A Summary of the Findings And Recommendations From a Review at Oaklands Regional Centre

Review Completed For:
Ontario Ministry of Community and Social Services

Review Completed By:
Craig Shields, Human Services Consultants

January 2005

In November 2004 the Minister of Community and Social Services, the Honourable Sandra Pupatello, announced an independent review into the circumstances surrounding the disappearance, and subsequent death, of a long-time resident at Oaklands Regional Centre. While this review was getting underway, there was a second incident of a resident leaving his residence at Oaklands without the awareness of the staff on duty. This second incident was added to the scope of the original review.

The review of these two incidents addressed a number of questions: What were the circumstances surrounding each disappearance? What happened at the time they disappeared? What are the expectations with regard to keeping adults with developmental disabilities safe? What might have been done differently? And what changes would reduce the likelihood of such events happening again?

In order to answer these questions, the reviewer examined a variety of background materials, reviewed the policies and procedures from Oaklands and other similar agencies, reviewed documents related to the circumstances surrounding the disappearance of both individuals, interviewed management and staff of Oaklands, and spoke with a number of Executive Directors of other large developmental services agencies.

Based upon this review process, the reviewer made a number of recommendations intended to reduce the likelihood of similar events occurring in the future. These recommendations were organized around four themes: the physical setting, policies and procedures, professional practices, and personal safety. The recommendations were based upon the findings of the review and reflect the circumstances at Oaklands at the time of the events in question. Since that time, the Minister of Community and Social Services appointed a manager to provide support to Oaklands in a number of areas, including the implementation of recommendations from this review. As a result, many of the recommendations are already being addressed. As well, a number of these recommendations were anticipated and acted on by Oaklands.

Summary of Findings re: Physical Setting

The two incidents of unannounced leaving occurred at different residences on the Oaklands grounds. The first residence is a two-storey townhouse accommodating eleven residents. The second is a single-storey house accommodating four residents.

The review found that both residences used an eclectic mix of strategies to monitor the movement of residents. The townhouse, for example, has five doors that lead to the outside; four on the ground floor and one fire exit that is accessible only from the second floor.

At the time of the first incident two of these doors were kept unlocked and alarmed, two were kept unlocked with no alarm but could only be accessed through interior doors which were kept locked, and one was neither locked nor alarmed.

The situation was more complicated with the smaller residence. The house has five exits to the outside, four of which had hard-wired alarms connected to a central panel in the office. The fifth door had no alarm, but was accessible only through an interior door which was kept locked. Also connected to the hard-wired system were two bedroom doors of residents with a history of running. The main entrance and one bedroom door also had stand-alone alarms that were not connected to the central system. In addition to the various alarms, the exterior door off a commons room was fitted with a key-lock device.

Recommendations re: Physical Setting

- Oaklands should implement a comprehensive and consistent approach to monitoring the use of both exterior doors (i.e. doors leading to the outside of the house) and interior doors (i.e. bedroom doors) across its residences. Instructions on how to use the monitoring system should be posted next to the central panel in the residence office.
- The monitoring system should include the following characteristics:
  a. All exterior and interior doors should be fitted with devices that are connected to a central monitoring panel in the office
  b. The alarm system for interior doors should allow for the activation of only those doors where there is a need to monitor resident movement
  c. The opening of any exterior or interior door should be signalled by both auditory and visual cues at the central monitoring station
  d. The opening of an activated interior door should provide a non-intrusive auditory signal that is different from the one used for exterior doors
  e. The opening of any exterior door should provide a non-intrusive auditory signal that can be heard throughout the house
  f. The auditory signal should be shut off only by resetting the signal at the monitoring station, not by the closing of the door
  g. There should be no way to shut down the monitoring system for exterior doors
  h. There should be a battery back-up for the monitoring system, in case of a power outage
  i. The system should be checked once a day by one staff opening each of the monitored doors and another resetting the alarm at the central monitoring station
  j. The daily check of the monitoring system should be recorded as part of the daily records for the house

Summary of Findings re: Policy and Procedures

The review found that Oaklands had clear policies in areas such as personal autonomy, freedom of movement, levels of support, and wandering/elopement. These policies were consistent in content with the policies obtained from other large developmental services agencies. Essentially these policies state that a resident has all the rights and freedoms of any other Canadian, and that freedom of movement is only restricted if warranted for particular individuals or in specific circumstances. All of the policies examined used a relative definition of wandering and elopement, based upon the unique characteristics and support needs of the individual resident.

