

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

---

**Name of Facility and Location:** Canadian County Regional Juvenile Detention Center  
El Reno, Oklahoma

**Date of Visit:** December 18, 2007

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

**Focus of Visit:** Unannounced Oversight Visit

**Date:** April 2, 2008

---

**Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit to the Canadian County Detention Center on December 18, 2007. The purpose of the visit was to assess the detention program's compliance with established responsibilities and facility policy and procedures; the sanction program was not evaluated during this visit. The facility is certified by the Office of Juvenile Affairs (OJA) for twenty-eight juveniles. Sixteen beds were designated for the detention program, and, in a separate wing, twelve beds were designated for the sanctions program. On the day of the OJSO visit, the census for the detention program was twelve.

Interviews Conducted

- Entry interview with the Detention Director and the Detention Coordinator
- Exit conference with the facility's Director, the Detention Director, and a District Judge
- Six juveniles in the detention program
- Eight staff members on-duty
- School teacher

Documents Reviewed

- Files on six juveniles in the detention program
- Personnel files and training records of six direct care staff members
- Office of the State Fire Marshal inspection report, dated June 6, 2007
- Oklahoma State Department of Health inspection report, dated October 3, 2006
- OJA Office of Public Integrity monitoring report, dated February 28, 2007
- Facility room confinement/restriction log for 2007
- Facility incident reports
- Facility grievance log

## Findings

### Resident Interviews

The OJSO interviewed six juveniles of the detention program. The interview questions pertained to the juveniles' perceptions of safety, detention programs and services, resident rights, discipline practices, and quality-of-life issues. The juveniles' responses to the interview questions indicated they:

- felt safe at the facility, primarily because of the security of the facility;
- received appropriate care by the staff (however, three of the six reported that staff members yell at the residents when correcting the residents' behaviors);
- participated in recreational activities;
- were knowledgeable of their rights;
- believed the quality and quantity of the food were appropriate; and
- were familiar with the facility's grievance process (however, none of the juveniles interviewed had filed a grievance since arriving at the facility).

No other issues of concern were noted from the juveniles' interviews.

### Staff Interviews

The OJSO interviewed eight staff members. The OJSO noted:

- Six staff reported that they did not have any training in suicide precautions.
- Staff described appropriate knowledge of the grievance procedures.
- Five staff rated the staff morale as medium to low.
- The vast majority of the staff reported that a petition, listing several areas of concern, had been circulated among the employees.

The majority of the complaints expressed by staff in the petition were in regard to procedural changes initiated by the new detention director. During the exit conference, the facility director and the district judge both expressed their support for the changes initiated by the detention director.

Three employees reported that the facility doctor ordered a resident to be transported to the hospital, but that the detention director refused to allow the transport. Staff also reported that the detention director contacted the resident's family and released the resident to his/her mother, without court approval. The OJSO reviewed the resident's medical record and noted that the medical notes stated that on May 19, 2007, at 8:00 p.m., the resident's blood pressure was 160/100 and "(he/she) complained of vomiting blood." The facility's doctor was notified of the symptoms and "ordered that (the resident) needs to be checked at the ER (emergency room) tonight." A release form stated that the resident was released to his/her mother on May 19, 2007, at

approximately 9:40 p.m. The form also stated that there was no release order and that the release was authorized by the detention director.

Staff reported that the detention director instructed the staff that they were not to enter a specific resident's room "even if the resident was trying to hurt (himself/herself)." The OJSO reviewed an incident report dated September 18, 2007, which stated, "(Resident's name) is to be given everything (he/she) needs through the bean hole. No one is to open the door to (his/her) room even if (he/she) is hurting (himself/herself) per (detention director's name)."

### Resident Files Review

The OJSO reviewed the files on six juveniles in the detention program. The files were well-organized, and the materials were easy to locate. No issues of concern were noted from the resident files reviewed.

### Staff Files Review

The personnel files of six direct care staff were reviewed for compliance with OJA detention standards. The OJSO noted:

- Two staff files did not contain documentation of current cardiopulmonary resuscitation (CPR) certification.
- Two staff files did not contain documentation of current first aid certification.
- Five staff files did not contain documentation of the required number of training hours.
- One staff file did not contain documentation of a valid criminal records check through the Oklahoma State Bureau of Investigation (OSBI). The employee's date of hire was listed as October 30, 2003, and the OSBI records check in the file was dated March 10, 2000.

No other concerns were noted from the staff files reviewed.

### Room Confinement/Room Restriction

The OJSO reviewed the room confinement/restriction log for 2007 and fifty-nine incident reports of room confinement occurring from September 1 through December 10, 2007. The OJSO noted:

- Seven instances of room confinement/restriction did not document the residents' release date and/or time.
- Four entries in the log stated that the resident was placed in his/her room "at resident's request." The OJSO noted that in three of the instances, the room request form was signed by the detention director for the resident. Incident reports indicated that the residents were placed in their rooms due to behavioral problems.

One resident was kept in his/her room for fourteen hours, fifteen minutes; another resident was kept in his/her room for thirty-six hours, fifteen minutes, and one resident was kept in his/her room for fifteen hours, forty minutes. In the fourth instance, the incident report stated that a staff member ordered the resident placed in his/her room; although, the incident report stated the resident was placed in his/her room "at resident's request." A room request form had not been signed by the resident.

