

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

**Report of a Complaint Investigation  
Central Oklahoma Juvenile Center**

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## **Introduction**

The Office of Juvenile System Oversight (OJSO) initiated a complaint investigation on July 7, 2009, at the Central Oklahoma Juvenile Center (COJC), located in Tecumseh, Oklahoma. The OJSO had received a complaint alleging staff had used improper techniques to restrain residents and that several of the residents had been severely injured as a result.

## **Interviews Conducted**

- Entry interview and an exit conference with the institutional superintendent
- Thirteen residents

## **Documents Reviewed**

- Three personnel records
- Facility CCR log for January 1, 2009, through June 8, 2009, of grievances referred back to the facility by the Office of Client Advocacy (OCA) of the Oklahoma Department of Human Services (OKDHS) for facility caretaker conduct reviews
- Facility caretaker conduct review (CCR) reports for January 1, 2009, through May 31, 2009
- Facility incident reports
- Thirty-five video recordings by the facility of physical restraints during the time frame of January 6, 2009, through June 8, 2009

## **Findings**

### Juvenile Interviews

The OJSO interviewed thirteen residents in regard to residents having been physically restrained by security staff. From the interviews, the OJSO noted:

- Six residents reported they had been seriously injured by staff while being physically restrained.
- Six residents reported they had observed staff improperly restrain residents, resulting in those residents having been seriously injured.
- Four residents had required hospital care due to the severity of their injuries from physical restraints by staff.
- Two residents reported they had received minor injuries while having been physically restrained by staff.

### Video Recording Analysis

Security officers at the facility carry portable video cameras to record the activities and interactions of residents and staff during restraints and/or escort. The OJSO randomly selected thirty-five video recordings of residents being physically restrained by staff for the time frame of January 6, 2009, through June 8, 2009. Of the thirty-five video recordings, the OJSO identified six recordings that appeared to demonstrate gross improper actions by the staff. The OJSO also reviewed the corresponding facility incident reports, in which staff had provided documentation regarding the physical restraints. The remaining video recordings will be discussed following the analysis of these six recordings.

#### ***Video 1, recorded at 1:22 p.m. on February 23, 2009***

The video recording began with the resident being escorted from a unit. It appeared that four to six security staff and two unit staff members were present. From the review of the video recording and the facility incident reports, the OJSO noted:

- The incident reports all documented that security staff had placed the resident in a two-person escort. In the video recording, two officers escorted the resident through the unit; however, in the escort, one officer walked directly behind the resident, holding both of the resident's arms at the elbows, and the second officer held the resident's left wrist. The Care and Custody Management System (CCMS) manual, page 3-3, states that when initiating a two-person physical escort, "[e]ach staff will limit the juvenile's arm movement by placing an open hand with extended fingers (or a closed grasp) on the juvenile's forearm area with their outside hand holding the juvenile's forearm and positioning the forearm across staff's upper body while using verbal de-escalation."
- In the video recording, the resident kicked backward with his/her right foot, missing the leg of the security officer. At that time, the security officer wrapped both of his arms around the resident, pinning both of the resident's arms to the resident's side. The security officer then turned the resident to the right and heaved the resident on the floor. The resident hit the back of his/her head on the floor and became unconscious. The resident appeared to remain unconscious for approximately one minute five seconds, according to the time counter on the video recording. The resident's legs visibly jerked while the resident lay unconscious on the floor. The security officer operating the portable video camera did not keep the resident in full

view, and, instead, focused on the back of an officer for approximately one minute nineteen seconds. In the video recording, the officers did not attempt to place the resident in a standing wrap hold or verbally de-escalate the juvenile's behavior, prior to the officer physically forcing the resident to the floor. The CCMS manual, page 4-7, states that the proper way for a staff person to take a resident to the floor is first to place the juvenile in a one-person standing wrap and to attempt verbal de-escalation of the juvenile's behavior. The CCMS manual also states that when taking a juvenile to the floor, the staff person should "pull the juvenile to the left over your right foot as your body and the juvenile's body turn to the floor you will both be going to the floor facing the floor. You will release the juvenile's right waist with both hands. This will allow the juvenile and yourself to catch yourselves when going to the floor."

