OKLAHOMA COMMISSION ON CHILDREN AND YOUTH
OFFICE OF JUVENILE SYSTEM OVERSIGHT

Name and Location of Facility:	Craig County Juvenile Detention Center Vinita, Oklahoma
Dates of Visit:	March 11 and 16, 2010
Oversight Reviewer:	Dana Holden, Oversight Specialist IV
Focus of Visit:	Unannounced Visit, 2010
Date:	May 4, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) began an unannounced visit on March 11, 2010, at the Craig County Regional Juvenile Detention Center (CCJDC), located in Vinita, Oklahoma. The OJSO returned on March 16, 2010 to complete the visit. The purpose of the visit was to assess the detention program's compliance with established responsibilities and facility policy and procedures. The facility was certified for eighteen juveniles by the Office of Public Integrity (OPI) of the Office of Juvenile Affairs (OJA). The OJA contracted with the Craig County Board of Commissioners for the detention center, and the county commissioners contracted with ROCMND Area Youth Services, Inc. for the actual operation of the facility. On the day of the OJSO visit, the census was eighteen.

Interviews Conducted

- Entry conference with the detention director on March 16, 2010 and an exit conference on April 5, 2010.
- Four residents
- Two direct care staff members

Documents Reviewed

- Fifteen resident files
- Office of the Oklahoma State Fire Marshal report dated February 27, 2009
- Oklahoma State Department of Health Food Inspection report dated July 13, 2009
- Room confinement log for July 2009, through March 11, 2010
- Restraint log for July 1, 2009, through march 11, 2010

Findings

<u>Resident Interviews</u>
Four residents were interviewed on the second day of the visit. All four residents gave favorable responses to interview questions concerning the food, staff, and the facility.

All four residents reported they are allowed approximately one to two hours of outdoor recreation each day. Each resident reported the grievance process was explained to them when they entered the facility. No issues of concern were identified during the resident interviews.

Staff Interviews

Two staff members were interviewed. The staff members were familiar with facility policies and reported having had all of the required training for his/her position. No issues of concern were identified during the staff interviews.

Resident File Review

Fifteen resident files were reviewed. The OJSO reviewed only incident reports located in the resident files. This information will be addressed in sections pertaining to room confinement and restraints.

Room Confinement Log Review

The OJSO reviewed the Room Confinement log for the period of July 2009, through March 11, 2010. The OJSO noted the following:

- There were a total of forty-eight incidents of room confinement during the period reviewed.
- There were Twenty-seven incidents of room confinement that based upon the documentation did not appear to meet the criteria for room confinement. Some examples of incidents that didn't meet criteria were:

  1. Refusing to work the program;
  2. Hitting cell door;
  3. Possession of contraband;
  4. Flooded cell; and
  5. Destruction of property.

- Eighteen of the incidents of room confinement reviewed did not have written incident reports.
- Staff did not document re-authorization of room confinement every three hours in twenty-nine of the incidents of room confinement reviewed.
- Staff did not document fifteen minute sight checks of juveniles in thirty-four incidents of room confinement reviewed.
- Residents were placed in room confinement for a designated amount of time for refusing to work the program. Staff did not document the three hour reviews or the fifteen minute sight checks.

There were no other concerns noted from the room confinement log.

Restraint Log Review

The OJSO reviewed the facility restraint log for the period of July 1, 2009, through March 11, 2010. The OJSO noted the following:

- There were a total of ten instances of restraints documented on the log for the time

frame reviewed.

