Death by System

How an Older Adult Died a Preventable Death While Government Followed the Rules



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ADVOCATE'S FOREWORD

It could have been any of us.

This introduction would be easier to write if this was wildly unusual. If someone didn't do their job, or if something got lost, or if something got missed, then I would pinpoint that failure and believe that the system would work to make sure it didn't happen again.

I know what to say when the system fails.

But what do I say when the system follows its own rules perfectly, and yet someone dies a preventable death?

This report details how an elderly woman was found on her last day, unconscious, alone, lying on the ground some distance from the place that had tried to keep her safe. She died in exactly the way people on the front lines warned that she might, found too late to be saved after wandering away from a special care home that everyone knew wasn't equipped to keep her safe. It would be comforting if I could share some remarkable detail, something that would tell us that this case was unique. If I could say that this had never happened before to others, or that it won't happen again. Unfortunately, I cannot do that.

There is no unforeseeable event, no rare condition, no hideous villain that explains away the tragic outcome. There is only the banality of everyone doing their jobs as the system told them to do them, every one of them alive to the rules but blind to the urgency of the situation.

Alice was one of us. She was a person, loving and loved, feeling, hoping, and living. Because of the arrival of dementia, that cruel condition which will strike so many of us as we age, she needed to trust and rely on others to keep her safe.

What ultimately ended Alice's life was that we broke that trust. In her confusion, she wandered away from the building and people who could keep her safe, and into a place where she could not protect herself.

I wish I could say that no one saw it coming. But many people saw it coming. There were some, on the front lines, who worried and warned and pleaded for help. And there were others who could have seen it coming but just kept moving the file along the bureaucratic conveyor belt, so numbed by the insulating routine of compliance that they couldn't see the vulnerable person in danger until it was too late.

When Alice wandered out of her special care home for the first time, she was found disoriented but safe by a highway. Her doctor advised that she needed more protection than the home could provide. The people at the special care home took that advice seriously and asked the

Department of Social Development to re-assess her, find out what she needed to keep her safe, and ensure she made it to that safe place.

It took the Department six months to even do the assessment, which told them what they had already been told – that Alice was not safe where she was. Another year passed without anything being done to keep Alice safer.

In that year of waiting, there were ten more incidents of Alice wandering away. The Department of Social Development received seven more incident reports. Every one of these was a warning. Yet no one at the Department escalated the file for expedited action. No one even proposed interim measures to protect Alice in the meantime.

During Alice's time at the home, she managed to wander away from the facility a total of 12 times. Care staff followed up by submitting incident reports to the Department as appropriate. No one knew that the last incident report would be the final warning, as Alice's final incident turned into a preventable death. The twelfth time, Alice was eventually found, unresponsive, and died.

In the language bureaucracies use to numb themselves to urgency, no one was responsible. The incident reports had been received and logged according to the rules. The pile of referrals had been processed according to the rules. The wait time for a new home had been managed according to the rules. The system got what it needed. The people processing the paper got the certainty of structure and rules. The people watching the budgets got the economy of no one asking for an extraordinary expense. The middle managers got that comfortable insulation from the worry and disruption of the front lines, because there was no rule empowering anyone to tell them that their rules might not meet the moment.

Everyone got what they needed from the system.

Except Alice. Alice was found alone and unconscious, and then Alice died.

In reports like *How It All Broke*, I've warned that our system values compliance over results. People are given steps to follow and processes to adhere to. There is no room to convey urgency. There is no incentive for being the one who warns that people are suffering. There is no spot in most employee evaluations for conveying urgency up the chain of command. Worry and compassion are for families and front-line workers. The rules protect the people who write them from experiencing the panic, from imagining the worst.

When the worst, the predictable worst, happens, families grieve and the hearts of front-line workers break. And the elected folks get microphones in their faces, asking what they will do to stop it from happening again.

But the system is built to make sure they won't see the next one coming, either. The rules, and the culture that places higher value upon compliance over compassion or common sense, live on. The rules, and the culture that venerates them, provide a very important service. They allow managers to feel good about compliance and, as long as the rules are followed, they never hear any of the warnings that might require them to escalate, to ask questions, or to warn the folks on higher floors that the rules and resources might not be enough. As the old saw goes, seldom is heard a discouraging word, because the rules are being followed and that's all we ask.

Over the two years since I wrote *How It All Broke*, I've heard a lot of folks say the right things. What I haven't seen is anyone cross the Rubicon and actually transform government social programs.

