Dangers of Being Left Unattended in Vehicles

This toolkit was created to provide information on the dangers of leaving people receiving services unattended in vehicles and to provide resources to agencies on how to prevent these incidents from occurring .

The Issue

People receiving services rely on the provider agency staff, clinicians, and family members to transport them to their various destinations. Whether it be a doctor's appointment, a trip to the store, or attending day programming or school, people receiving services trust they will be transported safely and responsibly. The Justice Center has received numerous reports regarding incidents in which people receiving services were transported to their destination and inadvertently left behind in the vehicle, putting them at risk for harm. Whether you are a driver, transportation aide, service provider, self-advocate, peer support counselor, or family member, you have a role to play in preventing a tragedy. The information provided in this toolkit will help raise awareness of the dangers of leaving people receiving services unattended in vehicles and provide tips to reduce risk.

The Risks

People receiving services are provided support and supervision for many reasons. Some people may not be able to communicate their presence in the vehicle or evacuate it without assistance. Verbal and physical limitations put the person at risk of being left behind unattended and developing, engaging in, or being a victim of the following:

- **Heat Stroke**
- **Hypothermia**
- **Medical Complications**
- **Elopement**
- **Property Destruction**
- **Inappropriate Interactions**
- **Injury**

In addition to the risks above, a lack of caregiver attention to a person can lead to neglect of the personal care and medication needs of the person receiving services.

Could This Happen in Your Program?

These case studies are offered for use in staff training and are loosely based on real Justice Center cases. The names of the people, settings and other information have been changed.

Case #1

Ann is an adult who lives with autism. She resides in the Connor Individualized Residential Alternative (IRA) and requires line of sight supervision at all times and support from her staff due to a lack of safety awareness. Ann has been attending Main Street Day Program for 10 years. On Tuesday morning, Carl, the bus driver, and Patty, the bus aide, assisted Ann and her six housemates onto the bus and transported them to day program. Ann was tired that morning so she laid down in her seat at the back of the bus and fell asleep. Once at the day program, Patty assisted the six other people receiving services into the day program while Carl did a check of the bus. However, Carl only did a visual check from the front of the bus and did not check each seat. As a result, he did not see Ann laying down in her seat. The day program staff saw the other people receiving services entering the building and assumed Ann was with them. Patty returned to the bus, and Carl drove them back to the bus garage. Their shifts were over so Carl and Patty left the bus without completing a final check and departed for the day. An hour after drop off, the Main Street Day Program staff realized Ann was not present. The day program staff searched the building for 20 minutes before reaching out to the residence. They contacted Ann's residence to inquire whether she was home. Upon discovering she was not home, the day program staff then contacted the bus garage and Ann was found awake in the back of bus.

Case Concerns:

- Patty did not do a head count when people came onto or off the bus.
- No documentation or check lists were completed to confirm who was present.
- Carl did not complete a visual check of the entire bus at drop off.
- Carl and Patty did not complete a final check of the bus before leaving their shift.
- The day program staff did not complete a head count.
- Did not have a formal process to track people's attendance at the program.
- The day program did not notice Ann was not present for an hour.
- Time was lost while staff searched the entire day program building before someone contacted the residence and then bus garage.

Case #2

Nick and Winston reside at a residential children's center. During the week, they are transported to their respective schools by staff. It is the center's policy that upon arrival at the school, staff are to walk all people present in the vehicle to the school when dropping each person off so that no one is alone in the vehicle. On Wednesday morning, the children's center assigned Katy, a temp staff, to transport them both to school. Katy had not reviewed the agency's transportation policy, Absent Without Consent (AWOC) policy or the Care Plans for Nick or Winston. Katy transported Nick and Winston to Nick's school first. Upon arrival at the school, Katy and Nick got out of the vehicle and walked into the school while Winston remained in the vehicle. When Katy arrived back at the vehicle, Winston was gone. She searched the general area for 10 minutes and went into the school, asking if anyone had seen him. Katy then called the children's center to ask what she was supposed to do. She was given instructions to contact the police. Three hours later, Winston was located by police.

