licensing standards, Section 154, (b), (1), (B), (vi), states that the service plan contains "the names and signatures, with the date, of those participating in developing the service plan."
5. Treatment plan reviews did not document the participation of parents or guardians, or the reasons for the lack of participation, nor were the reviews signed by the custodians or guardians, in any of the resident files reviewed. Department of Human Services licensing standards, Section 154, Social services, (b) Service planning, (2), Service plan review, (B), states, "The facility involves the resident and parents or custodian in the service plan review. If the parents or custodian do no participate in the service plan review, the reason for non-participation is documented in the service plan."
6. Chemicals were found unsecured on one unit. Department of Human Services licensing standards, Section 157, Physical facility and equipment, (j), Sanitation and safety, (1), in part, states, "Other poisonous, flammable, or harmful materials are kept under lock and when not under the supervision of an authorized adult."

EH:js

