

FINAL REPORT

Complaint No. 3423-04
Date Issued: September 23, 2004
Identified Report

OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Name of Facility: L. E. Rader Center

Dates of Visits: March 3, March 8 and 9, March 23, 24, and 25, March 30 and 31, and April 20 and 21, 2004

Purposes of Visits: Complaint Investigation and Routine Oversight

Oversight Persons: Dana Holden and Patricia Lumley, Oversight Specialists

Introduction

The Office of Juvenile System Oversight (OJSO) began a complaint investigation at the L. E. Rader Center on March 3, 2004, regarding the use of special clothing known as a suicide smock. In the course of the investigation, the OJSO received another complaint on the Rader Center alleging that a resident had been locked in a room on the crisis unit in excess of three months. The OJSO made subsequent visits to the facility on March 8 and 9, March 23, 24, and 25, March 30 and 31, and April 20 and 21, 2004. The OJSO advised the facility's Superintendent that a routine oversight visit would be incorporated into the complaint investigation. The Superintendent also was advised that the primary focus of the complaint investigation would be to review the current practices used on the facility's Mental Health Stabilization Unit (MHSU) and that other areas of the facility would be monitored, as needed. The MHSU is one of four units in the Intensive Treatment Program (ITP) at the Rader Center.

Complaint Allegations

The OJSO had received a complaint alleging that residents on the MHSU were forced to wear a device known as a suicide smock, along with large padded mittens and a helmet with a plastic face shield. The complainant described the smock as a green, heavy, dress-like garment made of canvas material. The complainant stated that residents placed on the unit had to wear the smock even if they were not suicidal, but rather, when they were at-risk of other self-harm.

On March 18, 2004, the OJSO received a second complaint alleging that a resident had been kept locked in a room in excess of three months, from approximately October 2002 until January 2003. The complainant alleged that the resident had not been allowed to participate in outdoor recreation and that he had not been allowed to use eating utensils during meals. The complainant stated that female staff members frequently had to accompany the resident when he used the bathroom and took showers. In addition, the complainant stated that two residents had recently been locked on the crisis unit for more than one month, due to assaulting a staff member. The complainant stated that when residents were kept locked on the crisis unit, they were not allowed to attend school, have contact with other residents, or participate in outdoor recreation.

Persons Interviewed

- Deputy Director of Institutions, Office of Juvenile Affairs (OJA)
- Superintendent, Rader Center
- Deputy Superintendent, Rader Center
- Administrator of Programs of the ITP, Rader Center
- Advocate Defender, Rader Center
- District Supervisor, OJA
- Former Juvenile Services Unit (JSU) worker, OJA
- Psychological clinician of the MHSU, Rader Center
- Chief of Security, Rader Center
- Twenty-five direct care staff members, Rader Center
- One former direct care staff member, Rader Center
- Fourteen residents, Rader Center
- Licensing staff, Division of Child Care of the Department of Human Services (DHS)

Documents Reviewed

- Files on residents, Rader Center
- Staff files, Rader Center
- Memoranda provided by the Administrator of Programs of the ITP, Rader Center
- Memoranda and letters provided by the direct care staff members, Rader Center
- Sixteen-hour schedule for the MHSU, Rader Center
- Incident reports, Rader Center
- Seclusion and restraint logs, Rader Center
- Inspection report dated November 3, 2003, State Fire Marshal's office
- Inspection report dated December 5, 2003, Oklahoma State Department of Health
- Inspection report dated February 19, 2004, DHS Division of Child Care
- Policies and procedures, OJA
- Procedures, Rader Center
- Oklahoma Statutes
- Terry D. Order of Dismissal and Appendix
- Individuals with Disabilities Education Act (IDEA), Sections 300.340 through 300.350 of Title 34 of the Code of Federal Regulations (C.F.R.)
- File on a former resident, a mental health facility

- *Standards for Juvenile Training Schools*, American Correctional Association (ACA)
- Oversight report dated December 5, 2002, OJSO

Issues Presented and Findings

The Mental Health Stabilization Unit

- 1. Is the use of the suicide smock for the residents on the MHSU consistent with OJA policy, which provides that juveniles are entitled to be protected and cared for in a safe, caring, and humane environment?**

Finding: Violation of OJA policy OAC 377:10-1-2, (a), (1).

Beginning on March 3, 2004, and continuing through April 21, 2004, the OJSO conducted a complaint investigation regarding the quality of treatment being provided to the residents of the MHSU at the Rader Center. According to the Administrator of Programs of the ITP, residents were placed on the unit for meeting acute care medical criteria and were evaluated during the initial ninety-six hours, not including weekends. During the evaluation period, the residents attended a mental health hearing that was conducted by staff at the facility. It could then be determined if a resident needed to be admitted to the MHSU. All initial stays and admissions onto the unit were approved by the Chief Psychologist of the OJA. However, the Administrator of Programs of the ITP stated that she also could approve admissions to the unit. Residents stayed on the unit until they were stabilized and no longer met the acute care criteria. The Administrator of Programs further stated that there had never been a time when all fourteen beds on the unit were occupied and that there had never been more than twelve residents on the unit at any time. According to the licensing staff of the DHS Division of Child Care, the MHSU is currently licensed as a secure residential facility for fourteen beds.

The complainant reported that the suicide smock was extremely dirty and possibly had fecal material on the inside. During the complaint investigation, the OJSO team examined the suicide smock, helmet, and mittens, which all were kept in a locked cabinet in the kitchen on the MHSU. The smock, which staff also referred to as a "suicide barrel," was made of heavily padded canvas and was in the shape of a sleeveless dress. The smock had wide, sturdy Velcro straps for which to close the opening. The suit did not restrict movement of arms and legs. The helmet was a regulation hockey headgear that had a chin strap and a clear plastic face shield. The mittens were made of cotton cloth, with approximately three inches of padding on one side, one inch of padding on the other side, and were secured with attached strings that tied around the wrists. There was an opening in each mitten near the thumb. Two direct care staff members, who were routinely assigned to the MHSU, stated that they washed the suits by hosing them down on the floor of the unit's shower room. At the time of the OJSO's inspection of one of the smocks, it did not appear dirty.

The Administrator of Programs of the ITP stated that the smock was designed to keep a resident from hanging himself. She said that research clearly pointed out that juveniles who were placed in an acute setting were at high risk of attempting suicide within the first few days. The Administrator of Programs stated that the smock signified to a resident, "You are safe and we are going to great lengths to keep you safe." The Administrator of Programs said that she knew of only one resident who had complained about wearing the suit.

During an interview with the Administrator of Programs of the ITP, she stated that all of the residents who were sent to the MHSU had come from the Rader Center and the other two state-operated training schools. She stated that all referrals to the unit were to meet acute care criteria of being an imminent risk of harm to self or others. She further stated that the stay of a resident's first admission to the unit could be for ninety days, the first hearing was on the seventy-sixth day of the first ninety days, and that every extension of stay was attempted by the seventy-sixth day.

The OJSO interviewed six of the seven residents who were living on the MHSU at the time of the OJSO's investigation. The seventh resident declined to be interviewed. Three of the six residents interviewed stated that they had worn the "Ninja suit" (suicide smock), and two stated that they had not been made to wear the smock. The OJSO failed to ask the sixth resident about the suicide smock. All of them said that the smock did not prevent a resident from attempting suicide. One resident stated that he had not been allowed to wear underwear while in the smock, and another stated that he had been allowed to wear underwear. All three residents stated that they were embarrassed while wearing the suicide smock. One resident said that no one had accompanied him to the bathroom while he was wearing the smock. One of the three residents who had worn the smock stated that wearing the smock did not keep him safe and that he was able to self-mutilate while wearing it. He gave an example of how he easily placed a piece of glass that he had found on the floor of the gymnasium in the cheek of his mouth and proceeded to cut himself with it. Another resident stated that it had been easy to slip his thumbs out of the mittens to hurt himself, and another stated that the mittens could be used to hide medications. Office of Juvenile Affairs policy OAC 377:10-1-2, (a), (1), states, "Juveniles are entitled to be protected and cared for in a safe, caring, and humane environment."

2. Do the residents and direct care staff members view wearing the suicide smock as a form of punishment?

Finding: Violation of OJA policy OAC 377:3-13-42, (7), (A).

The Administrator of Programs stated her view of the residents wearing the suicide smock as a form of treatment and suicide precaution. Seven of the direct care staff members and two of the six residents, however, viewed it as a form of punishment. Office of Juvenile Affairs policy OAC 377:3-13-42, (7), (A), states, "Facility staff shall

not discipline a juvenile by using corporal or unusual punishment." The OJSO believes that placing a teenage male resident, who is mentally fragile, in a garment that has the appearance of a dress would be humiliating and is an unusual form of punishment.

