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Identified Report

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Report of a Complaint Investigation
Southwest Oklahoma Juvenile Center
Manitou, Oklahoma

Investigation conducted by Harold Jergenson, Oversight Specialist
Report written by Harold Jergenson, Oversight Specialist

Introduction

The Office of Juvenile System Oversight (OJSO) began an unannounced complaint visit on October 19, 2009, at the Southwest Oklahoma Juvenile Center (SWOJC), located in Manitou. The OJSO resumed the visit on October 20 and 21 and completed the visit on November 5, 2009. The visit was in reference to a complaint received by the OJSO on October 13, 2009, that alleged on August 28 and 29, 2009, a major disturbance occurred after one resident agreed to threaten a second resident in an attempt to get the second resident moved off of the unit. Juvenile Security Officers (JSO) arrived on the unit and removed the resident who had made the threats, which led to the resident who was being removed and seven other residents on the unit to become noncompliant and assaultive toward staff. In response to the major disturbance, staff used zip ties to restrain residents, staff failed to remove the residents off of the unit after they were restrained, and staff left the juveniles in zip ties and then mechanical restraints for an excessive amount of time. During the visit the OJSO also assessed compliance with other established responsibilities pertaining to this type of disturbance. At the time of the alleged incident on August 28, 2009, SWOJC was licensed as a Secure Care Facility by the division of Oklahoma Child Care Services (OCCS) of the Oklahoma Department of Human Services (OKDHS). The facility was licensed for a total of seventy-nine male residents, adjudicated Delinquent or Youthful Offenders in the custody of the Office of Juvenile Affairs (OJA). SWOJC was accredited by the American Correctional Association.

Interviews Conducted

- Entry interview with the deputy superintendent
- Telephone interview with the division administrator of institutional services
- Five employees
- Seven residents (the eighth resident involved in the major disturbance was no longer at the facility)
- Exit conference with the superintendent

Documentation Reviewed

- SWOJC Maintenance Requests dated July 15, 23, 25, 29, August 6, 12, 13, and 14, 2009
- SWOJC Control Room log dated August 28 and 29, 2009
- Stationary video surveillance from 10:00 pm to 11:55 pm on August 28, 2009
- Eight SWOJC Use of Mechanical Restraints logs dated August 28, 2009
- SWOJC Critical/Major/Significant Incident Notification Check List dated August 28, 2009
- Critical Incident Review for Major Disturbance dated August 28, 2009
- Tillman County Sheriff's Office incident report dated August 28, 2009
- SWOJC Use of Physical Force/Debriefing report dated August 28, 2009
- Twenty-two OJA Multipurpose reports dated August 28, 2009
- Eight SWOJC Accident or Incident reports dated August 29, 2009
- State of Oklahoma Claim Jacket Voucher form dated October 27, 2009
- All Staff memo, Subject: Use of Mechanical Restraints dated September 3, 2009
- SWOJC Critical Incident Review narrative relating to events that occurred on August 28, 2009
- Ten personnel training files

Findings

Resident Interviews

The OJSO interviewed seven residents. The interview questions pertained to the residents' perceptions regarding safety, resident rights, discipline practices, mechanical restraints, and other residential program issues. The OJSO noted:

- Six residents reported that they were placed in zip ties by facility staff.
- Three residents reported that staff changed out the resident's zip ties with new zip ties after a couple of hours.
- Six residents reported that staff eventually removed the zip ties and placed them in mechanical restraints.
- One resident reported that he was placed in mechanical restraints while lying on his stomach and then allowed to get up and walk around, until staff removed the mechanical restraints.
- One resident reported that he was placed in mechanical restraints, and then left by the door, while staff left to assist with other residents.

Staff interviews

Five staff members were interviewed. The interview questions pertained to the staff members' perceptions regarding the use of mechanical restraints, zip ties, Care and Custody Management System (CCMS) procedures, discipline policies, and other staff training issues. The OJSO noted:

- Five staff reported that they did not know of any policy allowing for the use of zip ties.

- Five staff reported that they had not been trained in the use of zip ties.
- Three staff reported that two residents were placed in zip ties before the Tillman County Sheriff's Deputies arrived.
- Three staff reported that after the Tillman County Sheriff's Deputies left the facility, at least three of the residents had their zip ties removed and replaced with another set of zip ties.
- Five staff reported that eventually the zip ties were removed from the juveniles and replaced with mechanical restraints.