- Facility staff had reported the incident to the OCA for the OCA to decide whether or not an investigation was warranted regarding the security officers' conduct. According to documentation, facility staff reported that the juvenile had been "assaultive toward staff members; including kicking and hitting (the staff member)." In the video recording, the resident attempted to kick the security officer one time but missed and did not make contact by a kick to the officer. The resident was not observed in the video recording as attempting to hit the officer. According to documentation, when the staff person reported the incident to the OCA, the staff person failed to report that the resident was knocked unconscious, had to be transported to the hospital for medical treatment, and was diagnosed as having suffered a concussion.

### ***Video 2, recorded at 2:15 p.m. on March 30, 2009***

The video recording began with the resident being escorted from a building by two security officers. Once outside the building, one officer was relieved from the escort, and another officer assisted with the two-person physical escort. The resident could be heard telling the officers they were walking too fast, causing the resident's knee to hurt. The officers continued to walk. The resident's behavior began to escalate, with the resident yelling that his/her knee was hurting. The resident then let his/her legs go limp, at which time, the officers took the resident to the ground and placed the resident in a two-person prone restraint. The OJSO noted:

- When the resident was in the two-person physical escort, the resident was heard complaining that his/her knee was hurting. The staff continued walking and the resident's behavior began to escalate by complaining about knee pain. Even though the resident's behavior began to escalate, neither officer attempted verbal de-escalation of the resident. The CCMS manual, page 3-3, states that staff continue verbal de-escalation throughout the escort.
- In the video, when the resident raised his/her legs, the officers lowered the resident to the ground. The knee of the officer holding the resident's right arm hit the resident's back. The officer then assumed a sitting position on the ground next to the resident and secured the resident's right arm.

- In the video, when the resident raised his/her legs, the second officer fell forward and hit the resident in the upper back and the back of the head with his right shoulder and the full weight of his body. This caused the resident's chin and face to hit the ground. The resident immediately became quiet and calm. The CCMS manual, page 4-15, states that when a resident becomes uncooperative during a physical escort by raising his/her legs, the officers "slowly lower themselves to their knee closest to the juvenile. They both lean forward, still maintaining arm positioning as described in the physical escort."
- The two officers documented in incident reports that they "lowered the resident to the ground". One of the officers' reports stated that the resident "continued to say slam me (curse word removed)." This statement documented by the officer was not substantiated by the audio portion of the video recording.
- Facility staff had reported this incident to the OCA for the OCA to decide whether or not an investigation was warranted regarding the security officers' conduct.

***Video 3, recorded at 3:29 p.m. on April 25, 2009***

The video began with the resident lying on the ground with two officers holding the resident in a two-person prone restraint. According to staff, the resident had been escorted from a unit, but the video did not indicate the reason for the security officers placing the resident in a prone restraint outside of the unit. The resident was observed crying and holding up his/her right arm, which looked to have two compound fractures. The resident continued stating, "They broke my (curse word removed) arm."

- The resident lying on the ground with a broken arm was the only part of the restraint that had been video recorded. Facility documentation did not explain why the only portion of the incident recorded was after the resident had been restrained on the ground.
- Facility staff had reported the incident to the OCA for the OCA to decide whether or not an investigation was warranted regarding the security officers' conduct.

***Video 4, recorded at 5:52 p.m. on June 6, 2009***

The video began with two residents sitting on the ground, and who appeared to be refusing to cooperate with the security officers. The officers were observed trying to grab both residents to raise them from the ground to escort the residents to the Crisis Management Center (CMC); however, both residents began to struggle and were placed in prone restraints. Both residents had been escorted from the gym; however, the video recording did not begin until after the residents had been escorted away from the gym area. The OJSO noted:

- The security officers attempted to grab both residents and to place them in two-person physical escorts. The first resident struggled, and one officer fell and landed directly on top of the resident. The security officer was much heavier in weight than the resident. The resident was placed in mechanical restraints.

