

FAILURE TO PROTECT



OFFICE OF THE OMBUD NB SPECIAL REPORT REGARDING THE RESTIGOUCHE HOSPITAL CENTRE

FEBRUARY 2019



A REPORT OF THE OFFICE OF OMBUD NB

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EXECUTIVE SUMMARY

In May of 2017, the Office of the Ombud received an anonymous written disclosure alleging significant failures to protect patients of the Restigouche Hospital Centre (“RHC”) from mistreatment and inadequate care at the hands of staff.

Our investigation into the matter has concluded that these allegations are substantiated.

We believe that in multiple cases there has been significant mistreatment of RHC patients.

We recognize the issues involved are complex and we do not have clinical expertise to provide detailed recommendations. Nevertheless, we feel confident in stating these conclusions:

- There is an ongoing safety risk to both patients and staff at RHC. Corrective measures are urgently needed;
- There have been serious incidents of mistreatment of patients at RHC;
- RHC is not consistently providing adequate care to patients;
- Chronic understaffing has eroded the culture and service model at RHC; and,
- Sincere attempts to change the culture and improve the service delivery have not succeeded.

We recommend substantial revision of the mission of RHC. With the existing staff, the institution simply can not provide the entire range of mental health services it has been mandated.

We also recommend changes and increased vigilance to ensure proper incident reporting at RHC.

Finally, the longstanding and pervasive issues in recruitment and retention at RHC should lead to reconsideration of the youth mental health facility currently proposed for the same location.

RHC is not consistently meeting acceptable standards of care for a mental health institution.

BACKGROUND: WHAT IS RHC?



Figure 1: Photo credit: Vitalité Health Network

- 1 RHC in Campbellton is the province's chief provider of specialized in-patient mental health services. Opened in June 2015 at a cost of \$156.6M, RHC replaced the psychiatric facility known as the Provincial Hospital, where patients had received care since 1954. Managed by the Vitalité Health Network ("Vitalité"), RHC was envisioned to serve as a Centre of Excellence in assessing, treating, and reintegrating patients into the community. Connected to the main Campbellton Regional Hospital by pedway, RHC has a total capacity of 140 beds within seven units. Sixty beds are set aside for forensic psychiatry (court ordered assessments and treatments); the remainder are spread throughout the facility. While adjustments have been made to reflect staffing challenges and patient population, the envisioned division of units by specialization included:

UNIT	SPECIALIZATION
F1	Forensic psychiatry (Evaluation)
B1	Neurocognitive Disorders with Severe Behavioral Disorder
B2	Community Transition
C1	Autism Spectrum Disorders
C2	Concurrent Disorders
D1	Correctional Transition
D2	Psychotic Disorders

- 2 The number of units and the diversity of their patient populations highlights the challenges faced by RHC. Patients may have multiple diagnoses ranging from psychiatric illnesses to behavioral problems. Whatever the underlying issues, the patient population requires a wide range of care and resources. RHC was the facility designated to meet these needs.
- 3 RHC's mission is to provide highly specialized tertiary psychiatric care via interdisciplinary treatment in a "de-institutionalized environment." Where possible, the goal is to reintegrate patients back into our communities.
- 4 RHC's physical plant comprises 34,500 square metres (370,000 square feet). A tour of the building cannot help but leave any visitor impressed by its modern design and programming features. The facility includes a model Main Street complete with shops, banking, a hair salon, dentist, and chapel. This is in addition to a gymnasium, well-equipped exercise and games room, a music room with a full complement of instruments and equipment, a modern greenhouse, facilities for pet therapy and boarding companion animals, a woodshop, etc. The living units also feature well designed and maintained facilities, including games rooms, kitchens, quiet areas, and large screen televisions.
- 5 Our visits to the facility and reports all indicate that the physical plant is first-rate and is maintained to a very high standard. It presents as a welcome change from the darker appearance of mental health facilities of the past where mental health care sometimes amounted to little more than warehousing.

OUR INVESTIGATION

- 6 The mandate of the Office of the Ombud includes provincial government departments, municipalities, correctional facilities and regional health authorities. We regularly receive calls and letters from RHC patients or their families. The resulting investigations are often delicate. Patients may complain about staff conduct but be reluctant to provide details due to fear of reprisal.
- 7 The capacity of complainants from RHC sometimes creates additional challenges in the investigatory process. Patients may have difficulty communicating or providing details as to what occurred.
- 8 RHC patients are uniquely vulnerable. There is persistent stigma attached to mental illness. Valid complaints may not always be communicated in the most credible manner. In this context, patient records and incident reports take on added importance as a source of corroboration. Timely and detailed documentation of events become crucial to providing proper oversight.
- 9 In May of 2017, the Office of the Ombud received an anonymous written disclosure alleging that patients at RHC were victims of violence, negligence, verbal abuse, and excessive use of restraints and force by front-line staff. This letter raised concern about staff conduct, particularly in the responses to “Code White” incidents.

A “Code White” is called when patients exhibit aggressive behavior and need to be de-escalated, and/or when patients attempt to harm themselves or others.

- 10 Hospital emergency codes are a standardized system to alert and direct staff in emergency situations. The colour of the code describes the nature of the incident and dictates the expected staff response. A “Code White” is called when patients exhibit aggressive behavior and needs to be de-escalated, and/or when patients attempt to harm themselves or others. When a “Code White” is called, forensic attendants at RHC are expected to assist and control the patient in crisis by employing the minimum level of force deemed appropriate.
- 11 The May 2017 letter alleged that some staff members frequently utilize excessive force and restraints on the adults at RHC. While no specific allegations were made with respect to RHC’s youth population, the same staff also respond to codes on the youth side of the hospital. (Youth are currently housed at RHC while an adjoining “Provincial Centre of Excellence for Youth” is being built. While they form less than 10% of the facility’s total patient population, they are involved in over 40% of “Code White” incidents at RHC.)
- 12 The letter described a toxic work environment and a culture of intimidation as being deeply entrenched in many areas of RHC. The author(s) suggested that staff who try to “make a difference” become discouraged and end up resigning from RHC. In addition, the letter expressed deep concern regarding the lack of care patients were receiving.

The authors suggested that staff who try to “make a difference” become discouraged and end up resigning from RHC. In addition, the letter expressed deep concern regarding the lack of care the patients were receiving.