SWOJC Policy and Procedure Review

The OJSO reviewed the SWOJC Policy and Procedures and found no policy pertaining to the use of zip ties.

Personnel Training File Review

Ten personnel training files were reviewed. The ten personnel training files did not contain documentation that indicated staff had completed any training for the use of zip ties. No concerns were noted regarding the personnel training files.

SWOJC Control Room Log

The OJSO reviewed the SWOJC Control Room log dated August 28 and 29, 2009. The OJSO noted:

- The Control Room log dated August 28, 2009, recorded a signal 10-24 at 2119 (9:19 p.m.); however, based on the timestamp of the facility video surveillance system, the correct time of the signal 10-24 was 2219 (10:19 p.m.).
- The Control Room log failed to document a time that the Tillman County Sheriff's Deputies arrived at the facility, which according to the Tillman County Sheriff's Office Incident report was 2328 (11:28 p.m.).

SWOJC Accident or Incident Reports

The OJSO reviewed eight SWOJC Accident or Incident reports dated August 29, 2009, that were related to the complaint investigation. The OJSO noted:

- Seven Accident or Incident Reports documented the time the residents were seen by medical personnel was between 0020 (12:20 a.m.) and 0220 (2:20 a.m.) on August 29, 2009.
- One Accident or Incident Report documented that a resident was transported to the Tillman County Jail, and therefore was not seen by medical personnel.

SWOJC Use of Physical Force/Debriefing

The OJSO reviewed the SWOJC Use of Physical Force/Debriefing report completed by the Juvenile Security Officer Supervisor (JSOS) dated August 28, 2009. The OJSO noted:

- The summary concluded that when the Tillman County Sheriff's Deputies arrived, SWOJC staff placed the residents in mechanical restraints.

- The summary listed that all of the residents involved in the major disturbance were seen by medical staff between 2109 (9:09 p.m.) and 2117 (9:17 p.m.) on August 28, 2009.

SWOJC Use of Mechanical Restraints Log

The OJSO reviewed eight SWOJC Use of Mechanical Restraints logs dated August 28, 2009. The OJSO noted:

- Eight of the Mechanical Restraint logs documented that the eight residents were placed in restraints at 2119 (9:19 p.m.)
- One Mechanical Restraint log documented that a resident had the restraints removed at 0234 (2:34 a.m.).
- One Mechanical Restraint log documented that a resident had the restraints removed at 0404 (4:04 a.m.).
- Six Mechanical Restraint logs documented that the remaining residents had their restraints removed at 0434 (4:34 a.m.).

OJA Multipurpose Reports

The OJSO reviewed twenty-two OJA Multipurpose reports dated August 28, 2009. The OJSO noted:

- Eleven staff failed to document the “Justification for Use of Force” on their OJA Multipurpose reports.
- Seven staff failed to document the “Purpose of Report” on their OJA Multipurpose reports.
- Eleven OJA Multipurpose reports documented times that were not consistent with the timestamp on the video surveillance tapes.
- One staff’s OJA Multipurpose report documented at least three facts that were not consistent with the video surveillance tapes or other documentation.

SWOJC Critical Incident Review Narrative

The OJSO reviewed the SWOJC Critical Incident Review narrative relating to events that occurred on August 28, 2009. The SWOJC Critical Incident Review narrative noted the time the initial disturbance began was 2215 hours (10:15 p.m.) on August 28, 2009.

Stationary Video Surveillance

The OJSO reviewed the video surveillance from 2200 hours to 2355 hours (10:00 p.m. to 11:55 p.m.) on August 28, 2009. The OJSO noted:

- The video surveillance placed the time of the incident at approximately 2215 hours (10:15 p.m.).
- One resident can be seen walking around the unit, while wearing mechanical restraints.
- Areas in the unit were dark making portions of the incident indiscernible on the video surveillance.

- At least three staff can be seen placing zip ties on residents at the end of the disturbance.

Summary

In response to the alleged incident, the Superintendent issued an all staff memo on September 3, 2009, which further defined the facilities use of mechanical restraints. The memo authorized staff to place mechanical restraints on residents who are being assaultive, residents who have been placed in a prone restraint, and residents who have assaulted another resident or staff, but are no longer out of control. The resident is then to remain in the mechanical restraints until they have calmed down and the situation is under control. The attending staff makes the determination as to whether the resident's behavior is under control.