Case Concerns:

- The agency did not train Katy on the Care Plans.
- The agency did not train Katy on the agency's transportation and AWOC policy.
- Katy left Winston alone in the vehicle.
- Katy did not immediately notify the police upon discovery that Winston was missing.

Case #3

On a cold morning in December, direct support professionals Rosita and Terry were preparing to bring people to their day program. Terry asked Rosita to start the van so it could warm up before bringing people to program. Rosita started the vehicle; however, she left the vehicle unlocked, went back into the residence and let Terry know the van was warming up. Terry told people receiving services to head outside and three of the people, Mena, Mike, and Porsha went out to the van and discovered it was unlocked. They entered the van and Mena decided to sit in the drivers seat. She moved the vehicle's shifter to neutral and the van rolled backwards down the driveway and into a parked car. Terry ran to the van and put it back into park and assisted everyone out of the vehicle. The police were called and the accident was reported. Mena, Mike, and Porsha, were brought to the hospital for a medical evaluation.

Case Concerns:

- Rosita started the vehicle and left it unlocked and unattended.
- Terry told the people receiving services that they could go outside to wait, but did not inform the other staff.
- No staff were outside with the people receiving services.

Case #4

Sarah is a veteran staff who has been working at the Boyd Street group home for 10 years. Sarah's supervisor assigns her to drive and accompany Bill and Erin to a movie. Sarah's supervisor asks her to review the support plans for Bill and Erin' again prior to taking them on their outing so she is refreshed on their support needs. Sarah disregards her supervisor's request, she knows "her people" and can handle a trip to the movies. Sarah, Bill, and Erin attend the movie and depart the theater back to the vehicle. Once inside the vehicle Sarah realizes she left her jacket in the theater. She leaves Bill and Erin in the vehicle and returns into the theater. While alone in the vehicle, Erin begins touching Bill and makes sexual comments towards him. When Sarah returns to the vehicle she sees Erin touching Bill, who is visibly upset, and tells her to move to the front seat. Sarah, Bill, and Erin return to the residence and Sarah does not report what occurred. A week later Bill reports what occurred to Sarah's supervisor. The incident is reported to the Justice Center and Sarah is suspended.

Case Concerns:

- Sarah did not review the support plans prior to the outing as requested by her supervisor, which would have reminded her of Erin's history of inappropriate sexual behaviors and the safeguards.
- Sarah's mentality that Bill and Erin were "her people" and she knew them well resulted in her not taking the time to refresh her memory on each of their support needs and histories.
- Sarah did not ask Bill and Erin to accompany her into the theater to retrieve her jacket.
- Sarah did not talk to Bill about what occurred and provide him with support.
- Sarah did not report the incident to her supervisor or the Justice Center.

Case #5

Gene is a person receiving services who resides at community residence and receives support to help manage his Schizophrenia. Gene is prescribed clozapine to help manage symptoms of the disorder. During the summer, his agency throws a picnic for all people receiving services. Gene attends and starts feeling tired, so Tina, his primary counselor, allows him to sit in the agency van for a few minutes to rest. Tina left the windows of the car down so Gene could get fresh air. Tina checked on Gene about 30 minutes later and discovered Gene heavily sweating, red faced and he was confused when she asked him if he was okay. Tina immediately turned the air conditioning on in the car, got Gene cold water to drink, and moved the car into the shade. Gene began to cool down and feel better, but requested to go back to the residence. The house supervisor came to pick Gene up and brought him to Urgent Care to be checked out. The doctor at Urgent Care opined that due to his medication, Gene was susceptible to heat illnesses and based on his symptoms, he appeared to have suffered from the beginning stages of heat stroke.

Case Concerns:

- Neither Gene nor Tina were informed that his new medication put him at risk for heat related illnesses.
- Tina left Gene in the car alone for 30 minutes.

Lessons Learned:

The cases provided are just a few examples of how a simple trip to the school or program can result in a dangerous situation. The Justice Center has received numerous reports of vulnerable people left unattended in agency vehicles - many in the summer months when this mistake carried the highest risk. This is a statewide issue that has resulted in numerous incident reports since 2013. People receiving services were left unattended from two minutes to more than three hours.