The OJSO interviewed the psychological clinician for the MHSU about the use of the suicide smock. She stated that the smock was placed on those residents who were suicidal and that not all residents who were placed on the MHSU were made to wear the smock. The clinician said that she had the authority to make the decision as to whether a resident wore the smock. According to the clinician, the wearing of the smock was to give the message, "This is serious and we are going to take care of you." She also stated that a screening tool was used to assess whether a resident was suicidal, and if the resident was assessed as suicidal, then the resident was made to wear the smock. The clinician stated that the criterion for the smock to be taken off was the dissipation of self-harming behavior. The clinician reported that it had been the practice as long as she had worked on the unit, since September 2003, for the residents to be allowed to wear underwear and, sometimes, a tee shirt underneath the smock. She stated that a resident could be placed in the isolation room while wearing the suicide smock. She also stated that the helmet was used for residents who engaged in head banging. She added that the helmet had not been used since she had been working on the unit.

No documentation could be found in the files on the residents, the log books, or elsewhere that justified placing a resident in the special clothing. The OJSO attempted to review the seclusion log, restraint log, and shift notes of staff to determine whether a log was kept to document when residents were placed in the suicide smock, the helmet, or the mittens. No such log or notations were found on the unit or in the files on the residents. Clinical and direct care staff members confirmed that documentation was not kept regarding a resident wearing the special clothing. The OJSO noted that neither the OJA nor the facility had developed policy governing the use of the suicide smock. The decision to use the smock was based on the opinion of the Administrator of Programs of the ITP or the psychological clinician.

3. Do the residents on the MHSU receive appropriate mental health treatment?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-4C-16 and 3-JTS-4C-18; the Terry D. Order of Dismissal; and OJA policy OAC 377:10-1-2, (a).

One psychological clinician was assigned full time to the MHSU. The six residents on the MHSU who were interviewed were asked about the treatment they were receiving on the unit. Two residents stated that the psychological clinician for the unit was helpful. One of these two residents said that he believed the clinician was helpful, because she placed telephone calls for residents and prepared their court reports. The other resident stated that the clinician said helpful things and gave her home telephone

number to the residents if they wanted to talk. The clinician stated that she had been assigned full time to the unit since September 2003 and that her clinical work on the MHSU was assisted by a social worker and a unit manager.

The psychological clinician reported that the social worker conducted the cognitive group therapy sessions. The OJSO asked the clinician for the curriculum of the group sessions the social worker conducted. The clinician was unable to provide a formalized curriculum or a previously printed list of the group sessions that were conducted. The clinician wrote for the OJSO a list of the group sessions she said were conducted; however, there was no information provided as to when each group session was held or the goals for each group session. Please see Attachment 1. The clinician was unable to provide any of the written work of the current MHSU residents regarding their group sessions or therapy packets. The clinician had no explanation for the whereabouts of the documentation regarding the written therapy work that was to remain on the unit with the resident during the resident's stay, which could last several months. She stated that she did not keep a resident's therapy packet after the resident was discharged from the MHSU. She did provide the OJSO with copies of samples of the types of written work she might assign.

The clinician focused her explanation of the group sessions on the Teddy Bear Group, in which a basket of teddy bears was passed out to the residents. She said that a resident's work went back to the referring institution when the resident was discharged. The clinician had no explanation for the lack of documentation of written therapy work in the files on the residents who had been discharged from the MHSU to another unit of the Rader Center.

The clinician stated that the residents worked on packets at night that related to anger issues. The clinician commented on the benefits of the MHSU regarding specific residents. She stated that one resident could be managed with intensive treatment on the unit, yet the clinician was unable to explain the intensive treatment being provided or to provide documentation of it.

During the interview with the Administrator of Programs of the ITP, she stated that all of the residents on the MHSU attended a drug abuse/education group session that was led by a certified alcohol drug counselor. There was a lack of documentation in the files of groups held. When there was documentation of a group session held, the purpose and content of the group session and the participation by the individual resident were not documented.

The Administrator of Programs of the ITP stated that the psychological clinician on the MHSU had knowledge of and had been provided with a copy of the new form to be used by the MHSU direct care staff when writing progress notes. The same form was to be used by the ITP direct care staff. When the OJSO asked the psychological clinician about the new form, she stated that she had no knowledge of the form;

however, she did obtain a copy of the form from the ITP and provided the OJSO with a copy.

The Administrator of Programs of the ITP stated that a program change that had been implemented was that the MHSU program was more restrictive now, such as the residents ate in their rooms with their doors remaining open. She explained that she had implemented a form for direct care staff to document three-minute checks on each resident. She stated, "Every resident has a log on the unit from admission to discharge."

Based on the OJSO's review, the files on the residents did not indicate the dates of transfer to the MHSU of those who were former residents of another unit within the Rader Center. The OJSO was informed by staff that the dates of transfer could be obtained from the staff of the Records Department, which kept the information on a Rolodex card. The dates of admission to the MHSU for the residents from the other two state-operated training schools could be listed as the date the resident was sent to the Rader Center. The files reviewed did not clearly indicate the reasons for the admissions to the unit by stating how the residents met criteria for the MHSU.

Four of the six residents interviewed spoke of having nothing to do all day on the MHSU. Three of the four said that they spent their days sitting in chairs that were placed against the wall.

The Administrator of Programs of the ITP, the psychological clinician, and two direct care staff members stated that the residents were not allowed off the unit for any activities, except for time in the gymnasium, to attend education classes, and to be seen by the doctor on the medical unit. Some of the residents on the MHSU attended the onsite school, if they were not restricted to the unit or they were not wearing the suicide smock.

4. Are there specific criteria for admission to the MHSU, and if so, did the facility consistently adhere to it?

Finding: Violation of OJA Rule P-35-07-11, (2).

The psychological clinician stated that the unit was modeled after a program in Corsicana, Texas. She stated that the purposes of the MHSU were to identify a resident's mental health issue and to stabilize the resident, and that the resident was discharged when medically stable. The clinician explained that the initial stay on the unit was for ninety-six hours, not to include weekends. During the initial stay, the resident attended a mental health hearing conducted by facility staff. All admissions were approved by the facility's Chief Psychologist. The clinician stated that all fourteen beds on the unit had never been filled, there had never been more than twelve residents on the unit at any time, and they preferred to keep the census on the unit to no more than ten.

Three of the six residents interviewed stated that a minimum of ninety days was spent on the MHSU, whether or not the resident still met the criteria. One resident stated that he was admitted to the unit after hearing voices; however, he also stated that he had not heard the voices for four months and was still on the unit. Another resident stated that he was admitted to the MHSU for hitting people but had stopped doing so for several months, and yet, he was still on the unit.

The files did not document whether or not the residents on the MHSU were still meeting the criteria for being on the unit, nor did the files evidence therapeutic progress being made. Therefore, justification for keeping residents on the MHSU for several months could not be found.

5. Did the administration at the Rader Center provide the residents on the MHSU with appropriate opportunities for education and planned activities?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-5D-03, 3-JTS-5D-06, and 3-JTS-5F-03; the Terry D. Order of Dismissal; and OJA policies OAC 377:35-17-1 and OAC 377:3-13-42.

The OJSO interviewed the Rader Center's school principal regarding the provision of school work for the residents on the MHSU who could not attend the onsite school. He stated that for a resident who was confined to a residential unit, due to behavioral issues or medical needs, the teacher delivered the resident's homework to the unit; however, the teacher could not stay to teach a resident. The principal stated that the assignment for the teachers at the facility was to instruct in the classrooms, and the teachers could not be spared to instruct whole lessons to residents who were confined on the units. The principal explained that in the past two decades he had been at the Rader Center, a teaching position had not been afforded for those residents who were confined to residential units and were unable to attend the onsite school. The principal continued to explain that it was sometimes awkward for the direct care staff members to be in the position of assisting residents with their school work, because the work could be beyond the ability level of some of the direct care staff. Residents were often told to seek out other residents on the unit who might be able to offer assistance. The principal stated that the Rader Center was fortunate to have all of their teachers certified in Special Education.

According to the Administrator of Programs of the ITP, the residents were not allowed to attend school when wearing the suicide smock. They also were not allowed to attend school when kept on the MHSU or in the Crisis Management Center (CMC) for negative behaviors.

The Administrator of Programs of the ITP and the psychological clinician stated that each resident on the MHSU was only allowed to have a pencil for an hour a day. During that hour, the residents were to do their journaling, treatment packets, homework, and letter writing. If a resident wanted to file a grievance, the necessary

paperwork had to be done during that period. Three residents stated that the grievance process did not work so they no longer bothered filing grievances.

6. Did the treatment plans adequately address the needs of the residents who were assigned to the MHSU?

Finding: Violation of OJA policy OAC 377:10-1-2, (a), (2).

The OJSO reviewed the files and the treatment plans for the residents on the MHSU. At the time of the OJSO visits in March 2004, all of the files reviewed were lacking in current treatment plans and clinical progress notes for individual and group therapy sessions. The treatment plans and progress notes that were found in the files did not incorporate the physical and sexual abuse histories and substance abuse histories of the residents into their treatments. The treatment plans were centered on behavioral compliance with staff in their current placement. The treatment plans and direct care staff notes on two of the seven residents on the MHSU were concerning in that they demonstrated a worsening of symptoms during the months on the unit. Office of Juvenile Affairs' policy OAC 377:10-1-2, (a), (2), states, "Services provided to juveniles shall be based upon the individualized needs of each child, as determined by comprehensive assessment and evaluation, flexible, and available when needed for juveniles throughout the state." The files on the residents contained psychological-social evaluations and psychological evaluations; however, the treatment plans did not address the residents' issues as outlined in the evaluations.