- 13 Staff members at RHC play an important role by modelling behaviors for the patients. Mental Health care professionals are expected to provide a high level of commitment and service. This sets the standard of behaviour expected of their patients. The May 2017 letter alleged that the culture and practices at RHC had fallen below acceptable levels.
- 14 Anonymous allegations sent to our office may sometimes be heavily discounted in terms of credibility. However, this correspondence contained sufficient details which we felt could be independently evaluated. In addition, it referenced an expert report by Dr. Simon Racine containing 30 recommendations for Vitalité and asked that this report be made public.
- 15 The existence of an expert report gave us a concrete starting place for an investigation. On August 2, 2017 our office initiated an own-motion investigation as per section (12)1 of the *Ombud Act* which provides:
- (1) Subject to subsection (2), the Ombud may investigate, either on a written petition made to the Ombud or on his or her own motion, a decision or recommendation made, an act done or omitted or a procedure used with respect to a matter of administration by an authority or an officer of an authority whereby a person is aggrieved or, in the opinion of the Ombud, may be aggrieved.*
- 16 A “Notice of Investigation” letter was sent to the Department of Health (“DOH”) and Vitalité. At that time, we requested a copy of the Dr. Simon Racine report, any action plan in place, and all other pertinent information relating to implementing the recommendations of the report. We also questioned why this report had not been made public.
- 17 The Racine report, *[*“Organization and Functioning of the Restigouche Hospital Centre”*](#) can now be found on the Vitalité Website under the heading **publications > other publications**. Please note that this report is only available in French.
- 18 Our office acknowledges that officials at DOH, Vitalité and RHC have been responsive, professional and collaborative throughout the investigative process. On August 16, 2017 we were contacted by the Executive Director of Addictions and Mental Health Services from the DOH. Shortly after this telephone conversation, the Executive Director forwarded an electronic version of the Joint Standing Committee on Forensic Services Work Plan, which included items that specifically addressed the recommendations made by Dr. Simon Racine.
- 19 We were encouraged to learn that Vitalité was proactive in hiring two external consultants to identify the problems and suggest solutions. They had developed initiatives to implement best practices and improve the patient care and culture at the RHC. We were satisfied that those in charge were seized with the importance of the matter. Our office was considering concluding our investigation when we received our first detailed allegation of abuse during a “Code White” response. This confirmed our concerns with how front-line staff were responding to patients and gave further credibility to the May 2017 letter. Details of our findings with regards to that complaint can be found in Appendix A under Patient C.

*Vitalité Health Network, *“Organization and Functioning of the Restigouche Hospital Centre”*, https://www.vitalitenb.ca/sites/default/files/documents/autre_pub/vitalite_rapport_org-fonct_CHR.pdf.

Our office received a detailed allegation of abuse during a “Code White” response. This confirmed our concerns with how front-line staff were responding to patients in crisis and gave further credibility to the May 2017 letter.

- 20 Through the Provincial Joint Forensic Committee, DOH and Vitalité worked collaboratively with other partners in improving processes and practices throughout the province, including the RHC. DOH also advised that they were chairing a provincial committee on forensic psychiatry, and a clear action plan was shared with our office in August 2017.
- 21 We continued to carefully review patient complaints from RHC to ensure that any allegations of potential mistreatment were addressed immediately. Our office monitored the continuing efforts of Vitalité and RHC to address these issues.
- 22 Progress appeared to be slow and we grew more concerned based on complaints we were receiving from patients at RHC and other conversations in which patients related events they had witnessed. Our interest had become known and we began to receive more frequent and more detailed information regarding incidents at RHC. We were not always able to get the names of the parties involved or have those patients who were allegedly victims of mistreatment come forward despite our best efforts to convince them to trust our confidential services. Some expressed that it was not worth bringing matters forward to our office. They believed the staff and administration would simply cover for one another.

Some expressed that it was not worth bringing matters forward to our office. They believed the staff and administration would simply cover for one another.

- 23 These concerns led us to broaden our investigation and request more information on May 7, 2018. We requested a list of complaints dealt with by the administration of RHC. We asked for copies of clinical and medical cases that were subject to internal or external investigations since our notice of August 2, 2017. Additionally, we requested reports and statistics of injuries sustained by patients following incidents involving staff members; pictures of all injuries of patients and staff involved in incidents, if applicable; video footage of any suspected excessive use of force utilized on patients by staff. We asked if any patients were hospitalized as a result of incidents or neglectful treatment by all levels of staff (front-line, clinical, or medical); all incidents where the Coroner, Public Trustee or Mental Health Review Board needed to be implicated; and any other relevant information that would allow us to gain a better understanding of the situation at RHC.

- 24 On June 27, 2018, our office received a large volume of documentation from the RHC and Vitalité. Our office recognizes the effort that was put into gathering this information and acknowledges the transparency demonstrated in responding to our request not only here but also during subsequent discussions and meetings that took place with the administration to discuss this investigation and specific cases.
- 25 Ombud staff reviewed this documentation and prepared case summaries, a number of which are attached to this report under Appendix A. We did not include every incident in this Report. We did not conduct in-depth interviews in respect of each case. We relied on the detailed incident reports, emails, written declarations, medical notes, video footage, pictures and other relevant documentation such as the reports prepared by Dr. Simon Racine and Dr. Patrick Lapierre. We determined these to be sufficient to capture the realities of what some of these patients experienced.
- 26 The Racine report referred to an external audit conducted by Dr. Patrick Lapierre, which our office obtained and reviewed. Dr. Lapierre was asked to perform a clinical audit focused on the practices of members within the psychiatry department. Dr. Lapierre audited the majority of medical files relating to the Tribunal (**Mental Health Act*) and legal psychiatry dating back to April 2015. In addition, a random inspection of 2015-2016 files relating to tertiary psychiatry was done to assess medical practices involving short-term and long-term hospitalization at RHC. Dr. Lapierre released his findings to the President and Chief Executive Officer of Vitalité on March 13, 2017.
- 27 Dr. Lapierre's audit made a number of findings including:
- inadequate follow-up after (generally) with patients and inadequate follow-up following incidents where patients and staff sustained injuries; and,
 - Little to no medical notation in patient files (patient history, signs and symptoms observed during assessments, etc.) to support a diagnosis and create an appropriate record for all medical staff. Further, when a medical note was made it was inadequate, rendering it impossible to determine whether a diagnosis was evidence based.

**Mental Health Act, RSNB 1973, c M-10*

OUR CONCLUSIONS

- 28 Considering the evidence in its entirety, we have concluded that RHC patients were in fact victims of negligence, abuse, and unacceptable treatment.
- 29 This unacceptable treatment is a direct result of serious problems within RHC. These problems are deeply entrenched and impact negatively on patient care, staff safety, and the ability of RHC to monitor and manage incidents.
- 30 There are obvious shortcomings in incident reporting procedures which need to be addressed through retraining and increased vigilance. However, we feel those shortcomings are largely a symptom of a more systemic failure of the institution, and that any solutions which seek to significantly alter outcomes must go far beyond reforms to incident reports. Some of these larger problems were addressed by the expert analysis of Dr. Lapierre.
- 31 The number of the incidents and the disturbing details thereof demonstrate that the RHC is in crisis.
- 32 Challenges are inevitable given the nature of providing advanced mental health care. Serious mental illness may manifest itself in ways which make it difficult to diagnose and treat. For physical illness, there are often well-established protocols to diagnose, treat, and medicate. In contrast, the course of mental illness may be idiosyncratic to the patient. Proper care requires individualized care plans based on detailed assessments and ongoing monitoring with interventions by a team committed to addressing the patient's needs and complexities.
- 33 These challenges multiply when a facility seeks to provide care across multiple units to diverse patient needs. Ideally, each of the patient populations are served by a team with an approach catered to the needs of its group, and some synergies can be achieved in having access to another pool of trained staff nearby with related, if not identical, expertise.
- 34 The specific assessment of the quality of mental health services provided in individual cases is obviously a matter requiring specialized training and is thus outside the expertise of the Office of the Ombud. While this report springs in no small part from our assessment of individual cases, it should be understood that we are not expressing our own opinions regarding quality of care or individual care decisions. In each case where we formed or express an opinion, we are repeating what was told to us or what was written by persons who work in the field of mental health and whom the province hired to provide management, care, or advice. We asked questions, we were given answers. In cases where we felt it was important, we sought multiple opinions on the matter or confirmation that our understanding, although perhaps not clinically precise, was correct.

