

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

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**Name and Location of Facility:** Tulsa County Juvenile Detention Center  
Tulsa, Oklahoma

**Dates of Visit:** June 27 and 28, 2006, and February 6 and 7, 2007

**Oversight Reviewers:** Cliff A. Aldridge, Oversight Specialist, (both visits) and  
Kristal Nicholson, Trainer/Consultant, of the National  
Resource Center for Youth Services (NRCYS) of the  
University of Oklahoma (June 2006 visit)

**Subject:** Unannounced Oversight Visit, 2006

**Date:** May 17, 2007

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit to the Tulsa County Juvenile Detention Center on June 27 and 28, 2006. The OJSO returned unannounced to the facility on February 6 and 7, 2007, to complete the visit. The purpose of the visit was to assess compliance with established responsibilities.

The center was certified by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA) for fifty-five juveniles. On the days of the OJSO visit, the census was fifty. The OJA contracted with the Tulsa County Board of Commissioners for juvenile detention services. The detention center was operated by the Tulsa County Juvenile Bureau of the District Court. The OJSO met with the administrative team and conducted an exit conference on May 8, 2007.

### **Persons Interviewed**

- Entry interview with the Program Manager, the Accreditation Manager, and the Assistant Superintendent on the first day of the visit
- Ten residents
- Four detention counselors (direct care staff)
- Exit debriefing with the Superintendent and the Program Manager at the end of the first two days of the visit
- Entry conference with the Program Manager at the beginning of the second two days of the visit
- Subsequent brief conference with the Superintendent during the second visit

- Informal conversations with each of the two day shift supervisors
- The OJSO interacted with the OPI team during the course of their visit on June 27, 2006
- Subsequent telephone conversation with the Superintendent
- Exit conference with the administrative team on May 8, 2007

### Documents Reviewed

- Case records on four residents
- Personnel and training files of four detention counselors
- Facility Disciplinary Guidelines
- Facility room confinement log for November and December 2006 and January 2007
- Sample of four incident reports of room confinement during January 2007
- OJA annual assessment report, dated September 14, 2006, of a visit on June 27, 2006, and the facility Corrective Action Plan, dated October 10, 2006
- Office of the Oklahoma State Fire Marshal inspection report of October 17, 2006
- Oklahoma State Department of Health inspection report of January 18, 2007
- Tulsa County Juvenile Detention Home 2006 Resident Grievance Report

### Areas Toured

- Dayrooms
- Sample of sleeping rooms
- Outside secure recreational area
- Kitchen and dining room

### **Findings**

#### Interviews

Ten residents, two females and eight males, were interviewed relative to their perceptions of safety, detention program services, residents' rights, discipline practices, and other detention care issues. Most of the responses were favorable about the program, staff, and the services received by the residents; however, some themes of concern were identified during the resident interviews. The concerns included:

- Two residents said the water in the drinking fountains was hot.
- Two residents who had been confined to their rooms said they were not given a reason for the room confinement.
- Three residents who had been confined to their rooms said they were not given a chance to explain their behaviors.
- Six residents said they had been locked in their rooms; two of them reported being locked down for seventy-two hours.
- Six residents indicated they had been threatened with room confinement.

- When asked about recreation, only five residents reported participating in outside recreation; the most frequent outside recreation reported was twice per week.
- Six residents noted the use of group punishment.
- Five residents complained about staff, including rudeness, yelling, threats, favoritism, and not doing things they said they would do.
- Four residents said the staff cussed; although, the remaining six youth said staff did not cuss at the residents.

One resident interviewed by both the OPI and the OJSO reported being placed in a choke hold during a restraint. The OPI reported the incident to the Office of Client Advocacy of the Department of Human Services.

Four detention counselors, representing both detention units and the morning and afternoon shifts, were interviewed relative to their training and the facility's practices. The tenure of the staff interviewed ranged from almost two years to nine years. All four demonstrated familiarity with facility procedures and reported having received required training. No concerns were identified from the staff interviews.

The assistant superintendent was interviewed relative to the facility's physical restraint and mechanical restraint practices. Overall, the interview responses were compatible with the facility's written policy. The OJSO recommended training be added to the facility's mechanical restraint policy to ensure: (1) mechanical restraints were only applied by trained staff in a humane manner that did not restrict blood circulation; and (2) prohibition of restraining a resident to an immovable object. The OJSO also recommended that staff receive written guidelines on the use-of-force, in addition to that received during behavior intervention training. The assistant superintendent listed a range of interventions used to avoid the use of mechanical or physical restraint. Both policy and practices appeared to be in compliance with the OJA detention standards.