During the OJSO's visit to the Rader Center on April 14, 2004, the files on the residents on the MHSU were reviewed again for treatment plans and progress notes. One file on a resident was noted to have had two additional weekly treatment plan reviews for March 2004 since the OJSO's last review. The resident was admitted to the unit in January 2004, and the weekly treatment plan reviews for January and February 2004 had not been placed in the file at the time of the OJSO's visit on April 14, 2004. The progress notes in the resident's file for the group therapy sessions were deficient, in that there was only one note documenting one group session for this resident. When asked about the lack of treatment plans and progress notes in the files on the residents, the psychological clinician for the MHSU stated that she had "not printed any off since January or February (2004)." This was clarified by the psychological clinician as meaning that the work had not been completed. The clinician stated that she did them whenever she had the time and that she was currently behind. The OJSO reviewed the shift progress notes for the MHSU. The notes were focused on the residents' behaviors and gave the descriptions of good, bad, or participative. At best, the notes contained little clinically useful information, and yet, were described by the clinical staff as necessary for observations in deciding whether to extend a resident's stay on the MHSU.

All six of the residents interviewed stated that the psychiatrist was nice. They stated that they saw the psychiatrist weekly or every other week for medication management.

Two residents interviewed knew what medications they were currently prescribed and the reasons for taking them.

Solitary Confinement and Seclusion

1. **Did the administration of the Rader Center violate the provisions of the Terry D. dismissal order, DHS licensure standards, ACA standards, and OJA policy by keeping a resident in solitary confinement for approximately sixty-eight days over a three-month period of time?**

Finding: A resident was housed in isolation for approximately sixty-eight days over a three-month period of time. Violations of the Terry D. Order of Dismissal; DHS licensing standard, Section 154.2; *ACA Standards for Juvenile Training Schools*, 3-JTS-2C-04, 3-JTS-2C-10, 3-JTS-3D-06, 3-JTS-3D-07, 3-JTS-3E-02, 3-JTS-3E-03, and 3-JTS-3E-05; and OJA policy OAC 377:35-11-4.

The complainant reported to the OJSO that a resident was placed in solitary confinement from approximately October 2002 until January 2003. The Terry D. Order of Dismissal defined solitary confinement as "the involuntary removal of a child from contact with other persons by confinement in a locked room, including the child's own room, except during normal sleeping hours." The complainant stated that the resident had a history of self-mutilation and had been taken to the hospital several times.

There was no written documentation in the file that justified the resident's segregation. There also was no documentation of an incident having occurred that precipitated the order to remove him from the population or of incidents that justified keeping him in the isolation room for approximately sixty-eight days over a three-month period.

The complainant reported that the resident was placed in the room to punish him for his behavior. The OJSO had conducted an unannounced visit to the Rader Center on December 5, 2002. In the course of reviewing the facility's use of the isolation room, the OJSO was advised by staff that there was one resident being kept on the isolation unit. The OJSO report, based on information provided by the Administrative Programs Officer, stated the following:

At the time of the December visit, a portion of the isolation unit at the ITP was being used to house a single youth on a part-day basis. The young man had a history of serious self-injurious behaviors. The Rader administration had determined that the youth was not able to participate in the general program and had ordered he be placed on a special management program. The young man spent his days in the vicinity of the isolation cells but was under constant one-on-one supervision. He was not locked in a room but sat with a staff person through the day. The young man returned to the ITP unit to sleep in a secure room . . . Rader Center staff members indicated they, and others at the OJA,

were seeking a more appropriate placement for him but were not certain when an alternative placement would be arranged.

The Terry D. Order of Dismissal states, "Solitary confinement shall not be used for punishment at any OJA institution. No child shall remain in solitary confinement in excess of three (3) hours." Rader Center policy SE-2422 states that the definition of solitary confinement is "confinement in a room, including the juvenile's own room, when locked or unlocked or when juvenile is restrained (including verbally restrained) from leaving, except during normal sleeping hours. Room restriction beyond 60 minutes is considered solitary confinement." This policy was revised on January 10, 2002. The purpose of solitary confinement is to give the juvenile a safe place to de-escalate, and once the juvenile is sufficiently under control so as not to pose a threat to himself or others, the juvenile is to be returned to the general population. Department of Human Services licensing standard, Section 154.2, and OJA policy, OAC 377:35-11-4, prohibit using seclusion as a form of behavior management.

According to the log sheets, the resident spent most of his day while in the seclusion room either sitting in a chair or sleeping. For example, on October 3, 2002, the log sheet documented the following activities:

7:00 a.m. to 3:30 p.m., the resident either was lying or was sitting on his mattress.
3:20 p.m. to 3:30 p.m., the resident was looking in the security office.
3:30 p.m. to 6:50 p.m., the resident was sitting in a chair or was lying on his bed.
6:50 p.m. to 7:10 p.m., the resident was doing pushups and was stretching.
7:10 p.m. to 8:50 p.m., the resident was lying on his bed.
8:50 p.m., the resident appeared asleep.

Three days of log sheets are included as Attachment 2.

This schedule was indicative of the time the resident spent in the seclusion room. The resident remained in the seclusion room until November 8, 2002, when he was returned to Unit 1, which was already being referred to by staff as the MHSU. While on the MHSU, the resident had to remain with staff at all times. The resident was allowed to go to education classes, and he maintained a normal schedule. There were no instances of self-harm during the month of November 2002. In early December 2002, the resident inserted an object into his body and had to be taken to a hospital's emergency room. When he was returned to the facility, he was placed in the isolation room. The resident remained in the isolation room until early January 2003, when he was transferred to a mental health facility.

The OJSO interviewed the Administrator of Programs of the ITP on March 31, 2004. The Administrator of Programs described the resident as having mild mental retardation, with an intelligent quotient (IQ) of approximately 60. She stated that the resident was sly and manipulative. The Administrator of Programs stated that the

resident was placed in the isolation room in the fall of 2002, with two-to-one observation and under the surveillance of central control at all times. The staff helped the resident with his school work, and the Administrator of Programs did not believe that the teachers had worked with the resident while he was in the room. The administrator stated that the resident, at one point, was placed back onto the MHSU, but when he began to self-mutilate, he was returned to the isolation room. The Administrator of Programs told the staff not to speak to the resident, because it would cause him to escalate. The administrator confirmed that she told the female staff members to accompany the resident to the bathroom and to watch him. The administrator provided the OJSO with copies of the four memorandums she had issued to staff with regard to rules for the resident's confinement in the isolation room.

On March 23, 2004, the OJSO interviewed the resident who had allegedly been placed in isolation for approximately sixty-eight days over a three-month period of time. The resident confirmed that he had been in isolation for many weeks and had not been allowed to talk. He demonstrated how he had to eat with his hands and had to use his hands to scoop his food. He named some of the foods he had to eat with his hands that would normally be eaten with utensils, such as creamed corn, macaroni and cheese, and gravy. He stated that he was given foods that a person would use a fork or spoon to eat. He did not know why he had to live away from the other residents and he said that he had been in the room so long, the room was renamed with his last name. He talked about having been on the MHSU for a long time. When the OJSO asked him about the injuries on his arm, he stated that they were from inserting objects into his arm, such as staples and paper clips. He said that it was easy to obtain those items and other objects to insert into his body. He stated that the day before the OJSO's interview was the most recent time he had inserted anything into his body.

The OJSO reviewed the file on the resident on March 23, 2004. The resident's history included that at the age of fourteen, he suffered a severe head injury, which resulted in severe cognitive impairment. Prior to the accident, his intellectual ability was reported to be average. After the accident, his intellectual level was that of a five-year-old child and his IQ was between 43 and 53. Test results had varied slightly.

The OJSO reviewed the mental health facility's file on the resident. The resident was inpatient at the facility for four months. While at the facility, his privileges were able to be increased approximately every two days throughout his stay. The increases consistently occurred at short intervals and were based on his behavior. He was restrained only two times during the four months he was there. In contrast to the prescribed sensory deprivation at the Rader Center, he was able to remain calm while participating in activities on the unit and when interacting with others. He participated in the group therapy sessions. The administrative, medical, and direct care staff members of the mental health facility were interviewed by the OJSO in relation to their care of the resident during his stay. They stated that their nurturing caused him to respond positively to treatment. The most that the resident had self-mutilated was

when he placed the core of an apple in his ear. Staff stated that he was able to comprehend, and he responded positively to reasonable confrontation that was accompanied with a concrete explanation.

The OJSO interviewed the Rader Center's Chief of Security and one of the security officers. The OJSO was shown the room near the MHSU where the juvenile had resided for approximately sixty-eight days over a three-month period of time. The Chief of Security and the security officer stated that an officer and a Juvenile Services staff were assigned to watch the resident at all times and were told not to speak to the resident.