- After the resident was placed in mechanical restraints, a security officer began to escort the resident to the CMC by holding the resident by the left upper arm. The resident attempted to kick the officer. The officer pulled the resident by the resident's left arm and slung the resident to the ground. The resident landed on his/her right side and stomach.
- The security officer clearly used profanity toward the resident after the resident told the officer to "get the (curse word removed) off me". The security officer could be heard saying, "Shut the (curse word removed) up."
- The security officer put his forearm against the back of the resident's neck and pushed the resident's face into the concrete. The security officer could be heard saying, "You [resident] want to act like an ass, act like an ass." Three other security officers were observed standing next to the resident; however, none of the three security officers assisted to place the resident in a prone restraint. At one point, when the resident attempted to raise his/her head, the same security officer again used his forearm to push the resident's head back down on the concrete.
- In the incident report by the security officer who had slung the resident to the ground, the officer stated that he had "performed a blend take down" on the resident. The CCMS manual, page 4-4, states that to perform a blend take down, the staff member first positions himself behind the resident, then grasps the resident, gaining control of the resident's arms. The staff then pulls the resident backward, while rotating the resident to the left. One of the juvenile's arms is left free so the juvenile can catch himself/herself prior to going to the floor. The CCMS manual does not provide for a blend take down of a resident who is in mechanical restraints because the resident's hands are restrained and the resident is not able to catch himself/herself.
- Facility staff failed to report this incident to the OCA for the OCA to decide whether or not an investigation was warranted regarding the security officers' conduct.

***Video 5, recorded 11:02 p.m. on June 7, 2009***

One of the two residents discussed in this video recording was the same resident restrained in the above incident (Video 4).

The video began with two residents being escorted off a unit. The security officers were escorting the two residents to the CMC. During the escort, one resident sat down on the ground and refused to walk. One officer could be heard saying, "Okay, we'll play that game." The security officer then placed the camera on the ground, facing the lens of the camera toward the resident. Two officers then attempted to lift the resident by the resident's arms and to place the resident in a two-person physical escort. The resident struggled with the officers, and one officer fell on top of the resident. The resident was placed in a two-person prone restraint.

The other resident, who began to laugh, walked around the officers and told the resident sitting on the ground to get up. A third officer stood between the two residents. Approximately three minutes forty-six seconds into the restraint, the mobile resident

kicked the camera. At this time, the visual recording halted, but the audio portion continued to record. The OJSO noted:

- One officer involved in the prone restraint was heard telling one of the residents to “quit (curse word removed) around.”
- Approximately four minutes seven seconds into the restraint, the resident in the prone restraint was heard yelling, “Let go of my (curse word removed) fingers.”
- Approximately five minutes ten seconds into the restraint, the resident in the prone restraint was heard yelling, “What the (curse word removed) you doing pushing my head down like that.”
- At approximately six minutes forty-four seconds the resident in the prone restraint yelled, “Get your hand off my (curse word removed) neck.”
- At approximately seven minutes four seconds an officer was heard saying, “You’re the one being stupid. You remember that.”
- At approximately eight minutes twenty-five seconds, the resident being restrained was heard yelling, “You cannot do that to my (curse word removed) neck. That’s not legal, quit it. That is not a proper restraint.”
- At approximately nine minutes ten seconds, the camera came back into partial focus, and the resident who had been in the prone restraint was being escorted by an officer to the CMC. The resident was in mechanical restraints.
- The video camera operator appeared to zoom in the focus of the camera, and therefore, the resident was no longer visible. The resident was heard cursing at a staff member. The officer escorting the resident was heard saying, “That was not smart was it?” The video camera operator appeared to zoom back out, and the resident could be seen on the ground, handcuffed, in a one-person prone restraint.
- The staff incident report stated, “Resident (name deleted) walked to the door of the Crisis Center and started resisting and then lunged at a security officer. At that time the resident was lowered to the ground, until calm.” The audio portion of the video recording did not indicate the resident had struggled or attempted to lunge at a security staff. The video recording showed the security officer helping the resident to his/her feet and escorting the resident to the CMC. Later in the video, a security officer was heard telling the resident, “Now you’re all black and blue for nothing.”