The review found, however, that Oaklands (and other agencies for that matter) had no protocol governing expectations on staff once a resident had been returned from an incident of unannounced leave. Also, it found that the policies and procedures manual contained many generations and formats of policies and procedures from over the years. In the case of the second incident of wandering, there also were concerns that a decentralized approach to client records may have contributed to a missing personal support plan.

Recommendations re: Policy and Procedures

- The agency should have a written protocol regarding what to do when a resident has been returned to a house after leaving unannounced (e.g. wandering, elopement, running)
    a. The protocol should include expectations with regard to
        - Communication of the incident of unannounced leaving to all shift members
        - Documentation of the incident
        - Reporting of the incident to appropriate managers
        - Assessment of the level of risk of the resident leaving again
        - Development of strategies to reduce the risk of the resident leaving again
    b. The protocol should also include the expectation that after a first incident of unannounced leaving, the resident be kept in the sight of a staff member at all times until a decision has been made and documented to discontinue visual monitoring
    c. The protocol should be posted in the office of all residences
    d. All current staff (full-time, part-time and casual) should be oriented to this protocol as soon as possible
    e. All new staff (full-time, part-time and casual) should be oriented to the protocol and assessed for accurate understanding of it before working in a residence

- The agency should post the procedures for reporting missing persons in the office of each residence including:
    a. The steps to be completed
    b. The telephone extension numbers of potential participants in a search
    c. The areas to be searched, along with a map of the grounds and surrounding areas
    d. A form to be used for the recording of steps / searches, times, and lead responsibilities
- The agency should develop a form to record an inventory of each resident's clothing
- The agency should add "wandering / elopement" to the section "Type of Incident" on its Incident Report
- The agency should ensure that its policy and procedures for missing persons includes the expectation that all staff who have knowledge of the missing person's movements and clothing on the day of the disappearance are interviewed during the investigative process
- The agency should perform unscheduled drills of the missing persons procedures at least every six months, and review the accuracy and speed with which the procedures are carried out
- The agency should ensure that all policies and procedures related to the personal safety of residents, including those pertaining to missing persons and emergency procedures:
    a. Be reviewed and updated as necessary on an annual basis to reflect current standards, practices, and technology
    b. Indicate clearly on each page the title and source of the policy, the date it was approved/reviewed, and the page number along with the number of pages (e.g. page 2 of 8)
- The agency should reintroduce a centralized client filing system in order to ensure the security and confidentiality of client records.

Summary of Findings re: Professional Practices

The review found that in both incidents of unannounced leaving there were some discrepancies between agency policies and procedures and actual professional practices. In the first incident these discrepancies occurred in the areas of recording and reporting. In the second incident the discrepancy was in relation to resetting of the alarm system. The second incident may have been complicated by the fact that the staff person on duty was covering a shift for another staff member and had not worked in that house for some time.

Recommendations re: Professional Practices

- The agency should review the use of the Confinement Time-Out room in House 1 and subsequent recording and reporting for consistency with agency policy and procedures
- The agency should review the recording and reporting of wandering in House 1 for consistency with agency policy and procedures
- The agency should review the recording of the Mood Chart in House 1 for consistency with agency policy and procedures
- The agency should ensure that the levels of supervisory support recorded in section 2 “Levels of Support” of the Personal Support Plan include the numerical rating and descriptor (e.g. Level Two – Close Supervision), and that the levels of supervisory support for each resident are posted in the office within the house
- The agency should reinforce a consistent approach to recording times for shift reports, incident reports, and other practice-related documents, using either a 12-hour or 24-hour approach, but not a mixing of the two
- The agency should review its approach to selecting staff to cover shifts in order to ensure that:
    a. There are written criteria for assessing whether a staff member has the required level of familiarity with a house in order to work there
    b. There is a roster indicating which staff have satisfied the criteria to work in specific houses
    c. No staff member is assigned to work alone in a house for which they have not met the criteria

Summary of Findings re: Personal Safety

Oaklands does not currently use personal locator devices. While accepted in some sectors, such as health, to ensure the personal safety of individuals with a tendency to wander (such as Alzheimer’s patients), they raise serious questions in the developmental services sector with regard to personal autonomy, freedom of movement, and even feasibility. However, some families have expressed an interest in the use of personal locator devices, and because in this sector some clients are ordered to reside in certain locations by the courts, a discussion of the advantages and disadvantages of such devices seems warranted.

Recommendations re: Personal Safety

- The agency should engage in a consultation with residents, families, and staff regarding the advantages and disadvantages of a voluntary program using personal locator devices for residents at risk of wandering or running