The decision which cases to include and in how much detail has not been an easy one. We are providing these examples because we believe they demonstrate accurately the magnitude of the failure of RHC to provide proper care.

- 35 Appendix A details specific examples of cases where we feel the treatment of patients fell short of acceptable standards. These examples are disturbing, and more so when one recognizes the extreme vulnerability of these patients. The decision as to which cases to include and in how much detail has not been an easy one. We are providing these examples because we believe they demonstrate the magnitude of the failure of RHC to provide proper care. At the same time, each of these examples involves real people, and one patient in particular who was the victim. These patients are vulnerable to a degree few of us can imagine. We seek to acknowledge their experience in order to identify the problem and correct it. We want as much as possible to respect their dignity, while we identify in detail the ways in which RHC failed to do so.
- 36 We have sought throughout to protect the privacy of the victims. We have observed throughout the commitment of Vitalité and RHC to respect patient confidentiality as well. Naturally, any assessment of an institution consists of an evaluation of care in individual cases. We have tried as best we can to anonymize these evaluations while respecting our duty to provide the Legislative Assembly and the citizens of the Province of New Brunswick with an accurate portrayal of the situation at RHC. We recognize that the limited number of the patients carries with it an unavoidable risk of re-identification, which may further victimize blameless patients. We plead with both Members of the Assembly and those in the general public to be conscious of this risk, and to guide their public statements, particularly on social and other mass media, with care and sensitivity.
- 37 With a diverse patient population in a large facility, no challenge has either a single cause nor a simple solution. Any generalization will distort the complex reality of an institution in which hundreds of people interact. Nonetheless, a disturbing picture has formed of the present state of RHC. In its broadest possible terms, **RHC is chronically understaffed, and we believe it is failing to provide adequate care.** This failure manifests itself in multiple ways, which we would detail as follows:
- A RHC has been unable to build a critical mass of clinical psychiatric expertise. Some clinicians contracted by RHC seem to be providing very little care according to the institution's records. Others are stretched well beyond what is reasonable to attempt to make up for the shortage.
 - B. Because of the shortage of clinicians, there are unacceptable delays in patients receiving assessment. In many cases assessments are below the minimum which would be viewed as reasonable by those who work in the field. External experts hired by the province have concluded the work in a number of cases to be "negligent."

- C In contrast with the stated mandate of the institution, the vast majority of patients have no individualized care plan and receive very little patient-focused care. RHC operates largely as a residence in which some extra-curricular activities are made available on a unit-by-unit basis, but it is up to the patients themselves to take advantage of these opportunities, and they do so *ad hoc* and for their own reasons. Patients are not guided or encouraged to do activities based on detailed or individualized care plans.
- D Lack of regularized assessment and detailed care plans of patients is resulting in sub-standard care. These gaps have compromised patient health and in at least one case we believe that it may have resulted in the premature death of a patient.
- E Because of staffing shortages and lack of individualized care plans, a number of the specialized physical facilities at RHC are either underutilized or never used.
- F Inability to recruit and retain sufficient personnel has limited the ability to interact with individual patients to the degree they should.
- G Staff shortages have limited the institution's ability to excuse staff from day to day responsibilities in order to supplement their training. In a number of cases, staff capabilities have diminished due to the inability to maintain their training.
- H Staff shortages have curtailed management's capacity to discipline or correct staff. The severity of the staffing challenges has deterred management from investigating staff behaviours it suspects might not have been best practice.
- I The absence of proper care plans combined with a staff shortage has created a situation in which patients are more likely to exhibit problem behaviours requiring physical intervention by staff ("Code White"). Injuries related to "Code White" have been estimated to be twice as frequent at RHC than at other mental health institutions.
- J Chronic understaffing has created tangible physical risk for employees of RHC. Assistance in dealing with "Code White" incidents come from other units separated by significant physical distance, causing delay. Staff report concerns about their safety at work, and have adopted a number of coping behaviours which reflect this fear.
- K Rates of absenteeism and long-term disability are significantly higher than would be expected at a well-functioning mental health institution.
- L The combination of lack of patient plans and staff shortages has hobbled RHC. It can not discharge the mandate of a modern mental health treatment facility to provide treatment and reintegrate the patient into the community. RHC has been forced to revert to a "house or warehouse" service delivery in many aspects.
- M Management attempts to transition the institution and revitalize the culture are seen as unrealistic by some employees and resisted by others. A culture of silence and fear has taken hold.
- N Interfaces with the community and other departments are not functioning effectively. Patients who might otherwise be released are remaining inside the institution as a direct result.

- O The persistence of these issues over an extended period of time is reflected in a culture of resignation which undermines the efforts of those who wish to improve the situation.
- P RHC is not only failing in its ambition to be a Centre of Excellence, it is not even meeting the minimum standards of care for a mental health institution.

- 38 Both inside and outside the institution, a group of dedicated professionals continue to try to provide their patients with proper care. In a number of cases, the staff at RHC are sacrificing their personal lives and their emotional well-being. Their honest assessment is that over the last two years, progress has been minimal. Staff express fears of burnout and anxiety at what will occur if certain key team members become ill or take employment elsewhere.
- 39 We believe the problems at RHC are too acute to risk further delay. Our assessment is that the decision makers within Vitalité have been given an impossible task. They are aware that their abilities will be called into question when the reality of the situation is widely reported. They are conscious of the role RHC plays in the economy of the region as a source of stable and well-paying employment. They recognize the extraordinary effort being exerted by employees through RHC to maintain the facility's day to day operations, in the face of these very significant challenges. They are not in denial about the problems. They have been tasked with making the present model for RHC work; they are exerting themselves to the uttermost to make that happen.