- Seven instances of room confinement did not meet the criteria for room confinement: The reasons documented for the room confinements were:
  - The resident could not speak English.
  - The resident yelled at a staff member.
  - The resident commented about how long it had taken staff to restrain him earlier in the day.
  - The resident was making fun of another resident.
  - The resident had argued with staff.
  - Two residents were ordered to room confinement by the director.
- One instance documented that the resident was placed on "wing confinement"; however, the length of time of the confinement, from 1750 hours to 2015 hours, constituted room confinement.
- An incident report dated September 16, 2007, stated that (staff's name) "grabbed (resident's name) shoulders and pinned (him/her) against the wall." When the resident refused to talk to staff, he/she was placed in his/her room. The detention director reported the incident to the DHS Office of Client Advocacy on January 23, 2008.
- One resident had tested as high risk when admitted to the facility. The resident refused to eat or take fluids for the first two to four days at the facility. The resident made statements to staff that he/she wanted to kill himself/herself, repeatedly scratched his/her arms to the point of bleeding, ingested soap while washing his/her clothing, and ingested lotion. According to documentation, the resident repeatedly physically attacked staff and had to be restrained, and the resident made sexual remarks to staff whose gender was opposite of the resident's. Documentation did not indicate that the facility attempted to seek crisis counseling for the resident. Documentation did indicate that one of the facility's counselors met with the resident on one occasion.

### Grievance Log Review

The OJSO reviewed the grievance log for October 1 through November 12, 2007; no grievances had been filed since November 12, 2007. The resolutions to the grievances were vague and did not directly address the issues on the grievances. No other issues were noted from the review of the grievance log.

### Education Program Review

The OJSO reviewed the education program at the facility. The El Reno public school system provides the teacher for the facility. The teacher at the facility was not special education certified. The teacher stated that if a resident needed an updated

individualized education program (IEP), a special education teacher came to the facility and conducted the meeting. The teacher also stated that the residents' home school systems had cooperated well and that the facility had not encountered problems obtaining the residents' school records. No concerns were noted from the education review.

### **Areas of Concern**

1. Three of six residents stated that staff yell at residents when correcting residents' behaviors.
2. The detention director issued instructions stating that staff were not to enter a specific resident's room even if the resident was trying to self injure.
3. In three instances, the detention director confined residents to their rooms and listed the confinement on the incident report as "resident request." In another incident, a staff member confined a resident to his/her room and listed the confinement on the incident report as "resident request."
4. Resolutions listed on the grievance forms were vague and did not specifically address the residents' issues.

### **Violations**

1. Six of the eight staff interviewees reported they had not received training regarding suicide symptoms or prevention. OJA policy OAC 377:3-13-45, Program and services, (a), (6), Medical and health care, (E), (vi), (IV), states, "The secure juvenile detention facility shall develop and maintain written policy and procedure which establishes a training program that includes signs and symptoms of mental illness, retardation and drug and alcohol abuse."
2. The detention director refused to transport a resident to the hospital after the facility doctor had ordered the resident to be taken to the emergency room. OJA policy OAC 377:3-13-45, Program and services, (a), (6), Medical and health care, (B), in part, states, "Medical, mental health, and dental care involving medical judgment are the sole province of the designated physician, mental health professional or dentist."
3. The detention director released a resident without proper authorization. OJA policy OAC 377:3-13-41, Release policy and procedure, (2), states, "Written policy and procedure for releasing residents include, but are not limited to, provisions for facility staff to obtain documentation of authority for release, i.e., by court order or operation of law."
4. Two of six staff files did not contain documentation of current CPR certification. 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."
5. Two of six staff files did not contain documentation of current first-aid certification. 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. First aid training is updated every three years. . . .”

6. Five of six staff files did not contain documentation of the required number of annual training hours. OJA policy OAC 377:3-13-43, Staff requirements, (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.”
7. One of six staff files did not contain documentation of a valid OSBI criminal records check. OJA policy OAC 377:3-13-43, Staff requirements, (a), General provisions, (6), Criminal history investigation, in part, states, “The facility shall comply with statutory requirements mandating a criminal history investigation for each applicant for employment [10 O.S. Section 404.1].”
8. Seven instances of room confinement and/or room restriction did not document the date and/or time of release. OJA policy OAC 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (E), in part, states, “A written record shall be maintained on any juvenile placed in room restriction or room 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.”
9. Seven instances of room confinement did not meet the criteria for room confinement. OJA policy OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), in part, states, “Room confinement is used with detained juveniles:
  - i. for self protection;
  - ii. to separate juveniles from fighting;
  - iii. to restrain juveniles in danger of inflicting harm to themselves or others;
  - iv. to restrain juveniles who have escaped or who are in the process of escaping;
  - v. to prevent destruction of property if reasonably related to (i) through (iv); and
  - vi. stop behavior that incites other juveniles which jeopardizes the safety of staff and residents of the facility and is reasonably related to (i) through (iv).”

## Summary

An exit conference was conducted on January 15, 2008, with the detention director, the facility director, and the district judge. All findings and concerns were discussed. It appears there is some conflict between the employees and the detention director. The detention director has initiated new policy and procedural changes, which may be the cause for the conflict. The facility administration is aware of these problems and is willing to address the issues.

DSH:js

