



**Serving and Protecting All by Applying Lessons Learned -
Including People with Disabilities and Seniors in Disaster Services**

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Introduction

The intent of the following recommendations is to help California benefit from the lessons learned so that the State can build a strong and resilient infrastructure that will include the diverse populations of people with disabilities and seniors in all emergency services.

“... as we watched the stunning spectacle of people dying of starvation and thirst in the streets of an American city that seemed to have been abandoned by every form of government, I was struck time and again at the fact that while race had become “visible,” disability had not—even though we were watching the deaths of so many people with disabilities. ... It is not that their disabilities were invisible; paradoxically, it was quite the contrary. Who among us can forget that iconic image of the dead woman in the wheelchair outside the Superdome, covered only in a blanket? That might well have been the very symbol of Katrina’s devastation in New Orleans, the wheelchair—not the woman, who was not visible, but the wheelchair itself. For if you used a wheelchair, and you lived in New Orleans in late August, you were very likely subject to something I will not hesitate to call terror.”
(Berube 2005)

All too often in emergencies the concerns of people with disabilities and seniors are overlooked or swept aside. In areas ranging from the accessibility of emergency information to the evacuation plans, great urgency surrounds the need for responding to these concerns in all planning, preparedness, response, recovery, and mitigation activities. Prior planning will prevent poor performance.

Lessons Learned but Not Applied

Lessons learned, regarding disability and aging populations, during previous disasters often don't get incorporated into subsequent planning, preparedness, response and recovery activities. (**United States Government Accountability Office** 2006) Segments of disability communities continually report problems in participating and benefiting from emergency services over many decades. (National Council on Disability 2005) The hurricanes in the Gulf States reinforces lessons learned regarding management, policy and training issues identified in many previous large scale disasters such as Hurricane Andrew, the Loma Prieta and Northridge earthquakes, and September 11th Terrorist Attacks. The catastrophic scope and impact on seniors, people with disabilities, and those with medical needs in the Gulf States underscored and amplified the issues and made them all the more evident. (National Organization on Disability 2005)

Although local, state, regional, and federal government agencies play a major role in disaster planning and response, traditional government response agencies are not equipped to respond to the needs of disability and aging populations during emergency response. These recent events confirm what has been recognized for decades, traditional response and recovery systems are often not able to successfully meet many human needs. The usual approach to delivering emergency services cannot provide many of the essential services needed by people with disabilities and activity limitations. (National Council on Disability 2005) (National Organization on Disability 2005)

Who Are People with Disabilities?

Individuals with disabilities make up a sizable portion of the general population of the United States. According to the U.S. Census of 2000, they represent 19.3 percent of the 257.2 million people ages 5 and older in the civilian noninstitutionalized population, or nearly one person in five. The numbers are even larger when seniors and people who live with functional limitations, but do not identify as people with disabilities are included.

In this report, the term people with disabilities and seniors includes people who are “vulnerable” or “at risk” and cannot always comfortably or safely use some of the standard resources offered in disaster preparedness, relief, recovery and mitigation. They may include people who have a variety of visual, hearing, mobility, cognitive, emotional, and mental limitations, as well as older people, people who use life-support systems, people who use service animals, and people who are medically or chemically dependent.

Adopting a broad definition helps to ensure that no one is left behind, and the imperative is clear that everyone address the broad spectrum of disability and activity limitation issues (Reis 2004). If planning does not embrace the value that all will or should survive, they will not.

Disability and Aging Expertise

Disability and aging organizations include government and private organizations serving the needs of segments of the disability and aging populations. There is no one organization that does or can do all this work. These organizations represent a vast array of national, state, regional, and local human and social service organizations, faith based organizations, and neighborhood associations. They are critical to the response and recovery process. Disaster service workers could never adequately replicate their expertise, skill sets and resources of these organizations.

Disability and aging literate and competent organizations have unique and credible connections with the people they support and expertise in delivering services. Their unique skill-sets and understanding is a valuable, but an often overlooked resource for emergency planning, preparedness, response, recovery and mitigation activities. These organizations must be included as partners in working with local, regional, state and federal public and private response agencies to more effectively deal with and understand the needs, geography, demographics and resources of their local areas.