OUR RECOMMENDATIONS //

- 40 In our opinion, the situation calls for a deep revision of the mission of RHC. The institution currently operates with an unacceptable level of service to patients and an unacceptable risk to employees. We accept at their word the efforts of those trying to better this, but also note their own frank assessment of their inability to make meaningful progress over an extended period of time. Even if the province was willing and able to do so, the situation at RHC cannot be solved with more money.
- 41 Any recommendations we make must be considered within the context of the complexity of all this and our own office's limited resources and timeframe. That said, we have made the following recommendations:
- A An assessment of RHC's actual capabilities with existing staff levels must be made with the aim of significantly decreasing its mission and limiting it to one or two of the present mental health populations it is currently mandated to serve. This assessment should not assume the addition of new employees, but rather should acknowledge that a work culture focused on patient care within these limited fields may ultimately be unsuitable for some of the present employees. The institution must shrink its mandate to one which is realistic in order to have any chance to rebuild its culture and capacity.
 - B RHC staff must be in numbers and training sufficient to ensure the safety of staff at all times. This includes the capacity for a coordinated, timely, and effective "Code White" response during all shifts.
 - C Existing RHC staff must be retrained and that increased rigor be insisted upon in the preparation of timely, independent, and comprehensive incident reports following "Code White" events.
 - D Consideration must be given to the closure of a number of the present units of the RHC, which will result in significant disruption to both the patients and the care system throughout the province. This will require extraordinary co-operation between departments to avoid adverse patient outcomes.
 - E Given the impressive physical structure at RHC, opportunities could be sought to find use for this space for other populations in need of housing. These could be appropriately staffed by professionals with different training than those in a mental health institution.
 - F The population which is being sent to RHC for forensic psychiatry (assessment of fitness to stand trial and criminal responsibility) presents unique challenges. In order to securely serve this population, a facility must have advanced security features, such as those typically only available in correctional institutions. In order to provide timely and proper assessments, there must be a pool of capable clinicians willing and available to work at the facility. Determining whether RHC can continue to perform this function for the entire provincial court system should be evaluated frankly based on realistic assessments of present capacity, not optimistic expectations of an influx of new clinicians.

G Regardless of its mandate, the ongoing performance of RHC should be evaluated on a regular basis by experts from outside the jurisdiction.

H Given the proven and persistent challenges in staffing at RHC, the construction of a youth mental health facility adjacent appears particularly poorly advised. Such a facility if opened would inevitably suffer from the same problems, while compounding those of the RHC by further diluting the possible staffing pool.

42 It is our hope that, in bringing this matter to the Assembly's attention, decisive action will be taken to address these matters. We recognize this will require significant co-ordination across departments, and that there are others who are better positioned to provide government with advice far beyond the scope of our recommendations.

43 Given the issues involved, we have informed the departments that we would like to be briefed within the next 90 days as to their proposed response to our Report. After we have assessed that response and given the public the opportunity to make us aware of any additional concerns they may have regarding RHC, we will assess whether to proceed with a second investigation. Our investigation of RHC will remain an open file.

APPENDIX A: EXAMPLES OF FAILURE TO PROTECT

Warning: these stories contain graphic details that may be disturbing for some readers.

COMPLAINTS OF MEDICAL NEGLIGENCE:

PATIENT A*

PATIENT B

COMPLAINTS OF USE OF EXCESSIVE FORCE:

PATIENT C

PATIENT D

PATIENT E

**The case stories illustrated in this report have been shared with us in response to our investigation and these individuals have not all made complaints to our office. In order to respect the privacy of these individuals, we have anonymized all of their names in the following sequence: "Patient A-B-C-D-E."*

PATIENT A

Patient A lived in unit C1. In Spring 2018, Patient A was found unresponsive in bed. It was declared that Patient A had died unexpectedly overnight. The state Patient A was found in indicates they had passed some time before staff realized.

An internal investigation was launched by RHC to determine what exactly happened to Patient A. That investigation revealed disturbing circumstances Patient A experienced before their death.

It was said that Patient A was not known to be a complainer, but in the days leading up to their death, they often complained of pain in the chest, armpits and abdomen area. Three weeks before their death, Patient A was moaning in pain such that the unit physician ordered an evaluation at the Campbellton Regional Hospital. After many rounds of tests at the Hospital's Emergency Room, Patient A was sent back to RHC the same day with a diagnosis of a "benign round atelectasis" meaning their lungs were compromised and partially collapsed. Since an infection was not suspected during that time, no antibiotics were prescribed. Two days after the Emergency Room visit the unit physician prescribed two antibiotics as a course of treatment for a total duration of 10 days.

Patient A was not known to be a complainer, but in the days leading up to their death, they often complained of pain in the chest / armpits / abdomen area...

It is noted that the unit physician also saw Patient A on three out of the four days that followed. Patient A was also seen three weeks later. This physician had been caring for Patient A for three years. As per unit procedures, the unit physician does one round per week on the unit and can meet with patients by request when needed.

From the time the patient was seen at the hospital until their death, it is noted several times that Patient A continued to complain of soreness in their sides, chest and at the top of their abdomen. It is also mentioned on a few occasions that Patient A was often irritable, feverish and frequently seemed physically exhausted which caused them to miss a few of their usual activities.

It is noted that Patient A also asked to sleep a lot throughout the day and went to bed early in the evening. Night staff noted that they viewed symptoms of sleep apnea when Patient A was asleep one night while staff were assessing their vital signs. Two days before Patient A's death, staff notes indicate that the patient appeared dyspnoeic when they awoke in the morning, meaning Patient A was having difficulty breathing. Throughout that day it was noted that Patient A was breathing slowly.

Patient A's unit staff said that normally a patient's vital signs are taken once a week unless otherwise directed to do so. Despite not having a physician's order to take their vital signs more frequently that month, vital signs were, for the most part taken every day. However, there is a gap in the patient's file from four to 10 days after that Hospital's Emergency Room visit, where Patient A's file does not indicate that their vital signs were taken at all.

During the weeks before they died, Patient A's vital sign levels seemed to be inconsistent; their oxygen saturation gradually dropped throughout this period and had reached 85% near the end of the month. It is also frequently mentioned in staff notes that their oxygen saturation was low. Regardless of these observations, oxygen saturation levels are missing from vital sign logs on six separate occasions within a period of approximately three weeks. Patient A's respiratory levels are also missing from their chart on 14 occasions, including the day before Patient A was found unresponsive.

The internal investigation report indicates that Patient A's clinical portrait based on these levels was worrisome and an order should have been given to monitor their vital signs more closely. It also mentions that Patient A had tachycardia (an abnormally elevated heart rate) in their last few days.

The day before their death, Patient A awoke with lacerations on their nose and a black eye; Patient A said they fell from their bed during the night. They indicated that their injuries were not painful and the patient did not even realize they were hurt until a staff member told them to look into a mirror. When the nurse evaluated Patient A after their fall, it was noted they had a runny nose and a deep cough. During the same day, the unit physician prescribed a few medications as well as inhalers for their condition and a chest x-ray was ordered. The unit physician believed Patient A had bronchitis and a cold, but the physician did not write this in the patient's file until the following day – following Patient A's unexpected death.

The investigation report highlighted that the patient's file showed a pattern of notes being poorly documented. Information was not noted as it happened, but rather staff members would prepare a note for their entire shift. Consequently, it is difficult to establish the chronology of events or the status of Patient A's health as it occurred. Many notes were incomplete which also made it difficult to monitor all communications exchanged between staff and the physician. It was also mentioned that various communication tools between staff and departments were not properly used and could have contributed to confusion in regards to the continuity of the patient's care.

