

Spotlight on Prevention



PROTECTING PEOPLE WITH SPECIAL NEEDS FROM THE DANGERS OF BEING LEFT UNATTENDED IN VEHICLES

May 2015

The NYS Justice Center for the Protection of People with Special Needs (Justice Center) is committed to supporting and protecting the health, safety and dignity of people with special needs and disabilities. The Justice Center is launching a series of toolkits which provide facts, best practices and resources that can be used by everyone who has a vested interest in preserving the safety and well-being of individuals who receive services or supports.

This first toolkit focuses on a serious hazard that may endanger adults and children who, due to their disability, may be particularly susceptible to the risks of being unsafely left

unattended in a vehicle. The
Justice Center's 24-hour
abuse and neglect hotline has
received numerous reports of
adults and children who
needed assistance to exit a
vehicle, but were inadvertently
left behind in vehicles
operated by provider
agencies. Whether you are a
driver, transportation aide,
service provider, agency,
individual, self-advocate, or
family member -- you have a
role to play in preventing a



needless tragedy from happening. The information provided in this toolkit will help raise awareness of the dangers of leaving people unsafely unattended in vehicles and provides common-sense tips to reduce risk.

FROM OUR CASE FILES¹

The Risks

- Heat stroke, hypothermia and other medical complications related to dangerously high or low temperatures in the vehicle – infants and young children, elderly adults, people who are overweight or who have chronic medical conditions including those taking medications such as psychotropic medications and diuretics are at a higher risk for heat stroke, hypothermia and other medical complications related to extremely high or low body temperatures.
- Accidents and other emergencies lack of caregiver attention to a
 person who requires supervision and support can lead to many dangerous
 situations, including neglect of an individual's personal care and medical
 needs, prevention of high risk behaviors and accidents.

A Close Call

Ann-Marie is an adult who lives with a significant intellectual disability. She resides in a group home in upstate New York and requires supervision and support from her caregivers to ensure her safety. Ann-Marie regularly attends a day habilitation program. She and her peers are transported to the program in a 12-passenger van. One morning last July, Ann-Marie was accidentally left behind in the closed van for an hour in the program's parking lot. The temperature outside was almost 76 degrees. Despite rising temperatures inside the vehicle, staff found Ann-Marie before she suffered any harm.

¹ This case study, involving a fictitious victim, represents a collection of facts identified from multiple case investigations and is used for illustrative purposes only.

TITe Mistake: Ann-Marie is left behind in the van: 8:50 AM

The driver was distracted by a change in routine and allowed the group to separate.

Upon arriving at the day program, the driver, the only staff member assigned to the group, failed to keep the group together or to make sure all of the individuals safely exited the vehicle. It was raining hard that morning, so instead of parking the van and going to the building as a group, the driver pulled up to the program entrance and directed his passengers to exit the van there so they would remain dry. Without ever leaving the vehicle, the driver casually observed the individuals file out of the van and run inside. The van appeared empty from the rear-view mirror. No formal head-count, seat check, or other steps were taken to ensure that everyone had disembarked at the entrance. The driver parked and locked the van – leaving behind Ann-Marie who was lying down and asleep on the farthest backseat, out of view.

The ,St Missed Opportunity to Find Ann-Marie: 8:50-8:55 AM

Program staff had become complacent about their duty to take attendance. When the van pulled up to the program entrance, a staff member inside the building marked Ann-Marie and her hausemates as "present" on the attendance sheet, based solely on seeing the van arrive at the entrance. This staff member did not verify that Ann-Marie and her peers entered the building. It was later learned that this was a common practice.

The 2nd Missed Opportunity to Find Ann-Marie: 8:55-9:00 AM

The driver relied on faulty judgment (an assumption that no one was still in the van) instead of following good practices (conducting a full back-ta-front vehicle inspection to check for any remaining passengers). The driver sat in the van and documented various required post-trip information, which included a notation that everyone had safely disembarked. However, she failed to follow the agency's required post-trip inspection policy to check for remaining passengers. She relied instead on her informal observations and judgment when completing the report.

The 3rd Missed Opportunity to Find Ann-Marie: 9:00-9:40 AM

Program staff had developed bad habits surrounding Ann-Marie's supervision plan-.

The staff member assigned to Ann-Marie did not attend to her supervision plan that morning (Ann-Marie required eyes-on supervision and at least 15-minute documented well-being checks). It was well known that Ann-Marie had a habit of not going directly to her classroom in the morning. She often sat on a bench at the entrance of the building where she would informally engage with other program staff for as long as an hour

before she would agree to go to her classroom. The classroom staff person assigned to Ann-Marie did not consider her absence to be of concern. As a result, Ann-Marie's absence was not questioned until 9:40 a.m. when staff went to encourage her to join the group and she was nowhere to be found.