The NRCYS Trainer/Consultant provided information on staff training opportunities to administrative and supervisory personnel during the course of the first day of the oversight visit. She advised the administration that onsite training at the facility was available, in addition to the scheduled workshops for staff.

The OJSO was told during the visit that the facility was no longer accredited by the American Correctional Association (ACA). The superintendent reported during a subsequent telephone conversation that two years of a three-year-accreditation cycle were missed because of budget issues, but that there was a new contract with the ACA pending signatures by the Tulsa County Board of Commissioners.

The superintendent reported that the rate of staff turnover was severe. Although the majority of direct care staff had worked for several years, many of the newer employees tended to leave their employment after only a few months, resulting in a high overall turnover rate. The high staff turnover was partially to blame for training deficiencies,

documentation errors, and possible misuse of disciplinary sanctions. The administrative team indicated difficulties in providing detention programming for a delinquent population, while also housing children with significant mental health issues.

### Documentation Reviews

The OJSO reviewed four resident case records for compliance with detention certification standards. A small number of minor errors were observed, such as blanks, illegible entries, or errors. The medical history questionnaire on a carbonless form was unreadable in one of the files. The files reviewed reflected notification to the residents of the availability of the resident grievance procedure; however, the OJSO recommended a separate grievance notification form.

The personnel files of four detention counselors were reviewed for key items from the OJA detention certification standards. All four files were complete for employment requirements; however, training deficiencies were noted in all four files. One staff member had only seventeen of the required twenty-four hours of training for 2005 and had received only six hours for 2006 as of the June review. Cardiopulmonary resuscitation (CPR) certification had expired for another staff member. Another training file documented current CPR training but not current first aid training. The fourth file reviewed did not document first aid or CPR training. The OPI report noted similar findings, and the facility had written a corrective action plan to address the training issues.

The OJA annual assessment report requested corrective action plans in the areas of institutional operations, personnel records, and physical plant maintenance. The institutional operations findings were for the use of room confinement that did not meet the criteria for the use of room confinement and for documentation of a resident's release from room confinement. The OPI findings in personnel records pertained to staff training requirements that were not met. Other OPI findings included several physical plant deficiencies.

The facility's Corrective Action Plan to the OJA addressed actions, training, and internal oversight to prevent the misuse of room confinement and to improve the documentation of a resident's release from room confinement. The plan also addressed efforts to ensure that all staff members receive the required training. The facility's response to the OPI report included documentation of repairs and submission of work orders.

The Oklahoma State Department of Health's inspection report noted only that a food chiller was at 42 degrees. The Office of the Oklahoma State Fire Marshal's inspection report cited one minor violation that had been documented as corrected.

The grievance report for calendar year 2006 was reviewed. Fifty-six grievances had been filed during the year. All of the grievances were logged as resolved. The facility used numbered grievances.

Some issues were identified from the review of the facility's Disciplinary Guidelines. Although the policy emphasized a progression of interventions to be used by staff to manage resident misbehavior, some of the behaviors or misbehaviors were assigned a range of hours of room confinement to be used for disciplinary measures. Room confinement is to be used when the juvenile has been charged with a major rule violation, requiring confinement for his/her safety or the safety of others or to ensure the security of the facility. The standards require that juveniles "shall be released when staff determines that he or she can safely be returned to the group." The imposition of a specified number of hours of room confinement at the time of the behavior presupposes when a resident can safely be returned to the group.

Additionally, several of the behavior violations, such as writing names/graffiti on walls or property, damage to or loss of library books, minor contraband, making marks on their bodies, or receiving cigarettes by deception, listed in the policy as subject to the use of room confinement do not meet the OJA criteria for the use of room confinement. The criteria that must be met for the use of room confinement are, "(A) 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)." The OJSO is concerned that the policy conflicts with the OJA standards and is subject to misuse by staff. The OJSO recommends that the Disciplinary Guidelines be revised to reflect the necessary criteria that must be met for the imposition of room confinement.

According to the restraints log, there were thirty-seven instances of the use of physical restraint from November 2006 through January 2007. Room confinement was also imposed in thirty-four of those instances. Mechanical restraints were used in six of the incidents. A total of sixty-four instances of room confinement were documented in January 2007.

