

**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:** September 27, 28, and 29, 2010

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

**Focus of Visit:** Announced Oversight Visit, 2010

**Date:** January 19, 2011

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**Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an announced visit to the Tulsa County Juvenile Detention Center on September 27, 2010. The OJSO returned to the facility on September 28 and 29, 2010, to complete the visit. The purpose of the visit was to conduct a focused review of the resident files, room confinement log, and restraint log for the period of January 1, 2010, through September 27, 2010. The center was certified by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA) for fifty-five juveniles. On the first day of the OJSO visit, the census was forty-two. 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.

**Interviews Conducted**

- Entry interview with the program manager on September 27, 2010
- Exit conference with the program manager and support staff on November 2, 2010

**Documents Reviewed**

- Twenty-eight resident files
- Facility room confinement log for January 1, 2010, through September 27, 2010
- OJA annual assessment report dated February 23 and 24, 2010
- Office of the Oklahoma State Fire Marshal inspection report dated May 18, 2010
- Tulsa County Health Department inspection report dated August 24, 2010

**Findings**

### Staff Interviews

The OJSO conducted an entry interview with the program manager on the first day of the inspection. The protocol for the focused oversight inspection was discussed. There were no concerns noted from the staff interviews.

### Resident File Review

The OJSO reviewed twenty-eight resident files for compliance with detention certification standards. There were no concerns noted with the resident files.

### Room Confinement/Room Restriction Log

The OJSO reviewed the facility room confinement and room restriction log for January 1, 2010, through September 27, 2010. There were 135 recorded incidents of room confinement during this time frame. The OSJO noted:

- Of the 135 incidents of room confinement eight, did not meet criteria. This was down from fifty-one on the OJSO's previous visit in 2009. Some examples are:
  1. A resident was placed in room confinement for 23.25 hours for possession of contraband. The resident had a belly button ring.
  2. A resident was on room confinement for seven hours for possession of contraband. The resident was found with two wet erase markers in his room.
- There were twenty-two instances where staff did not accurately document the incident and/or times of confinement. Some examples of improper documentation are:
  1. Improperly documenting the start time of room confinement on different reports or logs.
  2. Not documenting the reason for extending the time a resident is on timeout.
  3. Staff gave back to back timeouts without documenting the new rule violation for the second timeout.
- There were twenty-two instances where staff did not conduct the three hour re-authorization of the room confinement.
- There were six instances where staff did not conduct the fifteen minute observation checks.
- There were twenty-seven instances where residents were kept in timeout in excess of the sixty minute time limit without documenting a reason for extending the timeout.
- There were ten instances of room confinement that were not documented on the room confinement log.
- There were eighteen instances where staff did not document a valid reason to continue the room confinement.
- One staff member documented three room confinement reviews and recommended keeping the resident in confinement even though the resident was discharged from the facility prior to the reviews. The purpose of the three hour reviews is to determine whether a resident can be safely returned to the general population.
- The staff members that conducted the three hour reviews waited until 1000 hours to conduct the first review of the day. During the exit conference, the program director agreed that the first review would be completed as soon as the resident is woke up and not later than 0900 hours if there is mitigating circumstances.
- Staff members that conducted the three hour reviews did not conduct three hour

reviews on the day the resident was released from room confinement.

There were no other concerns noted from the room confinement review.

### Other Documentation Reviewed

The OJSO reviewed the latest inspection report from the Office of Public Integrity (OPI) dated February 23 and 24, 2010. There were no concerns noted from the OJA report. The OJSO reviewed the latest inspection reports from the Oklahoma State Fire Marshal's office dated May 18, 2010, and the Tulsa County Health Department dated August 24, 2010. There were no violations noted in either report.

### **Areas of Concern**

1. Staff members waited until 1000 hours before conducting the first review of the day on residents in room confinement.
2. Staff did not always conduct reviews on the day the resident was released from confinement.
3. A staff member documented that they conducted face to face reviews on a resident who had already been discharged from the facility.
4. There was one incident where staff placed a resident in a restraint chair. The OJSO is very concerned about the use of the chair and the possible danger it can present to a juvenile. The OJSO feels the danger to residents if placed in a restraint chair outweigh the possible benefit to its use.

### **Violations**

1. According to the room confinement log, there were eight documented incidents of room confinement which did not meet the criteria for room confinement according to OJA policy, 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) 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. There were twenty-two instances where staff did not accurately document the incident and/or times of confinement. OJA policy, 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. There were twenty-two instances where staff did not conduct the three hour re-authorization of the room confinement. OJA policy, 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...."
4. There were six instances where staff did not conduct the fifteen minute observation checks. OJA policy, 377:3-13-44, Security and control, (c), (15), Procedure for room

confinement or room restriction, (B), states, "Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented."

5. There were twenty-seven instances where residents were kept in timeout in excess of the sixty minute time limit without documenting a reason for extending the timeout. OJA policy, 377:3-13-44, (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."
6. There were ten instances of room confinement that were not documented on the room confinement log. OJA policy, 377:3-13-44, (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."
7. There were eighteen instances where staff did not adequately document a reason to continue the room confinement. OJA policy, 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...."

## **Summary**

The OJSO noted that the facility administration had made progress in reducing the number of instances of room confinement. There were still some areas of concern that needed to be addressed, and with further training, it is anticipated that those areas of concern will be alleviated.

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