I suspect that quietly, some people have convinced themselves that it's all just idealistic, academic nonsense to believe we can change how government runs. We measure compliance, not outcomes, because that's how it has to be done, because that's all that has ever been done.

I think it's possible to create processes that require people to escalate files when the status quo is not good enough.

I think it's possible to change cultures to empower people to speak up when they fill out the forms and can see we are going to fail people.

I think it's possible to reduce red tape and empower people on the front lines to solve problems.

I think it's possible to evaluate middle managers and regional leadership by the good they do for people and not the consistency with which they fill out forms.

I think, in a world that's gone from transistor radios to iPads, from Pong to Virtual Reality, from 8-Tracks to streaming – and all in just a half century – that public governance could also change its way of doing things. In fact, I've seen it done.

It just takes the will to see things as urgent. The way the people who loved and cared for Alice saw the urgency of her situation, the urgency of those many times where the Department was warned that disaster was near.

At some point, it takes someone in charge to tell people that the urgency of compassion has to come before the comfort of compliance.

There's a poster in my office with a picture of William Wilberforce. It has some words he spoke in the British Parliament, so many years ago now, telling people about the horrors of the slave trade. He wanted them to confront what was painful to look at, and to act.

“You may choose to look the other way, but you will never say again that you did not know.”

I don’t know where the tipping point will be, when we finally look to change what we do and break out of the comfortable cycle of how government runs.

I know that a woman died. I know that she didn’t have to. I know that she died, and the system ran exactly as it was designed to run. I know that it will happen again unless we change.

I don’t know what the people in charge will do with that. I don’t know if the media and citizens will lament and criticize for a couple of days and then look away, again, until the next sad case. I don’t know if the people who make the laws and the people who apply them will do the work needed to prevent the next avoidable death. My job is to make sure that they can’t say they did not know.

They know, Alice. I am not sure what they will do. I can only be sure that they cannot now say that they did not know.

DISCLAIMER

This report has been prepared using de-identified information to protect the privacy of individuals. Names, locations, and other potentially identifying details have been altered, generalized, or omitted where necessary to reduce the risk of identification. No material facts have been changed. The events described, the sequence of those events, and the substantive issues remain accurate.

INTRODUCTION

The circumstances of this report are tragic, involving the death of a woman who wandered from her special care home and, when found, died shortly after.

The report is a review of Alice's care trajectory, from her initial placement in a special care home to the repeated incidents of elopement, the attempts to align her care with her needs, and the ultimate inability of the system to protect her. The report is the result of an analysis of all related incident reports, assessments, and correspondence with the Department of Social Development.

In 2024, the Advocate undertook a comprehensive review of the long-term care system, which led to two reports: *What We All Want* and *How it All Broke*. The first was an exacting examination of the flaws in the long-term care system, with recommendations for how to improve it. The second was an explanation of the kinds of broad governance flaws that plague many systems. The *How It All Broke* report exposed critical systemic issues that impede the effectiveness of how the civil service implements the laws enacted by the Legislature. That report critiqued the provincial government's management of social policy and identified five key governance flaws that contribute to the failure of social programs in New Brunswick. These flaws include a lack of effective human resource planning, a detachment of the budgeting process from reality, a preference for following rules over the need to achieve results, a deficiency in data collection and analysis, and a tendency to fund crises rather than invest in preventative solutions. These shortcomings are deeply ingrained within the government's structure and processes, hindering the effectiveness of social policy and ultimately harming citizens who rely on these services.

Later in that same year, the Advocate circulated a guidebook to members of the Legislative Assembly[1] outlining an approach to guide decision-making in operations, entitled *Right Thing, Right Now*. This approach focuses on defining problems and desired outcomes, empowering front-line staff to make decisions, and prioritizing solutions that meet immediate needs effectively. Building upon the insights of the *How it All Broke* report, *Right Thing, Right Now* advocates for transforming government-regulated operations from a reactive, rules-driven, and restrictive model to an entrepreneurial, proactive, and results-based model.

What follows in the report you are reading here is an application of the sad facts of Alice's death to the advice provided in *Right Thing, Right Now* and *How it All Broke.*

[1] Office of the New Brunswick Advocate. (2024). *Guidebook for Members of the Legislative Assembly*. https://www.defenseur-nb-advocate.ca/resource/guidebook-for-members-of-the-legislative-assembly

This report stemming from Alice's death proposes targeted recommendations aimed at reforming policies and practices. These recommendations are designed to enhance accountability, improve responsiveness, and ensure adequate resource allocation within the system governing special care homes.