One shelter manager involved in the Katrina response complained about the length of time it took to locate assistive devices, "...it would have been nice to have 'someone' local provide a list of resources in the area, rather than taking staff hours on phones all day trying to find equipment." Knowledgeable disability and aging organizations could have accomplished this task more efficiently, freeing shelter management staff for other activities, had they been plugged into the system with an assigned task and role. (National Organization on Disability 2005)

Including disability and aging focused CBOs in Mutual Aid Agreements can ensure these resources are part of the response.

Disability, Activity Limitations and Aging Issues Are Often Addressed Through Medical Eyes

During the 2005 Gulf States hurricanes response and recovery phases, disability advocates worked around the clock for weeks to try to get disability experts into the shelters to assess and assist with the needs of people who:

- couldn't hear the announcements over loud speakers,
- could not see the signage that directed them to assistance,
- were on the verge of losing their mental health stability because they didn't have access to their essential medication,
- whose eyes, kidneys, and hearts were threatened because they didn't have insulin,
- who didn't understand what they needed to do to get food and water because of a hearing, understanding, cognitive or intellectual disability, and
- couldn't stand in line for seven hours, or even seven minutes because they had lost their wheelchair during the evacuation. (National Organization on Disability 2005)

The disability community came together to try to take care of "our own", but many were excluded from the larger relief community and told that we would just be "in the way" and "make things worse". (Roth 2005)

Disability, activity limitations and aging issues often are viewed only through medical eyes, not independent living oriented or advocacy eyes. Assistance provided to disability and aging populations is often over-medicalized resulting in disability and aging issues treated only as medical issues. (National Organization on Disability 2005) This perspective means that some people are unnecessarily separated from families and support networks and transferred to medical shelters or nursing homes. Others in need of specific service support are not identified because of the lack of trained eyes as well as the lack of or inadequate combination of triage and screening questions. This causes some individuals' condition to deteriorate to the point where they did require transfer to a hospital, nursing home, or medical shelter.

Adequate and early identification of "at risk individuals" through screening and addressing of functional independence needs can prevent deterioration of individuals' medical, health and mobility status. Early disaster response intervention services offered through disability and aging literate and competent organizations allows people to maintain their health and independence, successfully manage in mass shelters and other temporary housing options. Effectively meeting these needs reduces the use of scarce, expensive and intensive emergency medical services as well as institutionalization.

Emergency management systems need help with the very specific and often complex needs of people with disabilities. Well-intentioned emergency medical and public service personnel cannot adequately address the complex and additional needs of this population without a deep and thorough understanding of the values and goals of independent living and self-determination and absolute clarity about the human and civil rights of people with disabilities.

No Use and Under-Use of Disability and Aging Organizations

Disaster response commonly reflects no use or, under-use of and sometimes just ignored offers of help from disability and aging organizations. There is often no designated entity or individual to “own” and coordinate disability and aging issues. Disability and aging community based organizations report difficulty in gaining access to emergency management authorities to coordinate response and service delivery. This leads to well intentioned but misguided actions only adding to the management difficulties on the ground. (National Organization on Disability 2005)

Recommendations:

Establish a **Disability Access Coordinator (DAC)**, a disability and aging services “go to person,” at the Deputy Director level within the Office of Emergency Service (OES). The DAC must be designated to act as a central focal point to lead and coordinate the priorities listed in these recommendations and be:

- vested with the responsibility, authority, and resources for providing overall day-to-day leadership, guidance and coordination of all emergency preparedness, disaster relief and recovery operations on behalf of disability and aging populations.
- in constant contact with other state departments allowing for a mechanism for collaboration and issues to be sent up the command chain for resolution.
- able to fund, orient, mobilize and deploy local disability and aging organizations to plan for and to offer service coordinated assistance in disaster planning, preparedness, response, recovery and mitigation activities. Such assistance must be integrated with existing emergency systems, immediate, flexible, and collaborative.

- integrate the strengths and skills of CBOs into the emergency service plans and strategies of local government through mutual aid agreements; and
- recruit, encourage and provide sustained funding incentives so CBOs can participate in disaster preparedness and relief.
- integrate and evaluate disability and aging specific scenarios, goals and objectives in all drills and exercises.