- In six of the ten restraints reviewed, residents were placed in mechanical restraints and three of the remaining four restraint's documentation was not clear as to whether mechanical restraints were used.
- Two of the ten restraints reviewed did not have an incident report in the file.
- It appears from the documentation that seven of the ten restraints reviewed did not meet the criteria. Some examples are:

  1. On October 8, 2009, a resident was observed with his sweatshirt top tied around his neck. When staff told the resident to remove it, the resident untied the sweatshirt; however, left it around his neck. The report states a staff member left the resident's room and retrieved mechanical restraints from the control room and placed the upper level residents in their rooms. When the staff member reentered the resident's room the resident "went toward" the staff and was restrained on the floor. The report does not adequately document how long the resident was in mechanical restraints. The report states the restraint began at 9:00 p.m. and ended at 11:15 p.m. It appears from the documentation that the resident was compliant until staff entered his room with the mechanical restraints.
  2. On October 9, 2009, staff entered a resident's room and asked the resident to sit on his bed. The report then states that the staff member "went to put (resident's name) on his bed and he reached for me as I was putting him down." Staff restrained the resident on the floor and placed the resident in mechanical restraints. After the resident was in mechanical restraints, the report states, staff "came in to deescalate." The report does not document how long the restraint lasted or why staff entered the resident's room to begin with.
  3. On October 10, 2009, a resident was told he would "be down for the rest of the night." The report states the resident became very aggressive. The report states staff later caught the resident "mouthing the other residents." Staff entered the resident's room and ordered the resident to sit on his bed. The resident refused and the report states the staff "put resident on his bed." The resident attempted to get up and was pushed back down by the staff member. Staff restrained the resident the second time the resident tried to get up.
  4. When mechanical restraints were applied, staff did not document the length of time the mechanical restraints were left on in six of the ten restraints reviewed.

It appears from the documentation that staff entered a resident's room any time a resident violated a rule. In some cases staff entered the room to inform the resident that they were being placed on room confinement status.

Areas of Concern

1. There were fourteen incidents of room confinement which according to documentation appeared questionable as to whether they met the criteria for room confinement.
2. Residents were placed in room confinement for a designated twenty-four hour period of time for refusing to work the program.
3. When mechanical restraints were applied, staff did not document the length of time the mechanical restraints were left on.

Violations

1. Residents were placed on room confinement for incidents that did not meet criteria. OJA policy, OAC 377:3-13-44, Security and control, (c), (14), Room confinement, (A), (i) through (vi), state, "Room confinement is used with detained juveniles: for self protection; to separate juveniles from fighting; to restrain juveniles in danger of inflicting harm to themselves or others; to restrain juveniles who have escaped or who are in the process of escaping; to prevent destruction of property if reasonably related to (i) through (iv); and [to] 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)."
2. There were eighteen incidents of room confinement which did not have an incident report documenting the incident which led to room confinement. Craig Co. JDC policy 4.5, Rules & Discipline, Room Confinement, paragraph XI, states, "A written incident report shall be prepared by the shift supervisor and all staff involved in the incident."
3. Staff did not document the three hour re-authorization of room confinement every three hours in twenty-nine incidents of room confinement reviewed. OJA policy, 377:3-13-44, Security and control, (c), (14), Room confinement, (B), states, in part, "Room confinement of juveniles shall be re-authorized every 3 hours, except during normal sleeping hours, by a supervisor/administrator who was not involved in the original incident."
4. Staff did not document fifteen minute sight checks of juveniles in thirty-four incidents of room confinement reviewed. OJA policy, 377:3-13-44, Security and control, (c), (15), Procedure for room confinement or room restriction, (B), states, "Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented."
5. Two of ten restraints reviewed did not have a written incident report in the file. OJA policy, 377:3-13-44, Security and control, (c), (8), Physical force, (F), states, "A written report is prepared following all uses of force and submitted to the facility administrator by the end of the shift."
6. Seven of the ten incidents of restraint reviewed did not appear to meet the criteria. OJA policy, 377:3-13-44, Security and control, (c), (8), Physical force, (A), (i) through (iv), state, "Written policy and procedure limit the use of physical force: for self protection; to separate juveniles from fighting; to restrain juveniles in danger of inflicting harm to themselves or others; and to restrain juveniles who have escaped or who are in the process of escaping."

Summary

The OJSO appreciated the helpfulness of the detention center staff for arranging the interviews and providing the necessary materials for review. An exit conference was conducted with the detention director on April 5, 2010.

DSH/LB