Several lessons learned:

- Provider agencies supporting people with significant intellectual and developmental disabilities appear to be at the greatest risk for making the mistake of leaving people receiving services unattended in vehicles. Incident rates occur more often with people receiving services who are non-verbal, unable to alert someone that they have been left behind, and those unable to exit vehicles on their own.
- Agency policies and procedures for ensuring vehicle safety that include inspection protocols and head counts that are documented are important steps to prevent incidents from occurring. Many incidents reported to the Justice Center occurred at agencies that **already had protocols in place** at the time of the incident to prevent staff from leaving a person receiving services behind in a vehicle. In additional to 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 move to the front of the van upon exiting the van, alarms, or use of non-tinted windows.

Several lessons learned continued:

- Certain staff actions appear to increase the likelihood that a dangerous mistake will occur. Although staff often follow routine safety protocols while in the community, these same staff appear to let their guard down once they arrive back at program by failing to:
  - Keep the group together;
  - Maintain supervision assignments;
  - Follow agency procedures regarding handing off supervision responsibility, and
  - Conduct head counts at off boarding.

Practices to avoid

- Certain agency practices appear to increase the likelihood that a dangerous mistake will occur. They include:
  - Assigning a new or untrained staff to a route who does not yet know the people receiving services or the procedures for completing transport;
  - 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;
  - Failing to have an emergency search protocol that directs staff to search high risk areas first (such as unattended vehicles); and
  - Dark tinted windows may preclude any spontaneous discovery of someone who had been left behind in a vehicle.

Recommendations for Transportation Procedures

It is important that service providers and contracted transportation providers implement procedures that ensure people receiving services arrive safely at their intended destinations. These procedures should include the following:

◊ Each person must be supervised inside the vehicle according to safeguards and supports identified in their service plan. No person receiving services should be left unattended in a vehicle unless there is documentation that explicitly states when they may be left unattended.

◊ Having a procedure for inspection to verify that no person remains inside the vehicle after a trip is completed. The procedure should identify the person responsible for the inspection (e.g., the driver or paid on-duty employee).

◊ Employees who accompany people receiving services during transportation, including those employed by transportation vendors, must be familiar with each person's support needs, supervision and safeguards. This may include wheelchair safety needs and special equipment.

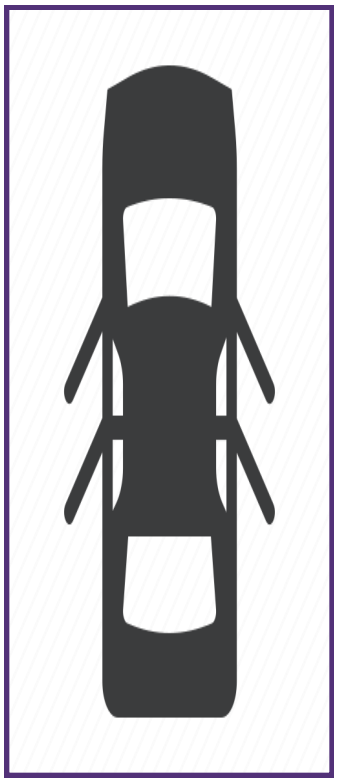
◊ Attendance procedures should include a means to verify attendance at the beginning of service and upon arrival at any new location following transport. A staff member should be assigned the responsibility to take attendance upon arrival at each service location.

◊ Agency procedures should include a means to verify the whereabouts of each person receiving services who is unexpectedly absent from the program or service location and should include:

- A requirement for contact with the person's residential program or home
- A protocol for determining when to contact law enforcement in an effort to locate a person who is unexpectedly absent from the day service and may be at risk.