A few staff members have stated during the investigation that they find it easier to evaluate a patient's mental state rather than their physical state. It was also mentioned in the investigatory report that none of the professionals caring for Patient A knew exactly what their role was in terms of escalating the file to a physician or other professionals when abnormalities are observed in a patient's overall health. As the patient's file notes were reviewed and interviews were conducted as part of RHC's internal investigation, it revealed that many staff members believed it was someone else's responsibility to act on these abnormalities. As a result, no-one inquired further to find the causes of these irregularities that they observed. It was concluded that this aspect could have contributed to the lack of continuity in Patient A's care.

At RHC, staff are typically divided into two relay teams who work 12-hour day or night shifts (from 8:00 am until 8:00 pm or 8:00 pm until 8:00 am). On Patient A's last night, staff working the day shift put them to bed. The night staff did not see Patient A when they began their shift. Night staff are required to do rounds and check on every patient to ensure they are secure and conscious every hour during their shift. Patient A was typically locked inside their room for safety reasons so staff would be required to look into the window of their room to do their check.

Staff notes on Patient A's file consistently mention that rounds were done every hour and that the patient was sleeping peacefully and snoring. After Patient A was found dead, staff notes were called into question. It would have been impossible for rounds to have been done every hour as indicated in the notes given the state Patient A was found in.

During the internal investigation performed by RHC, surveillance videos were reviewed to determine what exactly was done during night shift rounds. Throughout the night in question, the video shows staff doing rounds every hour except during one instance where the time elapsed between rounds was 90 minutes. It was revealed that staff never actually checked on Patient A or looked through their window to ensure they were in fact secure and conscious; they simply paused to listen at the door to Patient A's room.

After further investigation by RHC, a general practice for night shift staff on that unit no matter whom was working. When asked about this practice during the investigation, certain staff members explained that shining the flash light in Patient A's window normally wakes them and causes them to become agitated. In order to avoid this, they began the practice of listening for snoring sounds near Patient A's door. One of the attendants working on the unit's night shift during the night in question expressed not having any remorse for Patient A's situation because rounds had been done every hour and Patient A was heard to be snoring during all of them. The last round was done at around 6h07 that morning.

Patient A was found at 8:00 am by the same day shift employee that had put Patient A to bed the night before. The unit Nurse Manager noted at 10h13 that morning that when Patient A was found, Patient A had no pulse and their extremities as well as their lips presented with cyanosis, meaning a discoloration of the skin to a blueish color due to poor circulation or inadequate oxygenation of the blood. After the ambulance team arrived and CPR was performed, the Coroner was contacted and Patient A's death was confirmed at 8h36. In an incident report prepared by another medical professional present during the aftermath of Patient A's death, it was stated that the unit physician told the Coroner that Patient A died of pneumonia and that an autopsy was not necessary. The medical professional did not agree with the unit physician, especially since Patient A had fallen the day before and had hit their head. The Coroner ordered that an autopsy be performed.

PATIENT B

Patient B was admitted in 1993 but had been admitted 17 times previously. Patient B was diagnosed with paranoid schizophrenia with mental retardation and is now in their 70's. They have been appointed a Public Trustee for their personal and financial affairs.

Patient B was transferred to unit B1 in June 2017, which specializes in Neurocognitive Disorders with Severe Behavioral Disorder. In September 2017, Patient B was transported by ambulance to the Campbellton Regional Hospital. While there, the Emergency Room physician alerted the Public Trustee about concerns hospital staff had. Patient B's care may have been neglected because they had presented with signs of malnutrition as well as poor oral and perineum hygiene.

The Public Trustee's office reported their concerns to the Department of Social Development's Adult Protection and requested that an investigation into Patient B's care be completed. This investigation was completed in the Spring of 2018 and found the hospital's concerns to be founded. A negligent party was not identified because the situation was the result of gradual deterioration.

Here are the actions, or lack thereof, that led to Patient B's poor health state related to their September 2017 admission to the hospital.

Every unit at RHC is overseen by a physician for patient's general physical health and patients are normally seen by request from unit staff. File notes indicate that Patient B had not been seen by a physician since November 29, 2016 following a fall and subsequent hip injury.

When Patient B was transferred to their current unit, their physician also changed. The new physician had never met with the patient. Nonetheless, a request was sent to Patient B's physician on August 24, 2017 for a consultation in regards to pain they were experiencing in their hands, fingers and hips, and again on September 11, 2017 as a result of blood found in their urine and reports of lesions on their genitals. In both instances, the physician simply added a note to the file saying "done" and added the date. For the second consultation, the date indicated by the physician occurred during Patient B's hospital stay, therefore Patient B was not present at RHC for a consultation with the physician as indicated on the file.

Each patient at RHC is also under the care of a psychiatrist; in Patient B's case, the patient had been under the care of the same psychiatrist since at least 2007. On April 21, 2017, the psychiatrist noted in the file that Patient B had poor balance and that it was difficult to communicate with the patient directly because the patient only spoke French and the psychiatrist only spoke English. It is also noted that the patient's speech is difficult to understand. During this visit, the psychiatrist also reviewed Patient B's medication. The patient's medication was also reviewed during two other visits that took place on May 2 and May 16, 2017. One note mentions that the medication review was due to staff having difficulty managing Patient B due to their difficult behavior. A note dated May 16, 2017 also indicates that abdominal and bed restraints had been ordered to address the patient's unsteadiness; however, it is not clear if these were used. The psychiatrist's last visit to Patient B before their hospital admittance was on May 16, 2017.

On three separate occasions between April 21 and 25, 2017, RHC pharmacist added notes to the file cautioning against the prescribed decrease in Patient B's medication because of the associated negative symptoms. One of the pharmacist notes read as follows:

"...Some symptoms could appear in this patient following the April 21st ordered decrease in Seroquel dosage, including: decreased appetite, diarrhea, extrapyramidal symptoms (muscular rigidity, etc.) increased sweating, insomnia, nausea/vomiting, muscle pain, increased saliva production and vertigo/dizziness. Also, agitation, anxiety, and psychotic symptoms could worsen. Suggestion: monitor patient closely. A more gradual reduction in Seroquel may lessen rebound symptoms. Will follow-up with patient."

The psychiatrist simply wrote "Agree with above recommendations" to the patient's file without ordering a change in their medication. On April 25, the pharmacist also suggested the patient's vital signs be taken daily due to the medication prescribed and blood work be done. It is unclear in the file notes if this was actually done.

On September 6, 2017, it was noted that a nurse advised the psychiatrist of the pharmacist's recommendations for review. The psychiatrist advised that they would see the patient before accepting these recommendations. The notes in the patient's file show that this visit did not occur.