DAC qualifications should include:

- in depth understanding and proven experience practicing:
 - the values and goals of independent living and self-determination,
 - policies and procedures that implement and support the human and civil rights of people with disabilities
- experience in providing for the:
 - complex needs of people with disabilities and activity limitations including physical, communication, and program access issues.

The DAC should:

- Oversee incorporating disability and senior issues into the National Response Plan by integrating the issues in all appropriate plan annexes.
- Create a team that mirrors the management structure of the National Response Plan to deal with disability and senior issues.
- Oversee the organization of and be supported by a multi-jurisdictional team of qualified experts in the field.
- Assemble teams that consist of qualified disability and aging experts federal, state, and local (or regional) representatives who are knowledgeable in emergency management , as well as disability and aging organizations who can provide expertise on planning, preparedness, response, recovery, and mitigation activities.

- The teams:
 - Can oversee information dissemination, resource allocation, and service coordination among disability and aging organizations.
 - Can address such issues as providing accessible transportation, replacing essential medication and durable medical equipment, enrolling of students in temporary education classes, with accommodations as needed, assisting in locating employment, etc.
 - Would include people, on the ground, with expertise and advocacy experience in the State and local communities (and services available in such communities).
 - Would be present in shelters, temporary housing and other assistance centers.
 - Can institute tracking systems for people with disabilities and seniors, identifying support/service needs and the meeting of such needs.
 - Assess the general health, well-being and needed supports and services of disability and aging populations residing in shelters and temporary settings.
 - Quickly orient shelter personnel and emergency managers, during response phases, regarding the needs of disability and aging populations and the available resources. (National Organization on Disability 2005)

Service Coordination

Many people need assistance with activities of daily living (*i.e. dressing, feeding, toileting, and for some, assistance with activities requiring judgment, decision-making, and planning*), as well as, in some cases, primary medical care. Individuals frequently require assistance in arranging services and coordinating among multiple providers. The aftermath of Hurricane Katrina led to large-scale displacement that interrupted the networks of support that individuals with disabilities have put together. People need knowledgeable help in coordinating essential services in new environments with limited contacts and little knowledge of local resources. They need this help while they are scrambling to meet other essential needs such as housing and access to food.

Recommendations:

Utilize the skill sets and expertise of disability and aging organizations through the mandated inclusion of CBOs in Mutual Aids Agreements that would support the formation of local response teams to help prevent deterioration, expensive hospitalizations, or nursing home placements for some members of aging and disability populations. These organizations can:

- o Assist people in quickly replacing critical DME (durable medical equipment) and essential medications, could return their level of functioning so they can manage in a general population shelter and in temporary housing.
- o Benefit and service programs, including Medicaid, must continue to provide the services and supports needed to maintain the integrity of the family unit and allow individuals to live in the community as they continue to rebuild their lives.

Add screening questions to and utilized in the intake processes (shelters, and assistance centers and/or other services) that identify and triage the needs and/or issues of disability and aging individuals. This will allow for many people to maintain their functional independence by receiving their appropriate assistance, referrals, and long-term solutions.

Disability and aging populations who need long-term services must have the right to receive such services in the community. Disaster response services must not lead to forced and unnecessary institutionalization. That is, backtracking where people who have successfully lived in the community and received support services are now forced into institutions in order to continue receiving these necessary services.

Recommendations:

Continue to provide services, support benefits and programs, including Medicaid, to maintain the integrity of the family unit and to allow individuals to live in the community as they rebuild their lives.

Ensure that disaster relief services include financing to provide *medically necessary* long term services in community settings.

Evacuation

When participants of a Survey of Hurricane Katrina Evacuees were asked why they did not evacuate; 22% reported they were unable to leave and 23% had to care for someone unable to leave. (The Washington Post 2005) Accessible transportation is critical for some people with disabilities in evacuating and in evacuation and completing the recovery process. See Appendix: Disaster Experiences of People with Disabilities: “Benilda’s Promised Ride to the Superdome” and “Don’t Worry the Ambulance is Coming Soon.”

Recommendation:

- Ensure that **accessible transportation** is planned for and in place for evacuation and as well as traveling to and from shelters, housing and disaster relief centers.
- Ensure that people who require accessible transportation are evacuated first, and that such transportation is safe.
- Use the community’s and when needed adjacent community paratransit and public transit services.