Areas of Concern

1. Staff failed to employ handheld cameras during the major disturbance, and only used the handheld cameras during one of the eight resident escorts after the major disturbance.
2. The facility had a supply of zip ties in the control room at the time of the major disturbance; however, the facility did not have policy regarding the use of zip ties, nor were any staff trained on the use of zip ties.
3. Although the facility did not have policy pertaining to the use of zip ties, two residents were placed in zip ties by facility staff before the Tillman County Sheriff's Deputies arrived and took control of the facility. Facility policy at the time of the incident referred to the use of hand cuffs.
4. The visual quality of the video surveillance tapes was limited because the lights located in the back of the South Unit's dayroom were turned off during the major disturbance.
5. Three residents and three staff reported that after the Tillman County Sheriff's Deputies left the facility, staff replaced the zip ties on at least three residents, with a new set of zip ties. All staff and residents interviewed reported that after an unknown amount of time, the zip ties were removed and replaced with mechanical restraints.
6. The video surveillance system's clock appeared to be set twenty-seven minutes ahead of the actual time when the major disturbance occurred on August 28, 2009.
7. Written documentation reviewed concerning the major disturbance that occurred on August 28, 2009, contained facts that were not supported by the surveillance video, documented times that were incorrect, and had sections of the documentation that were left blank.

Violations

1. The lights located in the middle of the South Unit's dayroom were not functioning at the time of the major disturbance. OKDHS Licensing Requirements for Residential Child care Facilities, OAC 340:110-3-163, Buildings, utilities, and grounds regulations, (6), Lighting, states, "All areas used by residents are well-lighted."

2. The Control Room log dated August 28, 2009, recorded a signal 10-24 at 2119 (9:19 p.m.); however, the correct time of the signal 10-24 was 2219 (10:19 p.m.). The Control Room log also failed to document the time that the Tillman County Sheriff's Deputies arrived at the facility, which according to the Tillman County Sheriff's Office Incident report was 2328 (11:28 p.m.). SWOJC Procedure SW30100.18, Chapter: Security, Subject: Emergencies, Riots, & Serious Incidents, II, Staff Responsibilities, C, states, "Events are accurately recorded by the control room operator unless relieved as instructed by the Institutional Safety and Security Coordinator."
3. All of the five staff interviewed reported that they did not know of any policy regarding the use of zip ties, nor had they ever been trained in proper use of zip ties. SWOJC Procedure SW30100.11, Chapter: Security Control, Subject: Use of Mechanical Restraints, I, Use of Mechanical Restraints, D, states, in part, "Mechanical restraints will only be employed by trained staff. . . ."
4. Two residents were restrained and placed in mechanical restraints, but were not escorted off the unit for more than an hour. One resident was allowed to get up, still wearing mechanical restraints, and walk around the unit, until staff finally removed the mechanical restraints. SWOJC Procedure SW30100.11, Chapter: Security Control, Subject: Use of Mechanical Restraints, I, Use of Mechanical Restraints, D, states, in part, ". . . The juvenile will be restrained behind his back and escorted to the CMC Building. . . ."
5. According to the SWOJC Use of Mechanical Restraints logs dated August 28, 2009, seven of the residents were left in either zip ties or mechanical restraints for at least five hours; while the eighth resident was transported to the Tillman County Jail. During this time, the seven residents had all been seen by medical personnel and moved to different locations throughout the facility, without any further documented evidence of out of control behavior. SWOJC Procedure SW30100.11, Chapter: Security Control, Subject: Use of Mechanical Restraints, I, Use of Mechanical Restraints, A, states, "Mechanical Restraints may be used on a juvenile that is violently out of control but only as authorized by the Superintendent or Designee. The mechanical restraints will be removed as soon as the juvenile gains control or is confined, whichever occurs first. Under no circumstances will restraints be used as punishment. (3-JTS-3A-16)."
6. At least half of the OJA Multipurpose reports reviewed contained insufficient details and incorrect times documented. One OJA Multipurpose report documented at least three facts that were not consistent with the video surveillance tapes or other documentation. SWOJC Procedure SW30100.01, Chapter: Security Control, Subject: Reports, II, Multi-Purpose Report, A, states, "Any staff member involved either as a participant or witness to a reportable incident shall complete a detailed account of the incident on a Multi-Purpose Report (OJA ISD 32). . . ." Paragraph D, Importance of Content, further states, "This report is a legal document and might be used in court. Staff shall describe the details clearly and print so that every word is easy to read."