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	Texas County Juvenile Detention Center Hooker, Oklahoma
	October 17 and 23, 2006
	Dana S. Holden, Oversight Specialist
	Unannounced Visit, 2006
	January 9, 2007

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The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on October 17 and 23, 2006, to the Texas County Juvenile Detention Center, located in Hooker, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The facility was certified by the Office of Juvenile Affairs (OJA) for six residents. The OJA contracted with the Texas County Board of Commissioners for management of the detention center. The facility provides regional detention services to other counties. On the days the OJSO visited the facility, the census was six.

#### Persons Interviewed

- Entry interview and an exit conference with the facility Director
- Four residents
- Five direct care staff members

#### Documentation Reviewed

- Files on four residents
- Personnel files of two direct care staff members
- Training records of five staff members for 2005 and 2006
- Facility grievance log and seven grievances
- Most recent inspection reports by the Office of the Oklahoma State Fire Marshal and the Oklahoma State Department of Health
- Inspection report of June 15, 2006, by the Division of Child Care of the Department of Human Services (DHS)

## Areas Toured

- Entire facility



## Interviews

The OJSO interviewed four residents. The interview questions pertained to the residents' perceptions of safety, detention program services, the rights of residents, discipline practices, and other residential care issues. Comments included:

- R-rated movies were brought into the facility by a staff member and the residents were allowed to view the movies. Reportedly, the movies contained scenes of graphic violence, sexuality, and the depiction of child sexual abuse.
- Medical care was not provided in a timely manner to a resident who was injured playing a sport.

Five direct care staff members were interviewed. The interview questions pertained to the staff members' perceptions of program services, the rights of residents, discipline policies, and other residential program issues. Comments included:

- New employees were not provided formal orientation training prior to working with the residents. Reportedly, orientation training consisted of the employee reading the policy and procedures manual for "a couple of days," after which, the employee was allowed to provide care to the residents.
- Direct care staff members did not receive adequate training.
- A staff member was allowed to bring R-rated movies into the facility for the residents to view.

## File Reviews

The OJSO reviewed the files on four residents. The files were well-organized and complete for the items reviewed. No concerns were noted from the file reviews.

Two personnel files and the training records of five direct care staff members were reviewed for compliance with detention certification standards. The personnel files were well-organized and the materials were easy to locate. Four of the five training records indicated orientation training was not completed by the employees prior to working with the residents.

## Grievances

The OJSO reviewed the facility's grievance log and seven grievances. The OJA Office of Public Integrity had conducted an assessment of the facility's grievance procedures during its monitoring visit on June 15, 2006, and had cited the facility for noncompliance of OJA policy regarding the maintaining of the grievance log. The OJA reported that the last entry in the log was on November 25, 2004. The facility submitted a corrective action plan to the OJA.

The OJSO reviewed the seven grievances that had been filed by residents since June 15, 2006. The OJSO noted:

- The names of the persons assigned to resolve the grievances and the due dates for the resolutions were not documented.
- Documentation did not indicate whether or not the resolutions were accepted by the residents in two grievances.
- Documentation did not indicate an allegation of the assault of a resident by a staff member was reported to the DHS Office of Child Advocacy.

## Observational Tour

The OJSO conducted a tour of the facility for compliance with standards related to safety, security, quality of life, and other items. The OJSO noted:

- The food menus were not approved according to OJA policy.
- Broken window panes were observed in Rooms 4 and 5.

The OJA monitoring report of June 15, 2006, also cited deficiencies in the areas of personnel records, administrative requirements, the facility tour, and continuing deficiencies that were cited in the OJA monitoring assessment of June 3, 2005. Plans for corrective action of the deficiencies were submitted to the OJA.



In the past six months, two residents have gone absent without leave (AWOL) from the facility. (The OJSO reported the information regarding the AWOLs to the DHS Office of Client Advocacy). On the day of the OJSO visit, residents were observed in the day room yelling at each other and laughing loudly to the point of distraction. Staff members standing in the dayroom did not attempt to intervene. Staff and residents both reported that a staff member was allowed to bring R-rated movies into the facility for the residents to view. Staff members interviewed expressed concern regarding the quality of training provided to direct care staff.

5

1. Formal orientation training was not provided to new employees prior to providing care to the residents. Office of Juvenile Affairs 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."
2. Reportedly, a staff member was allowed to bring inappropriate movies into the facility for the residents to view. Office of Juvenile Affairs policy OAC 377:10-1-15, Use of audio/video equipment for recreational or programmatic activities in OJA-operated and contract facilities, (a), (1), Content of material, (A), states, "The facility may show those movies rated G, PG, or PG-13 by the Motion Picture Association of America. . . ."
3. The grievance log did not document who the grievances were assigned to for resolution, nor the due dates. Office of Juvenile Affairs policy OAC 377:3-1-28, General grievance procedure, (a), Informal grievances, (3), states, "The grievance must be numbered and logged in a grievance log on the day the grievance is received and distributed to the appropriate staff for processing and possible resolution."
4. An allegation of the assault of a resident by a staff member was not documented as having been reported to the OJA or the DHS Office of Client Advocacy. Office of Juvenile Affairs policy OAC 377:3-1-25, Abuse, neglect, and caretaker misconduct, (a), Requirements for reporting incidents of abuse, neglect, or caretaker misconduct, in part, states, "State law requires every person with reason to believe that a child or juvenile is or has been abused or neglected to report the condition or incident to the appropriate office for investigation. Title 10 § 7004-3.4(B)(2) confers on OCA the responsibility of investigating allegations of caretaker abuse and neglect of juveniles, regardless of custody, residing outside their own homes, other than the foster care level."

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