

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

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

Date of Visit: September 8, 2009

OJSO Reviewer: Dana S. Holden, Oversight Specialist IV

Focus of Visit: Unannounced Visit, 2009

Date: October 22, 2009

General Information

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on September 8, 2009, 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 was certified for six juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). 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 six.

Persons Interviewed

- Entry interview and an exit conference with the assistant director
- Four residents

Documents Reviewed

- Three personnel files
- Four resident files
- Office of the Oklahoma State Fire Marshal report dated December 17, 2008
- Oklahoma State Department of Health Food Inspection report dated June 8, 2009
- OPI annual assessment report regarding its visit conducted on February 3, 2009
- Facility incident reports for June 2009 through September 2009
- Facility room confinement/restriction logs for January 1, 2009, through September 8, 2009

Findings

Interviews

The OJSO interviewed four 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:

- All four interviewees stated they felt safe at the facility.
- None of the four interviewees reported having been placed on room restriction.
- One interviewee stated that he had witnessed another resident having been mistreated by a staff member; however, the OJSO determined that the behavior described by the reporting resident did not constitute mistreatment.
- Two interviewees stated residents were not allowed recreation outdoors; another interviewee stated the residents were allowed recreation outdoors one time per week; and the other interviewee stated the residents were allowed recreation outdoors one time daily.

No other concerns were noted from the resident interviews.

The OJSO did not interview the direct care staff members on duty. All three staff members had been employed less than two months.

The OJSO conducted an informal interview with the shift supervisor. The only issue discussed with the shift supervisor was the lack of outdoor recreation for the residents. During the visit, the OJSO observed the large muscle activity and noted that staff chose one resident to exercise outside in a completely fenced area by the back door. The shift supervisor confirmed that outdoor recreation was limited at times, due to the weather and staff shortages. No other concerns were noted from the staff interview.

File Review

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

Three personnel files were reviewed. The OJSO noted that one file did not document the required three reference checks. The files were complete and well-organized, with the one exception noted. No other issues of concern were noted from the staff file review.

Room Confinement/Restriction Logs Review

The OJSO reviewed the room confinement/restriction logs for January 2009 through September 2009. The facility had documented seven instances of room confinement

and one instance of room restriction between January 2009 and September 2009. The OJSO noted that the logs did not record the required documentation for when the residents were assigned to their rooms and the door to the room remained open. In these instances, the facility had not documented the reason for the separation, the date and time of the separation, and the time for when the resident returned to the general population. No other areas of concern were noted from the room confinement/restriction logs review.

Incident Report Review

The OJSO reviewed the incident reports for all but one of the incidents of room confinement or room restriction between January 2009 and September 2009. The OJSO noted:

- The date and time were not documented for when residents were placed in room restriction or room confinement.
- Documentation indicated that staff frequently placed residents in their rooms for various periods of time and the door to the room remained open; however, the reasons for the separation from the general population, the date and time of the separation, and the time of the residents' return to the general population were not documented.
- Documentation in the resident files had indicated four residents were placed in their rooms to separate them from the other residents; the time of release for each resident was not documented.

Inspection Reports Review

The OJSO reviewed the most recent inspection reports by the fire marshal's office and the health department. No deficiencies were cited on either report.

The OJSO also reviewed the most recent OPI report and noted that the OPI had cited violations in the areas of personnel records, juvenile interviews, and facility tour. The facility had submitted a corrective action plan dated March 11, 2009, which the OJA had accepted. No concerns were noted by the OJSO.

Area of Concern

1. Incident report documentation did not indicate whether the residents had been placed on room restriction or room confinement when separated from the general population.

Violations

1. Residents were not afforded outdoor recreation on a regular basis. OJA policy, OAC 377:3-13-42, Juvenile rights, (5), states, "A juvenile shall have access to on-site recreational opportunities, including daily outdoor exercise, weather permitting. . . ."
2. One of the three personnel files reviewed did not document the required personal reference checks. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (7), Personnel records, (A), (iii), states, "The facility shall keep on file a written personnel record available for review for every staff person employed by the facility. The personnel record includes . . . three written references and/or documentation of telephone interviews. . . ."
3. Facility staff did not document the disciplinary reason for separating the juveniles from the general population. OJA policy, OAC 377:3-13-44, Security and control, (c), (12), Procedures for separation from general population and/or general activities for disciplinary reasons, in part, states, "If a juvenile is separated from the general population, the reasons for the separation and length of time shall be documented. . . ."
4. Facility staff did not document the time of release in four incidents of room restriction. OJA policy, OAC 377:3-13-44, Security and control, (c), (13), Room restriction, states, "Room restriction is one means of informally resolving minor juvenile misbehavior. It serves a 'cooling off' purpose and has a short time period (up to 60 minutes) that is specified at the time of the assignment."

Summary

The OJSO conducted an exit conference with the assistant director. The OJSO discussed with the assistant director the lack of documentation for when residents were separated from the general population. The OJSO had noted that staff did not record the required documentation in the room confinement/restriction log when a resident was assigned to his/her room and the door to the room remained open. The assistant director stated that since the door was left open, the facility did not consider the separation from the other residents as room restriction or room confinement. According to the assistant director, the OJA during its visits had not cited the facility with a violation for not documenting the separation as a room confinement/restriction. The OJSO explained to the assistant director that criteria was met for room restriction or room confinement when a resident was separated from the general population of residents by assigning the resident to his/her room, whether or not the door to the room remained open, and therefore, the required information for room confinement or room restriction must be recorded on the facility room confinement/restriction log. The OJSO advised that the facility must document the reason for the separation, the date and time of the separation, and the time for when the resident returned to the general population. The OJSO also advised that when a resident remained assigned to his/her room for more than sixty minutes, the facility must document the reason for the extended separation.

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