

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

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**Name and Location of Facility:** Southwest Oklahoma Juvenile Center  
Manitou, Oklahoma

**Date of Visit:** May 27 and 28, 2008

**Oversight Reviewer:** Ellen Harwell

**Oversight Review Team:** Ellen Harwell and Anthony Kibble,  
Oversight Specialists

**Focus of Visit:** Unannounced Routine Visit

**Date:** August 12, 2008

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### **Introduction**

The Office of Juvenile System Oversight (OSJO) conducted a routine, unannounced visit on May 27 and 28, 2008, of the Southwest Oklahoma Juvenile Center in Manitou, Oklahoma. The facility is a medium secure rehabilitation program for male juveniles adjudicated Delinquent or Youthful Offender who are in the custody of the Office of Juvenile Affairs (OJA). This was a focused oversight that consisted of staff and juvenile interviews and grievances. The facility is licensed for 78 residents. The census the day of the visit was 76.

### **Interviews Conducted**

- Entry conference with administrative staff
- Exit conference with the superintendent and administrative staff
- Twenty-five male residents
- Seven staff members

### **Documents Reviewed**

- Grievance logs for February, March, April 2007
- Office of the Oklahoma State Fire Marshal report dated April 21, 2008
- Oklahoma State Department of Health Food Inspection report dated December 13, 2007
- Oklahoma Department of Human Services (DHS), division of Oklahoma Child Care Services (OCCS) inspection report, May 22, 2008

## Areas Toured

The OJSO did not conduct a tour of the facility during this oversight visit.

## Findings

### Resident Interviews

The OJSO interviewed twenty-five residents. All of the residents were 15 years of age or older. The average age of residents was 17.4. Twenty-four of the 25 residents interviewed were 16 years of age or older. Thirty-six percent (9 of 25) were 18 years of age or older, compared to 31% during the previous oversight visit. Forty-eight percent (12 of 25) reported their county of residence was Oklahoma County, the highest county representation. Reported lengths of stay at the facility ranged from one week to two and a half years. The OJSO noted:

- All residents reported they received a copy of resident rights upon admission. The same number reported receiving written notification of policies regarding visitation, mail, phone calls, gifts, and discipline.
- Eighty percent (20 of 25) reported the information received upon admission was also explained to them.
- All residents reported previous admissions to other facilities. Types of facilities included detention centers, jails, level E group homes, shelters, adventure programs, psychiatric hospitals, Central Oklahoma Juvenile Center (COJC) and the L. E. Rader Center.
- Eighty percent (20 of 25) reported they received enough food.
- Ninety-two percent (23 of 25) reported additional helpings of food were allowed if residents desired them.
- Residents were asked to rate the quality of food on a scale of one to five, with one being the worst and five being the best. Residents' ratings were as follows: 1 – 8%, 2 – 36%, 3 – 44%, 4 – 12%, 5 – 0%.
- Fifty-two percent (13 of 25) reported having been physically restrained within the last six months.
- Fifty-two percent (13 of 25) reported the use of group sanctions within the last six months.
- Twenty-two of twenty-five residents interviewed reported having an individualized treatment plan. Three juveniles were new residents whose comprehensive treatment plan was not yet due.
- Fifteen of the twenty juveniles that had a comprehensive treatment plan reported they participated in the development of the treatment plan.
- All residents with treatment plans were able to recall treatment objectives.
- Sixty-four percent (16 of 25) reported receiving individual counseling.
- Eighty-three percent (19 of 23) reported receiving substance abuse treatment. Two juveniles' substance abuse treatment was not one of their treatment objectives due to history and testing not indicating it was needed.
- Fifty-two percent (13 of 25) reported receiving family counseling.
- Sixty percent (15 of 25) reported receiving Independent Living Skills counseling.