Four of the instances of physical restraint and the use of room confinement during January 2007 were reviewed. The documentation included an incident report, a disciplinary report, and a disciplinary hearing committee record for each of the incidents. Noncompliance with the OJA detention standards was documented in the materials reviewed in all four instances. Some items required to be documented were missing. Behavioral descriptions in all four instances tended to establish that the criteria for room confinement were met, although in one instance, the staff member completing the form indicated that the behavior was not a major rule violation.

- Detention standards require that facility staff explain the reasons for confinement to the juvenile and give the juvenile an opportunity to explain his or her behavior prior to room confinement. The staff signatures documented the reasons for confinement and the opportunity for the juveniles to explain their behaviors at the time of release from,

instead of prior to, room confinement in all four instances. In two instances, the resident signatures also documented the explanation and opportunity after the confinement. In the other two instances, one was dated but not signed by the resident, and the other was signed but not dated.

- As noted above, detention residents are required to be released from room confinement when the staff determines it is safe to do so; however, in all four instances reviewed, forty-eight hours was imposed at the time of room confinement, and all four residents were confined for forty-eight hours to document violations of the detention standards.
- In all four of the instances reviewed, the juveniles were in room confinement in excess of twenty-four hours without the opportunity of an administrative review by the administrator or designee who was not involved in the incident. In one of the incidents, the administrative review was documented five days after the resident was placed in room confinement.
- In two of the instances, the name of the person authorizing release from room confinement was not recorded.
- None of the disciplinary hearing records had been reviewed by the facility administrator.

### Observational Tour

The facility was briefly toured, because the OPI had conducted an extensive tour of the facility on the first day of the OJSO visit. Eight residents were on suicide alert and were in the general population. Three residents were on room confinement on B unit. Overall, the facility was clean and well-maintained. The OJSO noticed a hole in the top of a half wall of the shower in the female wing of the facility, graffiti was observed on painted window frames, and paint was peeling in spots from the impact resistant window panes of the shower walls. The water in the B unit dayroom drinking fountain was warm. The room temperature on B unit was warm during the tour, and the OJSO was advised that a part was on order to repair the cooling unit. Materials required to be posted were posted in both dayrooms, in areas accessible to the residents. Emergency procedures and equipment were in place. The facility appeared to be secure.

### **Summary**

The Tulsa County Juvenile Detention Center is a large facility that houses juveniles adjudicated for or charged with serious delinquent offenses. Overall, the facility staff appeared to respond quickly to physical plant issues. Deficiencies noted in the OPI report were addressed in the facility's Corrective Action Plan. The OJSO noted similar findings in the use of room confinement and staff training. The OJSO made a number of informal recommendations that represented refinements in practice, rather than violations of standards. Those recommendations included posting the name of the grievance coordinator with the other posted grievance materials, providing a separate notification to residents of the grievance process, adding clarifying language to the use of force/mechanical restraint policy, and the establishment of a de-briefing committee to review incidents of physical restraint.

Staff training deficiencies were identified both by the OPI and the OJSO. The facility's

corrective plan to the OPI included actions to correct the training deficiencies. The OJSO will closely monitor the effectiveness of the corrective actions during future oversight visits.

## Violations

1. The facility's disciplinary policy authorized the use of room confinement for behavioral violations that did not meet the detention standards criteria for the use of room confinement. The OJA detention certification standard OAC 377: 3-13-44, (c), (14), states, "(A) 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)."
2. The facility's disciplinary policy permitted the imposition of a specified number of hours of room confinement (24-48) which is contradictory to the detention certification standard OAC 377: 3-13-44, (15), (D), that requires, "The juvenile shall be released when staff determines that he or she can safely be returned to the group."
3. The facility's documentation of the use of room confinement was incomplete in each of the four incidents reviewed, according to the OJA detention certification standard OAC 377: 3-13-44, (15), (E), "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."
4. In each of the four instances of the use of room confinement, the staff did not explain the reasons for confinement to the juvenile or give the juvenile an opportunity to explain his or her behavior prior to room confinement. The OJA detention certification standard OAC 377: 3-13-44, (15), (A), states, "Prior to room restriction or confinement, facility staff shall explain the reasons for the restriction or confinement to the juvenile and shall give the juvenile an opportunity to explain his or her behavior."
5. The interview responses indicated that the residents were not receiving daily outdoor exercise. The detention certification standard OAC 377:3-13-42, (5), states, "A juvenile shall have access to on-site recreational opportunities, including daily outdoor exercise, weather permitting. The facility shall provide adequate and appropriate recreational equipment."

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