Background

Alice moved into a special care home after Social Development's Long-term Care assessment revealed that she had dementia.

For the first two and a half years, Alice lived peaceably in her new home without major incident. In the next months, however, it was clear that her mental health was deteriorating, and it became significantly more challenging for the care home staff to look after her while ensuring her safety. Alice managed to walk out of the special care home and was later located on the highway, fortunately unharmed. This event prompted staff to submit an incident report to the Department of Social Development and request that Alice's care needs be reassessed. During an appointment following that incident, the doctor noted that Alice's dementia had advanced to a point where she required more care than the home could provide as a 'Level 2' facility. The Department of Social Development, however, did not undertake the requested reassessment.

Five months passed before Alice succeeded in leaving the facility again. She was found on a road. As they had done previously, the special care home staff sent the Department of Social Development an incident report and made a second request for Alice to be reassessed. A couple of weeks following this second request, Alice was reassessed by the Department and determined to require 'Level 3B' care, validating what care home staff had suspected and what Alice's doctor had previously communicated. Alice was placed on the provincial nursing home waitlist.

However, for a year following her reassessment, Alice remained at the 'Level 2' special care home instead of being transferred to a nursing home for the 'Level 3B' care she required. Despite Alice's reassessed care requirements, the special care home received no additional funding, staffing, or enhanced supports from the Department of Social Development to bridge the gap in care while awaiting an appropriate placement.

During that year, Alice was documented to have left the facility ten times. Special care home staff filed seven incident reports to the Department of Social Development.

Almost exactly one year from the time she was reassessed and determined to require 'Level 3B' care, which the special care home was never equipped to provide, Alice wandered away from the facility for the final time.

Even with police intervention, efforts to locate Alice were unsuccessful throughout that afternoon and overnight. She was eventually discovered the following afternoon. Paramedics immediately rushed her to hospital, where she died after arrival.

An Adult Protection investigation concluded that the allegation of lack of supervision against the facility was unsubstantiated.

Identifying the Issues

The problems in this case related to the Department of Social Development are easily described. They are these:

- A lengthy delay in having Alice reassessed for a higher level of care;
- Endangering Alice's safety and well-being by not ensuring a placement with the level of care deemed appropriate by assessment;
- Inadequacy in ensuring additional resources to mitigate the risk to Alice while she remained in the special care home, despite repeated incident report concerns; and
- Not identifying any specific or systemic concerns in the ensuing Adult Protection investigation.

The reasons each of these problems arose are not so easily explained.

It took the Department approximately five months to reassess Alice's needs after the special care home sent their initial request. Social Development's response, when asked about the delay, was that it was likely due to numerous requests for reassessments. The Department confirmed that there are still long lists of clients in special care homes that require reassessments, and the time it takes for the Department to respond can be extensive.

Even after her reassessment, Alice remained in a special care home that was not resourced to meet her needs. She remained there until her death approximately one year following the Department's reassessment that had determined she required a much higher level of care.

During this time, despite the Department being aware that Alice was assessed at a higher level of care than the special care home could provide, and despite the home continuing to submit incident reports to the Department, there was no response or support offered from the Department to the special care home that would have assisted the home in keeping Alice safe.

After Alice's death, an Adult Protection investigation occurred. Rightly, the examination of 'lack of supervision' by the special care home was found to be unsubstantiated. However, the Adult Protection investigation did not address any concerns related to the actions – or rather inaction – of the Department itself.

The analysis of these issues in this report will first consider the administrative problems apparent in the last years and the death of Alice, through the lens of the *Right Thing, Right Now* philosophy. It will then consider the governance problems that relate to this case, through the lens of the *How It All Broke* report.

ANALYSIS – ADMINISTRATIVE PROBLEMS

Not Asking the Right Questions to the Right People.

The special care home appropriately identified the need, along with a medical professional, for Alice to be reassessed, and made requests to the proper authorities (the Department of Social Development). However, the lack of timely response from Social Development suggests a failure within the Department itself to engage with the right people promptly. When a decision-maker at any level of the Department is faced with a problem, it is of no use to assume that the system is not equipped to address the problem with the urgency needed and therefore do nothing. Compliance with internal constraints, and silence about them, leaves the whole system in jeopardy of being unable to identify and address flaws. This kind of problem should have been communicated by the intake professional to supervisors and carried on up to the highest level of authority within the Department. Instead, the problem was never addressed because the problem was never assessed. The problem persisted in silence.

