

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

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**Name and Location of Facility:** Beckham County Juvenile Detention Center  
Elk City, Oklahoma

**Date of Visit:** July 3, 2007

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

**Focus of Visit:** Oversight Visit

**Date:** July 31, 2007

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**General Information**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on July 3, 2007, to the Beckham County Juvenile Detention Center, located in Elk City, Oklahoma. The purpose of the visit was to monitor compliance with established responsibilities. The facility was certified by the Office of Juvenile Affairs (OJA) for six juveniles. The OJA contracted with the Beckham County Board of Commissioners for the detention center, and in turn, the County Commissioners contracted with the Western Plains Youth & Family Services for the daily operation of the detention center. The facility provided regional detention services to other counties. On the day of the OJSO visit, the census was five.

Persons Interviewed

- Entry interview and an exit conference with the Assistant Superintendent
- Two direct care staff members
- Five residents

Documents Reviewed

- Two personnel files
- Files on five residents
- Office of the Oklahoma State Fire Marshal inspection report, dated October 11, 2006
- Oklahoma State Department of Health inspection report, dated March 8, 2007
- Annual assessment report issued by the OJA Office of Public Integrity regarding a visit conducted on April 3, 2007
- Incident reports
- Facility logs on room confinement/room restriction

## **Findings**

### Interviews

The OJSO interviewed all five residents. The interview questions pertained to the residents' perceptions of safety, detention program services, the rights of the residents, discipline practices, and other residential care issues. The OJSO noted:

- All five residents stated they felt safe at the facility.
- Three of the five residents stated that either they had been mistreated by a particular staff member or they had witnessed the staff person mistreating other residents. The residents stated that the staff member targeted specific residents by placing them on room restriction for violations of rules for which other residents were not disciplined. Each of these three residents named the same staff member. The OJSO discussed the information with the Assistant Superintendent. The Assistant Superintendent agreed to address the issue.
- Four of the five interviewees stated residents were only allowed recreation outdoors an average of one time per week; the fifth interviewee stated residents were allowed outdoor recreation an average of two times per week. Facility notes indicated the residents received daily recreation; however, the documentation did not specify outdoor or indoor recreation. The Assistant Superintendent confirmed that outdoor recreation was limited, due to the weather and staff shortages.

Two direct care staff members on-duty were interviewed. Both reported receiving appropriate training and demonstrated familiarity with the facility's policies and procedures and the detention standards. No concerns were noted from the staff interviews.

### File Reviews

The OJSO reviewed the files on the five residents. The files were essentially complete and well-organized. No issues of concern were noted from the resident file reviews.

Two personnel files were reviewed. The files were complete and well-organized. No issues of concern were noted from the staff file reviews.

### Room Confinement/Restriction Logs Review

The OJSO reviewed the room confinement/restriction logs for April through June 2007. Three incidents of room confinement were documented for the three-month period. The OJSO noted that the rule violations documented did not meet the criteria for room confinement. The residents were placed on room confinement for the following reasons:

- One resident was found with paint chips in his room.
- A staff member observed pieces of a floor mat near one resident's chair.

- One resident stated that he was not going to follow the rules when taken off of room restriction.

The OJSO noted that the information recorded on the room confinement log regarding the three incidents was inconsistent with information documented in the incident reports and on the well-check sheets. In addition, the OJSO noted that documentation indicated the resident placed on room confinement for having paint chips in his room received three administrative reviews. During the first review, the staff documented that the resident was “not following rules.” The next review stated that the resident was “complying with rules,” and the third review stated the resident was “very cooperative.” The resident was released from room confinement approximately fifteen minutes after the third review. The staff did not document in the first review how the resident was not following the rules and did not document why it was not safe to release the resident from room confinement after the second administrative review.

## **Summary**

The OJSO reviewed the most recent inspection reports by the Office of the State Fire Marshal, the Oklahoma State Department of Health, and the OJA Office of Public Integrity. No violations were cited in the three reports.

## **Violations**

1. Three of the five residents stated they had been mistreated by a staff member or had witnessed another resident being mistreated by the staff member. All three residents identified the same staff person. OJA policy OAC 377:3-13-42, Juvenile rights, (7), (B) and (C), states, “Facility staff shall not discipline a juvenile by using humiliation (or) mental abuse.”
2. The OJSO reviewed three incidents of room confinement and noted that the reasons documented for the confinement did not meet criteria. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), states, “Room confinement is used with detained juveniles:
  - (i) for self protection;
  - (ii) to separate juveniles from fighting;
  - (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
  - (iv) to restrain juveniles who have escaped or who are in the process of escaping;
  - (v) to prevent destruction of property if reasonably related to (i) through (iv); and
  - (vi) (to) stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility and is reasonably related to (i) through (iv).”
3. Documentation regarding room confinement was inaccurate. The times documented in the incident reports and on the room confinement log and the well-check sheets were inconsistent; therefore, the OJSO could not determine the lengths of time the residents remained on room confinement. OJA policy OAC 377:3-13-44, (c), (15), Procedure for room confinement or room restriction, (E), states, “A written record shall be maintained on any juvenile placed in room restriction or confinement. It includes a log stating who authorized the action, names of persons observing the

juvenile and times of observation, the person authorizing release, and the time of release.”

4. Documentation indicated a resident remained on room confinement for approximately two hours after staff recorded that the resident was abiding by the facility rules and was cooperating with staff. OJA policy OAC 377:3-13-44, (c), (15), Procedure for room confinement or room restriction, (D), states, “The juvenile shall be released when staff determines that he or she can safely be returned to the group.”

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