On August 14, 2017 the same RHC pharmacist urged caution for certain doses of medication the patient was receiving. The medication the patient was prescribed combined with the patient's advanced age could cause negative symptoms. The pharmacist suggested that certain doses be adjusted based on the information they had researched about combining these medications together. RHC protocol requires the psychiatrist to sign the review sheet prepared by the pharmacist. Patient B's psychiatrist never signed this review sheet. On September 6, 2017, it was noted that a nurse advised the psychiatrist of the pharmacist's review recommendations. The psychiatrist advised that they would see the patient before accepting these recommendations. The notes in Patient B's file show that this visit did not occur.

According to the dentist at RHC, Patient B had been having issues with their gums for many years which made wearing dentures difficult. Despite this, notes indicated that the dentist last saw Patient B in December, 2015 and the notes were not placed in the patient's file as they were required to be, but had remained with the dentist.

Patient B's file noted that they had lost weight in 2004 and a dietician had regular follow ups with the patient. Patient B was given nutritional supplements and staff have been advised to offer additional snacks or supplements at any time during the day, even if outside normal snack hours since Patient B was known for refusing their meals / snacks. Despite these efforts, Patient B continued to maintain a below normal weight. On May 2, 2017, an employee from the nutrition department added a note to the Patient B's file after meeting with the patient stating that they had lost 5.4% of their body weight in

the past two months and indicated that unit staff mentioned they had not been doing well in the past few weeks. This employee also refers to a note left by the pharmacist stating that a recent reduction in Patient B's medication could diminish their appetite. The employee visited Patient B again on May 29, and June 24, 2017 and noted a slight weight gain, however Patient B's weight remained below what it should be. According to RHC files, Patient B's weight was the same on September 2, 2017 as it was in May.

It was noted on the file that Patient B had sores around their tailbone as well as redness around their hips. Patient B was being monitored under the wound prevention program, but the nurse specialized in this area was not involved with Patient B's care because the wounds were considered minor and were being treated with cream as well as specialized bandages. Unit staff mentioned that it was difficult to reposition the patient on a regular basis because Patient B could easily reposition their body into their preferred position.

A physiotherapist visited Patient B on May 26, 2017 and the patient told the employee that they were very afraid of falling. It was noticed there was an important loss of autonomy since their last visit. Patient B lacked coordination in their movements and had a loss of control over many bodily movements. The note also read the following: *"...Writer also noted an obvious loss of weight and muscular mass in the last month: bone definitions are very visible..."*

On September 8, 2017 the same physiotherapist visited Patient B again and noted that the patient had difficulty holding a drinking glass, could not grasp chips to eat them, and had not walked in a while because their condition was not permitting them to do so. It was also mentioned that Patient B complained of pain in their legs, the physiotherapist was unable to fully straighten Patient B's right knee and the patient was unable to move their fingers when asked to do so.

On May 4, 2017, Patient B was seen by an occupational therapist so they could be fitted for a geriatric chair. The therapist noted that Patient B's condition had deteriorated lately and the patient was now at an elevated risk of falling which is why the chair was needed.

According to the information gathered as part of RHC's internal investigation that was made available to our office, the practice on Patient B's unit is for patients to receive two full baths every week and partial baths daily. Between the 1st and 15th of September 2017, it was noted that Patient B received two full baths (in bed), eight partial baths (in bed) and three therapeutic baths (in a tub). Patient B's incontinence diapers were changed on average six times a day and perineal care was done each time; the area was washed with soap and a cream was applied.

A multidisciplinary meeting was scheduled for September 7, 2017; the last one for Patient B had occurred in October 2016. Patient B's psychiatrist was paged, but did not answer in time to participate in the meeting.

From September 1 to 15, 2017, it was noted at different times that Patient B was experiencing pain in their legs and hips; that their movements seemed robotic; that the patient was loud, in bad moods, and notes mentioned Patient B as saying that their mind was in turmoil. Patient B also vomited on one occasion and had a fever during the last few days before being admitted to the hospital.

The Emergency Room physician diagnosed Patient B with "*acute renal failure, malnutrition.*" The physician also noted that the patient was dehydrated, feverish, had irregular heartbeat, was "*skin and bones*" with practically no muscle mass, redness on their abdomen and on their genitals, was non-responsive and had ceased feeding on their own. As a result, Patient B was admitted to the intensive care unit.

PATIENT C

Patient C is well known to RHC and has been a patient since November 2000. Patient C suffers from a great deal of anxiety. When Patient C's anxiety gets too high, they may act out by either self-harming or trying to harm staff members which instigates a code to be called. Between January and July 2017, a total of 31 codes were called due to the patient's aggressive behavior towards staff, other patients, or because their pattern of unpredictable behavior increased their risk of self-harm. Patient C also has a history of being aggressive during bath time; out of the 31 codes, five of them occurred during bath time.

On July 16, 2017, three staff members were assisting Patient C with their bath in a tub nicknamed the "banana tub" because of its shape; it resembles a banana when held horizontally. It is narrow, has a side door to assist patients with getting in and out as well as a seat inside the tub. When filled, water will come as high as the door and just above the seat. The tub can then be reclined so that water reaches the patient's abdomen to give them the feel of getting a traditional bath (see figure 1).



Figure 1: banana tub
Source: photo provided by RHC.

During the bath, Patient C became aggressive towards staff and a code was called. Eventually, the patient was restrained into their geriatric chair and placed in a secluded area as per internal protocols.

Senior Management at RHC were made aware of possible inappropriate actions by an employee during this particular code in an August 11, 2017 letter ("the letter") which was given to them by one of the staff members. This staff member ("the author") was present during the beginning of Patient C's bath and remained present during the code. The author makes a written declaration that another employee had used "exaggerated force" during the patient's bath where the code was called on July 16, 2017. It is important to note that an internal investigation was immediately launched by the administration of RHC on the same day they received this letter. RHC also contacted the family to make them aware of the allegation made. The investigation revealed that during an interview that took place with the author, details of the events changed and were minimized from the initial description. The investigation report mentions that out of nine written declarations made by staff members present during the code, two

made mention of an employee placing their hands on the patient's face to avoid Patient C from biting them. Consequently, how exactly the events during the bath unfolded remain unclear because there are no surveillance videos in the tub room for privacy reasons and the statements made by staff present during the incident differ from each other.

Nonetheless, it is our understanding from reading the various interview reports conducted by RHC staff that during the bath, Patient C seemed tense. An employee asked Patient C if they were okay and if they wanted to continue with the bath; after some time, the patient said yes. Shortly after, Patient C began moving their arms around in the tub and eventually hit / pushed away an employee's hand as they were preparing to help with the bath. This employee later said they were not hurt by the patient's action, but another employee eventually called a code to ask for assistance with the patient due to their increasingly aggressive behavior towards them. At some point, it is noted that Patient C sunk their body into the tub, and off the seat, into a fetal position. At this point, several other employees had entered the washroom to help restrain Patient C and the tub had also been unplugged to let the water out.

