

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

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

Dates of Visit: December 21 and 22, 2009

Oversight Reviewer: Dana S. Holden, Oversight Specialist IV

Subject: Unannounced Oversight Visit, 2009

Date: March 8, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit at the Tulsa County Juvenile Detention Center on December 21, 2009, and returned on December 22, 2009, to complete the oversight. The purpose of the visit was to conduct a focused oversight regarding room confinement, room restriction, and restraint of residents. In addition, information from this unannounced oversight was requested for purposes relevant to an OJSO systemic review.

The detention 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 forty-eight. 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.

Person Interviewed

- Entry interview and an exit conference with the program manager

Documents Reviewed

- Five resident case records
- Facility policies regarding use-of-force and resident grievance procedures
- Facility room confinement log for July 1, 2009, through December 15, 2009
- OJA OPI annual assessment report dated July 21, 2009
- Office of the Oklahoma State Fire Marshal report dated July 7, 2009
- Oklahoma State Department of Health Food Inspection report dated November 4, 2009
- Facility use-of-force report for July 1, 2009, through December 15, 2009
- OJSO report for December 2008 visit

Findings

Interview

The OJSO conducted an entry interview with the program manager on the first day of the visit. The protocol for the focused oversight was discussed.

Resident File Review

The OJSO reviewed five resident case records for compliance with detention certification standards. The OJSO noted:

- Four of the five resident case records reviewed did not contain documentation to indicate medical consent/authority to treat the residents.
- Two of the five resident case records reviewed did not document school history or education information.

No other concerns were identified from the resident case record review.

Facility Room Confinement Log Review

The OJSO reviewed the facility room confinement and room restriction log for July 1, 2009, through December 15, 2009. During that time period, 123 incidents of room confinement were recorded. The OJSO noted:

- Fifty-one of the 123 incidents of room confinement did not meet criteria for room confinement. The OJSO cited the facility for this same violation in the OJSO report from its visit on December 3 and 4, 2008. Examples of assigned room confinement that did not meet criteria in the 2009 visit were:
 - A resident was placed on room confinement for 48.5 hours for drawing a picture that represented a gang. Documentation did not indicate that the resident shared the drawing with other residents.
 - A resident was placed on room confinement for 27.75 hours for possession of contraband. Allegedly, the resident had scratched his/her name on a wall.
 - A resident was placed on room confinement for 22.5 hours for possession of contraband. The resident was found with two packages of peanut butter crackers and one package of saltines in his room.
- Sixteen of the 123 incidents of room confinement did not document accurately the date and time of release from room confinement. The OJSO cited the facility for this same violation in the OJSO report from its visit on December 3 and 4, 2008.
- Documentation regarding three instances of room confinement did not indicate that an administrative review was conducted after the resident had been confined to his/her room for twenty-fours.
- Documentation regarding five instances of room confinement did not indicate that authorization for continued room confinement had been obtained every three hours.

- Documentation regarding seven instances of room confinement indicated that the resident was made to take off his/her shirt and long pants when the resident was assigned to room confinement. Documentation did not indicate that every resident had to remove his/her shirt and long pants when he/she was placed on room confinement. In four of those seven instances when a resident's clothing was removed, documentation indicated that the resident had refused to undress. The OJSO contacted the OJA OPI Program Manager for clarification on whether this was an acceptable practice in accordance with OJA policy. The OPI Program Manager stated it would be improper for a facility to request that a resident undress during room confinement unless the facility documented a valid reason.
- Documentation indicated that some staff required an admission of guilt by the resident before the resident could be released from room confinement. According to documentation, the admission occurred prior to a disciplinary hearing occurring where the resident would be afforded the opportunity to contest the alleged infraction.

No other concerns were identified from the room confinement log review.

Use-of-Force Report and Restraint Log Review

The OJSO reviewed the restraint log for July 1, 2009, through December 10, 2009. Twenty-eight incidents of physical restraint were recorded. Mechanical restraints were used in seven of the twenty-eight incidents of physical restraint. The facility maintained a use-of-force report that provided documentation regarding physical restraint and mechanical restraint use. According to the facility program director, a restraint chair was available in the facility; no instances were recorded to indicate the restraint chair had been used. The OJSO noted:

- In each incident reviewed in which mechanical restraints were used, documentation did not indicate that a staff person remained with the resident while the resident was being mechanically restrained. An example of non-supervision by staff during mechanical restraint use appeared to have occurred in this documented incident at the facility: "The resident was placed in "handcuffs". The resident "continued to stand on the toilet and hit the light for 10 minutes".
- Documentation indicated that staff placed residents in mechanical restraints for reasons that did not meet criteria for the use of mechanical restraints. Examples of mechanical restraint use that did not meet criteria were:
 - A resident on room confinement tore up a Bible and tried to stop up the toilet. Staff placed the resident in handcuffs and leg restraints when he/she refused to calm down.
 - A resident walked out of a class and ran to his/her room. The resident refused to remove his/her clothing when the resident was placed on room confinement. Mechanical restraints were applied to the resident.
 - A resident was placed in mechanical restraints for attempting to destroy county property and "bring injury to himself". The documentation further indicated, "The

resident was placed in “handcuffs”. The resident “continued to stand on the toilet and hit the light for 10 minutes.”

No other concerns were identified from the use-of-force log review.

Other Documentation Reviewed

The OJSO reviewed the most recent report by the OJA OPI from its visit on July 21 and 22, 2009. The violations cited were:

- Juvenile records: Eight juvenile records did not contain documentation of court authorization for treatment or request for medical consent form.
- Security and control:
 1. Two room restrictions did not document the reason for the room restriction.
 2. Eleven of the room restrictions reviewed did not document a start and release time regarding the restriction.
- Grievance Requirements: The numbering system in the grievance log was not recorded in consistent order.
- Personnel records: Five of twenty-one records reviewed did not have completed first aid and cardiopulmonary resuscitation (CPR) training documentation within the required time frame.
- Facility Tour: A number of wash basins throughout the detention center did not have running hot or cold water.
- Corrections from OJA visit of March 24 and 25, 2008.

No other concerns were identified from the OJA OPI report review.

The OJSO also reviewed the most recent reports by the State Fire Marshal’s office and the Tulsa Health Department. Neither report had cited any violations.

Area of Concern

1. Documentation indicated that some staff required residents to make an admission of guilt for an alleged infraction before the resident could be released from room confinement. This admission occurred prior to the resident having a disciplinary hearing where the resident was afforded the opportunity to contest the alleged infraction.

Violations

1. Four of the five resident case records reviewed did not contain documentation of court authorization for treatment or request for medical consent form. OJA policy, OAC 377:3-13-40, Records, (a), (16), states, “Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at the minimum . . . medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent.”
2. Two of the five resident files reviewed did not document education information and

school history. OJA policy, OAC 377:3-13-40, Records, (a), (13), states, "Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at the minimum . . . education and school attended."

3. The room confinement log for July 1 through December 15, 2009, documented fifty-one incidents of room confinement that did not meet criteria for 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)."
4. The room confinement log for July 1 through December 15, 2009, documented sixteen incidents of room confinement in which the date/time of release from room confinement was not recorded. 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."
5. The room confinement log for July 1 through December 15, 2009, documented three instances of room confinement in which an administrative review of the incident was not conducted after the resident remained in room confinement for more than twenty-four hours. OJA policy, OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (C), states, "A juvenile shall not be in room confinement in excess of 24 hours without the opportunity of an administrative review by the administrator or designee who was not involved in the incident."
6. The room confinement log for July 1 through December 15, 2009, documented five instances of room confinement in which staff did not request authorization every three hours for continued room confinement. OJA policy, OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (B), states, "Room confinement of juveniles shall be re-authorized every 3 hours, except during normal sleeping hours"
7. The room confinement log for July 1 through December 15, 2009, documented seven instances of room confinement in which staff did not document a valid reason for requesting that the residents remove their shirts and long pants when the residents were placed in room 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. Exceptions shall be justified in writing by clear and substantial evidence."
8. The room confinement log for July 1 through December 15, 2009, did not document that a staff member remained with a resident when the resident was placed in mechanical restraints. OJA policy, OAC 377:3-13-44, Security and control, (c), (9), Use of Mechanical Restraints, (I), states, "A juvenile placed in restraints shall not be left unattended."
9. Reasons documented for placing residents in mechanical restraints did not meet criteria

for the use of mechanical restraints. OJA policy, OAC 377:3-13-44, Security and control, (c), (9), Use of Mechanical Restraints, (A), states, "Restraints are used only: (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; and (v) [to] prevent destruction of property if reasonably related to (i) through (iv)."

Summary

It was concerning that room confinement policy violations continued to be an issue with the facility. The OJSO and facility administration discussed the issue and agreed that some of the problems seemed to stem from the way staff documented the incidents in their reports. The administration was addressing the issue during staff training sessions. Although there were no instances where residents were placed in the restraint chair, the facility had the restraint chair available for use. The OJSO believes the danger to residents, if placed in a restraint chair, outweighed the possible benefit to its use.

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