

**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

Dates of Visit: December 29 and 30, 2009

Oversight Reviewer: Dana S. Holden, Oversight Specialist IV

Focus of Visit: Unannounced Visit, 2009

Date: March 22, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit on December 29, 2009, at the Canadian County Juvenile Detention Center, located in El Reno, Oklahoma. The OJSO returned to complete the visit on December 30, 2009. The purpose of the visit was to assess the detention program's compliance with established responsibilities and facility policy and procedures. In addition, the information from this oversight visit was obtained for reporting in the OJSO systemic review regarding room confinement at Office of Juvenile Affairs (OJA) facilities. The facility was certified for twenty-eight juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). Sixteen beds were designated for the detention program; on 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 sixteen. The sanctions program was not evaluated during this visit.

Interviews Conducted

- Entry interview and an exit conference with the detention director and the facility director
- Three residents in the detention program
- Two staff members on-duty

Documents Reviewed

- Three detention program resident files
- Two direct care staff member personnel files and training records
- Office of the Oklahoma State Fire Marshal report dated February 10, 2009
- Oklahoma State Department of Health Food Inspection report dated July 13, 2009
- OJA OPI annual monitoring report dated June 17, 2009

- Facility wing/room restriction and room confinement log for July 1, 2009, through November 30, 2009
- Facility incident reports for July 1, 2009, through November 30, 2009

Findings

Resident Interviews

The OJSO interviewed three residents in the detention program. The interview questions pertained to the residents' perceptions of safety, detention programs and services, resident rights, discipline practices, and quality-of-life issues. All three interviewees:

- reported they felt safe at the facility;
- indicated they received appropriate amounts and types of recreational activities;
- reported they received appropriate education;
- stated that the quantity of the food was appropriate; and
- demonstrated familiarity with the facility grievance process.

No concerns were identified from the resident interviews.

Staff Interviews

The OJSO interviewed two staff members. No concerns were identified from the staff interviews.

Resident File Review

The OJSO reviewed the files on three residents in the detention program. The files were well-organized, and the materials were easy to locate. No concerns were identified from the resident files reviewed.

Staff File Review

The personnel files of two direct care staff were reviewed for compliance with OJA detention standards. No concerns were identified from the staff files reviewed.

Incident Report Review

The OJSO reviewed the facility incident reports for the period of July 1, 2009, through November 30, 2009. The OJSO noted:

- One incident report stated that when a detention officer checked on a resident at 8:00 a.m. in the resident's room, the detention officer found the resident "unresponsive". Staff reported the resident's condition to a supervisor who advised the detention officer to wake the resident at 9:00 a.m. Documentation did not

indicate that staff took immediate steps to determine why the resident was unresponsive.

- One incident report stated that after a resident was admitted to the facility, the resident presented with a knife on a lanyard around his neck and threatened to harm himself/herself. Documentation indicated that the knife had not been discovered when the juvenile was searched during the intake process.
- The incident reports authored by five staff members involved in an incident described the resident's behavior as "out of control". Documentation indicated that staff physically restrained and used mechanical restraints to manage the resident's behavior. Three of the five staff members each documented a different time in their incident reports for when the mechanical restraints were applied, and one of these three staff members failed to document when the mechanical restraints were removed. The remaining two staff members of the five staff members involved in the incident failed to document in their incident reports that staff used mechanical restraints to manage the resident's behavior.
- One incident report listed a resident as having been placed in his/her room for medical reasons; however, the medical reasons were not documented in the incident report. The incident report narrative stated that the resident was upset and was not working the detention program.

No other concerns were noted from the incident report review.

Wing/Room Restriction and Room Confinement Log Review

The OJSO reviewed the wing/room restriction and room confinement log for July 1, 2009, through November 30, 2009. The OJSO noted:

- The dates/times that room confinement and/or wing restriction began or ended were not documented correctly in eight incidents.
- Documentation indicated that one resident was placed on wing restriction, followed by room restriction, and then assigned to room confinement. Staff did not document the individual times for each form of restriction and confinement. The OJSO could not determine how long the resident was on wing restriction, room restriction, and room confinement.

No other concerns were noted from the wing/room restriction and room confinement log review.

Areas of Concern

1. Documentation indicated that staff reported to a supervisor that a resident was unresponsive in his/her resident room. According to documentation, after becoming aware of the resident's condition, staff did not attempt to wake the resident for approximately an hour. Staff did not document whether a medical or behavioral reason had caused the juvenile to be unresponsive.

2. Eight instances of wing/room restriction and/or room confinement were not documented properly. Staff documented different times of occurrence and failed to document whether or not the residents were restrained and/or placed in confinement.

Violations

1. A juvenile was not properly searched during the intake process, allowing the juvenile to bring a knife into the facility. Facility policy, Security and Control, (8), (b), states, "All new intakes will complete a clothing exchange and be searched for contraband upon admission to the facility." Since the incident, the detention director implemented new policy requiring the transporting officer to remain at the facility through completion of the intake process.
2. Documentation in the wing/room restriction and room confinement log did not indicate the dates and/or times of release in eight instances of confinement. OJA policy, OAC 377:3-13-44, Security and control, (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 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."

Summary

The OJSO conducted an exit conference on December 30, 2009, with the facility director and the detention director. All concerns and findings were discussed.

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