Relocation: Shelters, Temporary and Permanent Housing

Sheltering

“In a country that still thinks nursing home placement trumps community based care for people with disabilities on a sunny day, it is obvious that we can’t rely on generic decision makers to make smart decisions about the needs of people with disabilities after disasters.” (Roth 2005)

In response to Katrina, Red Cross shelters were reportedly turning people with disabilities away or separating them from family, friends, personal assistants, caregivers and service animals. , Shelters sent them to medical needs shelters and nursing homes when they couldn’t maintain their independence. When inquiring about the sheltering needs of people with disabilities, one Red Cross operations official said, “we aren’t supposed to help those people, the local health departments do that. We can’t hardly deal with the “intact” people. Don’t you understand that we’re taking volunteers off the street to run these shelters?” (Roth 2005)

A shelter manager reported, “(Special needs training is)...not a Red Cross responsibility, most of it is common sense anyway”. The misguided impression that aging and disability issues is not of concern to mass shelter managers is a common assumption. (National Organization on Disability 2005)

There must be a realization that all shelters, emergency managers and disaster relief centers, do serve disability and aging populations even if not specifically articulated in their task assignment and contracts. Some people with disabilities do have specific needs (e.g., transferring from wheelchair to cot, providing a guide for a person who is blind through crowds to the restroom). Shelters staff can be trained to recruit volunteers quickly from shelter residents to assist with these tasks. Most people do not need medical shelters or segregated services. However, they may need of a variety of complex, and sometimes not well understood, community services to reestablish and piece segments of their lives back together.

Recommendations:

Establish Memorandums of Understanding to utilize the assistance of disability and aging organizations in identifying, triaging and meeting the needs of people with disabilities and seniors.

Train shelter managers in how to distinguish between people who only need assistance in maintaining their:

- medical stability by replacing essential medications (blood pressure, seizure, diabetes, psychotropic, etc) or
- mobility by replacing lost or damaged durable medical equipment (wheelchairs, walkers, scooters, canes, crutches, walkers, etc) and essential consumable supplies (catheters, ostomy supplies, padding, dressing, sterile gloves, etc.)

and those who have needs that cannot be met in a shelter because they are not self-sufficient or do not have adequate support from family or friends for assistance with:

- managing unstable, chronic, terminal or contagious health conditions require observation, and maintenance
- managing medications, intravenous (IV) therapy, tube feeding and/or regular vital signs readings
- Dialysis, oxygen, and suction administration
- Managing wounds, catheters or ostomies
- Operating power-dependent equipment to sustain life

Train shelter managers in how to reduce access barriers by making “quick access fixes” and include chart of reminders in Managers “Shelter Opening Packet.”

Establish clear contractual requirements with the American Red Cross that details their obligation to accept members of the aging and disability communities into mass shelters. Requirements should include:

- To accept members of the aging and disability communities into mass shelters. The “we don’t do special needs” is not an acceptable policy.
- To include in the inventory all potential shelter sites accessibility information. This will allow the degree of a facility’s accessibility to contribute to the decision regarding which shelters to open when there is a choice.
- Utilize the assistance of disability and aging organizations in identifying and quickly meeting the needs of members of this population.
- To recognize and address the communication needs: of people who are self-sufficient but need information provided in methods that are understandable and usable by people:
 - who don’t speak, read or understand English,
 - with reduced or no ability to speak, see, and hear,
 - with limitations in: learning and understanding. (Examples include people who cannot: hear verbal announcements, see directional signage to assistance services, and understand what they need to do to get food, water and other assistance because of a hearing, understanding, cognitive or intellectual limitations.)

Examples of how these needs can be met include:

- posting the content of oral announcements in a public area so that people who are deaf, hard of hearing or out of hearing range can go to a specified area to get or read the content of announcements.
- designate a specific time of the day and place where interpreters will be available to communicate information.

Housing

The same housing crisis that keeps hundreds of thousands of people in restrictive living environments putting previously independent and self-sufficient large-scale disaster survivors in hospitals and nursing homes for lack of appropriate housing that allows people use of accessible homes that include use of bathrooms, kitchens, exits, etc.).

