

**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 3 and 4, 2008

Oversight Reviewers: Cliff Aldridge, Oversight Specialist IV; Anthony Kibble and Harold Jergenson, Oversight Specialists; and Joanne Verity, Programs Manager

Focus of Visit: Annual Unannounced Visit, 2008

Date: April 13, 2009

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit at the Tulsa County Juvenile Detention Center on December 3 and 4, 2008. The detention center was certified for fifty-five residents by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). 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 census was thirty-nine on the first day of the visit and forty-three on the second day of the visit.

Interviews Conducted

- Entry conferences with the Program Manager and the Accreditation Manager to begin each day of the visit
- Subsequent brief entry conference with the Superintendent on December 3, 2008
- Fourteen residents
- Six detention counselors (direct care staff)
- Exit conference with the administrative team on December 4, 2008

Documents Reviewed

- Two resident case records
- Two personnel files and training records
- OJSO visit report for 2007 and the facility response
- OJA OPI Annual Assessment Report for 2008 and the facility response
- Facility Detention population logs for December 3 and 4, 2008
- OJA Juvenile On-Line Tracking System (JOLTS) daily court dockets for December 3 and 4, 2008

- JOLTS daily population sheets for December 3 and 4, 2008
- Two incident reports regarding attempted suicides
- Facility Incident Reports (Use of Force) log for September, October, and November 2008
- Facility Disciplinary Reports (room confinement) log for September, October, and November 2008
- Facility "Detention Home Resident Orientation and Acknowledgement of Orientation and Juvenile Rights" forms
- Facility regular program schedule
- Facility daily shift schedule for the week of December 1 through December 7, 2008
- Oklahoma Department of Human Services (OKDHS), Office of Client Advocacy (OCA) incident referral record from September 1, 2007, through December 3, 2008
- Facility Critical Incident Notification dated November 18, 2008
- Facility's Disciplinary Guidelines
- Office of the Oklahoma State Fire Marshal report dated May 14, 2008
- Oklahoma State Department of Health Food Inspection report dated October 3, 2008
- Caretaker Conduct Review (CCR) reports prepared by the facility between September 6, 2007, and December 3, 2008
- OJA Requirements for Secure Juvenile Detention Facilities

Areas Toured

- Dayrooms of both units
- Sample of sleeping rooms on each of the wings
- Dining room during a meal

Findings

Resident Interviews

The OJSO selected fourteen residents for interviews. The residents were interviewed relative to their perceptions of safety, detention program services, resident rights, discipline practices, and other detention care issues. Although several residents interviewed expressed minor complaints, overall their responses were favorable. Some residents complained of gaining weight because of the amount of food they were given, other residents stated that they received enough food, and some residents stated they got enough to eat only part of the time.

A small minority of the residents interviewed had difficulty explaining the grievance procedures, some of the residents interviewed had not filed any grievances, and some of the residents interviewed reported that their grievances had been resolved or that the grievance process worked. All of the residents interviewed reported participating in two or more periods of recreation each day.

None of the residents interviewed reported being physically restrained. All of the residents interviewed reported receiving educational services consistent with public

schools. One resident reported being kept in his/her room for a time-out for more than an hour. The resident stated that a medical emergency had occurred with another resident and that the staff had overlooked that he/she had not been returned to the general population. Two or three residents stated that the classrooms were too cold. No consistent themes of concerns were identified from the resident interviews.

Staff Interviews

The six staff members interviewed demonstrated familiarity with the facility's policies and practices for safety, security, and detention programs. Each staff member interviewed reported receiving appropriate training and presented a positive attitude about his/her role in working with children. No concerns were identified from the staff interviews.

Observational Tour

The OJSO made only cursory observations of the unit wings and a sample of the rooms. The facility's mobile restraint chair was observed by some of the OJSO team members; however, there had been no recent incidents involving the use of the chair. The team members also viewed a blanket and a smock made of a durable material designed to prevent wrapping or tearing. Neither of the two incidents of attempted suicide reviewed had involved the use of the blanket or smock.

Male and female residents ate their meals in adjacent but separate dining areas. Casual conversation with the residents during the OJSO walk-through tour of the dining areas indicated that the residents were satisfied with the quality and quantity of the food at the meal.

The OJSO review team observed the dayrooms, classrooms, and other common areas during the course of the oversight visit. The light was observed to be out in the gymnasium. The OJSO was told that the maintenance unit had been contacted to remedy the problem. No concerns were identified from the tour or the observations.

Resident File Review

The OJSO reviewed two resident case records for compliance with detention certification standards. No concerns were identified from the resident files reviewed.

Personnel File Review

The personnel files for two detention counselors were reviewed for key items from the OJA detention certification standards. No concerns were identified from the personnel files reviewed.

Documentation Reviews

As noted above regarding the tour, two attempted suicide incidents from the log for the period of September, October, and November 2008 were reviewed. In both instances, the staff members responded quickly and appropriately as a team to ensure the safety of the residents. No concerns were identified from the log reviewed.