The OJSO had observed the resident’s shoulders during an oversight visit after becoming aware of the allegations. The resident’s shoulders and both wrists were bruised. Documentation indicated that the entire restraint incident had lasted approximately one hour, twenty-three minutes, fifty seconds.

- Facility staff failed to report this incident to the OCA for the OCA to decide whether or not an investigation was warranted regarding the security officers’ conduct.

#### ***Video 6, recorded at 5:36 p.m. on June 8, 2009***

The video began with a resident on the floor in a two-person prone restraint. A security officer was heard saying, “We gonna fight or what we gonna do?” The resident was heard threatening an officer. A security officer stated, “You’re either going to relax and you’re going to convince me that’s what’s going to be and we’re going to move you

around.” The resident was observed to calm down and the security officers to escort the resident to the CMC. The OJSO noted:

- The resident was observed sitting in the CMC with his/her head down. According to the security officer’s incident report, when speaking to the resident, he repeatedly stated, “This is Crisis Management, not nap time.” It was observed on the video recording and documented in the security officer’s report that the security officer pushed a metal stool into the desk to try to keep the resident awake.
- In the video recording, the resident got up and walked toward the door. The security officer documented in the incident report that the resident had said, “If you’re going to keep doing that I’m going to make you restrain me.”
- In the video recording, the security officer stood up and attempted to block the resident from the door. The officer was observed holding his arm out, and the resident was observed pushing the security officer’s arm away several times. The officer then held his hands up and moved back by the desk.
- The resident continued to stand near the door, and the security officer began to push the stool into the desk again. The resident walked out of the CMC. The security officer was observed running out of the CMC into the hall.
- The video recording from the CMC showed the security officer pulling the resident backward and taking the resident to the floor in a prone restraint. A signal was called by the security officer working the control center. A second security officer arrived and assisted with the prone restraint. A third officer arrived and began recording the restraint on a hand-held video camera. The resident was heard saying, “These (curse word removed) hit me.” The resident calmed down and was escorted back into the CMC.

In the other twenty-nine randomly selected video recordings of physical restraints, the OJSO noted:

- The operators of the portable video cameras frequently did not keep the residents being restrained in view during the recording. The OJSO observed recordings where the camera was focused on the back of an officer, pointed above where the restraint was taking place, or zoomed in so close the restraint was not visible.
- The operators of the portable video cameras did not provide a narrative of the restraint, the names of the staff involved, the resident’s name, and the date and time of the restraint.
- The staff involved in the restraints did not use proper de-escalation techniques to attempt to calm the resident and diffuse the situation.
- Staff placed residents in mechanical restraints although their behaviors had de-escalated, and they were not physically aggressive.

## **Summary**

The number of injuries to residents as a result of physical restraints at the facility is concerning to the OJSO. In almost every incident reviewed where a physical restraint had been used, a sufficient number of staff members had been present to control the resident without placing the resident in a prone restraint; however, not every staff

member who was present at the time assisted in the restraint. The audio portion of the video recordings indicated that rather than attempt to de-escalate the resident's behavior, the staff often made statements that further angered the resident and often led to the officers physically restraining the resident.

The OJSO is also concerned that the staff who reported incidents to the OCA did not accurately provide all of the information regarding the residents' injuries.

### **Areas of Concern**

1. Some staff did not attempt to de-escalate residents' behaviors prior to the staff executing physical restraints.
2. Some staff used improper techniques to escort residents to the CMC.
3. Some staff members who were involved in physical restraints of juveniles did not provide accurate documentation of their actions. Facility staff routinely used terms such as "lowered the juvenile to the floor" or "performed a blend take down", when, in fact, the visual and audio recordings indicated the officers used improper restraint techniques or excessive force.

