

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

**Juvenile Detention Center  
Second Quarter, 2005**

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**Name of Facility:** Pottawatomie County Juvenile Detention Center (Carter Hall)

**Date of Visit:** May 20, 2005

**Reviewer:** Jon Trzcinski, LCSW

**Subject:** Unannounced Visit

**Date:** June 29, 2005

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit to the Pottawatomie County Juvenile Detention Center on May 20, 2005. The purpose of the visit was to assess compliance with established responsibilities.

### Documents Reviewed

- Certification standards for secure detention facilities (OAC 377:3-13-35 through OAC 377:3-13-62) issued by the Office of Juvenile Affairs (OJA)
- Facility policy and procedures manual (revised June 1, 2004)
- Case records on two juveniles

### Interviews Conducted

- Three juveniles
- Seven staff

### **Overview**

The OJSO conducted an entry interview with the facility's Commander. The purpose of the visit was explained. At the time of the OJSO's visit, the census was twelve (ten boys and two girls).

### Observational Tour

The OJSO conducted a tour of the facility, hosted by the facility's Commander. The facility appeared in a generally good state of repair; however, the OJSO noted that some areas of the facility were dingy and needed repainting.

The outdoor recreational area had a significant “flaking” problem with its layered concrete surface. The surface flaking was occurring in several large spots of the recreation area. Much of the surface was uneven, and pieces of the surface had broken off as people walked over it. Some of the broken pieces had sharp edges and were large enough (approximately 1” by 2¼” thick) to cause potential security problems. The pieces could easily be concealed by residents and used to inflict self injury or used as a weapon against staff or other residents.

The facility’s Commander was aware of the problem. He said he had explored ways to fix the surface but had yet to find a cost-effective way to correct it. He said re-paving over the old surface would cause drainage problems and potentially cause water to enter the building. Possible solutions might be to cover the area with an artificial surface, such as an outdoor carpet, or to remove the first layer of the surface and then resurface the area. Whatever the solution, the problem needs to be corrected.

#### Policy and Procedures Manual Revisions

The Commander indicated that the facility’s policy and procedures manual had been revised and approved (effective June 1, 2004) by the facility’s Executive Director, and was now in use at the facility. The OJSO’s review of the policy and procedural manual revealed that not all areas of revision had been completed. For example, the sections on volunteers, religion, and education were blank pages. The Commander said that the manual had not been submitted to the OJA. The OJSO encouraged the Commander to complete the missing sections of the manual and to submit it to the OJA for their review.

#### Use of the Mobile Humane Restraint Chair

The Commander pointed out that there was now a section in the policy and procedures manual governing the use of the facility’s mobile restraint chair. There was an incident in March 2005, in which a female resident had been restrained in the chair on one occasion. This action was approved by the Executive Director in an effort to ensure that the resident could not harm herself. The resident had pulled some of her hair out, attempted to swallow a rock, scratched herself, hit the wall, and attempted to choke herself with her undergarments. Several efforts to have the resident gatekept into a mental health facility had been attempted but were rejected.

According to the Commander, the Executive Director determined that the facility’s first priority was to make certain the resident could not hurt herself and authorized the use of the mobile restraint chair. The Commander said that the resident calmed, was again gatekept, and eventually left the facility. He said the resident was not in the restraint chair for a long period of time. The times of placement in the chair and release from the chair were not recorded on the facility’s incident report. The Office of Client Advocacy of the Department of Human Services investigated the incident and made no finding of abuse, neglect, or mistreatment.

The Commander said the OJA was also notified as to the use of the restraint chair. During the ensuing discussions, concern was expressed by OJA staff about the use of the restraint chair and the absence of facility policy governing its use. As a result, policy governing the use of the chair was developed; however, staff had not yet been trained on the policy. The facility's Executive Director directed that the mobile restraint chair not be used until staff training on the policy was completed. At the time of the OJSO's visit, the restraint chair was not on the premises, having been loaned to the new adult detention facility located just to the north.