Not Assessing the Problem and Potential Remedies

The complete failure to address the problem was, in essence, simply giving up in the face of the inadequacy of the system.

The special care home understood the problem, and the doctor assessed it, but the Department was the sole body that could address it. First, however, the Department itself would have to assess the problem to trigger action. They did not. And therefore, no immediate action was taken to even consider how to mitigate the risk, let alone remedy it.

In addition, the Adult Protection investigation did not attempt at all to assess the actual problem and, therefore, considered no potential remedies that the Department could have or should have put in place before Alice died. Instead, the Adult Protection investigation focused

solely on the actions of the care home and in so doing failed to address the systemic issue of delayed response and inaction by the Department. This narrow focus prevented a comprehensive assessment of the problem and its root causes. Nothing was learned.

Not Putting the Result Ahead of Rigidly Applied Rules

The incident reports and expert advice provided clear evidence of Alice's needs, yet the response from the Department of Social Development focused on adherence to its own caseload burdens and staffing limitations, rather than finding interim solutions to meet her needs before being transferred to a nursing home.

Moreover, the rigid adherence to nursing home waitlist procedures, despite knowing Alice was contending with an inappropriate level of care, left Alice with no appropriate support and left the special care home with an impossible task. While rules and procedures are important, prioritizing Alice's safety and well-being should have been the primary goal.

Not Knowing Whether What Is Done Is Working

The continued elopements by Alice, despite multiple incident reports, demonstrate that the existing care plan was not working. This lack of improvement should have triggered a review and adjustment of the plan to ensure her safety, but this did not occur firstly due to the five-month delay in the Department's reassessment, and secondly due to the Department's subsequent failure to actually act on the reassessment for a full year.

Again, the Adult Protection investigation did not identify or address this failure.

Not Understanding How Today's Decisions Affect Tomorrow

The delay in reassessing Alice and the subsequent inaction to move her to a more appropriate facility ultimately left her in an inadequate care situation until her death. There cannot possibly be a more serious example of how neglecting to consider the long-term impacts of decisions impacts the future.

The lack of support and funding for the special care home, while Alice awaited placement in a nursing home, placed undue burden on the special care home staff and ultimately jeopardized Alice's safety. The lack of action to expedite the move to a nursing home exacerbated the situation.

Again, the Adult Protection investigation neither identified nor addressed this failure.

ANALYSIS – GOVERNANCE PROBLEMS

The Lack of Effective Human Resource Planning

The extended waitlist for reassessments and the further extended waitlist for placements in appropriate care facilities suggests a shortage of qualified personnel to conduct assessments and manage the needs of individuals like Alice. The immediate concern of not having adequate personnel to do these assessments is the delay in identifying an appropriate level of support for the individual.

Further, the lack of additional funding being made available to the special care home to address Alice's increasing needs in the interim points to a disconnect between funding allocation and actual staffing needs in service delivery. The repercussions of this lack of resource planning are felt most by the resident who is left in limbo with an inadequate level of care while awaiting reassessment.

In order to connect human resource planning, service standards, and future needs, the Department should be asking itself questions and diligently finding answers. What are the current service standards for this program, and what data support them? What is the projected demand for this program's services over the next five and 10 years, and what data support those projections? How many professionals are needed to meet the current and projected service standards, and how was that number determined? What specific human resource plan is in place to ensure the program has the necessary staff to meet current and future needs? How are human resource allocation decisions made for this program, and what role do service standards and future needs play in those decisions?

Detachment of the Budgeting Process from Reality

Even if resources had been provided to the special care home to meet Alice's serious needs – as they should have been – this would still have pointed to a reactive budgeting approach that prioritizes crisis management over necessary solutions, since she simply should not have been in that special care home.

Moreover, the fact that Alice remained in that 'Level 2' facility for a year after being assessed as needing 'Level 3B' care suggests a clear misalignment between budget allocation in the long-term care system and the actual needs of New Brunswick's population.

Budget decisions are made by the central authorities of the Executive Council Office and the Department of Finance and Treasury Board, often based on the previous year's spending. These billion-dollar decisions are made centrally, without all the necessary information and context from the departments delivering the social programs and, therefore, without comprehensively

considering actual social outcomes or future needs. It is a governance flaw when there is a lack of connection between the budgeting process, objective targets, and measurable outcomes for citizens.