In the recent federal case of the U.S. vs. Louisiana, Civil Case No. 98-0947-B-1, the settlement agreement stated, "Juveniles engaging in suicidal or self-mutilating behavior shall not be held in administrative segregation for behaviors resulting from their conditions." At the Rader Center, the Administrator of Programs of the ITP and the administration pursued a course of action that punished the resident because he suffered from a mental illness. The settlement agreement in the federal case outlined the circumstances for removing a juvenile from program participation, none of which were for self-destructive behaviors.

- 2. Did the Rader Center's Superintendent, Deputy Superintendent, and Advocate Defender violate the provisions of the Terry D. Consent Decree's dismissal order by authorizing the resident to be kept in solitary confinement for approximately sixty-eight days over a three-month period of time?**

Finding: Violation of the Terry D. Order of Dismissal.

The OJSO interviewed eleven Rader Center staff members who had been responsible for the direct care of the resident while he was locked in the room. One employee reported that the Administrator of Programs of the ITP had ordered that the juvenile be placed in the room. One staff member reported that he had observed both the facility's Superintendent and the OJA Deputy Director of Institutions visit the resident in the isolation room. On March 31, 2004, the OJSO interviewed the Deputy Superintendent, who stated that he was aware of the resident being housed in an isolation room and that he had given the original order to place him there. The Deputy Superintendent stated that he believed the placement was temporary and the resident would return to the unit. The Deputy Superintendent stated that he knew about the guidelines the Administrator of Programs of the ITP had placed on the staff. The Deputy Superintendent also stated that he was aware female staff members were having to accompany the male resident to the shower and stated that he thought it was the OJA Deputy Director of Institutions who had authorized that action.

On April 5, 2004, the OJSO interviewed the Advocate Defender. He stated that he visited the resident while he was staying in the isolation room. The Advocate Defender stated that he had problems with the resident being kept in isolation but was told by the

Administrator of Programs of the ITP that the OJA State Office was aware of the situation and had approved it. The Advocate Defender stated that he dropped the issue. The Advocate Defender stated that the Rader Center's Administrative Programs Officer knew about the resident being in isolation, and it was his job to ensure that the facility did not violate the Terry D. dismissal order.

On June 1, 2004, the OJSO contacted the Rader Center's Superintendent. The OJSO attempted to interview the Superintendent about the resident who was kept in the isolation room. The Superintendent stated that he was told by an Assistant Attorney General assigned to the OJA not to discuss the incident with members of the Oklahoma Commission on Children and Youth. The Superintendent then ended the conversation with the OJSO.

- 3. Did the OJA Deputy Director of Institutions know that the resident was being kept in solitary confinement for approximately sixty-eight days over a three-month period of time?**

Finding: Violation of Rader Center policy SE-2422.

On May 26, 2004, the OJSO interviewed the OJA Deputy Director of Institutions. He stated that he was aware the Rader Center had placed the resident in the isolation room. The Deputy Director also stated that he had visited the resident in the room, and at one point, told a staff member to remove a candy lollipop from the isolation room, as such objects were not allowed in the room with the resident. The Deputy Director stated that it was his position that the resident was not kept in solitary confinement because the room was not locked and there were two staff members in the room with him. Rader Center's policy SE-2422 defines solitary confinement as being in a room "when locked or unlocked or when juvenile is restrained (including verbally restrained) from leaving." The policy outlines the staff responsibilities, which include making frequent contact with the resident to check on his/her welfare. The Deputy Director stated that this case was no different from a case in which the Department of Mental Health and Substance Abuse Services kept a juvenile in a room, supervised at all times by two staff members, and isolated from the general population. That juvenile was in OJA custody at a training school in Oklahoma and was transferred for treatment to a mental health facility in Norman, Oklahoma. The juvenile had a history of swallowing objects and had caused serious injury to himself in the past. The OJSO conducted oversight of the juvenile's progress while he was housed at three different facilities.

The OJSO reviewed the files on the residents to ascertain whether the circumstances were comparable. While both residents were placed on two-to-one supervision, the similarity ended there. The course of treatment for the juvenile who was transferred to a mental health facility was designed to provide intensive therapy to address the issues that caused the resident's self-destructive behaviors, while the course of treatment for the juvenile at the Rader Center appeared to incorporate isolation, social deprivation,

and restriction of privileges. Yet, the MHSU is described as acute care stabilization, which is the same level of care as a mental health facility provides. Initially, when the one resident was placed at a mental health facility, he was on close observation, with no contact with peers, and received few privileges. The staff, however, interacted with the juvenile, and he immediately began receiving counseling and treatment. The juvenile placed at the mental health facility was denied writing materials, recreation time, and personal property in his room until it was determined safe to grant those privileges to him. While at the mental health facility, the juvenile received individual therapy sessions two times a week. The therapy focused on his feelings and coping skills, rather than his self-destructive behaviors. The juvenile later received group therapy three times a week to provide him with feedback and support from peers. Group therapy was beneficial in that the juvenile was able to share his experiences and warn his peers about self-abusive behaviors. The juvenile received family therapy one time a week; however, it did not occur on a regular basis at the mental health facility. The juvenile was given individual instruction by a school teacher while he was confined to his room at the mental health facility and was later allowed to attend classes. The resident was placed on an individual recreational therapy plan. He received recreation therapy four times a week, when his behavior permitted. The activities included weight lifting, cycling on a stationary bike, and playing with a basketball. The resident received individualized pet therapy on a weekly basis to promote bonding and building relationships. As the juvenile began responding to treatment at the mental health facility, he was given privileges to reinforce his good behavior. The therapy sessions were frequent and intensive, using a variety of techniques such as feeling cards and games. There were times when the resident had some setbacks and lost his privileges for a period of time; however, they were always restored within a few days, as warranted by his behavior. As the resident progressed in his treatment, new therapies were introduced. The therapeutic program was effective to the extent that the resident could be discharged from the facility. At the time of discharge, the resident was no longer determined to be a danger to himself or others. The resident was discharged to attend public school and outpatient therapy.

The psychological clinician for the MHSU stated that she had visited the resident at the Rader Center only a few minutes per week for any treatment or individual time. Family therapy was not being provided to the resident as well, based on a review of the file on the resident. His educational services amounted to being given his current homework assignment. The observation logs documented that the resident was only allowed a total of 4.5 hours of large muscle activity for the month of October 2002 and six hours for the month of November 2002. According to ACA standard 3-JTS-5F-06, all juveniles should receive a "minimum of one hour per day of large muscle activity and one hour of structured leisure time activities." Recreation time for the resident consisted of playing basketball alone. The resident's recreation time in the gymnasium was suspended by the Administrator of Programs of the ITP, due to the resident's attempt to injure himself. At times during the resident's approximate sixty-eight days of seclusion, staff members were not allowed to talk to him, while the staff at the mental

health facility interacted with the other resident almost continuously. The resident at the Rader Center was not rewarded for good behavior. His treatment plan was not driven by his good behavior. He was given consequences whether or not he behaved well. His segregation from the population and the sensory deprivation imposed upon him was not the least restrictive environment. When behaving well, he was still restricted from engaging in conversation, using eating utensils, and at times, having a bed on which to sleep. The OJSO did not find any evidence to support the claim that the treatment of these two residents was the same.

The OJSO interviewed eight staff members who were assigned to observe the resident while he was in the isolation room at the Rader Center. The staff members stated that the room was kept locked during the day and evening shifts. This prevented the other residents from passing things to the resident and prevented the resident from having any communication with his peers.

- 4. Did the staff members violate policy and procedures by not completing an incident report after the resident was restrained or was searched, to detail the reason for the search and what contraband was seized?**

Finding: Violation of OJA policy OAC 377:35-3-8.

On October 2, 2002, the Administrator of Programs of the ITP issued a memorandum to all ITP staff in reference to the resident. The memorandum stated, "This is to be standard operating procedure (for the resident)." The memorandum also stated, "(Resident's name) IS NOT to have any eating utensils or straws. He must earn back the right for this privilege." Please see Attachment 3. The Administrator of Programs reiterated this directive in a third memorandum dated December 11, 2002. Please see Attachment 4. The memorandum of October 2, 2002, further stated that staff members were to search the resident hourly, and if there was any reason to suspect that the resident had any contraband, he was to be strip searched. The memorandum also stated that the security monitoring crew would be asked to keep a log of the resident's activities. On April 2, 2004, the OJSO requested copies of all of the log sheets documenting the resident's activity and was informed by the Deputy Superintendent that the log sheets for the timeframe of October 2002 through January 2003 were unable to be located. The OJSO requested copies of the incident reports resulting from staff searches and restraints of the resident and was told that they were unable to find any incident reports. Office of Juvenile Affairs policy OAC 377:35-3-8 states, "After any search, staff shall make a full report of the scope of the search, detailing any item confiscated." Copies of the log sheets, which were obtained by the OJSO through other means, indicated that the resident was searched six times and was restrained six times by staff in October 2002. The reports of November 2002 indicated that the resident was searched eight times and had no restraints. In June 2004, the OJSO was advised by an Assistant Attorney General assigned to the OJA that she had copies of the completed search report forms, but that she would need to review them before providing copies to the OJSO. The OJSO had not received the copies of the report forms at the time this report was written.