A Delay in Finding Ann-Marie: 9:40-9:50 AM

The agency's missing person protocol did not direct staff to conduct a methodical search of high-risk locations first. Valuable time was lost when staff searched the entire building before someone thought to check the van. Ann-Marie was finally located at 9:50 a.m. in the locked, parked vehicle, a full hour after she was believed to have exited the vehicle. She was found asleep and unharmed.

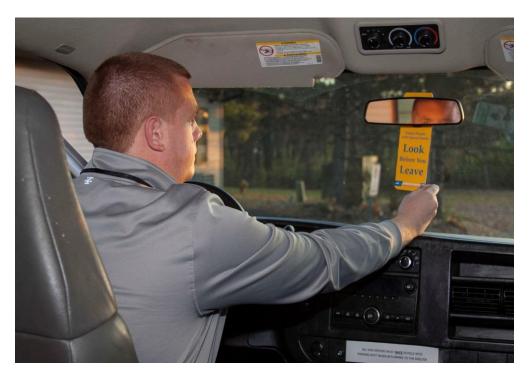
Lessons Learned

Ann-Marie's story is not an isolated incident. In the past year, the Justice Center received numerous reports of vulnerable persons left unattended in agency vehicles—many in the summer months when this mistake carried the highest risk. Similar incidents occurred throughout the state. The pins on the map represent counties where at least one incident was reported. Individuals were left unattended from two minutes to more than three hours. Fortunately, none of the reported incidents resulted in severe injury or death.

Several lessons can be learned from these incidents:

Service providers supporting people with significant intellectual and developmental disabilities appear to be at the greatest risk for making this dangerous mistake. The overall incident rate was significantly higher for Day Habilitation Programs. This is likely because these programs proportionately serve more people who are non-verbal, unable to alert someone that they have been left behind and often lack the ability to safely get out of a vehicle on their own. These programs also often have a "self-contained/one route" transportation program.

- Agency policies and procedures for ensuring vehicle safety that include inspection protocols is an important first step—but is not sufficient to preventing this dangerous mistake. Most incidents reported to the Justice Center occurred at agencies that <u>already had significant protocols in place</u> at the time of the incident that were meant to prevent staff from leaving someone behind in a vehicle. In addition to sound policies, agencies may need to:
 - Increase supervisory attention to staff safety practices;
 - Regularly evaluate whether their system is working; and
 - Consider adding environmental controls to help prevent a recurrence such as having a physical item in the back of the van that is required to be moved to the front of the van upon exiting the van, alarms or use of nontinted windows.
- Certain staff actions appear to increase the likelihood that this dangerous mistake will occur. Although staff often follow routine safety protocols while in the community, such as ensuring proper supervision, keeping a group together, routinely taking informal headcounts, and handing-off supervision before leaving an individual these same staff appear to regularly let their guard down once they arrive back at the program by failing to:
 - Keep the group together;
 - Maintain supervision assignments;
 - Follow a prescribed handoff of supervision responsibilities before leaving an individual;
 - Conduct head-counts at off-boarding; and
 - Complete post-trip back to front vehicle inspections.



"Look Before You Leave" message reminds drivers to conduct a post-trip inspection.

Certain agency practices appear to increase the likelihood this dangerous mistake will occur. They include:

- Assigning a new or untrained person to a route who does not yet know the individuals or the procedures can increase the risk of leaving someone behind;
- Requiring lengthy post-trip documentation may distract the driver from actually completing post-trip safety-related responsibilities;
- Failing to have an effective compliance monitoring plan to ensure staff follows safety procedures can result in poor staff habits;
- Failing to have an emergency search protocol for missing persons that directs staff to search high risk areas first (such as unattended vehicles) can result in dangerous delays in finding someone who has been left behind in a vehicle; and
- Darkly tinted windows may preclude any spontaneous discovery of someone who has been left behind in a vehicle.

PARTNERS IN PREVENTION: WHAT YOU CAN DO

We are all responsible for ensuring transportation related safety. By working together, we can reduce the risk of someone being left behind in a vehicle.