In order to connect budgeting processes, objective targets, and measurable outcomes, the Department should again be asking itself questions and looking for answers. What are the specific social policy goals this program aims to achieve, and how are those goals measured? What data and analyses were used to determine the program's budget allocation, and how does that budget connect to achieving the stated social policy goals? If the program were to receive a budget increase, what specific improvements in service delivery or outcomes would be expected as a result of that increase, and how would these be measured to determine success? If the program experienced a budget cut, what specific impacts on service delivery or outcomes could be anticipated, and what steps would be taken to mitigate those impacts? How is the program's performance being tracked and measured against its stated social policy goals, and what mechanisms are in place to ensure accountability for achieving those goals?

Failure to Amend the System When It Does Not Achieve Intended Results

The lack of flexibility and creative problem-solving in Alice's case, despite clear evidence of her needs and the risks associated with failing to provide the care she required, is reflective of multiple cases we see. It highlights a culture of rule-following that hinders effective service delivery. The Department presently does not have adequate mechanisms to even identify when results are not achieved, let alone to take action to address that problem.

In observing that the Adult Protection investigation was both ineffective and inadequate, we see a textbook example of the governance flaw that occurs when employees follow a structured process that is wholly divorced from needs-based results. From our perspective, it appears as though this investigation into the shocking death of a special care home resident was carried out because it was viewed as a rubber-stamp procedural necessity instead of a mechanism for accountability and improvement of critical social service delivery. The investigation did not produce any significant findings or recommendations to prevent such occurrences from happening in the future. The Department was made aware on many occasions that the special care home struggled to supervise Alice as she required a higher level of care that the Department never provided, and yet they made no finding as to *why* her death occurred, even though there was evidence to suggest that the Department itself should have been held accountable. To be clear: nowhere in the *Family Services Act*, Regulations, or the Department’s Practice Standards is there an obligation that Adult Protection, or any other review mechanism, should examine the conduct of the Department. It is perhaps not a surprise that it did not happen in this case, as adult protection workers are guided by their Practice

Standards. Whether those Practice Standards are well-aligned with the will of our elected officials as found in the *Family Services Act* is another question. After all, the preamble to the *Act*, which is a declaration of the Legislature as to the law's objectives, includes this wording: "it is recognized that elderly, disabled and dependent persons are entitled to protection".

When programs prioritize adherence to rigid procedures and eligibility criteria, they often discourage the creativity and flexibility that can lead to better results. In order to avoid this flaw, the Department should once again be asking itself questions and looking for answers. What flexibility do front-line staff have to deviate from program rules or procedures when it would lead to better outcomes for clients? How often are there examples of situations wherein strict adherence to program rules has resulted in negative outcomes for clients? What steps need to be taken to promote a results-oriented culture within the program, one in which achieving desired outcomes is prioritized over simply following rules? Are successful, innovative approaches to service delivery identified and shared within the program, and could front-line staff be encouraged to adopt best practices? Are there any plans to review and revise program rules or procedures to remove unnecessary barriers or restrictions that hinder achieving desired outcomes?

Lack of Data, Analysis, and Follow-Up

The lack of response to the initial incident reports filed by the special care home suggests a Departmental inability to effectively utilize data to identify and address emerging risks.

The Adult Protection investigation's narrow focus on the care home, without adequately considering the systemic issues related to the Department of Social Development's response, prevents the Department from collecting comprehensive data to analyze and follow-up to address the broader system context.

Data collection is often limited in the civil service, and even when data are available, they are not used often enough to inform program improvements or drive accountability for achieving results. To address this problem, the Department should once again be asking itself questions and looking for answers. What specific data are being collected to track the program's performance and to measure its progress toward achieving its stated social policy goals? How are the collected data analyzed and used to identify areas for program improvement, assess the effectiveness of different interventions, and inform resource allocation decisions? Are there examples of how data analysis has led to specific changes or improvements in the program? What mechanisms are in place to ensure the accuracy and reliability of the collected data, and how are data gaps or limitations addressed? How are program staff trained to use data effectively in their work, and how is data literacy promoted within the program?

In Alice's case, it is unclear how the information from each incident report was analyzed and used to identify areas for program improvement, assess the effectiveness of different interventions, or inform resource allocation decisions.

Not Budgeting for Solutions

The apparent lack of appropriate staffing levels to conduct assessments and ensure timely placements reflects a funding strategy that allows for crises.