- Twenty percent (5 of 25) reported being required to complete sex offender treatment and stated they have received services.
- Residents were asked how many times a week group sessions or counseling are held. Forty-four percent (11 of 25) reported group is held one to three times per week. Forty-eight percent (12 of 25) reported group is held four to six times per week. Eight percent (2 of 25) reported group is held seven or more times per week.
- Residents were asked who did the majority of the talking in group. Twelve percent (3 of 25) reported staff members did most of the talking. Twenty percent (5 of 25) reported residents did most of the talking. Sixty-four percent (16 of 25) reported both residents and staff members equally spoke. One resident did not respond.
- Sixty-four percent (16 of 25) reported everyone was encouraged to talk in group.
- Ninety-two percent (23 of 25) identified a career goal.
- Sixty-five percent (15 of 23) reported they had shared their career goals with staff members.
- Eighty-four percent (21 of 25) reported having filed a grievance.
- Twenty-percent (5 of 25) reported the grievance process does work. Thirty-six percent (9 of 25) reported the process does not work. Forty-four percent (11 of 25) reported the process sometimes works.
- Forty-eight percent (12 of 25) reported staff members have used curse words when addressing them.
- Fifty-two percent (13 of 25) reported witnessing staff members curse at other residents.

### Supervision

Residents were asked to respond, using a Likert scale, how often direct care staff members check on them while in the dorm area. The options given were Frequently (every 15 to 20 minutes), Occasionally (every 1 to 2 hours), Rarely (every 3 to 4 hours), Very Rarely (every 5 to 6 hours), and Never. Eighty percent (20 of 25) reported staff members check on them frequently. One resident reported staff members rarely check on residents in the dorm area, and one reported staff members never check.

Residents were also asked how often security officers check on the living units. A Likert scale again was used. The options given were Frequently (every 1 to 2 hours), Occasionally (every 3 to 4 hours), Rarely (every 5 to 6 hours), and Never. Eighty-eight percent (22 of 25) reported that security officers check on them frequently. One resident stated occasionally, one stated rarely, and one stated “very rarely”.

### Safety

Residents were asked about physical and sexual assaults and the presence of dangerous contraband at the facility. The OJSO noted:

- Fifty-six percent (14 of 25) reported seeing residents in possession of dangerous contraband. Items included tobacco, lighters, matches, alcohol, pills, mushrooms, money, a needle, tattoo guns, razors, and shanks.

- Forty percent (10 of 25) reported being physically assaulted by other residents.
- Twelve percent (3 of 25) reported being assaulted by staff members. Of the residents that reported physical assaults, the OJSO verified that either a report had been made to the Department of Human Services (DHS) Office of Client Advocacy (OCA) or the OJSO made a report to the OCA.
- All residents denied sexual assaults by peers.
- Twelve percent (3 of 25) reported sexual misconduct by a staff member. All reported the incidents had been reported and investigated.

Residents were asked how often they felt safe at the facility. Using a Likert scale (Very Frequently, Frequently, Occasionally, Rarely, Very Rarely, and Never), the responses were as follows: Very Frequently 28% (7 of 25), Frequently 16% (4 of 25), Occasionally 20% (5 of 25), Rarely 12% (3 of 25), Very Rarely 4% (1 of 25), and Never 16% (4 of 25). One resident did not respond. Residents were asked what contributed to their feeling of safety. The options were staff, facility police officers, peers, or their ability to keep themselves safe (self). Residents could choose more than one and reported the following: Staff 32% (8 of 25); Police Officers 32% (8 of 25); Peers 40% (10 of 25); and Self 68% (17 of 25). One resident reported that nothing would make him feel safe, and one resident reported there was no reason to feel unsafe.

Residents were also asked what contributed to feeling unsafe. Their options were staff members, facility police officers, and peers. Residents could choose more than one. Residents' responses were as follows: Staff 52% (13 of 25); Police Officers 32% (8 of 25); Peers 56% (14 of 25). Five of the 25 youth reported they felt safe at the facility and stated none of the choices listed made them feel unsafe.

### STAFF INTERVIEWS

The OJSO interviewed seven direct care staff members. The interview questions pertained to the staff members' perceptions of the rights of residents, discipline policies, and other residential issues. Length of employment ranged from long term employees to new employees. The OJSO noted the following:

- Staff members were asked about their highest level of education. Four reported having earned a high school diploma. Two staff members reported earning an associate degree, and one reported having earned a bachelor degree. One staff member reported being in the process of earning a GED.
- Five of seven staff members reported prior experience working with juveniles.
- All reported current training in first aid, CPR, and the behavioral intervention technique used by the facility.
- All staff members reported having been involved in a restraint.
- Five of seven staff members reported being injured during a restraint.
- Six of seven reported seeing another staff member injured during a restraint.
- Six of seven reported seeing a resident injured during a restraint.
- Three of seven reported they receive enough information about the residents to provide appropriate care.
- All staff members reported residents may have additional servings of food.