During this time, the author alleged that another employee who responded to the code placed their fist on Patient C's face to hold it down against the tub's seat in an effort to restrain the patient. In doing this and because there was still water in the tub, an allegation was made that the patient's face was submerged in approximately an inch of soapy water. When the author asked the employee to stop, it is alleged that the employee answered that they did not want to get bitten by Patient C. It was mentioned in several incident reports that an employee was seen leaving the tub room in tears during the incident in question. Patient C was eventually taken out of the tub and put back into their geriatric chair. The letter alleged that the employee who acted inappropriately lifted the patient out of the tub so abruptly that water flew everywhere.

The letter also goes on to mention other incidents of inappropriate behavior with other patients by this same employee; it alleges that the employee in question likes to scare and torment patients. The employee has also allegedly been implicated in other similar forceful actions on patients at RHC. On the day the letter was received, the employee was suspended with pay for the duration of the investigation. The employee was eventually reinstated.

During the investigation, one employee who had been giving Patient C their bath and remained present during the entire code said that if all implicated staff had taken more time to de-escalate Patient C's emotions that they may have been able to convince the patient to get out of the tub on their own without incident and the code could have been avoided. To this day, Patient C's family continues to have concerns about the continuity of the care Patient C has been receiving at RHC which they allege negatively affects their behavior and in turn causes them to act in ways that prompt codes to be called.

PATIENT D

Patient D, mid-30s, was first admitted to RHC in July, 2017 for a court ordered assessment. Evaluations of fitness to stand trial may require up to 30 days to complete. RHC employs a number of trained Forensic Attendants (these employees are referred to internally as correctional agents and are trained in this field) to help ensure staff and patient safety. These forensic attendants are also called upon to restrain patients showing aggressive behavior. Medical staff such as nurses or nurse's aides are also employed to ensure patients personal care.

It was noted in their admission assessment by a nurse that Patient D was irritable and defensive, but quickly became more cooperative after being offered a shower and food. Patient D arrived to RHC with a cast on their right arm. It is often mentioned in the notes that Patient D did not socialize much in the first few days of their stay at RHC. It was also mentioned that Patient D became verbally agitated on their second day, giving menacing comments to staff and getting into an argument with another patient.

Patients at RHC are permitted to call their family and friends on two specific days a week. On these days, patients are shown a schedule in the morning and asked to reserve two spots on the list for their calls of the day. Four days after the patient was admitted, Patient D had reserved two spots with the help of a staff member who stated in their notes that Patient D saw what times were marked for the calls on the sheet. The sheet had been posted on the wall all day for ease of reference; both allotted times were in the morning. To avoid incidents with using the phone among patients, RHC has a policy that time slots cannot be changed once the times are set.

At around 17h35 that day, Patient D came to the half open door at the nurses' station; the top part, a window, was open. Patient D blamed staff for having chosen an inappropriate time slot for a call to their family, as the family member would have been unavailable at the previous scheduled time. However, due to their persistence, the nurse told the patient they could make a call this one time, but staff notes say Patient D continued to be argumentative about it after permission was granted by the nurse.

A forensic attendant, who was also inside the nurses' station during the argument, got up to assist the nurse with the ongoing situation. Notes from the nurse whom the argument was directed at indicate that the forensic attendant gave an ultimatum: do you want to use the phone or not? The same notes indicate that the forensic attendant "politely" asked Patient D to calm down and tried closing the top half of the door when Patient D violently punched the door with their fist to open it again. Patient D then firmly grabbed the forensic attendant's shirt collar. As per the same nurse's notes, this action prompted the "Code White" to be called at 17h44. Four forensic attendants had great difficulty restraining Patient D because the patient was strongly resisting.

The note does not give details about how the forensic attendants restrained Patient D and states that the patient was placed into a secluded area as per protocol so they could calm down; the psychiatrist and physician were contacted soon after. A staff member on the unit mentions in a note that the handle of a utensil was noticed sticking out of a cast on Patient D's arm during the argument for the phone. It was later confirmed that the patient had a plastic knife (which had not been tampered with) in their cast as well as a calling card and a paper which Patient D was seen placing there in the video footage.

Most incident reports prepared by staff who were present during the altercation say that Patient D violently punched the door, threatened to hit the forensic attendant inside the nurses' station, and that the patient strongly resisted being restrained. Most incident reports were signed in the beginning of August; in some cases, it was two weeks after the incident. One employee mentioned in their report that they were unsure about the sequence of events during the incident. A forensic attendant reported that Patient D hit them in the face with their right elbow which was covered by a cast while another said the patient tried to bite them.



Figure 2: blood stain following an incident

Source: snapshot of RHC video footage of the incident reviewed by Ombud staff.

After the incident, blood was observed on the floor (as seen above in figure 2) where Patient D was restrained. The blood was determined to have come from their nose when Patient D was later assessed by nurses and the on-call physician. After vomiting a couple of times, the physician ordered the patient be brought to the Campbellton Regional Hospital for further evaluation. Patient D was eventually diagnosed with a concussion and a fracture under their right eye. Patient D was referred to an ophthalmologist who later said the patient's vision should not be affected, but there was no guarantee the numbness below the affected eye would dissipate.

An employee present during the entire event was later interviewed about what happened during RHC's internal investigation. It was indicated to the interviewers that the facts brought forward in the incident reports were not always accurate. It was said that forensic attendants often intimidate staff especially new staff when there are altercations with patients, telling staff things like: "*you did not see or hear anything.*" Staff are like a tight family and you will only "*get in*" if you close your eyes on certain things. The employee goes on to say that when incidents happen, it is important that incident reports be prepared together and everyone copies off of each other so that the stories match. After saying this, the employee gives their "proper" version of what happened saying they would never dare put any such information in their official reports.

As per this interview, it was said that the forensic attendant who initially tried to diffuse Patient D's verbally aggressive behavior towards the nurse further provoked Patient D's behavior by having an aggressive tone and swearing back to the patient, adding that this is typically how forensic attendants address patients. It was also said that Patient D did not "violently punch," but rather hit the door with their hand to open it. The interview also revealed that the forensic attendant jumped on Patient D putting them to the ground and the patient wasn't resisting as much as others had said, even saying that the patient screamed "I'm not resisting" to the forensic attendant while being restrained. Furthermore, the interviewed employee said they saw a forensic attendant hold Patient D's face and give the patient three knee strokes directly in the face. It was also mentioned that things could have happened differently had they continued to talk it out with Patient D and utilize de-escalation techniques. It was also noted that some of the forensic attendant looked shaken after the incident and that one forensic attendant said the code should not have been called.

Video footage corroborates some of this employee's declaration. The forensic attendant who initially intervened in the nurses' station can be seen pointing a finger at Patient D while they are talking to the patient. Patient D did not grab the forensic attendant's shirt collar as was mentioned in the nurse's report. After Patient D hit the door, they took a step back, had their hands down and did not appear to be acting aggressively. At this point, a forensic attendant came from behind Patient D without their knowledge and took them down by the throat. Other forensic attendants then intervened and a "Code White" was called. A forensic attendant can be seen raising a fist towards Patient D with a punching motion. Seconds later, this same forensic attendant is seen making the movement of giving three knee strokes towards Patient D.



