**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<br>Elk City, Oklahoma |
| **Date of Visit:** | April 29, 2008 |
| **OJSO Reviewer:** | Dana S. Holden, Oversight Specialist |
| **Focus of Visit:** | Oversight Visit, 2008 |
| **Date:** | May 22, 2008 |

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## Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on April 29, 2008, at the Beckham County Juvenile Detention Center, located in Elk City, Oklahoma. The purpose of the visit was to monitor compliance with established responsibilities and facility policy and procedures. The facility is certified by the Office of Juvenile Affairs (OJA) for six juveniles. The OJA contracts with the Beckham County Board of Commissioners for the detention center, and the County Commissioners contract with the Western Plains Youth & Family Services for the daily operation of the detention center. The facility provides regional detention services to other counties. On the day of the OJSO visit, the census was six.

Interviews Conducted

- Entry interview and an exit conference with the Assistant Superintendent
- One direct care staff
- Three residents

Documents Reviewed

- Files on four residents
- Files on two staff members
- Training records for eight employees
- Office of the Oklahoma State Fire Marshal inspection report, dated January 11, 2008
- Oklahoma State Department of Health inspection report, dated January 28, 2008
- Annual assessment report issued by the OJA Office of Public Integrity regarding a visit conducted on January 4, 2008
- Incident reports

## Findings

Interviews

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

- Two interviewees stated they felt safe at the facility.
- Two interviewees reported that a resident was placed on room confinement for tapping his foot on the floor.

No additional concerns were noted from the resident interviews.

One direct care staff member on-duty was interviewed. The staff member 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 interview.

File Reviews

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

The OJSO reviewed the complete personnel files and training records of two employees and the training records of an additional six employees. The personnel files were complete and well-organized. No issues of concern were noted from the personnel file reviews.

The eight training records reviewed indicated:

- Five files did not contain current training in first aid.
- One file did not contain current certification in cardiopulmonary resuscitation (CPR).
- Two files did not document the required number of training hours for 2006 and 2007.

Room Confinement Review

The OJSO reviewed four incident reports regarding room confinement for February 28 through April 28, 2008. The OJSO noted that the rule violations documented did not meet the criteria for room confinement and incident reports were not filled out properly. The reasons for room confinement were:

- One resident refused to do his school work.
- One resident refused to quit tapping his foot. The resident became upset and refused to speak to staff. The staff sent the resident to his room at 1:35 p.m. on April 21, 2008, and released him at 9:55 a.m. on April 22, 2008.

- An incident report stated that on April 27, 2008, at 6 p.m., a resident was placed in room restriction for making noise and trying to watch television. At 7:00 p.m., staff took the resident to the classroom to talk to him, and at 7:30 p.m., the resident was placed on room confinement. The resident remained on room confinement until 7:30 a.m. on April 28, 2008. The incident report stated the resident was released from room confinement and placed on an "intervention program." Under this program, the requirements for the resident were:

  1. eat all meals in his room;
  2. keep separated from the other residents; and
  3. remain in his room, with the door open, when other residents are in the dayroom.

The OJSO discussed this incident with staff and informed them that room confinement was assigned when the resident was kept in his room and separated from the general population. The staff reported that they believed the resident's disruptive behaviors would possibly incite the other residents and could pose a threat to the safety of the staff. However, it appears the facility reacted prematurely, as the resident was placed on room confinement even though his behaviors had not incited other residents to misbehave. OJA policy does not allow for residents to be placed in confinement based on what might happen.

**Violations**

1. Five employee files did not contain current certification in first aid. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (E), in part, states, "Within 90 days after employment, all direct-care staff shall have successfully completed first aid training from an instructor certified by the American Red Cross or its equivalent."
2. One employee file did not contain current certification in CPR. OJA policy OAC 377:3-13-43, Staff requirements (a), General provisions, (8), Staff training, (F), in part, states, "All direct-care staff shall be certified in cardiopulmonary resuscitation (CPR) within 90 days after employment and recertified annually."
3. Two employee files did not document the required number of training hours for 2006 and 2007. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (8), Staff training, (G), in part, states, "Full-time direct-care staff and administrators shall obtain at least 24 clock hours of training per employment year."
4. The facility placed residents on room confinement for rule violations that did not meet the criteria for room confinement. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), states, "Room confinement is used with detained juveniles:
   (i) for self protection;
   (ii) to separate juveniles from fighting;
   (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
   (iv) to restrain juveniles who have escaped or who are in the process of escaping;
   (v) to prevent destruction of property if reasonably related to (i) through (iv); and

(vi) [to] stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility and is reasonably related to (i) through (iv).

**Summary**

The OJSO reviewed the most recent inspection reports by the Office of the State Fire Marshal and the Oklahoma State Department of Health. No deficiencies were noted in either report. The OJSO also reviewed the most recent inspection report by the OJA Office of Public Integrity. The report cited the facility for one staff not having the required training in first aid and certification in CPR. A corrective action plan was submitted to the OJA.

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