The OJSO reviewed the CCR reports that had been returned to the facility for investigation since the previous OJSO visit in September 2007. No issues of concern were identified by the OJSO during the review of the CCR reports.

The OJSO reviewed the Incident Reports (Use of Force) log for the period of September, October, and November 2008. Fourteen instances were recorded, but one instance involved only a physical escort. Five of the use-of-force events also involved the use of mechanical restraints. According to the documentation, none of the uses of force or mechanical restraints involved the use of the restraint chair. Twelve instances of use of force also involved the use of room confinement.

One instance of use of force on November 17, 2008, indicated that the resident was also placed on room confinement; however, the Disciplinary Reports (room confinement) log report did not document the use of room confinement for the resident on that date. Room confinements were logged for the resident on November 13 and November 19, 2008, but the OJSO was unable to determine from the information provided whether a third incident was not logged or if the date was incorrect. One of the logs used employees' first names while the other log used first initials and last names only. The details from the log summary failed to clarify the issue; there appeared to be a documentation error.

The Disciplinary Reports (room confinement) log for September, October, and November 2008 reflected 105 instances of room confinement. Dates and times when the residents were room confined were consistently recorded; however, 19 of the instances of room confinement did not document the times or dates when the residents were released from room confinement.

The log documented the duration of room confinements in whole hours, apparently omitting the hours when residents would normally be locked in their rooms during the night. The OJSO was concerned that the hours reported were misleading. For example, according to the dates and times of admission to and release from room confinement for one resident, the OJSO calculated that the resident was locked down for 138 hours 30 minutes. The log for the event documented the duration of room confinement as only 102 hours.

The log included an entry for the violation by the resident for each instance of room confinement. Typically, the violation entries were one to five words. Entries, such as "Fighting" or "Assaulting Staff", appeared to meet the OJA detention certification standards for the use of room confinement. Other entries, such as "Profanity",

“Disobeyed a Direct Order”, and “Negative Behavior”, did not meet the detention certification standards for the use of room confinement.

Additionally, in nineteen instances of room confinement, the single word “Inciting” was listed as the violation for which the resident had been room confined. The OJSO was concerned that the term “inciting” was being overused by staff and did not meet the criteria for room confinement.

Thirty-seven grievances were filed by the residents during the period of September, October, and November 2008. All of the grievances had been resolved with the residents within three days. A sample of four individual grievances was reviewed. No concerns were identified from the grievances reviewed.

In the critical incident report to the OJA, the facility reported that a traffic accident in the nearby neighborhood had resulted in three power poles being knocked over, with the subsequent loss of electrical power to the facility. The facility’s back-up power generator came on, and the facility operated on an emergency status until the following day when the power lines were restored.

Inspection Reports Review

The Oklahoma State Department of Health inspection report cited only one non-critical item: A light was out in a walk-in freezer. The Office of the Oklahoma State Fire Marshal report indicated that the facility met minimum standards on the day of the inspection.

The OJA OPI Annual Assessment report noted deficiencies and requested corrective action plans regarding the use of room confinement, personnel records documentation, and physical plant issues during the 2008 visit and noted that these areas represented recurring findings from the May 2007 visit. The facility’s Corrective Action Plan dated April 25, 2008, appeared to adequately address the OPI findings.

Areas of Concern

1. The room confinement log report apparently subtracted sleep hours from the total hours a resident spent in room confinement. The documentation was misleading. There was concern that the practice subverted the administrative due process review that was to occur whenever a detention resident was locked in his or her room for more than 24 hours. In the example cited above, the resident was apparently continuously “locked down” for 138 hours 30 minutes, but the log indicated the period of confinement was only 102 hours.
2. The use of the single word “inciting” in nineteen incidents of room confinement was insufficient to document that the behavior met the OJA detention standards for the use of room confinement. The administration should carefully review each of the individual incident reports to ensure that the term was not overused by staff. The standard would not be met unless the behavior incited other juveniles, involved

safety concerns, and was reasonably related to the criteria for the use of room confinement.

Violations

1. An instance of room confinement documented in the Use of Force report log was not recorded on the Disciplinary Reports log (Room Confinement log). The OJA detention certification standards, 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."
2. Nineteen instances of the use of room confinement did not document the date or time of the release from room confinement. The OJA detention certification standards, 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."
3. Some behaviors of residents documented as violations resulting in the use of room confinement did not meet the criteria for the use of room confinement. The OJA detention certification standards, OAC: 377:3-13-44, Security and control, (c), (14), Room confinement, (A), states, in part:

Room confinement means locking a juvenile in his/her room 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.

(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) [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).

Summary

The OJSO appreciated the helpfulness of the detention center administration and the detention center staff for arranging interviews, conducting the tour, and providing necessary materials for the oversight visit.