Post Katrina disability advocates are still working to get to the tables where key decisions are made about temporary and permanent housing. Housing decisions are being made that will result in discrimination, further limited options and institutionalization of people who could and should be in our communities and in our workforce. Advocates want to imbed universal design, accessibility and visitability standards as the housing stock gets replenished. (Roth 2005)

Recommendation:

Mandate that qualified senior and disability advocates are part of the planning for shelters, temporary and permanent housing.

Cross Training

Disability and aging advocates and service providers need to strengthen their understanding of emergency management systems. In order to improve effectiveness they need to be provided with an orientation to emergency management organizations and structure as well as the roles of traditional recovery organizations such as FEMA, the American Red Cross, and other Voluntary Agencies Active in Disaster (VOAD). Likewise, emergency managers need to strengthen their understanding of disability and aging populations.

Recommendations:

Emergency managers and disability and aging organizations should engage in cross orientation, training and planning activities before and immediately after an event.

Use disability and aging organizations to strengthen responders understanding regarding:

- which organizations can offer what services under what conditions,
- people with disabilities and seniors are not a homogenous group. Individuals with disabilities have differing capabilities, opinions, needs, and circumstances, and no one individual or organization speaks for all people with disabilities.
- People with disabilities and seniors can and are responders and many manage the CBOs that can best respond.

Disaster Recovery Centers

Disaster recovery centers can include agencies from all levels of government as well as not-for-profit and community based organizations. They should ensure that disability and senior organizations are included.

Recommendations:

- OES in coordination with local and state authorities needs to include disability and senior groups in the planning for, and securing space in the facility. These centers must incorporate local, state, and federal disability and aging organizations and services into their service delivery process in order to assist people in transitioning from shelters to temporary and/or permanent housing, and accessing an array of other services.
- These organizations must develop mechanisms to coordinate with each other to maximize resources and eliminate duplication of effort. Multiple service organizations can coordinate their service delivery to identify and resolve gaps in services. This would allow for the most appropriate assignments while eliminating duplicative efforts and resources.
- Allow opportunities for cross-training so that organizations become familiar with existing programs and can make appropriate referrals.
- Recognizing that not all individuals go to the disaster centers, descriptions of services should be disseminated using multiple accessible (captions, reading of all text information arteries (radio, TV, internet, fax sheets, posters, etc.). (National Organization on

Disability 2005)

- Recognizing that not all people can access typical communication networks such as television, internet and newspapers. Communication and public warning plans must include populations who are homeless, whose language is not English or who use alternate methods of communication.

Emergency Funding Proposal Selection Criteria

Current emergency funding proposal selection criteria lack disability specific indicators for evaluating proposals.

Recommendations:

Where appropriate to the grant or contract focus, these indicators should specifically detail and show evidence of how applicants will:

- Deal with the communication, evacuation, transportation, physical access, and health needs of people with disabilities and seniors.
- Form partnerships among first responders, emergency planners and people with disabilities and senior organizations to ensure accurate training information and usable services are developed.
- Increase communication and cooperation with the disability and senior communities.
- Appoint qualified people with disabilities to emergency planning committees, and as advisors, trainers, contractors, and consultants and project staff.
- Assist localities in reviewing and where needed creating access specific policies and regulations.
- Integrate new and update disability specific training content into general training and preparedness materials as well as inform people how to access more customized materials.

Involve Disability and Aging Organizations in Disaster Activities

Encourage CBOs to integrate disaster work into their mission by offering funding contracts and other sustained financial incentives that encourage participation in the full continuum of disaster activities.

Recommendations:

- Provide funding and other incentives to encourage CBOs to be involved in disaster planning, preparedness, response, recovery and mitigation activities.
- Negotiate pre-existing state and local emergency response contracts with disability specific CBOs, to augment government services for seniors and people with disabilities during disasters.
- Integrate disaster preparedness responsibilities into funding contracts, by way of sustained financial incentives that encourage participation by CBOs in disaster activities. Such activities can include:
 - Community networking and planning.
 - Building relationships with other CBOs to coordinate efforts.
 - Establishing cooperative agreements with other CBOs that support and assist similar populations,:
 - Allows for helping each other when some staff or resources are reduced or unavailable.
 - Participating in cross training with disaster response personnel and disability organizations so:
 - All gain a better understanding of each others expertise and roles and can plan together for coordinated response.
 - Participating in Community Emergency Response Teams and Citizen Corps.
 - Assisting people in developing individual and family preparedness and mitigation plans.
 - Establish CBO disaster plans which are:
 - practiced through table-top exercises and drills,
 - evaluated in writing,
 - revised and updated yearly.

