

**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: November 29 and 30, 2010
Exit Conference: December 6, 2010

Oversight Reviewer: Janice Sharp, Oversight Specialist

Focus of Visit: Unannounced Visit, 2010

Date: January 31, 2011

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit on November 29, 2010, at the Canadian County Juvenile Detention Center, located in El Reno, Oklahoma. The OJSO returned to complete the visit on November 30, 2010. The purpose of the visit was to assess the detention program's compliance with established responsibilities and facility policy and procedures and to conduct a complaint investigation. The facility was certified for twenty-eight juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). Twenty-two beds were designated for the detention program; on a separate wing, six beds were designated for the sanction program. On the first day of the OJSO visit, the census for the detention program was thirteen. On the second day of the visit, the census for the detention program was nine. The sanction program was not evaluated during this visit.

The OJSO had received a complaint alleging that the residents cleaned the toilets using chemicals at the facility and that the residents were not provided with barrier gloves to clean the toilets. The OJSO did not substantiate the complaint allegation.

Interviews Conducted

- Entry interview with the facility director, the detention director, and the program coordinator on November 29, 2010
- Four residents in the detention program
- Three direct care staff members on-duty
- Exit conference with the detention director and the program coordinator on December 6, 2010

Documents Reviewed

- Three detention program resident files
- Three direct care staff personnel files and training records
- Office of the Oklahoma State Fire Marshal report dated March 2, 2010, and the facility corrective action plan dated March 10, 2010
- Oklahoma State Department of Health Food Inspection reports dated March 17, 2010, and November 22, 2010
- Facility wing/room restriction and room confinement log for July 1, 2010, through November 28, 2010
- Facility incident reports
- Facility detention program grievance log for July 15, 2010, through November 28, 2010
- Facility grievance reports
- Facility policy and procedures manual
- Facility population reports for November 29 and November 30, 2010
- Facility staff roster
- Permanent certificate to operate as a juvenile detention center; expiration date January 2011
- OJSO report dated March 22, 2010, for the visit conducted on December 29 and 30, 2009, and the facility response dated April 20, 2010

Areas Toured

An informal tour of the facility was hosted by the detention director.

Findings

Resident Interviews

The OJSO interviewed four 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. The OJSO noted:

- Three of the four interviewees reported that they attended school at the facility; the remaining interviewee had been newly admitted and had not yet attended school at the facility.
- All four interviewees stated that they received enough to eat at the facility.
- Three of the four interviewees stated that they received recreation daily; the other interviewee had been newly admitted and had not yet received recreation at the facility. When asked about outdoor recreation, the three interviewees who reported receiving daily recreation stated that they were allowed outdoors for recreation when weather conditions were suitable.
- Two of the four interviewees stated that they felt safe at the facility. One of the other two interviewees stated, "Somewhat," and the other interviewee stated, "I guess," when each was asked if he/she felt safe at the facility. The two interviewees who

stated that they felt safe reported that staff was the reason for feeling safe. Neither of the other two interviewees could name anything that made them feel unsafe at the facility.

- All four interviewees reported that they had not been physically restrained at the facility.
- All four interviewees reported that they had not been assigned to room confinement at the facility for a major rule violation.
- One of the four interviewees reported that he/she had been assigned to room restriction for inappropriate behavior. The remaining three interviewees stated that they had not been assigned to room restriction at the facility for inappropriate behaviors.
- Three of the four interviewees reported that they had been assigned to wing restriction for inappropriate behaviors. An example of an inappropriate behavior that had resulted in wing restriction was a resident talking without permission; according to the interviewees, a wing restriction for talking without permission lasted usually ten minutes. The remaining interviewee stated that he/she had not been assigned to wing restriction at the facility for inappropriate behavior.
- All four interviewees reported that they had not been cursed at, assaulted, or mistreated by staff and that they had not witnessed other residents having been cursed at, assaulted, or mistreated by staff at the facility.

No concerns were identified from the resident interviews.

Staff Interviews

The OJSO interviewed three direct care staff members. The OJSO noted:

- All three interviewees reported certification in cardiopulmonary resuscitation and training in first aid and a behavior management technique.
- All three interviewees reported having received written guidelines regarding the use of physical force.
- All three interviewees reported having received training on the use of mechanical restraints.
- Two of the three interviewees reported having received training on suicide prevention and intervention; the other interviewee reported not having received training on suicide prevention and intervention.
- All three interviewees demonstrated knowledge of frequency of standard and non-standard observation checks of residents.
- All three interviewees reported that grievance forms were accessible to the residents.
- All three interviewees stated that residents received outdoor recreation daily, weather permitting. According to the interviewees, the residents went to the facility's gym every day. Examples of the recreation allowed were basketball, volleyball, exercising, and yoga.
- When asked to describe the most beneficial part of the detention program for the residents, the interviewees' responses were: Staff helping the residents to succeed

in the program, residents understanding that people cared about them, residents learning to respect themselves and others, the program meeting the needs of the residents, and residents learning life skills.

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.

Personnel File and Training Record Review

The personnel files and training records of three direct care staff were reviewed for compliance with OJA detention standards. The documentation contained in one training record indicated that the annual training hours requirement would not be met, given the number of days remaining in year 2010. No other concerns were identified from the personnel files and training records reviewed.

Facility Wing/Room Restriction and Room Confinement Log Review

The OJSO reviewed the facility wing/room restriction and room confinement log for July 1, 2010, through November 28, 2010. The restriction and confinement log did not document the identity of the staff person authorizing the restriction/confinement, the identity of the staff observing the resident during the restriction/confinement, the times of the observation, the identity of the staff person authorizing release, and the time of release. No other concerns were identified from the facility wing/room restriction and room confinement log review.