Vehicle Inspection Tips

- Reminders assist with preventing people receiving services from being left behind, some examples are:



  - Printed attendance sheets for each route can also be used to enhance safety. Before the trip, a staff signs each person receiving services onto the bus. Upon arrival at the destination, this list is checked again by a staff person as each person receiving services gets off. On the return trip, the list is again updated and signed by a staff member during both boarding and off boarding of the vehicle.
  - Use of a procedure involving opening of car vehicle doors to ensure individuals exited from all seating areas inside the vehicle.
  - Use of an on-board back to front inspection procedure to ensure that all passengers exited.
  - Use of electronic devices, such as the Child Check-Mate System, in vehicles to minimize the possibility of a person being left behind. These devices sound to alert staff and will only turn off by walking to the back of the vehicle and manually turning the sound off.

- When electronic sensor devices are used, there should be documentation verifying that the devices are inspected and periodically tested.

- This Spotlight on Prevention Toolkit includes one low-tech option that may be utilized to confirm a post-trip inspection has been performed.

  - One example is to place a hangtag in the back of the vehicle and then require that it be returned to the rear-view mirror before the driver exits to ensure a walk-through has been done. The opposite procedure takes place upon entering the vehicle, providing an easy way to confirm that a visual sweep of the interior of the vehicle has taken place.
  - As an alternative, the yellow hangtag could be flipped to the reverse white side to verify the vehicle has been checked. If a hang tag is not visible on the rear-view mirror of a parked and empty vehicle, it could serve as a visual indicator that the check had not been completed.
  - Please note: **The hangtag is not to be left on the rear-view mirror while the vehicle is in motion as this is a safety hazard.**
  - Similarly, posting “Look Before You Leave” hangtags at appropriate building exits may serve as additional reminders to staff. Hangtags can be obtained by contacting the Justice Center at webmaster@justicecenter.ny.gov

Preventing Future Incidents: What You Can Do

We are all responsible for ensuring transportation related safety.

CAREGIVERS, DRIVERS, AIDES	PROVIDER AGENCIES
Know Your Role Attend trainings on transportation standards and other vehicle safety topics.	**Be Proactive** Have *Missing Persons Search Protocols* that direct staff to immediately check transport vehicles as soon as people are reported missing.
Know Your Passengers Ensure you know the people receiving services on your route and are familiar with their special needs when traveling by speaking with them and/or their caregivers. Review support plans to ensure you are aware of any specific transportation requirements.	**Implement Policies, Procedures, and Training** At a minimum, a transport safety plan should include safe vehicle operation and post-trip vehicle inspection procedures, policies for attendance and notification of unexpected absences, and transportation plans.
Don't Let Your Guard Down Stay alert. Stay together, follow supervision assignments, conduct a head count and a hand-off of supervision responsibilities. Alert the driver if you fear someone is about to be left behind.	**Training** Train your staff on all relevant policies before they begin transporting people receiving services and offer retraining on a regular basis. Supervise and coach staff to ensure that they consistently follow standard safety procedures.
Look Before You Leave Perform on-board inspections. Make it your routine to complete post-trip vehicle inspections. Check the entire vehicle — back to front for passengers.	**Re-evaluate Your System of Safeguards** Include routine compliance monitoring measures. Work with transportation providers and other service providers to develop and improve vehicle safety plans.

Report Abuse or Neglect to the Justice Center's 24/7 Statewide Toll-Free Hotline.
Call 1-855-373-2122
TTY 1-855-373-2123

Additional Resources

Spotlight on Prevention Toolkit: Protecting People with Special Needs From the Dangers of Being Left Unattended in Vehicles	
Fact Sheet for Drivers, Transportation Aides & Staff	https://www.justicecenter.ny.gov/system/files/documents/2019/01/sopunattendedvehiclesfactsheetdrivers.pdf
Fact Sheet for Provider Agencies	https://www.justicecenter.ny.gov/system/files/documents/2019/01/sopunattendedvehiclesfactsheetproviders.pdf
People Receiving Services, Families, Friends	https://www.justicecenter.ny.gov/system/files/documents/2020/12/caregiver-fatigue-fact-sheet-for-people-receiving-services-final.pdf
Infographic Poster on Heatstroke Dangers	https://www.justicecenter.ny.gov/system/files/documents/2019/01/infographicpostervehiclesafety.pdf
Vehicle Inspection Safety Tips	https://www.justicecenter.ny.gov/system/files/documents/2019/01/sopvehiclesafetytips.pdf