- Creation of guidance material for Emergency Managers Agencies on how to integrate access priorities into grant making process.
- Develop emergency preparedness materials that integrates information re: people with disabilities and activity limitations into:
 - General materials, and
 - Informs readers how to access more customized materials.
- Compile and distribute, and when not available, create customized preparedness materials that:
 - have disability specific content, useful and relevant to people with limitations in hearing, vision, mobility, speech, and cognition.
- More specificity and detail:
 - Cross disability focus
 - Written by and for qualified people with disabilities
 - Not about what people can do for us, but what we can do for ourselves!
 - Easy to get
 - Alternative formats

Special Needs Label Is Unclear and Confusing

The special needs label often used as “emergency responder short cut language” to describe the disability and aging populations is confusing and unclear. Some people interviewed were unclear as to what groups are included in this term. Some responder’s definition of who was included in the group was quite narrow. Because in the emergency management field the term “special needs” is defined in multiple ways, often some important segment of this diverse group are overlooked (i.e. people with non-apparent or hidden disabilities, people with serious mental illness, people with intellectual and cognitive disabilities, people with a variety of visual, hearing, mobility, cognitive, emotional and mental disabilities and activity limitations.) (National Organization on Disability 2005) (Kailes 2005)

The “special needs” population is often viewed as homogenous group. This practice and pattern, although understandable, is dangerous given its significant size. A more effective and sophisticated view, and the recent Gulf States’ experiences reinforce and underscore that it is beyond time to disaggregate this diverse group! The lumping together of these groups using an unclear label translates into vague planning which results in response failures.

Recommendation:

Consider a framework based on essential functions needs such as **maintaining functional independence**, communication, supervision, medical needs. Addressing functional limitations allows planning and responding to be more inclusive because it not only includes people who identify as having a disability, but it also includes an even larger range of people who do not identify as having a disability , but in fact do have limitation in hearing, seeing, walking, learning, or understanding.

Appendix

Disaster Experiences of People with Disabilities

Most of the 2005 Gulf States hurricane experiences of people with disabilities will go undocumented and, therefore, under-reported. Here are a few that represent thousands of untold stories.

Benilda's Promised Ride to the Superdome

On the morning of August 29th, 2005 (day) I received a call that I will never forget....My friend and colleague called me to enlist my help because her sister-in-law, a quadriplegic woman in New Orleans had been unsuccessfully trying to evacuate to the Superdome since Saturday. In my naiveté I thought a few phone calls to the "right" people would help, and I was sure I knew who to call. After many calls to the "right" people, it was clear that this woman, Benilda Caixetta, was NOT being evacuated. I stayed on the phone with Benilda for most of the day, assuring her that I was doing all I could to make sure help would be coming as soon as possible. She kept telling me she had been calling for a ride to the Superdome since Saturday, but, despite promises, no one came. The very same paratransit system that people with disabilities can't rely on in good weather was what was being relied on in the evacuation. It's no surprise that didn't work.

I was on the phone with her that afternoon when she told me, with panic in her voice, "the water is rushing in" and then her phone went dead.

We learned five days later that she had been found in her apartment, dead, floating next to her wheelchair.

Sometimes things like this can't be prevented. Despite the magnitude of the catastrophe, this was not one of those times. **Benilda did not have to drown.** (Roth 2005)

Charles Had a Home and a Good Job

Charles, a man with a good job, his own home in New Orleans, and flood insurance hasn't been able to bathe in ten weeks. He is quadriplegic and he is homeless. The lack of personal care has landed him in the hospital twice and he now has a staph infection as a result of his last hospitalization. His insurance will pay over \$100,000 to repair his accessible home, but his community is destroyed. There is no public transit system, no grocery store and no healthcare system. He can't afford to keep paying the mortgage and taxes on a home he can't live in and he can't afford to move to Baton Rouge where he could continue working and access healthcare and other disability related services. \$100,000 won't pay off his mortgage and it won't allow him to buy a new home in Baton Rouge. The cost of housing is just too high there. What is he to do? (Roth 2005)

Selena Survived But ...