The OJSO has not found documentation of the OJA's position on the permissibility of the use of a mobile restraint chair in a juvenile detention facility. Office of Juvenile Affairs policy OAC 377:3-13-44 requires that the detention facility administrator or designee must approve "any instrument of restraint." The OJA policy then describes when restraints may be used, who can approve the use, that restraints be removed when the juvenile regains control, that the juvenile may not be restrained to an immovable object, and that while both hands and feet may be restrained, the juvenile's hands and feet cannot be tied together as in "hogtying."

The facility's policy permits the use of four- and five-point restraint so that "the hands, feet and chest/head are immobilized, such as the use of the Mobile Humane Restraint Chair." Before the restraint chair can be used, the policy requires "advanced approval . . . from the Director, Commander or Lieutenant." The policy also requires that the facility's nurse be notified in order "to assess the resident's medical and mental health condition."

The facility's policy also includes the following points:

- The chair can only be used in an extreme instance.
- The chair can only be used after other mechanical restraints have been ineffective.
- The chair cannot be used as punishment.
- The resident must demonstrate a total lack of control and/or possible mental disorder marked by a severe aggression and is inflicting harm to him/her self or others.
- All staff must be trained on the use of the chair.
- While in the chair, the resident must be under constant staff supervision; never left unattended or unsupervised.
- Documentation must occur in at least five minute intervals.
- There must be fifteen minute safety checks on the "points of restraint;" that is, points where the restraints physically come into contact with the youth. The purpose of these checks is to assure that the youth's respiration and circulation are not impeded in any fashion.

The facility's policy is generally in compliance with the American Correctional Association's standards governing the use of four- and five-point restraints as contained in the standards for juvenile detention facilities and juvenile training schools. The facility's policy does not limit the time a youth may be held in the restraint chair except

to say he/she must be released when control has been regained. There is also no provision for a mandatory administrative or health authority review of the situation, should the situation continue for an extended period of time. These provisions should be added to the facility's policy.

It is recommended that the OJA address the question of the permissibility of the use of a restraint chair in a secure juvenile detention facility. If the use of such a chair is determined to be permissible, then the OJA should define what kind of equipment is acceptable, the circumstances in which it can be used, who has the authority to authorize its use, who should review its use, how long it can be used, and to whom should the use be reported. Given the increasing numbers of youths in secure juvenile detention that have serious mental health issues and the dearth of mental health services available in juvenile detention, the OJA should provide guidance to secure detention operators regarding what is or is not permissible and under what circumstances.

### Resident Records Review

The OJSO reviewed the case records on two residents; one was an open case and the other a closed case. One case file was complete and contained all appropriate information. The second case file was generally complete, but some of the use-of-force reports did not contain documentation as the time the restraint equipment was placed on the youth, who authorized the application of the restraint equipment, and the time of its removal.

### Holding of OJA-Custody Youths at the Facility

The Commander said that approximately one-half of the twelve youths being held at Carter Hall were in the custody of the OJA and were waiting for placement. He said that was representative of the general pattern. Two of the three youths who were interviewed were waiting for placement in an OJA placement.

Since facilities such as Carter Hall are not designed as treatment programs, youths who have been placed in the custody of the OJA for care and treatment should not wait in secure detention facilities for extended periods of time before their treatment begins. Time spent waiting in secure detention is often called "dead time" by the youths. The waiting period has the effect of extending the youth's length of time in OJA custody without the provision of treatment services.

### Collocation with the New Adult Facility

In the last few months, the new adult detention facility in Pottawatomie County became operational. The new facility is located directly to the north of Carter Hall. The Commander said that they were exploring the possibility of obtaining Carter Hall's food service from the food service department at the adult facility. Currently, Carter Hall operates a small kitchen that is manned by the on-duty detention officers. If this

arrangement is made, the food would be brought to Carter Hall via a “hot cart.” The primary advantage to this possible arrangement would be that it would relieve an on-duty staff from the responsibility of meal preparation and allow the staff more time to interact with the residents. There may also be some economy of scale that could result in food service costs being reduced. The Commander said that before the proposed arrangement could be implemented, it would need to be verified that the meals from the adult facility meet the nutritional needs of juveniles and the requirements of the school lunch program. There is no target date for this possible change.

