

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

Name and Location of Facility: Texas County Juvenile Detention Center
Hooker, Oklahoma

Date of Visit: April 17, 2007

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: Unannounced Visit, 2007

Date: May 17, 2007

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on April 17, 2007, to the Texas County Juvenile Detention Center, located in Hooker, Oklahoma. The purpose of the visit was to monitor compliance with established responsibilities. The detention center was certified by the Office of Juvenile Affairs (OJA) for six juveniles. The OJA contracted with the Texas County Board of Commissioners for the detention center. On the day of the OJSO visit, the detention center had six residents. The facility provided regional detention services to other counties.

Persons Interviewed

- Entry interview and an exit conference with the Detention Director
- Two direct care staff members
- Six residents

Documents Reviewed

- Files on six residents
- Personnel files of two direct care staff members
- Facility grievance log and grievances for 2007
- Room confinement/room restriction logs for 2007
- Most recent inspection reports by the Office of the Oklahoma State Fire Marshal and the Oklahoma State Department of Health

Findings

Interviews

The OJSO interviewed six residents. The interview questions were generally regarding the residents' perception of safety, detention program services, the rights of residents, discipline practices, and other residential care issues. The OJSO noted:

- Most of the six residents stated they had heard a staff member cuss at a resident.
- Most of the six residents stated that staff had refused to give them a grievance form when requested.

The OJSO interviewed two direct care staff members. There were no concerns noted from the staff interviews.

File Reviews

The OJSO reviewed the files on six residents. The files were complete and well-organized, with one exception: The intake form in one file was not filled out completely. The form did not document the medical consent/authority to treat, legal authority to accept, and the resident's religious preference. No other concerns were noted from the resident file reviews.

The personnel files and training records of two direct care staff members were reviewed for compliance with detention certification standards. The files were well-organized, and the materials were easy to locate. The documentation in one file did not indicate the staff member, who had been employed since July 2006, was certified in cardiopulmonary resuscitation (CPR) or had received first aid training. No other issues of concern were noted from the personnel file reviews.

Room Confinement Review

The OJSO reviewed the room confinement logs for January through April 2007. Documentation indicated staff removed the residents' mattresses and bedding from their rooms when residents were placed in room confinement. The facility director stated during the exit conference that the bedding was removed "because that's the way we've always done it."

The OJSO noted that in five incidents of room confinement, the documentation did not match. The times listed on the incident reports, action reports, and fifteen-minute resident check sheets did not coincide. The OJSO also noted that seven incidents of room confinement did not meet standards for room confinement. Examples of the incidents of room confinement that did not meet criteria were:

- January 15, 2007: A resident was placed on room confinement for talking without permission and refusing to “move away.” The action report stated the resident was placed on “room restriction”; however, the fifteen-minute check sheet documented that the resident was kept in his room from 6:00 p.m. until 7:30 p.m., which constituted room confinement.
- January 16, 2007: A resident was placed on room confinement because he refused to participate in the exercise program. The room confinement report did not reflect the time the confinement began or when it ended.
- January 17, 2007: All residents were placed on twenty-four-hour administrative lock down because four residents were “yelling, cussing, and kicking their doors.”
- March 23, 2007: A resident was placed on room confinement from 9:50 a.m. until 7:00 p.m. The incident report stated that a resident was talking and whistling as he walked around the dayroom without permission.
- March 24, 2007: A resident was placed on room confinement from 7:45 p.m. until 9:00 p.m. for becoming upset because staff would not allow her to change the channel on the television. Documentation indicated the resident went to the bathroom without permission, was non-compliant, and was very angry with the staff.

Grievance Procedures Review

The OJSO reviewed the facility’s grievance procedures. The OJSO noted:

- Fifteen of the eighteen grievances reviewed did not have the box marked on the forms to indicate whether the resident wanted to appeal the resolution.
- One grievance alleged unfair treatment by a staff member. The grievance was assigned for resolution to the staff member named in the grievance.
- The resolution for one grievance did not address the issue listed on the grievance.
- The forms of two grievances filed by a resident were marked and signed by the resident to indicate the resident wanted to appeal the resolutions to the OJA State Office. The boxes indicating acceptance of the resolutions were marked with black ink, as was the grievance coordinator’s signature signed in black ink. The resident stated that she did not check the boxes to indicate acceptance of the resolutions and that she wanted to appeal them.
- One grievance did not have a resolution written on the form; however, the form was signed by the resident.
- One grievance filed on February 11, 2007, alleged that a male staff member made improper sexual remarks about a female resident’s breasts. The resolution by the grievance coordinator was, “Talked to (juvenile’s name) about (staff’s name) behavior. Should not happen again.” The OJSO noted that two witnesses to the incident also filed grievances concerning it. The OJSO advised the facility director that he needed to report the incident to the Office of Client Advocacy of the Department of Human Services. The allegation was reported to the OCA on April 18, 2007.
- Twelve of the eighteen grievances filed between January 2007 and April 2007 were concerning the same staff member.

Observational Tour

The OJSO did not conduct a tour of the facility. The facility was recently visited by the Office of the Oklahoma State Fire Marshal and the Oklahoma State Department of Health. Neither of the reports issued cited physical plant violations.

Summary

Personnel files, staff training records, and the files on the residents were substantially in compliance with OJA detention standards, with the exceptions noted. The OJSO has concerns regarding the number of reported incidents of room confinement and the violations noted in the grievance process.

Violations

1. Residents stated that a staff member had cussed at a resident. OJA policy OAC 377:3-13-42, Juvenile rights, (7), (B) and (C), states, "Facility staff shall not discipline a juvenile by using humiliation [or] mental abuse."
2. Grievance forms were not provided to residents when requested. OJA policy OAC 377:3-13-42, Juvenile rights, (3), states, "The facility shall have a written grievance procedure, in accordance with OJA policy and approved by the Advocate General. Facility staff shall explain and make the grievance procedure available to the juvenile."
3. The intake form in the file on one resident did not document the medical consent/authority to treat, legal authority to accept, and religious preference. OJA policy OAC 377:3-13-40, Records, (a), (14) and (16), and (b), (1), in part, states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at a minimum . . . religious preference [and] medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent. The case record includes, at a minimum . . . when and where applicable, documented legal authority to accept juvenile."
4. First aid training and CPR certification was not documented for one staff member who had been employed at the facility since July 2006. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (E), and (F), states, "Within 90 days after employment, all direct-care staff shall have successfully completed first aid training . . . First aid training is updated every three years . . . All direct-care staff shall be certified in cardiopulmonary resuscitation (CPR) within 90 days after employment and recertified annually."
5. Residents placed in room confinement were not provided with bedding and mattresses during their confinement. OJA policy OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (C), states, "Juveniles placed in room confinement shall be afforded living conditions and essential services approximating those available to the general juvenile population."

6. The logs regarding room confinement were not documented accurately. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (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 of persons observing the juvenile and times of observation, the person authorizing release, and the time of release."
7. Residents were assigned to room confinement for incidents that did not meet criteria. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), in part, 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;
 - (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) 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).

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