Provider Agencies Know Your Role in Ensuring Be Proactive. Have Missing **Speak Up.** Alert the driver if Persons Search Protocols that Vehicle Safety. Attend vou fear someone is about to trainings on transportation direct staff to immediately check be left behind. standards and other vehicle transport vehicles when an at-risk **Speak Out**. Ask transportation passenger safety topics. individual is discovered missing. providers and other service **Implement Policies and Know Your Passengers.** providers to share their Understand who is on your Procedures. At a minimum, a transportation safety plans with route and their special needs transport safety plan should you. include safe vehicle operation and when traveling by speaking with them and/or their care givers. post-trip vehicle inspection Request policies that include procedures, policies for Solicit relevant information "Look Before You Leave" attendance and notification of protocols for drivers and aides, about their requirements when unexpected absences, agency attendance and traveling. transportation plans, and emergency contact procedures emergency missing persons Don't Let Your Guard Down at for unexpected absences, and Your Final Destination. Stay search procedures. emergency search procedures alert. Stay together, follow that prioritize checking transport supervision assignments, Train and Mentor Your Staff. vehicles immediately for missing conduct a headcount and a Train your staff on all relevant vulnerable persons. hand-off of supervision policies before they begin Inform providers of your or your responsibilities. transporting individuals and offer loved one's special needs for retraining on a regular basis. Look Before You Leave. Supervise and coach staff to transport safety and emergency contact information. ensure that they consistently Perform on-board inspections. follow standard safety procedures. Make it your routine to Report Abuse or Neglect to the complete post-trip vehicle Regularly Re-evaluate Your Justice Center's 24/7 inspections. Check the entire vehicle -- back to front for System of Safeguards. Include Statewide Toll-Free Hotline. Call 1-855-373-2122 passengers before you leave it, routine compliance monitoring measures and utilize all TTY 1-855-373-2123 every time. appropriate environmental Report Abuse or Neglect to the controls. **Justice Center's 24/7** Report Abuse or Neglect to the Statewide Toll-Free Hotline. Justice Center's 24/7 Statewide Call 1-855-373-2122 Toll-Free Hotline.

Call 1-855-373-2122

ADDITIONAL RESOURCES:

Spotlight on Prevention Toolkit: Protecting People with Special needs from the Dangers of Being Left Unattended in Vehicles

- Fact Sheet for Individuals, Self-Advocates, Families & Friends
 http://www.justicecenter.ny.gov/sites/default/files/documents/SOP_Unattended_Vehicles_Fact_
 Sheet_Individuals.pdf
- Fact Sheet for Drivers, Transportation Aides & Staff
 http://www.justicecenter.ny.gov/spotlight-prevention/toolkits/unattended-vehicles/fact-sheet-drivers
- Fact Sheet for Provider Agencies
 http://www.justicecenter.ny.gov/sites/default/files/documents/SOP Unattended Vehicles Factor-to-sheet-Providers.pdf

- Hang Tag Orders: Send an email to <u>communicationsoffice@justicecenter.ny.gov</u>, and specify the quantity, contact person and delivery address.
- Video Gallery: Heatstroke Danger in Vehicles
 http://www.justicecenter.ny.gov/spotlight-prevention/toolkits/unattended-vehicles/video-gallery

New York State Agencies

NYS Department of Transportation: www.dot.ny.gov

NYS Office of People With Developmental Disabilities: www.opwdd.ny.gov

- Oversight of Individuals in Our Care
- Safeguarding Alerts
- Van Safety
- Health and Safety Alerts/Heat RelatedJuly2014

NYS Office of Child and Family Services: www.ocfs.ny.gov

Never Leave Children Unattended In or Around Vehicles

NYS Department of Health: www.health.ny.gov

NYS Office of Mental Health: www.omh.ny.gov

Medical Alert - Increased Risk of Heat Illness

Health and Safety: Extreme Heat Prevention Resources

Federal Agencies

Centers for Disease Control and Prevention: www.emergency.cdc.gov/disasters/extremeheat

Vehicle Safety Resources

National Highway Traffic Safety Administration Parents Central: www.safercar.gov/parents/index.htm

American Academy of Pediatrics: www.aap.org

KidsandCars.org: www.kidsandcars.org

About the NYS Justice Center for the Protection of People with Special Needs

Established by Governor Andrew M. Cuomo and the Legislature, the NYS Justice Center for the Protection of People with Special Needs is dedicated to supporting and protecting people with special needs and disabilities. The Justice Center serves as a law enforcement agency which seeks to ensure that individuals who receive services from a facility or provider that is operated, licensed or certified by six state agencies, are protected from abuse, neglect and mistreatment. Assessing risks to the health and safety of individuals receiving services, and supporting commensurate action to prevent potential abuse and neglect are critical components of the agency's independent oversight role. Through its advocacy-related services, the Justice Center also provides information, technical assistance and training to support and empower individuals with disabilities of all ages, in all settings.

For more information, please contact the Justice Center's Information and Referral staff at:

Toll-Free: 1-800-624-4143 (8:30 a.m. to 4:30 p.m.)

Relay users, please dial 7-1-1 and give the operator 1-800-624-4143.

Email: infoassistance@justicecenter.ny.gov

Website: www.justicecenter.ny.gov