The laundry from the juvenile facility is now being sent to the central laundry at the adult facility. Formerly, detention officers on the overnight shift did the laundry for the facility. The new arrangement has relieved those officers from this duty.

The adult facility does have an indoor recreation area that is available to the residents of Carter Hall. The Commander said that sight and sound separation of the adults and juveniles would have to be ensured and this would likely be accomplished by scheduling. Supervision of the Carter Hall residents would be done by Carter Hall staff.

The Commander was aware of the need to maintain the separation of the adult and juvenile programs. He said that the two facilities did not share staff and that the residents of the two facilities did not have any contact. He indicated he had paid special attention to this because adult facility trustees had been doing the yard maintenance between the two buildings.

### Resident and Staff Interviews

Comments from the residents during the interviews were generally positive in nature. The length of time the interviewed residents had been in the facility ranged from a few days to five weeks. The three residents interviewed indicated they felt safe in the facility. They commented that while there were sometimes disagreements among the residents, fights were rare. All three residents said they were able to have outdoor recreation on a daily basis if the weather permitted. The residents were able to explain the facility’s rules, levels system, and the resident grievance procedure. All three of the youths were able to explain the rules governing telephone calls and visitation. All three said they received enough to eat and that the food was “okay.” The residents commented that they generally liked the staff and believed that the staff were doing a good job.

The staff indicated they believed that they had formed a good working relationship with each other. One said, “We do well as a team. We help each other.” They generally commented that morale was good. The staff described the duties they must perform and demonstrated knowledge of their job expectations.

## Other Staffing Observations and Comments

The Commander said that all staff positions were currently filled. There were twenty-two full-time and part-time staff at the facility.

The Commander said that the facility always met or exceeded the required staff-to-resident ratio. During the site visit, there were at least three detention service officers on duty with the twelve residents. This ratio was the same during the morning and afternoon hours. Both male and female officers were on duty.

At the time of the site visit in January 2004, the Commander informed the OJSO that the administration was working to reduce time when staff congregated in the control room and were not in the day room with the residents. During the May 2005 visit, the OJSO observed that the detention officers seemed to be spending more time in the day room with the residents and less time in the control room. All staff are to be commended for this improvement.

## **Summary**

The OJSO conducted an exit conference with the Commander and the Lieutenant. The Executive Director was unable to attend. The observations and results of the site visit were shared. Concern was expressed over the shortcomings of documentation of the March incident that involved the use of the restraint chair. There was a lengthy discussion about the need for clarification by the OJA on the use of such equipment. There was a discussion about the need for some repainting at the facility and the repair of the outdoor recreation area's surface.

## **Concerns**

### The Pottawatomie County Juvenile Detention Center:

1. The Pottawatomie County Juvenile Detention Center should complete its revision of the policy and procedures manual.
2. The Pottawatomie County Juvenile Detention Center should repair the outdoor recreation area's surface as quickly as is practicable.
3. Case files, use of force reports, and other documents should be periodically audited by the administration to assure that all necessary and required documentation has been gathered and is accurate.

### To the Office of Juvenile Affairs:

1. The Office of Juvenile Affairs should revise its standards for secure juvenile detention and determine its position on the use of a restraint chair in a juvenile detention facility. If it is determined that use of such a chair is permissible, then the OJA should define the kind of equipment that is approved, under what circumstances it can be used, who has the authority to authorize its use, the amount

of time that such a chair can be used, staff training required to use the chair, and what type of documentation and review process should occur.

2. The Office of Juvenile Affairs should take action to reduce or eliminate the practice of youths placed in the custody of the OJA waiting extended periods of time in a secure detention facility before beginning their treatment program.

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