Ohio Department of Developmental Disabilities

Division of Information Systems

DODD INCIDENT REPORT (ITS)

Incident Number			Group Name	
2011-009-0382			Butler	
Client Number	**Client Name**	**Gender**	**Waiver Type on Incident**	**Age at Discovery**
[redacted]	[redacted] LAUREN 350 KOLB DRIVE FAIRFIELD, OH 45014	F		23

Final Due Date	Incident Date	Discovery Date	Created Date	Fax Date
09/15/2011	07/21/2011	07/21/2011	07/21/2011	

Category Type:

Decided

Alleged Neglect	Supervision	Staff

Alleged

Alleged Neglect	Supervision	Staff

Substantiated		Was Substantiated
Alleged Neglect	Supervision	Substantiated

Injuries

Severity: None

Supervision: Other Not Met

Visual range (Assigned staff can see the resident at all times) in day program.

Behavior Support Plan: No

Restrained from 0 to 0 Hrs

Restrained by:

Law:

Law Enforcement Involved: Yes

Outcome: Investigated None

Neglect: Left in Vehicle

Risk Assessment: Substantial

Living Arrange:

9698260 ICF/IID

Location: Non-County Operated Program Day Program

Incident Provider:

1809001 The Creative Learning Workshop, LLC

Residential Provider:

No Data Available

Adult Day/Employment Provider:

No Adult Day/Employment Provider

DODD INCIDENT REPORT (ITS)

Notifications	Coroner
9698260 Provider: 07/21/2011 Guardian: 07/21/2011 County: 07/21/2011	Notified: Accepted: Autopsy: Rec. Closure: 09/15/2011 Rec. Closure By: Rebekah Lyons Incident Review Status: Closed Closed Date: 09/20/2011 Investigated By: Investigative Agent Owens, Lisa Closed By: Daniel L Butler Last Change By: Daniel L Butler

Others

Name	Other Type Description	Relation Type Description	Systems Issue	Contract Number	Provider Name
Cheryl Collins	PPI	Direct Care Staff	No		

Initial Report 07/21/2011 1552537

On 7/21/11, Lauren [redacted] was left on a bus without proper care and superivison from approximately 10:15am until 11:45am after the bus arrived at The Creative Learning Workshop (CLW). The PPI failed to ensure Lauren exited the bus to go into CLW. Lauren was discovered on the bus at 11:45am when staff/individuals were leaving for an outing.
<Karen S Bessette Added on 7/21/2011>

Immediate Action 07/21/2011 1552538

Lauren was immediately assessed by the nurse. Bolus fluids given per g-tube. Vitals were WNL other than initial body temperature reading was 99.8. Cool compresses were applied and residential provider notified. Lauren was sent home as opposed to ER due to vitals improving. Upon arrival home, Lauren was given a cool bath, additional fluids and was closely monitored. No signs/symptoms of distress noted.
PPI placed on suspension pending the investigation.
<Karen S Bessette Added on 7/21/2011>

Question 09/14/2011 1576330

Please provide an update, thanks.
<Daniel L Butler Added on 9/14/2011>

Response 09/15/2011 1576849

Ok
<Rebekah Lyons Added on 9/15/2011>

Final Report 09/15/2011 1576861

Q)List of persons interviewed and documents reviewed
A)Interviews/Statements:
Lauren [redacted] individual- did not interview due to limited verbal/cognitive functioning
Lisa Owens, IA/BCBDD spoke with the following:
Tanya Vance, RSD-MUI/Takoda Trails
Cheryl Collins, PPI/CLW
Devinn Parms, driver/CLW
Alissa Muir, ATA/CLW
Crystal Fry, ATA/CLW
Mike Burge, ATA/CLW
Karea Saylor, ATA/CLW
Floyd Swigert, driver/CLW
Anthony Nimoh, ATA/CLW
Darlene Maidlow, Director/CLW
J Josh Morris, PD/CLW
Lt. Rick Jones/ Forest Park PD
Detective Jackie Dryer/Forest Park PD
[redacted] father

Documents Reviewed:
Ohio DODD ITS Report
Incident report
Past MUI involving Lauren/CLW
ICF-MR Investigation Summary- Takoda Trails
RAAG
Health Assessment
Nursing Notes

Others

MAR
Witness Statements
Weather History
Photographs of Vehicle
CLW Policy/Procedure
In service Record

Q)Summary of interviews and documents reviewed
A) Lauren is a 23 year old female who resides in Home 4 at Takoda Trails. She is blind and has history of seizure activity. Other diagnoses include Profound MR and CP, etc. She requires visual range supervision in the community and day program. Lauren is non verbal and ambulatory. Because Lauren lives in an ICF-MR, this investigation was completed by the facility investigator with additional information provided by Lisa Owens, IA/BCBDD and this IA. This IA is in agreement with all conclusions.