The Adult Protection investigation did not address this issue. But that investigation was certainly allocated a lot of budgeted resources from the Department. Dozens of residents of the special care home were interviewed. Dozens of former and current staff members of the special care home were interviewed, as were the operators. None of this effort would have any impact whatsoever on the governance flaw that needs to be corrected: budgets that are reactive and crisis-oriented instead of budgets that are proactive and solutions-oriented.

The tendency to overspend on crisis response while underfunding preventative programs and necessary services is one that every aspect of government should be constantly aware of. Such a reactive approach addresses problems after they escalate, or looks back on those problems feebly and helplessly, leading inevitably to higher system costs and less effective solutions. In order to avoid this situation, the Department should once again examine the questions that obviously arise. What research has been done to identify preventative programs or services that could be funded to reduce the likelihood of individuals requiring crisis intervention services provided by this program? What key performance indicators, data, or analyses support the current allocation of resources between crisis response services and preventative programs, and how is the cost-effectiveness of this allocation evaluated? How common are examples of situations where a lack of funding for preventative programs has led to increased demand for crisis response services and higher overall costs? Are there any plans to shift resources toward preventative programs and services, and what strategies are being considered to achieve this shift? How are partnerships with community organizations and non-profit groups leveraged to deliver preventative programs and services, and how is the effectiveness of these partnerships evaluated?

CONCLUSIONS

Alice's story is a tragic one. One that we all would try to avoid imagining befalling any of our own loved ones in care. We would want to assume that what happened to Alice was indeed a rare event, that the long-term care system is set up to protect our most vulnerable, giving them

the opportunity to live out their remaining years in peace and comfort. That is the intention of the system, of course, and those who work in special care homes and nursing homes and in the Department of Social Development, do so because they care very deeply. When the people who work in the system are doing what they feel they can, but when the long-term care system is not set up for them to succeed in doing so, it calls for systemic corrections.

This Office undertook a review of the long-term care system as a whole, leading to the *What We All Want* report in 2024. That report was informed by over 300 individual submissions from the public, over 50 submissions from organizations, dozens of one-on-one interviews, and a review of over 350 case files at our own Office. Addressing all of the systemic flaws in long-term care will undoubtedly take time, as new legislation, policies, and structures will be necessary. But there are immediate problems to solve in the interim, problems that cannot wait, like Alice couldn't.

Special care homes, nursing homes, and adult protection services comprise critically important aspects of the long-term care system. If the administrative and governance flaws identified in the *Right Thing, Right Now* approach and the *How It All Broke* report are not addressed, there is no hope of preventing more deaths like Alice suffered.

Recommendations

The following are recommendations to the Department of Social Development under Section 23 of the *Child, Youth and Senior Advocate Act*.

1. The Department needs to hold regional offices accountable for outcomes.

The Department of Social Development should develop results-based scorecards for regional offices and integrate outcome-based measurements into the evaluation of all senior leadership at the regional level. These outcomes should be based upon the well-being of the seniors, children, and vulnerable adults who rely upon programs of the Department.

2. The Department needs to create mandatory timelines for reassessment requests.

The Department of Social Development should implement clear, enforceable timelines for responding to reassessment requests from special care homes, physicians, or other care professionals. When these timelines are not met in a region, there needs to be mandatory follow-up and investigation.

3. The Department needs to empower people on the front lines to propose and escalate proposals for interim measures when the safety and development of vulnerable people is at risk.

Where an individual is assessed as requiring a higher level of care but remains in a lower-tier setting due to waitlists or placement issues, the Department should require that:

- Consideration of interim funding, staffing supports, and safety assurance plans be documented; and
- Decision-makers justify deviations from expert advice and explain the basis for risk decisions.

4. The Department needs to create a culture where workers have permission to escalate concerns around inadequate resources, rather than just fill out forms.

To close the gap between information the Department receives and action it fails to take, there should be a policy obligation placed upon all regions to track incident reports that indicate operational failure (e.g., repeated elopements) and a mechanism to trigger escalation protocols when risk thresholds are met.

The Department should further develop and implement a standard protocol that triggers immediate placement review and action for individuals who:

- Are assessed at a higher level of care than their current placement;
- Have repeated high-risk incidents; and
- Have remained in a facility without appropriate resourcing.

5. The Department should hold itself systemically accountable.

The Department should amend its procedures to ensure that Adult Protection investigations not only evaluate the conduct of care facilities but also assess Departmental oversight and decision-making. The reports should include an analysis of whether appropriate and timely responses were made to known risks and whether resource allocation contributed to outcomes.