On October 28, 2002, the Administrator of Programs of the ITP issued a second memorandum in reference to the resident. The memorandum stated that the resident was no longer allowed to go to the gymnasium, because he continued to acquire contraband to insert into his body. The only recreation that the resident received was to go to the gymnasium. By taking away that privilege, the facility was not in compliance with ACA standards 3-JTS-5F-01 and 3-JTS-5F-06 and OJA policy OAC 377:3-13-42. The October 28 memorandum also stated that staff members were to accompany the resident when he used the bathroom. Please see Attachment 5.

5. Did the Rader Center's administration violate policy by subjecting the resident to humiliation by assigning female staff members to watch him shower, urinate, and defecate?

Finding: Violation of OJA policy OAC 377:3-13-42, (7), (B).

On December 12, 2002, the Administrator of Programs of the ITP issued a fourth memorandum entitled, "Staff Instructions for (resident's name)." The memorandum stated, "Staff are not to talk to (resident's name) or EACH OTHER while they are watching (resident's name) . . . This is important because we are trying to bore (resident's name) as well as avoid giving him any material to fuel his oppositional defiant behavior . . . (Resident's name) is to wear the oven mitts at all times." The memorandum further stated, "Staff, even female staff, are required to go into the bathroom with (resident's name) and monitor him while he urinates or defecates. Do not turn your back or avert your eyes while he is doing this." Please see Attachment 6.

Three staff members who were interviewed stated that they believed the resident was embarrassed and was humiliated at having female staff members watch him use the bathroom. Seven staff members interviewed stated that both male and female staff had to watch the resident shower, even though the memorandums did not specifically direct them to do so. Three staff members stated that the resident eventually became accustomed to having female staff members present, and at times, the resident received sexual gratification from being watched by a female staff member while showering. The OJSO believes that this directive was counterproductive to his treatment as a juvenile with sex-offending behaviors. Seven staff members interviewed stated that they were offended regarding the directive to accompany the resident to the bathroom and shower. Eight staff members stated that if staff violated any of the directives by the Administrator of Programs, they would receive a write-up or be terminated from their job.

The Department of Justice's case of the U.S. vs. Louisiana, Civil Case No. 98-0947-B-1, addressed the issue of staff members who were of opposite gender of a juvenile observing the juvenile while showering and using the toilet. The settlement agreement stated that the genital area of the juvenile was to be covered by the use of a screen. The orders by the Administrator of Programs directed staff to observe the resident and did not make any provision for the resident's right to privacy.

6. Does the Rader Center discriminate in the psychological treatment of the residents because of gender?

Finding: Violation of OJA policy OAC 377:3-13-42, (1) and (2).

The facility established the MHSU to treat only male residents. On May 20, 2004, the OJSO interviewed the Chief Psychologist for the OJA. He stated that if a female resident in a training school was in need of psychological services or mental health stabilization, she would be transferred to a private facility. Admissions onto the MHSU consisted of males from the three state-operated training schools. A female resident meeting acute care medical criteria might be sent to a private facility. However, the program developed for the resident in question involved being housed in isolation, being denied use of eating utensils, and having male and female staff persons observe him while he showered or used the bathroom. The OJSO believes the Rader Center and the OJA clearly have discriminated between the mental health treatment of female residents and male residents. Office of Juvenile Affairs policy OAC 377:3-13-42, (1) and (2), states, "A juvenile shall have freedom from discrimination because of race, national origin, color, creed, sex, or physical handicap. Male and female juveniles shall have equal access to all programs and services offered in a detention facility housing both sexes."

7. Did the Rader Center's administration deny the resident who was housed in solitary confinement his right to an education and treatment from the psychological clinician?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-5D-02, 3-JTS-5D-03, 3-JTS-5D-04, 3-JTS-5D-06, and 3-JTS-5D-08; the Terry D. Order of Dismissal; and OJA policies OAC 377:35-17-1, OAC 377:3-13-42, and OAC 377:3-13-45.

Two staff members stated that while the resident was kept locked in the room, he was not allowed to attend school and the psychological clinician for the MHSU did not visit with the resident. Two direct care staff members stated that the school sent the resident's work to the MHSU and the staff helped him with it. Staff stated that most of the assignments given by the school consisted of reading and word search puzzles. The Administrator of Programs of the ITP, the psychological clinician, and one direct care staff member stated that they believed that the resident was low functioning because of a traumatic brain injury he had received when he was fourteen. The log sheets that were later sent to the OJSO documented that the Administrator of Programs of the ITP visited the resident in the isolation room on five occasions in October 2002. As of April 2004, there was no documentation of visits by the psychological clinician of the MHSU during the time the resident was housed in the isolation room.

The OJSO interviewed the teacher of the resident who was housed in the isolation room for approximately sixty-eight days over a three-month period of time. She allowed the OJSO to review the resident's current school work, and she answered questions regarding his education during those approximate sixty-eight days. She stated that during that time, she delivered the resident's school work to the MHSU, but that little work was returned to her. She was able to take time to explain the work to him; however, she was not able to teach him his assignments.

The administration and staff of the Rader Center are required to provide a free and appropriate public education (FAPE) to all of the identified residents needing special education services, pursuant to the IDEA, 34 C.F.R. § 300.340 through 300.350; Section 504 of the Rehabilitation Act of 1973; and the Americans with Disabilities Act. The resident had a current individualized education program (IEP), but the facility failed to follow the IEP when this juvenile was kept in the isolation room. The resident also was not provided a teacher who was prepared to teach a juvenile with a full-scale IQ of 53. The teacher's statements regarding his level of ability concurred with the OJSO's findings in the review of his current school work. The resident was able to do work on the first grade level in most subjects and on the second grade level in some subjects. The Administrator of Programs of the ITP and three direct care staff members stated that the resident often required assistance throughout an assignment in order to comprehend the work.

8. Did the administration violate ACA standards and/or OJA policy by not allowing the resident to participate in outdoor recreation?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-5F-01 and 3-JTS-5F-06, and OJA policy OAC 377:3-13-42.

All staff members interviewed stated that the resident was not allowed to go outside for physical exercise, except on rare occasions. When the resident was allowed to leave the room, he normally was taken to the gymnasium to play basketball. The resident was only allowed to play alone. American Correctional Association standard 3-JTS-5F-06 states, "There should be opportunities for exercise and constructive leisure time activity for at least two hours on school days and three hours on non-school days, not including time spent watching television." The log sheets that were received by the OJSO at a later date indicated that the resident was placed in the seclusion room on October 2, 2002. The fifteen-minute observation logs indicated that the resident spent the majority of his day lying on his mattress or sitting in a chair, with no physical activity. According to the log sheets, the resident was allowed a total of four hours and thirty minutes of recreation time for the month of October 2002. The resident received only thirty minutes of outdoor recreation time in October 2002. The resident received a total of five hours recreation time for the month of November 2002, of which one hour and ten minutes were for outdoor recreation. The log sheets for the partial month of December 2002 did not show any recreation time afforded the resident.

9. **Did the OJA attempt to obstruct the OJSO's investigation by not providing documents and instructing staff to decline requests for interviews by the OJSO?**

Finding: Violation of Section 601.6, B., (1), of Title 10 of the Oklahoma Statutes.

A source at the Rader Center provided the OJSO with copies of the suicide precaution observation records for the months of October, November, and the partial month of December 2002 for the resident in the seclusion room. The staff also provided copies of census reports for the partial month of November 2002 and the full months of December 2002 and January 2003. The copies of records were mailed to the OJSO during the course of the investigation. The observation records documented that the resident was kept in a seclusion room during this time period. The records indicated that the staff had named the seclusion room after the resident. It is concerning that the Deputy Superintendent repeatedly denied that the reports existed.

In addition, the OJSO telephoned the Records Manager at the Rader Center and requested the dates of when two residents were placed in the CMC and the dates for when these residents were released from the CMC. The Records Manager stated that she would need to check and call back. The Records Manager never called back with the information, and the OJSO had to locate the information from another source.

Also, as mentioned earlier in the report, the facility's Superintendent declined to be interviewed by the OJSO and cited instructions by an Assistant Attorney General for the OJA. Four requests by the OJSO to conduct an exit conference to report these findings to the Rader Center's administration went unanswered. Please see Attachment 7.

10. **Did the Rader Center's administration attempt to conceal from the ACA auditors the fact that the resident was kept in solitary confinement, by placing the resident on the MHSU while the audit took place, and then returning him to the seclusion room when the audit was completed?**

Finding: No violation was found. The OJSO did not substantiate the allegation that the resident was removed from the seclusion room to deceive the ACA auditors. The resident was not returned to the seclusion room until four days after the audit ended.