- Six of seven staff members reported that a group of residents cannot be punished when one or some of them break a rule.
- All staff members conveyed an understanding of their duty to report abuse and/or neglect. All staff members reported they could report issues anonymously if needed.
- Two of six reported feeling administrative staff members work well with direct care staff. One did not respond to the question.
- Four of seven reported feeling their input is valued by the administration.
- All staff members reported that recreation is available to the residents two or more times per day.
- Interviewees were asked to classify the morale of staff members as low, medium, or high. Six staff members reported morale was low. One staff member reported morale was medium. Reasons given were a shortage of staff members, not being able to rotate weekends off, low pay, and lack of support from administrative staff members.
- Interviewees were asked to classify the morale of residents as low, medium, or high. One reported morale was low. Five of seven reported the morale of residents as medium. One reported morale was high.

### Safety

Using a Likert scale (Always, Usually, About half the time, Seldom, and Never), staff members were asked if co-workers treated them with respect. Responses were as follows: Always – 2, Usually – 2, About half the time – 2, and Seldom – 1. The same scale was used when staff members were asked if they thought their co-workers were willing to put forth as much effort as necessary to get work done. Four of seven reported usually, and three reported about half the time. Staff members were asked, “Do you feel safe while at work?” One stated always. Two stated usually, and three stated about half the time. One staff member stated seldom. Staff members were asked if they believe the facility is involved in and committed to improving life for the residents. Two stated always, and four stated usually. One reported seldom.

Staff members were asked how often police officers completed checks of the living units. Three stated every hour. Three stated two to three times per shift, and one stated checks rarely occur.

### RESIDENT FILES

The OJSO reviewed eight resident files. The OJSO noted:

- File 1 lacked receipt of the juvenile handbook.
- Files 2, 3, 4, and 6 contained a final treatment plan that did not have a signature by the parent and/or guardian.
- The final treatment plan in File 4 was not signed by the juvenile.
- The treatment plan review deficiencies were as follows:
  - File 2 –Treatment plan reviews for December 2007 and January, February, and March 2008 lacked the signature of the parent/guardian.

- File 3 – Treatment plan reviews for February, March, and April 2008 lacked the signature of the parent/guardian.
- File 4 – Treatment plan reviews for December 2007 and January, February, March, and April 2008 lacked the signature of the parent/guardian.
- File 5 – Treatment plan reviews for December 2007 and January, February, March, and April 2008 lacked the signature of the parent/guardian.
- File 6 – The treatment plan review for March 2008 lacked the signatures of the drug and alcohol treatment coordinator, a school representative, and the recreational therapist. The March and April 2008 reviews were not signed by the parent/guardian.
- File 7 – The treatment plan review for April 2008 was not signed by the parent/guardian.

### GRIEVANCES

The OJSO reviewed grievance logs for February, March, and April 2008. Appealed grievances are assigned to the superintendent as the supervisor. The OJSO noted:

- February 2008
  - A total of 222 grievances were filed.
  - Forty-two percent (93 of 222) did not meet the three-day time frame for resolution.
  - Thirty-seven grievances were appealed to the superintendent.
  - Forty-one percent (15 of 37) of appealed grievances failed to meet the five-day time frame for resolution.
- March 2008
  - A total of 248 grievances were filed.
  - Twenty-four percent (60 of 248) did not meet the three-day time frame for resolution.
  - Thirty-six grievances were appealed to the superintendent.
  - Thirty-one percent (11 of 36) of the appealed grievances failed to meet the five-day time frame for resolution.
- April 2008
  - A total of 153 grievances were filed.
  - Twenty-four percent (37 of 153) did not meet the three-day time frame for resolution.
  - Twenty-eight grievances were appealed to the superintendent.
  - Eighteen percent (5 of 28) of the appealed grievances failed to meet the five-day time frame for resolution.