Selena, a quadriplegic, started in her own home in Bayou La Batrie, Alabama. She had chosen to pay for college rather than pay for homeowners insurance, gambling that it was a better investment. On August 29th, she evacuated first to family, and then to a crowded, understaffed special needs shelter where she slept in her wheelchair. When the shelter was unexpectedly closed down, she was sent to a bed and breakfast without an accessible bathroom. Ultimately her skin couldn't take the abuse and she developed a life-threatening pressure sore. She ended up in the hospital and yesterday, she was transferred to a nursing home. Selena SURVIVED the hurricane but she hasn't done so well in the ten weeks after the hurricane. Due to inadequate care, she now faces surgery and months of recovery. She is living in a nursing home. She has no place else to go. (Roth 2005)

The Man Has Got To Have A Plan!

Sent: Sun, 25 Sep 2005 08:42:16 -0700
To: katrinadisability@yahoogroups.com
Subject: [katrinadisability] Stories

I am Robert Darden from Virginia a polio quad using power chair and vent-2 years ago. I was caught by HURRICANE ISABEL a little part-our area was knocked out hard-thousands of trees--no power for over a week--and no help from the authorities I mean none I survived because of GOD-and a local fireman--i could not believe my situation was HAPPENING -WHY WAS I surprized-well-i live in a urban area-population million people I am 20 minutes from major trauma center--i live in the biggest military center-in the world I am a good advocate-but I had no idea how the disabled person is overlooked in a major DISASTER

So Robert, I'm curious -- what have you done since Isabel, to strengthen your own preparedness? June Kailes

ROBERT WHO wrote:

i live in Norfolk va-on east coast-near va beach-as I mentioned this is a great urban area--central to major interstate highways but my called the tidewater area is a pennsulia--we are connected by tunnels-to major cities-NOW I KNOW THAT EVERY INDIVIDUAL ABLE-DISABLED-SHORT TALL FAT BLIND OR ELDERLY MUST ASSUME THEY ARE ON THERE OWN--NOW I AM a single person with my own home so my direction is different from a nursing home or group home---because I depend on power for vent-oxygen-ie conscentrator-power chair--i purchased a home generator on a easy payment plan--that will provide for chair-second I switched from power concentrator to liquid oxygen--no power REQUIRE I bought a very old jazzy powerchair-as a backup-as you know the jazzy has built in battery that can be charged at any power outlet---then I realize my car was not practical for long distances--so I am getting a van---i have collected can food products--and water-our power company now is offering generators for the entire home-it is very expensive-but I see no choice---more info later-Cheers R

Don't Worry the Ambulance is Coming Soon

Family demands answer in 2 deaths - Pair died despite evacuation promises

By SANDY DAVIS

Advocate staff writer

http://theadvocate.com/stories/102605/new_promises001.shtml

CHALMETTE -- Dorothy Hingle lit a candle sometime after 9 a.m. Monday, Aug. 29, in her small brick home on Rosetta Street. She crawled into bed with her quadriplegic son, Russell Embry, put her arms around him and prayed. Then she waited.

That's what her daughters have pieced together as her final actions while Hurricane Katrina cut its deadly path through St. Bernard Parish.

A wall of water came crashing over Chalmette within an hour, swallowing mother and son in a small bed in the rear bedroom of the home.

Hingle and Embry died.

Their relatives say the two had waited since Saturday for Acadian Ambulance and Med Air to come and pick them up.

But Acadian never showed up.

Embry, 54, a quadriplegic since 1974, was on a special-needs list compiled by the parish's Department of Human Resources. The list was for those who needed to be evacuated by ambulance in the event of a hurricane.

Hingle was listed as Embry's caretaker and, over the years, was always evacuated with her son.

"It was like clockwork," said Sally Viada, one of Hingle's three daughters. "My mother and brother had been picked up and evacuated by ambulance before every hurricane for at least the last 10 years."

During Hurricane Ivan in 2004, Acadian picked up Hingle and Embry, who was 6 feet, 4 inches tall and weighed about 250 pounds, and evacuated them to Barksdale Air Force Base.