The staff reported that the Administrator of Programs of the ITP had instructed the resident's move from the isolation room during the time period of October 9 through October 11, 2002. The log sheets indicated that the resident was returned to the ITP on the morning of October 9, 2002, which was the day the ACA audit began. The OJSO obtained a copy of the report from the ACA audit and noted that the audit occurred from October 9 through October 11, 2002. The resident injured himself on October 15, 2002, by inserting an object into his body and had to be taken to the

hospital. When the juvenile returned to the facility, the log sheets indicated that he was returned to the seclusion room.

11. **Did the OJA Executive Director, the OJA Deputy Director of Institutions, and the Rader Center's administration violate the provisions of the Terry D. Consent Decree's dismissal order, ACA standards, and OJA policies by keeping two male residents locked in solitary confinement in excess of forty days?**

Finding: Violations of the Terry D. Order of Dismissal; ACA Standards for Juvenile Training Schools, 3-JTS-2C-04, 3-JTS-3D-07, 3-JTS-3E-01, 3-JTS-3E-02, 3-JTS-3E-03, and 3-JTS-3E-05; OJA policy OAC 377:35-11-4; and Rader Center policies SE-2419, SE-2420, and SE-2422.

The OJSO was advised by two direct care staff members, the Deputy Superintendent, and the Advocate Defender that two male residents had been placed in the CMC for assaulting staff. The staff members stated that these two residents had been in the CMC since early February 2004. The OJSO observed both residents on the crisis unit. The log book documented that one of the two residents was placed on the crisis unit on February 10, 2004, and the other resident on February 18, 2004. The Deputy Superintendent of the Rader Center stated that during a meeting with the OJA Executive Director, the OJA Deputy Director of Institutions, the Rader Center's Superintendent, and the Rader Center's Administrator of Programs of the ITP, the OJA Executive Director gave instructions for both residents to be housed in the CMC. The Deputy Superintendent stated that the OJA Executive Director told him that if there were any problems, he would take care of them.

The Administrator of Programs of the ITP issued a set of precautions for the CMC. Please see Attachment 8. The precautions indicated that the residents would be allowed out of their rooms from 6:30 (p.m.) to 8:00 (p.m.) to watch television and have leisure time, if they behaved appropriately throughout the day. The precautions did not specify a separate time for recreation or for how long recreation would be. The precautions stated that only one resident was allowed out of their room at a time, unless the residents were attending group therapy sessions or having recreational activities. The residents had to eat their meals, do their school work, and work on their treatment assignments in their rooms. The rules did not allow for recreation time; however, staff members were advised that the residents were allowed to go to the gymnasium for forty-five minutes each day.

Rader Center policy SE-2419, revised on June 19, 2003, stated, "The goal of crisis management is to resolve problems and conflicts of juveniles toward their continued living within the general population." The policy stated that a juvenile could only be housed in the CMC for twenty-four hours, unless an exception was noted in accordance with Rader Center policy SE-2420, which stated, "A juvenile may be retained in the Crisis Management Center for a period not to exceed 72 hours." While in the CMC, the residents were permitted to participate in regular programs and services, except when participation posed a physical danger to others.

Although both residents were housed in the same building, their isolation from each other constituted solitary confinement. Rader Center policy SE-2422 defined solitary confinement as "confinement in a room, including juvenile's own room, when locked or unlocked or when juvenile is restrained (including verbally restrained) from leaving, except during normal sleeping hours. Room restriction beyond 60 minutes is considered solitary confinement." The policy stated, "No juvenile shall remain in solitary confinement in excess of three hours In the event a juvenile is not sufficiently under control to be returned to the general population following a period of solitary confinement, he/she may be held in the Crisis Management Center in accordance with policies governing crisis management." The OJSO noted that the CMC log book indicated that one of these two residents was housed on the CMC for approximately fifty-two days and the other for forty-four days.

12. **Was the Advocate Defender aware that residents were housed in solitary confinement, and did the Advocate Defender fail to report to the DHS Office of Client Advocacy allegations of abuse and/or neglect and violations of the Terry D. Consent Decree's dismissal order?**

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-5D-03 and 3-JTS-5D-06; the Terry D. Order of Dismissal; and OJA policies OAC 377:35-17-1, OAC 377:3-13-42, and OAC 377:3-1-25.

On April 1, 2004, the OJSO interviewed the Advocate Defender by telephone. The Advocate Defender stated that he was aware that two residents were housed in the CMC and that he believed it was a violation of the Terry D. Order of Dismissal. The Advocate Defender stated that he contacted the OJA Advocate General and the Rader Center's Superintendent to share his concerns. The Advocate Defender stated that he was told that they were following the directives of the OJA State Office.

Both residents filed grievances on March 22, 2004, requesting to be moved out of the CMC. One resident stated in his grievance that he was not receiving education services and was not being provided with recreation time every day. The Advocate Defender stated that he had filed a complaint and a grievance with the DHS Office of Client Advocacy on behalf of one of the residents, because he believed that the resident's rights were being violated. The Advocate Defender stated that the resident was not receiving any treatment and was not being seen by the psychological staff as required by policy.

The OJSO noted that the Advocate Defender did not file a complaint with the DHS Office of Client Advocacy until April 1, 2004. On April 13, 2004, the OJSO contacted the Advocate Defender and requested copies of the complaint and grievance he had filed on behalf of the resident. The Advocate Defender advised the OJSO that he had been told by the OJA Advocate General that he could not provide the OJSO with copies of the grievances. The Advocate Defender stated that the OJSO would have to go to the facility and make the copies.

The OJSO was copied on an electronic message dated April 2, 2004, from the DHS Office of Client Advocacy to the Advocate Defender confirming receipt of the referral on April 1, 2004. The DHS Office of Client Advocacy's referral was in reference to the Administrator of Programs of the ITP allegedly implementing a new program on March 27, 2004, where staff members were instructed to have the two residents housed in the CMC and the two residents were to do their school work and to eat their meals in their rooms. On June 2, 2004, the OJSO requested a copy of the Advocate Defender's report from the DHS Office of Client Advocacy. The report to the DHS Office of Client Advocacy gave the dates that the residents were locked in the CMC as March 27 to April 1, 2004. The Office of Client Advocacy told the OJSO that the referral was sent back to the facility for them to complete a caretaker conduct review. The OJSO provided the Office of Client Advocacy with additional information as to the exact dates the residents were housed in the CMC and requested that the Office of Client Advocacy reinvestigate the allegations. The OJSO was copied on an electronic message, dated April 7, 2004, from the Office of Client Advocacy that it was alleged in the referral that the residents "placed in solitary confinement" were not receiving psychological counseling, as required by OJA policies, *ACA Standards for Juvenile Training Schools*, and the Terry D. Order of Dismissal.

- 13. Did the Rader Center's administration violate OJA policies, ACA standards, or the Terry D. Consent Decree's dismissal order by denying the residents' rights to an education and assistance from their teachers?**

Finding: Violations of *ACA Standards for Juvenile Training Schools*, 3-JTS-5D-03 and 3-JTS-5D-06, and OJA policies OAC 377:35-17-1 and OAC 377:3-13-42.

While the two residents were housed in the CMC, their school work was delivered to the CMC by the teacher; however, no onsite teaching was provided for the residents. According to the Rader Center's school principal, it was not the practice for the school to provide teachers for the residents who were being housed in the CMC.

Office of Juvenile Affairs' policy OAC 377:35-17-1 states that each resident "shall be evaluated, assessed for educational needs, and have access to appropriate teaching, educational materials, and books." The school principal stated that there were only enough teachers for coverage of each class. Office of Juvenile Affairs' policy OAC 377:3-13-42, (14), states, "A juvenile shall receive educational instruction to which the juvenile is entitled under provisions of state education laws and regulations."

- 14. Did the Rader Center's administration report all serious incidents in a timely manner to the DHS Office of Client Advocacy?**

Finding: Violation of OJA policy OAC 377:3-1-25, (a).

It is a violation of the Terry D. Order of Dismissal to house a resident in a locked room in solitary confinement in excess of three hours. The Advocate Defender stated that he believed it was a violation of the Terry D. dismissal order, but he discontinued his

complaint when he was told that the OJA State Office knew about the situation. No report was filed with the DHS Office of Client Advocacy regarding the resident being housed in isolation. Office of Juvenile Affairs policy OAC 377:3-1-21 states that the Advocate Defender is responsible for ensuring that allegations of abuse, neglect, or mistreatment are properly reported to the DHS Office of Client Advocacy. State law requires that every person with reason to believe a child is being abused and/or neglected must report the incident for investigation. The Advocate Defender did not report the information to the Office of Client Advocacy until both residents were kept in solitary confinement in an excess of forty days. The OJSO reviewed a copy of the report the Office of Client Advocacy received from the Advocate Defender regarding one of the residents who was housed in the CMC. Although the Advocate Defender did report to the Office of Client Advocacy on April 1, 2004, that the resident was being held in the CMC, his complaint was that the psychological clinician had not visited the resident. The Advocate Defender did not report to the Office of Client Advocacy that the resident had been housed in the CMC since February 18, 2004.