Figure 3: knee blood stain on the forensic attendant's pants

Source: snapshot of RHC video footage of the incident reviewed by Ombud staff.

It is noted in Patient D's file by multiple staff members that the patient showed unpredictable behavior and moods could change quickly. Patient D was often calm and cooperative during examinations, but could make threatening comments to staff or patients soon thereafter. One entry in the file after the incident in question states that another patient approached staff saying they were scared of Patient D and had concerns about their aggressive behavior. Patient D was transferred back to a correctional center eight days after their arrival to RHC.

PATIENT E

Patient E was a patient on the Unit C1. The Risk Management Department does not review video footage of every incident since “Code Whites” are a common occurrence at RHC. Two Program Managers witnessed a “Code White” that was called in relation to Patient E in June 2018 at 14h32. Immediately after the incident, these Program Managers approached staff from Risk Management to request that video footage be reviewed. The Program Managers believed excessive force had been used to restrain Patient E, particularly by a specific staff member (the Forensic Attendant). An investigation was launched by Risk Management; the video footage was reviewed at 15h30 the same day the incident occurred.

Our office was also contacted by the patient alleging that excessive force was used against them and they wanted to contact the RCMP. As our office had already launched a systemic investigation, we provided the patient with the contact information and also asked them to contact us if they experienced any difficulties contacting the authorities. We also requested more details around the incident. We immediately followed up with the administration at RHC and requested that all documentation, incident reports, photos of injuries video footage and all relevant details relating to this incident be forwarded to our office.

As per video footage, Patient E can be seen talking to staff members and the Forensic Attendant implicated in the incident is part of that conversation. Patient E is then seen walking away from them towards a set of locked doors and is followed by the Forensic Attendant. The Forensic Attendant is seen opening the doors with their security card for the patient. Patient E goes through the door then slams the door shut behind them. The video footage shows that the Forensic Attendant was not hit by the door, however, the agent proceeded to reopen the door and run towards Patient E. When Patient E notices the agent coming after them, the patient is seen running away and kicking a garbage can. Patient E then turns around in a non-threatening manner when the Forensic Attendant is near. The agent then uses their forearm to push on Patient E’s face or neck area to bring the patient to the floor (see figure 4).

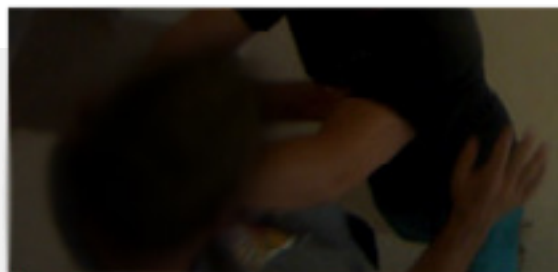


Figure 4: Forensic Attendant takes the patient down

Source: snapshot of RHC video footage of the incident reviewed by Ombud staff.

Statements in the investigation report mention that the events that unfolded next were difficult to assess on the video footage due to the camera angle staff members arriving to tend to the code huddling around the patient. Our office can corroborate this statement to be true. Nonetheless, the Program Manager reported that the Forensic Attendant was restraining Patient E by the throat and was holding a spit hood tightly around their throat. As per protocol, Patient E was then placed in a secluded area and restrained because they continued to be agitated after the incident. The entire event lasted approximately seven minutes.

It is mentioned in one of the Program Manager's incident report that Patient E was quite agitated during the code, but was restrained to the ground during the entire altercation. It was also mentioned that Patient E screamed to the Forensic Attendant *"You like hurting me... I'll make sure you never work in Campbellton again!"* The other Program Manager said that the Forensic Attendant's thumb was shoved into Patient E's carotid artery for 5-10 seconds. The incident report says that Patient E's face was bright red and the patient told the Forensic Attendant *"I can't breathe, I can't breathe!"* The Program Manager even mentions feeling bad for Patient E in that moment. It is also noted that the Forensic Attendant continued to hold Patient E's face while being transported and barely moving, and that it seemed like the force used was not necessary for the situation.

During the debriefing of a few staff members by the same Program Manager, the Forensic Attendant said "no" when asked if the patient had hit them, but the response was then changed to "yes"; saying they received a hit to the head. The Forensic Attendant said they used such force because they were attacked by the patient. During the debriefing, the Program Manager told the Forensic Attendant not to worry because the surveillance videos would protect them if they used the force that the situation necessitated. The incident report mentions that the Forensic Attendant became very defensive when it was implied that the video footage could be reviewed, saying things like *"No, no, you have no business looking at the cameras (footage). There is no need for that."* [TRANSLATION].

When the Program Manager approached Risk Management staff the concern was raised that staff notes on Patient E's file were not accurate in describing the situation. Risk Management staff confirmed this to be true in written communications reviewed as part of our investigation. One note from a nurse on the unit says Patient E *"...kicked the garbage and leapt towards the employee (Forensic Attendant)."* [TRANSLATION]. Video footage showed this assertion to be false. Patient E had not hit or leapt towards the Forensic Attendant or any employee before being brought to the floor by this person. The Forensic Attendant's note to the file says that after Patient E kicked the garbage, they went after the patient to try and calm their apparent frustration. Patient E hit them in the head then attempted to hit them with their feet, which is why such force was used to bring the patient to the ground. As per video footage, this is also not completely accurate. Patient E can be seen trying to kick the Forensic Attendant, but only after being brought to the floor. Patient E did not hit the Forensic Attendant before force was used to restrain them.

The following morning, Senior Management was contacted and they immediately addressed this situation. The report states that at 8h55 the next day, while Risk Management staff were discussing how to address the incident, a “Code White” was called on the Patient’s unit, so they went to investigate the situation. When they arrived, the patient was still in seclusion and said they had contacted our office for the RCMP’s number because they wanted to press charges against the alleged Forensic Attendant. After being provided the telephone number by our office, Patient E says they took the phone to call the RCMP, but an employee told them to put the phone down or that a “Code White” would be called, which is what happened. The report says Patient E was calm, but showed emotion in explaining to RM staff what had happened and why they wanted to report the incident to the RCMP. Patient E also agreed to have pictures taken of the injuries (as seen in figure 5). Risk Management staff and the Program Manager told Patient E to rest up and that they would be back with their social worker to assist with contacting the RCMP.

The investigation report says that at 10h35, the physician was in the unit when they were asked about Patient E’s injuries. The physician says they were never contacted on the day of the incident to assess Patient E’s status. The evaluation showed bruising and scratches to the patient’s left clavicle and ear as well as to their throat (as seen in Figure 5). Patient E also mentioned having soreness in their tailbone. Following the physician’s evaluation, Patient E was given the opportunity to file a complaint with the RCMP. An officer attended RHC that same afternoon to look into the matter and took a statement from the patient.



Figure 5: patient injuries
Source: photo provided by RHC