Facility Incident Report Review

The OJSO reviewed facility incident reports for the period of July 1, 2010, through November 28, 2010. The OJSO noted documenting errors on some incident reports. For example, one incident report documented that the resident was placed in room confinement at 9:00 p.m. on October 17 and released from room confinement at 1:30 p.m. on October 17. Another example of a documenting error was that an incident report documented that from 10:30 a.m. to 11:45 a.m. on August 27 a resident was both on wing restriction and room confinement. The OJSO noted corrections that had been made to incident reports. For example, an incident report documented that the resident was placed on room restriction at 5:39 p.m. on October 31 and released from room restriction at 8:45 p.m. on October 31. A line had been drawn through the release time and 6:26 p.m. had been written, and room confinement was indicated. The initials of the staff member making the correction to the release time appeared to be the author of the report. The initials of the staff member making the correction from room restriction to room confinement appeared different from the author's initials. Neither correction

was dated. Three other staff members also had authored incident reports regarding this same incident. Those three incident reports also documented that the resident was placed on room restriction at 5:39 p.m. and released at 8:45 p.m. A line had been drawn through the 8:45 p.m. release time on all three incident reports and 6:26 p.m. had been written; the initials of the staff member making the corrections on those three incident reports appeared to be the initials of the author of the first incident report. There were no dates to indicate when the corrections were made. One of those three incident reports did not indicate whether the resident's separation from the general population was a wing restriction, room restriction, or room confinement; the other two incident reports indicated room restriction. The descriptions of the incident in all four incident reports did not appear to meet criteria for room confinement. Another example of a correction that was made to an incident report was regarding an injury to a resident playing basketball in the gym. In the section of the incident report where the author was asked to describe what happened, the staff person wrote, "While in the gym on 10-15-10 at 9:40 pm while the A and B level kids were playing basketball . . . (one resident's) head hit (another resident) in the mouth. . . ." The staff person documented that medical care was ordered for the resident at 9:30 p.m., which would have been previous to the incident occurring, according to documentation. A line had been drawn through the time documented as to when medical care was ordered and 10:00 p.m. had been written above; the correction was not initialed or dated. No other concerns were noted from the facility incident reports reviewed.

Facility Detention Program Grievance Log Review

The OJSO reviewed the facility grievance log for July 15, 2010, through November 28, 2010, regarding the detention program. No concerns were identified from the grievance log review.

Facility Grievance Report Review

The OJSO reviewed facility grievance reports for the period of July 15, 2010, through November 28, 2010. No concerns were identified from the grievance reports reviewed.

Inspection Reports Review

The OJSO reviewed the most recent reports by the OJA OPI monitoring unit, the fire marshal's office, and the health department. The OJA OPI monitoring report cited one violation: One personnel record indicated that first aid training was not completed within ninety days of employment; a facility corrective action plan was not required. The fire marshal's office report cited four deficiencies. According to the facility's corrective action plan, three of the four deficiencies had been corrected and actions had been taken to correct the remaining deficiency. The health department report from its visit on March 17, 2010, did not cite any deficiencies; the health department report from its visit on November 22, 2010, cited one minor deficiency, in which the facility had at least ninety days to correct. No concerns were noted from the other inspection reports review.

Areas of Concern

None listed.

Violation

1. The room restriction/room confinement log was not a complete record. 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 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

In the exit conference on December 6, 2010, the OJSO provided the detention director and the program coordinator with a facility exit checklist that identified the files reviewed and areas of concerns and violations listed, with the files identified in which the deficiencies were found. The OJSO and facility administration discussed each item listed. The facility provided documentation or gave explanations for the items that could be resolved. On December 13, 2010, via facsimile, the facility provided the complete training record for the staff member whose training record on the day of the OJSO visit indicated that the annual training hours requirement would not be met, given the number of days remaining in 2010. The documentation facsimiled verified that the staff person had received the required number of training hours for 2010.

An item listed on the facility exit checklist that was discussed at length during the oversight visit and in the exit conference was the use of voluntary room requests. A resident could complete a room request form, and if the request was granted, the resident was allowed to remain in his/her room "for a period of up to 24 hours". The OJSO expressed its concern that the voluntary room request option could be overused by the residents or misused by the staff. In the resident and staff interviews, the OJSO asked the interviewees questions pertaining to the voluntary room request option. The interviewees reported that a resident voluntarily made the request to stay in his/her room and that the resident was not influenced by staff to request the room request as a means of room confinement. The resident and staff interviewees also reported that when a resident requested to stay in his/her room that staff talked to the resident in an attempt to convince the resident to participate in the detention program. The facility administration reported that voluntary room requests were monitored in an attempt to ensure that residents did not use the room request option as a way to keep from participating in certain parts of the detention program, such as school. Also, according to facility administration, in an attempt to prevent this type of misuse, the resident usually had to remain in his/her room for the whole twenty-four hours.

Another item discussed in the exit conference in length was documenting inaccuracies that had been identified by the OJSO. The OJSO provided the facility administration

with copies of documentation regarding documenting inaccuracies noted during the file reviews. The detention director advised that the facility had reviewed facility documentation to correct documenting errors regarding the residents' daily living in the detention program. According to the detention director, some of the documenting inaccuracies regarding wing restriction, room restriction, and room confinement were that staff documented the clock times for when an incident began and ended rather than the clock times for when the restriction or confinement began and ended. The OJSO suggested that the facility provide staff with additional training regarding accurate recordkeeping.

The OJSO advised that the voluntary room requests and accurate recordkeeping would be reviewed again in the next oversight visit.

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