15. **Does the Advocate Defender for the ITP at the Rader Center ensure that grievances are collected, properly assigned, and resolved in a timely manner?**

Finding: Violation of ACA Standards for Juvenile Training Schools, 3-JTS-3D-09.

The OJSO reviewed the grievance process for the ITP. The OJSO met with the Advocate Defender on April 4, 2004, and made copies of the grievances that were filed in February and March 2004 and the grievance logs for the same time period. The grievance logs for February and March 2004 indicated that approximately twenty grievances had not been resolved and were not on appeal. The OJSO also reviewed the grievance logs for October and November 2003. The logs indicated that twenty-seven grievances had not been resolved and were not on appeal. Office of Juvenile Affairs policy OAC 377:3-1-28 allows three days for a grievance to be resolved informally once it is assigned to staff. If the grievance cannot be resolved informally, it is appealed to the supervisor, who has five days to resolve the issue. The juvenile has the right to appeal the decision as a formal grievance, and the Advocate General has five days to process the grievance. The Advocate General then forwards a copy of the grievance to the appropriate Deputy Director, who has seven days to respond. The juvenile has the right to appeal the decision to the OJA Executive Director, who has ten days to respond.

The OJSO noted that the time requirements on all of these had been violated. Attempts to contact the Advocate Defender to clarify whether the grievances had been resolved were not successful. Three of the six residents interviewed on the MHSU stated that they no longer bothered completing grievance forms, because the grievance process did not work.

The OJSO reviewed specific grievances to ensure proper procedures were being followed and to check for accuracy. On February 7, 2004, a resident filed a grievance alleging that a staff person had given an early bedtime of 6:00 p.m., had refused to allow the resident to shower, had not allowed the resident to have his snack, and had told other residents not to talk with the resident. The Advocate Defender assigned the grievance to the Administrator of Programs of the ITP for resolution and requested that the administrator verify whether the staff person had given the resident an early bedtime. The administrator's response to the grievance was, "Uncertain if this occurred but staff have been told no EBTs (early bedtimes) before 7:00 p.m." The Administrator of Programs did not conduct an investigation, and the resolution did not address all of the allegations made by the resident. Another resident had filed a grievance on March 17, 2004, alleging that the Administrator of Programs of the ITP had threatened him with certification as an adult. The Advocate Defender assigned the grievance to the Administrator of Programs for resolution. The response to the resident by the Administrator of Programs stated, "This is a lie. (Resident's name) asked what was going to happen and I told him there was a good chance he would go to the Penitentiary since he had 5 felony assaults. He has vastly distorted this conversation." Two staff members related that they had heard the Administrator of Programs threaten residents with adult certification.

16. Did the Administrator of Programs of the ITP deny juveniles recreation time as a form of punishment?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-5F-01 and 3-JTS-5F-06, and OJA policy OAC 377:3-13-42.

Three memorandums issued by the Administrator of Programs of the ITP, given to the OJSO by a Rader Center staff member, indicate that residents were at times denied recreation time. The Administrator of Programs would list a juvenile or a group of juveniles as an escape risk, even though there was no documentation in the files to support the conclusion. A staff member provided the OJSO with a copy of a memorandum dated August 1, 2003, issued by the Administrator of Programs, denying outdoor recreation activities to some of the residents until further notice, due to the residents being escape risks. One of the residents listed was obese and had a bone disease that caused his bones to break with little pressure. Due to the physical characteristics of this resident, it would be extremely difficult for him to climb the fence around the facility to escape. On April 16, 2004, the Administrator of Programs issued a memorandum denying outdoor recreation to all of the residents on the MHSU. The memorandum stated, "These juveniles have been deemed to be an escape risk." There was no supporting documentation to indicate that any of the residents on the MHSU were threatening or had attempted to escape.

17. Did the Rader Center violate DHS licensing standards, ACA standards, and OJA policies by serving unpalatable food and not allowing the juveniles to have second helpings?

Finding: Violations of DHS licensing standard, Section 154.4, (b), (2); ACA Standards for Juvenile Training Schools, 3-JTS-4A-01; and OJA policy OAC 377:35-5-1.

The OJSO received complaints from both staff and residents about the quantity and quality of the food at the Rader Center. Eleven of the seventeen staff members interviewed about the food service stated that the quality of the food was poor and six stated that the food was fair. Six staff members stated that they had found bugs or bug parts and hair in their food. American Correctional Association standard 3-JTS-4A-01 states that the Food Service Manager has the responsibility to provide "three meals a day that are nutritionally adequate, palatable, and attractive and produced under sanitary conditions." Ten of the fourteen juveniles interviewed about the food stated that they did not get enough to eat and that they were always hungry. The OJSO noted that staff and juveniles both stated that they were not allowed to have seconds at meal time. The facility required all of the juveniles on the MHSU to eat their meals on the unit. Three of the residents on the MHSU described the food in detail as nasty. Four spoke about the frequent lack of adequate food. They described being hungry on weekdays and having more food on weekends, due to not having to feed the staff members.

Three staff members reported that the kitchen delivered the food approximately one hour early to the MHSU. The OJSO observed the food being delivered approximately forty-five minutes to one hour early before meal time on three occasions. The staff then had to take time to heat the food or to serve it at the cooled temperature. Staff stated that if there were only two staff members working on the unit, they could not take the time to reheat the meals and maintain adequate coverage for the juveniles.

18. Did the Rader Center violate state law or OJA policies by allowing juveniles to prepare and/or serve food on the MHSU?

Finding: Violation of the State Department of Health's regulation OAC 310:256-3-3, (11).

The OJSO was advised that the facility used juveniles from other units in the facility to serve the food on the MHSU. On April 14, 2004, the OJSO observed a juvenile serving food in the kitchen, without any staff supervision. The facility was using juveniles and staff, who had not been properly trained in food preparation and the handling of food, to serve and prepare food for the residents on the MHSU. On March 9, 2004, during the OJSO's observational tour of the kitchen on the MHSU, food was observed in the microwave oven. The staff advised that the food was for a juvenile who had returned from court. The OJSO observed the food in the microwave oven at approximately 1:30 p.m. and noted that the food had remained in the microwave since approximately 11:30 a.m. The inspector from the health department stated that he had notified the facility that there had to be at least one

person who was a certified food handler in the kitchen supervising when the food was being served to the residents.

19. Did the Rader Center violate OJA policy and/or ACA standards by not providing adequate hygiene items to the juveniles?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-4B-14, and OJA policy OAC 377:35-5-6.

The OJSO was advised by four staff members on the MHSU and the ITP that there was an inadequate supply of hygiene items for the residents. One staff member on the MHSU showed the OJSO that there was only one bottle of shampoo for the entire unit. Staff on the two units stated that for several months, the residents did not have shampoo. The residents had begun to shower with their shampoo because of the fragrance. This had caused a shortage of shampoo for all of the units. The staff stated that the hygiene items that were being purchased would not adequately clean the residents when they showered. Staff reported that even when a resident showered on a daily basis, severe body odor remained a problem. Staff stated that one staff member was disciplined for bringing hygiene items to work for the residents to use.

20. Did the Rader Center violate ACA standards or DHS licensing standards by not providing adequate bedding for the residents on the MHSU?

Finding: Violations of ACA Standards for Juvenile Training Schools, 3-JTS-2C-03, and DHS licensing standard, Section 157, (k), (1).

The mattresses and pillows on the MHSU were not usable. Three of the mattresses were foam rubber only and did not have plastic covers. Three other mattresses had large rips in the plastic covers. A mattress being used by one resident had a large rip down the side, giving the resident easy access to exposed springs and wires inside. The psychological clinician for the MHSU described the resident as psychotic and self-destructive.

Residents on the MHSU were required to turn in their bedding and mattresses each morning. The bedding and mattresses were reissued in the evening at bedtime. There was no control to ensure that the residents received their own bedding, which could present a health and safety issue due to illness or communicable disease. Residents on the MHSU who were on suicide watch were issued a safety blanket, which was a thin, one-piece, green canvas pad and blanket. The resident had to sleep on the floor, next to the staff desk. Department of Human Services licensing standard, Section 157, (k), (1), states that each resident is to have an individual bed, with its own mattress and bedding.

Conclusions

This report pertains to an investigation by the OJSO of the Rader Center, which was conducted over a number of visits. During the visits to the Rader Center, the OJSO reviewed the practices and procedures of the MHSU and found numerous violations of the Terry D. Consent Decree's Order of Dismissal, the ACA *Standards for Juvenile Training Schools*, DHS licensing standards, OJA policies, and Rader Center policies and procedures.