### CARETAKER CONDUCT REVIEWS

Alleged incidents of caretaker abuse, neglect, and misconduct are reported to the Department of Human Services (DHS) Office of Client Advocacy (OCA). Depending upon the specific allegations, the Office of Client Advocacy may investigate allegation(s) of caretaker misconduct or ask the facility to complete a Caretaker Conduct Review

(CCR). Eight CCRs were reviewed by the OJSO to determine compliance with OAC 340:2-3-33 and OAC 340:2-3-37 sections (c) through (f). None of the reviewed CCRs were submitted to the OCA within 30 days as required by OAC 340:2-3-37 (f). None of the CCRs reviewed contained written statements of witnesses, victims, or caretakers as required by OAC 340:2-3-27(c)(3).

### **Areas of Concern**

1. When asked about what contributed to their sense of safety, the highest percentages of residents' responses were their peers (40%) and their own ability to keep themselves safe (68%) rather than staff members or facility police officers. When asked what contributed to feeling unsafe, the highest percentages were staff members (52%) and peers (56 %).
2. Six of the seven staff members interviewed reported morale was low. One staff member reported morale level was medium. Staff members expressed concern over a shortage of staff members, not being able to rotate weekends off, low pay, and a desire for more support from the administration.
3. Office of Juvenile Affairs policy, OAC 377: 3-1-28, General grievance procedure, (a), Informal grievances, (5), states, "If the grievance is not resolved within (3) three working days, the juvenile may appeal to the supervisor." Of the three months reviewed, 30% (190 of 623) did not meet the initial three-day time frame for resolution. The facility should strive to meet this time frame.
4. CCRs completed by the facility did not meet the 30-day time frame for completion. OAC 340:2-3-37 (f) states, "The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR." Seven of eight CCRs were reviewed and approved by the state office and could have been submitted to the OCA within 30 days. It was reported to the OJSO by the facility that the completed CCR must be sent to the OCA with original signatures. After approval of the CCR by the state office, the CCR is sent back to SWOJC who then mails the completed report to the OCA. This process resulted in the CCR not meeting the 30 day time frame.

### **Violations**

1. One resident file did not contain documentation verifying receipt of the juvenile handbook. Facility procedure SW50100.02 (I)(A)(1) states, "General orientation will include issuance of the facility's rules, regulations, Juvenile Handbook, and services . . . .The juvenile will sign that he has received and understands the above."
2. Four resident files reviewed lacked the signature of the parent or guardian on the comprehensive treatment plan. The treatment plans did not document a reason for the lack of participation. DHS Licensing Standard for Residential Child Care Facilities, OAC:110-3-154(b)(1)(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.” DHS Licensing Standard for Residential Child Care Facilities, OAC:110-3-154(b)(1)(B)(vi), states the service plan contains “the names and signatures, with the date, of those participating in developing the service plan.”

3. One final treatment plan was not signed by the juvenile. Facility procedure SW50200.02 (III)(E) states that the treatment plan is “signed by the staff and by the juvenile.”
4. Six resident files did not contain the parent’s or custodian’s signature on the treatment plan review. DHS Licensing Standard for Residential Child Care Facilities, OAC 110-3-154 (b)(2)(C)(v), states the service plan review includes “the names, and signatures, with the date, of those participating in the review.”
5. One CCR did not meet the 30-day time frame for completion. The facility completed and sent the CCR report to the Office of Juvenile Affairs state office on the 30<sup>th</sup> day which did not allow time for the report to be reviewed and sent to the OCA by the due date. OAC 340:2-3-37 (f) states, “The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR.”
6. None of the CCRs reviewed contained written statements from persons interviewed. OAC 340: 2-3-37 (c)(3) (A) through (D) requires that the CCR report include written statements and interviews with:
  - (A) each alleged victim;
  - (B) each eyewitness;
  - (C) other persons with knowledge relevant to the allegation; and
  - (D) each accused caretaker;

## Summary

In June 2008, the superintendent informed the OJSO a gap had been discovered between the time the superintendent resolves the grievance and the time the Social Services Inspector documents the grievance as being resolved. Because the months reviewed during the current oversight were prior to this discovery and correction, a finding is not being made at this time. Grievances will again be reviewed during the next oversight visit to determine compliance. Although deficiencies were noted in participation and signing of treatment plans and reviews, all treatment plans were current. Progress notes documenting therapies were also current. Even though staff members reported low morale, all expressed a commitment to the youth being served. Staff members were knowledgeable about their duty to report suspected caretaker abuse, neglect and/or mistreatment.