### **Violations**

1. Security staff members improperly restrained residents causing serious physical injuries. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.2, Behavior management (b) Prohibitions, (1), states, ". . . facility policy prohibits: shaking, striking, spanking, or other cruel treatment." COJC policy, C030400.01, Juvenile Rights, (IV), Protection From Harm, (A), states, "Juveniles have the right to not be subjected to personal abuse, corporal punishment, personal injury, disease, property damage, and harassment." OKDHS policy, OAC 340:2-3-2, Definitions, Instructions to Staff, 8, (2) and (4), states, "Neglect includes, but is not limited to, use of a restraint under circumstances that the person(s) involved in executing the restraint knew or should have known that . . . the type of restraint used is not an approved method . . . or the amount of force used was excessive."<sup>1</sup>
2. The OJSO documented incidents where facility staff reporting incidents to the OCA did not accurately report the residents' injuries. OKDHS policy, OAC 340:2-3-33, Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation, (d), False reporting, (1), in part, states, "Any person who knowingly and willfully makes . . . a report that the person knows lacks factual foundation, may be reported by OKDHS to local law enforcement for criminal investigation and, upon conviction, is guilty of a misdemeanor."
3. Facility staff frequently placed residents in mechanical restraints whose behaviors did not meet the criteria for use of mechanical restraints. OJA policy, OAC 377:3-13-44, Security and control, (c), (9), Use of mechanical restraints, (A), (i)-(v), states:  
Restraints are used only:  
(i) for self protection;

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<sup>1</sup> All incidents reviewed in this report occurred prior to July 1, 2009. The OKDHS Licensing Requirements for Residential Child Care Facilities were applicable to COJC at that time.

- (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 are in the process of escaping; and
  - (v) prevent destruction of property if reasonably related to (i) through (iv).
4. The OJSO observed and heard on the video recordings reviewed that security staff used profanity toward residents during restraints. OJA policy, OAC 377:10-1-3, Discipline, (b), (6), states, "OJA staff and contractors shall adhere to OJA rules regarding discipline of juveniles. Prohibited disciplinary actions include, but are not limited to . . . use of profanity by OJA or contract staff."
  5. The facility staff failed to report incidents where residents were injured during restraints to the OCA. OKDHS policy, OAC 340:2-3-33, Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation, (a), Reporting requirements and reportable incidents, (3), states, ". . . employees of . . . Office of Juvenile Affairs (OJA) . . . who have reason to believe that caretaker misconduct, as defined in OAC 340:2-3-2, with regard to a client has occurred promptly refer it to OCA intake. . . ."
  6. Facility security staff and supervisors witnessed and permitted other security staff to use excessive force against residents and failed to report their actions to the facility administration. OJA policy, OAC 377:3-13-44, Security and control, (c), (8), Physical force, (D), states, "Facility personnel shall not encourage or knowingly permit any person to use physical force which is contrary to policy."
  7. Video recordings documented facility security staff intentionally provoking residents into a physical confrontation which required staff to physically restrain the residents. OJA policy, OAC 377:3-13-44, Security and control, (c), (8), Physical force, (E), states, "Staff members shall not provoke physical confrontation by taunting, harassing, or cursing a resident or otherwise manipulating a resident into activities which would justify physical force."
  8. The staff operating the hand-held video cameras frequently did not keep the resident being restrained in view and did not provide a narrative of the restraint as it progressed. COJC policy, C030100.20, Security and Control, states, "Purpose: The portable audiovisual digital camera is an important tool used to record incidents involving staff and juveniles and utilized to confirm or dismiss allegations of abuse, neglect, or mistreatment against employees, visitors, and juveniles at this institution." In addition, the same policy, paragraph II, Recording, B, states, "The Police Officer will verbally narrate the incident and identify the staff/juvenile involved and the location of the incident."

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