

**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:** August 28-30 and September 6, 2007

**Oversight Reviewer:** Dana S. Holden, Oversight Specialist

**Subject:** Unannounced Visit, 2007

**Date:** October 16, 2007

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on August 28, 2007, at the Tulsa County Juvenile Detention Center, located in Tulsa. The OJSO returned on August 29 and 30, 2007, to resume the oversight. The visit was completed on September 6, 2007. The purpose of the oversight was to assess compliance with established responsibilities.

The facility was certified by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA) for fifty-five juveniles. 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. On the days of the OJSO visit, the census was fifty-five.

### Persons Interviewed

- Entry interview with the Program Manager and the Assistant Superintendent on August 28, 2007
- Fourteen residents
- Six detention counselors (direct care staff)
- Exit conference with the administrative team on September 26, 2007

### Documents Reviewed

- Case records on sixteen residents
- Personnel files and training records for thirteen detention counselors
- Facility Disciplinary Guidelines
- Grievance log for January through August 2007

- Facility room confinement log for January through August 2007
- OJA annual assessment report of May 15 and 16, 2007, and the facility's Corrective Action Plan, dated July 17, 2007
- Office of the State Fire Marshal inspection report of April 27, 2007
- Oklahoma State Department of Health inspection report of May 16, 2007
- Facility Use of Force report from January through August 2007

### Areas Toured

- Kitchen and dining area

### **Findings**

#### Interviews

The OJSO conducted an entry interview with the Program Manager and the Assistant Superintendent on the first day of the visit. The protocol for the oversight visit was discussed, along with concerns regarding the facility.

Fourteen residents 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. The concerns identified from the resident interviews were:

- Nine of the fourteen residents interviewed had been placed on room confinement; four of the nine stated they were not given reasons for the room confinement, and five stated they were not allowed to explain their actions.
- Six of the fourteen residents interviewed rated the quality of the food as poor and five rated the food as fair.
- Four of the fourteen residents interviewed rated the quantity of the food served as poor and eight rated the quantity of food as fair.

The OJSO interviewed six detention counselors. The interview questions pertained to training and the facility's practices. The OJSO noted:

- Three of the six staff interviewed rated the quality of the food as poor and two rated the quality as fair.
- Five staff reported frequently finding hair in the food served, one reported finding fingernails, and three reported finding bugs.
- Two of the six staff interviewed rated the quantity of food served as poor and one rated the quantity as fair; two interviewees stated that the servings were larger for staff than for residents.
- Four of the six staff interviewed rated the morale of staff as low. The low morale was attributed to a shortage of staff at the facility and a lack of support from administration.

## File Reviews

The OJSO reviewed the case records on sixteen residents for compliance with detention certification standards. The OJSO noted:

- One of the sixteen files reviewed did not contain documentation of consent to provide medical treatment/authority to treat.
- Two of the files reviewed did not contain documentation of legal authority to admit.

No other concerns were noted from the resident files reviewed.

The personnel files and training records of thirteen detention counselors were reviewed for compliance with detention certification standards. The OJSO noted:

- Seven of the thirteen staff files reviewed did not document current cardiopulmonary resuscitation (CPR) certification.
- Three of the staff files reviewed did not document current first aid training.
- One of the staff files reviewed did not contain documentation of the three required references.

## Review of Grievances and the Grievance Log

The OJSO reviewed the grievance log for January through August 2007. The OJSO noted:

- The three-ring binder used to file the grievances of 2006 contained some 2007 grievances.
- The binder containing the grievances for 2007 was disorganized (i.e., the grievances in January were located in the middle of the book, and the grievances in May and July were located in the back of the book).
- Documentation indicated one resident filed four grievances that were never addressed; the grievances were found in the back of the grievance book.
- Some of the 2007 grievances were entered on the grievance log sheet for 2006.

## Review of the Room Confinement Log

The OJSO reviewed the facility room confinement log for January through August 2007. The facility recorded 391 incidents of room confinement during the timeframe. The OJSO noted:

- Criteria for room confinement were not met in 169 of the 391 incidents.
- Documentation regarding 33 of the 391 incidents of room confinement either was recorded inaccurately (date and time of the confinement) or was missing.
- Documentation indicated a predetermined amount of time was imposed in 36 of the 391 incidents of room confinement.

- Documentation regarding eight incidents of room confinement did not indicate that the residents were given the reasons for the confinement or that the residents were allowed to explain their actions prior to the confinement.
- Documentation regarding seven incidents of room confinement indicated residents remained on room confinement for more than an hour.
- Disciplinary reports were not prepared for ten incidents of room confinement.
- The disciplinary reports for three incidents of room confinement listed a witness who was also a member of the disciplinary hearing committee for the confinement.