"It never occurred to me that anything could go wrong," Viada said, crying quietly during a recent interview.

And it is Acadian that holds the exclusive rights to provide the wide array of ambulance services needed by residents in St. Bernard Parish. Parish officials signed a contract with the company in February 2004, said Larry Ingargiola, director of the parish's Office of Homeland Security and Emergency Preparedness.

"Acadian has had exclusive rights to operate in St. Bernard Parish for more than a year," Ingargiola said. "It's the only ambulance service operating in the parish. It's the only one the contract allows."

When meteorologists determined on Saturday, Aug. 27, that Hurricane Katrina would likely make landfall somewhere in southeast Louisiana or Mississippi, parish officials ordered a mandatory evacuation and the special-needs list was given to Acadian.

"Acadian assured us they were picking everyone up on the list," Ingargiola said.

But somehow Hingle and Embry were not picked up.

And since the storm, Ingargiola has discovered that others on the list were left behind.

"We're doing an investigation," he said. "We're going to find out what happened."

Acadian officials refused to comment on the allegations surrounding Hingle's and Embry's deaths.

Steven Kuiper, Acadian's vice president of operations, said Monday the company was not conducting a special investigation into the deaths. Instead, he said, the company was conducting a post-storm "status review," which is "standard operating procedure."

"We're evaluating the disposition status of all the transports in the tri-parish area in the days before the storm," Kuiper said, adding that the tri-parish area included St. Bernard Parish. "That's part of our normal self-critiquing after a major storm."

Kuiper also refused to provide records that would show how many times Hingle called Acadian between Saturday and Monday before the storm.

"That's part of our investigation," he said. "I don't have all of those facts. It's part of our total evaluation."

He also said that evacuating residents on the special-needs list is not "specific to the contract" his company has with St. Bernard Parish.

But parish officials disagree, though they note that the contract was lost in the storm along with much of the parish's paperwork.

"If they agreed to the exclusive contract and they're the only service allowed in the parish, who else would be responsible for moving people on the special-needs list?" asked Lynn Dean, a parish councilman. "That doesn't make any sense."

To the family, there is only one question.

"Acadian talked to my mother several times over that weekend, and each time they told her they were coming to pick her up," said Betty LeBlanc, one of Hingle's daughters. "What I can't understand is when they knew they weren't going to come, why didn't they just call and tell her that? Instead, Acadian played God, and that's unforgivable."

Left behind

Dorothy Hingle was at the center of her family. She was the person her daughters went to for advice or to be picked up when life dealt them a blow. Despite her 83 years, Hingle was known for her strength and faith and dispensed wisdom to her girls on a regular basis, they said.

As the storm approached on Saturday, each of the three daughters -- LeBlanc, Viada and Hazel Cooley -- talked to Hingle to make sure Acadian was on its way.

Viada worked at Sears in the parish's small town of Violet.

"I worked late Friday night and early Saturday," Viada said. "So it wasn't until Saturday afternoon that I found out about Katrina."

Viada called her mother immediately.

"My mother told me to go on and leave," Viada said. "She told me that she had just spoken to Acadian and they were coming to get her within the hour. That was the last time I ever spoke to her."

And Viada left.

"The ambulance could only take my brother and a caretaker," she said. "I learned that a long time ago. They had always come before, so there was no reason for me to question it this time."

LeBlanc also spoke to her mother on Saturday. LeBlanc planned to evacuate in her new car, following her son out of the parish. But her mother told her not to go in two cars.

"I'm 61 years old, but when I told my mother I was going to follow my son's family out of Chalmette, she said, 'Oh no, you can't do that. What if you get separated from him? It will be a nightmare. You have to ride with him,' " LeBlanc said.

LeBlanc left her 3-week-old car behind and did as her mother told her to do.

That was the last time LeBlanc talked to her mother.

Herb Stansbury, who has lived next door to Hingle for about 30 years on Rosetta Street, was surprised when he saw her at his door Sunday afternoon with a cake.

"I couldn't believe she was standing with some cake," Stansbury said. "I was surprised she was still there. She and her son had always been picked up by ambulance this close to the storm's arrival. I said, 'What are you doing here?' She said, 'The ambulance is coming soon. Don't worry.' "

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