The OJSO requested a clinical consultation by a licensed psychologist, who has experience in juvenile and correctional settings, regarding the quality of treatment being provided to residents on the MHSU. The consultant cautioned that his draft report was "based on a very superficial review of available documents and relatively brief interviews with those deemed most essential to the fact gathering." His concerns were the apparent lack of response to the allegations made by numerous employees regarding the conditions of the Rader Center's MHSU, the conflicts between departments and individuals within the Rader Center, and a lack of staff training for treatment of the program's population, specifically mental illness, developmental disabilities, and the skills needed to manage that special population. The consultant stated that the mental health and medical staff members on the MHSU needed to be able to communicate with the psychiatrist for the facility. His recommendations were that a committee should be established to review the medication issues, the original allocated funding for the MHSU should be reallocated back to the MHSU for needed staff and resources, existing policies should be revised and an officially recognized written plan should be developed, and residents who have severe cognitive deficits, either from a developmental disability or brain injury, should not be housed on the MHSU, since its purpose was for psychiatric acute care stabilization. The consultant found no significant problems with the care provided the MHSU juveniles.

In the initial stages of the OJSO's investigation, the Rader Center was cooperative in providing the documents that were requested. However, the administrations of the OJA State Office and the Rader Center denied the existence of important documents, including medical records, incident reports, and log sheets, which, when copies were obtained by other means, conclusively proved that the resident was housed in the seclusion room during the timeframe of October 2002 to January 2003. The OJSO is concerned about the level of cooperation received. Since the OJSO later received copies of the log sheets from a source other than the OJA State Office, the logical conclusion was that the OJA State Office administration may have intended to deny the OJSO access to the records or they allowed their records keeping system at the Rader Center to become so disorganized that they did not know what documents they had or did not have.

All services provided at the Rader Center, including food, education, leisure, and counseling, were found to be problematic. The punitive approach to treatment by the administrations of the Rader Center and the OJA State Office was concerning. The administrations of both the Rader Center and the OJA State Office were verbally informed

by the OJSO of the most serious problems at the Rader Center and were offered an exit conference four times in order to be given a comprehensive review of the OJSO's findings. However, the four requests for an exit conference went unanswered by the Rader Center and the OJA State Office.

The OJSO interviewed twenty-five current direct care staff members and one former direct care person. The staff reported that a rift had developed between the administration and the direct care staff. Eleven direct care staff members stated that they did not believe that the administration was supportive of them and six stated that they believed the administration would retaliate against the employees if they complained. On June 28, 2001, twenty-seven employees signed a letter that was written to the Rader Center's administration and the OJA Executive Director expressing their concerns regarding safety issues. The direct care staff members interviewed stated that their safety issues were never addressed. On August 14, 2003, forty-eight employees signed a letter that was delivered to an Assistant Attorney General assigned to the OJA. The Assistant Attorney General stated in a letter dated September 3, 2003, that the employees' complaint letter was reviewed by the Chief of the General Counsel unit and the First Assistant to the Attorney General of the Oklahoma Attorney General's office. The letter from the Assistant Attorney General stated that the Chief of the General Counsel unit and the First Assistant to the Attorney General both had determined that the situation at the Rader Center did not rise to the level of criminal violations by the Rader Center's administration. The Assistant Attorney General also stated in his letter that the Attorney General's office did not have investigators who could conduct an independent investigation and that the Attorney General's office had the option of requesting the Oklahoma State Bureau of Investigation to conduct an investigation into any allegation of wrongdoing by a state employee or agency. The Assistant Attorney General further stated in his letter that it was his estimation that an independent investigation could cost approximately \$40,000 to \$50,000. The Assistant Attorney General wrote, "Given the budget situation in State agencies in general and the Office of Juvenile Affairs in particular, I am certain that a request for an outside investigation would be rejected on the basis of its cost. This leaves us with the following two possible courses of action as I see it. First, if the employees have a proposal for an outside investigation and a way to pay for it, by all means let me know." Please see Attachment 9.

A representative for the employees requested a meeting with the Assistant Attorney General and two OJA board members. The employees' representative requested that the meeting be held without attendance by the OJA Deputy Director of Institutions and members of the Rader Center's administration. On October 7, 2003, the Assistant Attorney General notified the employees' representative that the meeting was scheduled for October 13, 2003, and that the chairman and the vice-chairman of the OJA board and a representative from the Governor's Office would attend. The OJA board members were not present at the meeting; however, the OJA Deputy Director of Institutions was present and requested to tape record the meeting. The employees' representative requested that the meeting be cancelled.

In a letter dated October 20, 2003, the Assistant Attorney General stated, "The Office of Juvenile Affairs will investigate the specific allegations made in the employees' petition." The OJSO contacted the director of the OJA Office of Public Integrity (OPI). The OPI Director stated that he had not conducted an investigation into the allegations presented by the Rader Center's employees and was not fully aware of the allegations.

Recommendations

To the Board of Directors of the Office of Juvenile Affairs:

1. Review the actions of the OJA administration to determine appropriate action for possible violations of state law, DHS licensure standards, ACA standards, and OJA policies by allegedly ordering two residents to be housed in the CMC in excess of forty days.
2. Review the actions of the Advocate Defender to determine whether personnel action is warranted for violations of state law, DHS licensure standards, ACA standards, and OJA policies by failing to report to the DHS Office of Client Advocacy that two residents were being housed in the CMC in excess of forty days and one resident was in isolation for approximately sixty-eight days over a three-month period of time.
3. Review the concerns of the direct care staff members and establish a forum for employees to voice their concerns, without fear of retaliation from the OJA administrative staff.

To the Office of Juvenile Affairs:

1. Review the actions of the Rader Center's Administrator of Programs of the ITP to determine personnel action warranted for violations of state law, DHS licensure standards, ACA standards, and OJA policies by allowing a resident to be housed in seclusion for approximately sixty-eight days over a three-month period.
2. Review the actions of the psychological clinician of the Rader Center's MHSU to determine personnel action warranted for violations of state law, DHS licensure standards, ACA standards, and OJA policies by allowing a resident to be housed in seclusion for approximately sixty-eight days over a three-month period and not providing adequately modified and individualized group curriculum, treatment plans, and progress notes.
3. Review the contract with the school district to ensure that **all** residents are allowed to attend or to receive instruction from a certified teacher, if the residents are unable to attend the onsite school, and that the IEPs are followed.
4. Establish an independent panel of experts to review the practices, policies, and procedures of the MHSU to determine what changes can be made to ensure proper therapeutic and humane treatment of the residents.

To the L. E. Rader Center:

1. Cease use of the suicide smock, because it is not effective in preventing residents from injuring themselves and it is perceived by some staff and some residents interviewed as humiliating and used for punishment.
2. Develop procedures to ensure that residents who are not allowed to go to school are given the same opportunities for education as residents who are attending school.
3. Ensure that residents who are currently on IEPs are provided educational opportunities as guaranteed under FAPE of the IDEA.
4. Ensure that the policy for solitary confinement is adhered to in all situations.
5. Ensure that all staff members adhere to policies and document when a resident is restrained or searched and that the information is documented in the file on the resident.
6. Ensure that all residents are afforded an opportunity for structured outdoor recreation time and that they receive the appropriate amount of recreation time according to policies and ACA standards.
7. Ensure that staff document all serious incidents and properly and accurately report them to the DHS Office of Client Advocacy in a timely manner.
8. Review the practices of the Advocate Defender and provide training to ensure that all grievances are addressed properly and in a timely manner.
9. Ensure that the denial of recreation time is not used as a form of punishment and that group punishment is not allowed, according to OJA policy.
10. Ensure that the quality of the food meets standards and that second helpings are available at each meal, according to licensure requirements.
11. Ensure that residents are provided with the proper amount of hygiene items and that supplies are kept available on the units.
12. Ensure that all residents are provided with a serviceable mattress and that if the mattresses must be turned in each day, a system is established to ensure that each resident receives the same mattress he originally was issued.
13. Cease the practice of having residents place their mattresses on the floor when on suicide watch or on close observation.

To the DHS Office of Client Advocacy:

1. Review the procedure of referring complaints back to the facilities for investigation as a caretaker conduct review. Establish policy and safeguards to ensure that if a complaint is referred back to a facility, the complaint is investigated completely and properly by an independent source.
2. Conduct an assessment of the caretaker conduct reviews to ensure that the investigations were conducted properly and completely and that the findings were correct.

To the DHS Division of Child Care:

1. Assess the MHSU to determine if it should be licensed separately from the rest of the institution.

To the Oklahoma Licensure Board for Licensed Professional Counselors:

1. Review the actions of the Administrator of Programs of the ITP, who is a Licensed Marriage and Family Therapist and a Licensed Professional Counselor, and the treatment procedures she established for the resident who was locked in solitary confinement to determine possible licensing violations.

To the Licensed Marital and Family Therapist Advisory Board:

1. Review the actions of the Administrator of Programs of the ITP, who is a Licensed Marriage and Family Therapist and a Licensed Professional Counselor, and the treatment procedures she established for the resident who was locked in solitary confinement to determine possible licensing violations.

To the American Correctional Association:

1. Conduct an audit of the Rader Center to ensure that the facility is in compliance with ACA accreditation standards.

To the Oklahoma Legislature:

1. Review the systemic problems at the Rader Center and make recommendations to the OJA.

To the Federal Court Monitor of the Terry D. Consent Decree:

1. Review the findings of this report for compliance with the Terry D. Consent Decree's Order of Dismissal.

DH:js