### Review of the Facility's Disciplinary Guidelines

The OJSO reviewed the facility's Disciplinary Guidelines. Disciplinary Policy No. 14-02, dated August 24, 2005, permitted room confinement for minor rule violations. The facility had revised the policy to come into compliance with OJA's criteria for room confinement (major rule violation, safety of residents, and security of the facility). The revised policy did add clarity regarding the chargeable offenses to warrant room confinement, but the policy, as written, continued to set prescribed amounts of time for room confinement. The imposition of a specified amount of time of room confinement at the time of the behavior presupposes when a resident can safely be returned to the group.

### Observational Tour

The OJSO conducted a tour of the kitchen and dining area because of the information received in the interviews regarding the food. On the day of the OJSO visit, the kitchen floor appeared dirty; however, the food preparation areas and the appliances appeared clean.

### **Summary**

The most recent OJA annual assessment report requested corrective action in the areas of juvenile records, institutional operations, personnel records, facility tour, and corrections from a previous OJA visit. The OJA cited the facility for the use of room confinement that did not meet criteria (institutional operations) and for all staff not being current in first aid training and CPR certification (personnel records). The facility submitted a corrective action plan, dated July 17, 2007. The plan addressed the facility's proposed actions to provide training and to conduct internal oversight to prevent the misuse of room confinement. Three and a-half months after the OJA's visit and more than a month after the facility submitted its corrective action plan, the OJSO found that the misuse of room confinement was still occurring at the facility and that all staff were not current in CPR certification and first aid training.

The OJSO reviewed the most recent inspection reports by the Oklahoma State Department of Health and the Office of the State Fire Marshal. No violations were cited in either report.

## Violations

1. The facility's disciplinary policy permitted the use of room confinement for behavioral violations that did not meet the detention standards criteria for the use of room confinement. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), 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) [to] 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 room confinement log documented 169 incidents of room confinement that did not meet the criteria for room confinement, according to OJA policy OAC 377:3-13-44, Security and control, (c), (14), (A), (i)–(vi), cited above.
3. The facility's disciplinary policy permitted the imposition of a specified number of hours (twenty-four to forty-eight) of room confinement, in contradiction of the detention certification standards. OJA policy OAC 377:3-13-44, Security and control, (15), Procedure for room confinement or room restriction, (D), states, "The juvenile shall be released when staff determines that he or she can safely be returned to the group."
4. Dates and times of room confinement were not accurately documented on the log, or entries regarding the room confinements were not made on the log, in thirty-three incidents reviewed. OJA policy OAC 377:3-13-44, Security and control, (15), Procedure for room confinement or room restriction, (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."
5. Documentation did not indicate that staff explained the reasons for confinement to the residents or gave the residents an opportunity to explain their behaviors, prior to room confinement, in eight incidents reviewed. OJA policy OAC 377:3-13-44, Security and control, (15), Procedure for room confinement or room restriction, (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."
6. Residents were confined to their rooms in excess of an hour in seven incidents reviewed. OJA policy 377:3-13-44, Security and control, (c), (13), Room restriction, states, "Room Restriction is one means of informally resolving minor juvenile misbehavior. It serves a 'cooling off' purpose and has a short time period (up to 60 minutes) that is specified at the time of the assignment."
7. Ten incidents of room confinement were not documented on incident reports or disciplinary reports. OJA policy OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (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."

8. Six of fourteen residents and three of six staff interviewed rated the quality of the food as poor, as well as, five staff reported frequently finding hair in the food, one reported finding fingernails in the food, and three reported finding bugs in the food. Four residents and two staff rated the quantity of food served to residents as poor. American Correctional Standards, 3-JDF-4A-04, states, "Written policy, procedure, and practice require that food service staff develop advanced, planned menus and substantially follow the schedule; and that in the planning and preparation of all meals, food flavor, texture, temperature, appearance, and palatability are taken into consideration."
9. Seven of the thirteen training records reviewed did not document current CPR certification. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (F), in part, states, "All direct-care staff shall be certified in cardiopulmonary resuscitation (CPR) within 90 days after employment and recertified annually."
10. Three of the thirteen training records reviewed did not document current first aid training. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (E), in part, states, "Within 90 days after employment, all direct-care staff shall have successfully completed first aid training from an instructor certified by the American Red Cross or its equivalent."
11. Two of the sixteen resident files reviewed did not contain documentation of legal authority to admit. OJA policy OAC 377:3-13-40, Records, (b), (1), in part, states, "The case record includes, at a minimum . . . documented legal authority to accept juvenile."
12. Some of the grievances filed in 2007 were not properly entered onto the log or numbered. OJA 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."
13. Four grievances reviewed were not resolved within the proper time frame. OJA policy 377:3-1-28, General grievance procedure, (a), Informal grievances, (4), states, "The assigned staff shall review each grievance and attempt to resolve the grievance with the juvenile."

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