Investigation summary reviewed, which indicated that Lauren boarded the CLW bus on 7/21/11 at 9:15am to go to her day program. She rode in the first seat on the right side of the bus (her usual spot). Per CLW driver/Devin Parms, they arrived at the workshop (approximately 2 miles away) at 9:30am that day. Devin reported that he and Cheryl Collins, bus monitor/CLW were responsible for unloading and assisting the clients from the back parking lot into the program. He carried the client's bags and lunches inside to distribute to the appropriate areas. When he returned, Cheryl met him with the van keys as well as his personal keys, which were on the console. He assumed that Cheryl had unloaded everyone (including Lauren) since she secured the van by putting the lift up and locking the door, pulling the keys from ignition.

Cheryl was interviewed by investigators and law enforcement. She reported consistently that she did not see Lauren on the bus. She was visibly shaken when interviewed, but made no excuses for the fact that she left Lauren on the bus.

CLW aide Crystal Fry discovered Lauren approximately 11:45am, still sitting in her designated seat. Crystal was preparing for an outing when she made this discovery. The temperature was noted to be 91 degrees Fahrenheit, with a heat index of 105. Lauren was observed to be soaked with sweat and very hot. Several staff interviewed confirmed that Lauren's clothes were damp and she appeared hot but did not seem to be in distress. She was immediately taken to the nurse for assessment. Vitals were taken and she was given 200 ml H2O per g-tube with cool compresses to her neck and arms. Her temperature was 99.8 at 11:50am; 98.8 at 12:00pm; 98.3 at 12:18. Lauren was transported back to Takoda Trails upon request and her physician was notified. Dr. Zakem ordered Pedialyte to ensure she was hydrated, and staff gave a lukewarm shower. No further orders or concerns were noted.

Tanya Vance, Facility investigator/Takoda Trails and Lisa Owens, IA/BCBDD inspected the bus. Per Tanya Vance, Lauren should have been visible from the place where the aide had to stand to raise and secure the door lift. Investigators also used a small thermometer to measure temperature inside the bus. It registered approximately 80 degrees and then was placed in the bus for approximately 5 minutes at the same time of day that incident occurred 24 hours prior. The temperature rose to 103 quickly in a short amount of time.

Investigators spoke with administration from CLW regarding how they keep track of attendance, etc. Darlene Maidlow, CLW Administrator stated that attendance was completed in the afternoon. It was confirmed that CLW had no previous attendance records to track clients on location. There is a driver's log in each van with a check off list, but no pre-determined format in which data is collected or who reviews it. CLW was unable to provide past records because they only retain them for one month.

Forest Park Police Department was contacted, however no charges were pressed.

No previous related incidents were found for Lauren in ITS. However, there was a previous incident in May 2010 in which another client was left unattended on a CLW vehicle. This was substantiated as neglect; the afternoon checklist was implemented as a result, which obviously did not help in this case.

PPI Cheryl Collins had a previous MUI filed for neglect, which was unsubstantiated. That allegation was unrelated in nature to the current concern.

<Rebekah Lyons Added on 9/15/2011>

Findings and Conclusions **09/15/2011** **1576862**

This allegation of neglect can be substantiated. The bus monitor stated that she did not see Lauren on the bus while she

Others

was unloading clients on the morning of 7/21/11 and failed to assist Lauren off the bus. There was no protocol in place at the time to ensure that Lauren was not missed on the bus or in the program. This resulted in Lauren being left on the bus for 2 hours with the doors and windows closed. This error placed Lauren at high risk as she has history of seizures, and is additionally unable to unbuckle her safety belt or call for assistance. Temperatures and heat index was noted to be extremely high on this date, and Lauren was observed to be in physical discomfort (soaked with sweat, very hot) upon discovery.
<Rebekah Lyons Added on 9/15/2011>

Cause And Contributing Factors	09/15/2011	1576863

- Bus monitor was on a substitute route.
- Human error- Monitor did not see Lauren.
- No system in place to ensure Lauren was not missed for this time period.
- Miscommunication

<Rebekah Lyons Added on 9/15/2011>

Prevention Plan	09/15/2011	1576864

• New orders given for Pedialyte to ensure hydration.
• Staff continued to monitor; no further medical treatment was required.
• PPI was terminated due to the severity of this incident.
• New protocol for checking attendance was implemented at CLW on 7/26/11, including a new checklist for off site driver and aide responsibilities.
• CLW advised that attendance will now be completed twice daily, at 10:15 and 4:00pm.
• Team to continue monitoring for trends or issues; meet and revise plan as needed.

<Rebekah Lyons Added on 9/15/2011>