
# A companion document to the special investigation into the use of restraints in adult psychiatric facilities in New Brunswick.

September 2025

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NEW BRUNSWICK • NOUVEAU-BRUNSWICK

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# A CAUTION TO READERS

The content of this document describes the experiences of individuals placed in restraints in an adult psychiatric facility. The situations described may be upsetting for some people. It also contains language that could be considered vulgar.

For those who have received psychiatric treatment, or their families and friends, the following may bring to mind memories of traumatic personal experiences or those of loved ones.

If you or someone you know requires support, please reach out to any of the following services:

If you are struggling and need someone to talk to, help is available 24/7. Call the free **New Brunswick Addiction and Mental Health Helpline** at 1 866-355-5550.

**211 New Brunswick** provides programs and community services. Service is available by phone at 2-1-1, toll free 1 855-258-4126, toll free text based line 1 855-405-7446, email **211nb@findhelp.ca**, or online through **https://nb.211.ca/search/**.

**9-8-8 Suicide Crisis Helpline** is a safe space to talk, 24 hours a day, every day of the year if you are thinking about suicide, or if you are worried about someone else. Call or text 9-8-8, or go online to **https://988.ca**.

**Hope for Wellness Helpline**: Indigenous people who require support can also contact the Hope for Wellness Help Line and On-line Counselling Service. The service is available by phone at 1 855-242-3310 (toll-free) or online through **https://www.hopeforwellness.ca/**.

# CONTEXT

This companion document summarizes the complaints and experiences of patients who were placed in restraints while admitted for psychiatric care at the Restigouche Hospital Centre (RHC) from February 2021 to October 2023. These summaries are presented in the order in which we received the complaints. We are only publishing summaries of those we were able to reach before the date of the publication

Please note that all names have been changed to protect the identities of these individuals.

The drawings depict actual situations observed in video footage. Minor details have been omitted to protect the identities of the individuals involved.

# JONATHAN

*Jonathan had a number of admissions at the RHC throughout the years. In February 2021, our office received a complaint from one of his family members stating that he had been placed in seclusion and left in restraints for an extended period without proper intervention while on the Community Reintegration Unit.*

In reviewing five hours of video footage from Jonathan's time in seclusion, it was clear that staff did not respond to his frequent requests for help. Jonathan knocked on the door and waved to the camera. He was shouting loudly for help for more than an hour. After becoming increasingly agitated, he broke down. He kicked the door repeatedly until it broke. Following this, a code white was called and approximately 13 staff members entered his room to place him in physical restraints. Jonathan remained tied to the bed for three consecutive hours without any further assessment or intervention by staff.

During our investigation, we discovered that there was a known defect in the design of the doors at the RHC, as these have been repeatedly broken by patients. Both staff and patients relayed their concerns for their own safety.

# ISABELLE

*Isabelle was a patient at the RHC for over 20 years. In March 2021, a family member made a complaint about her physical health and time spent in restraints while on the Tertiary Psychiatric Care Unit. The family member was concerned about respiratory issues Isabelle had been experiencing over a few months, and her physical and mental health seemed to be deteriorating rapidly. The relative also mentioned that their request for Isabelle to receive a second medical assessment was not being granted. They expressed concern that Isabelle was in restraints for most of the time and didn't have many opportunities to walk around. They believed that her physical health issues could be linked to this lack of mobility. .*

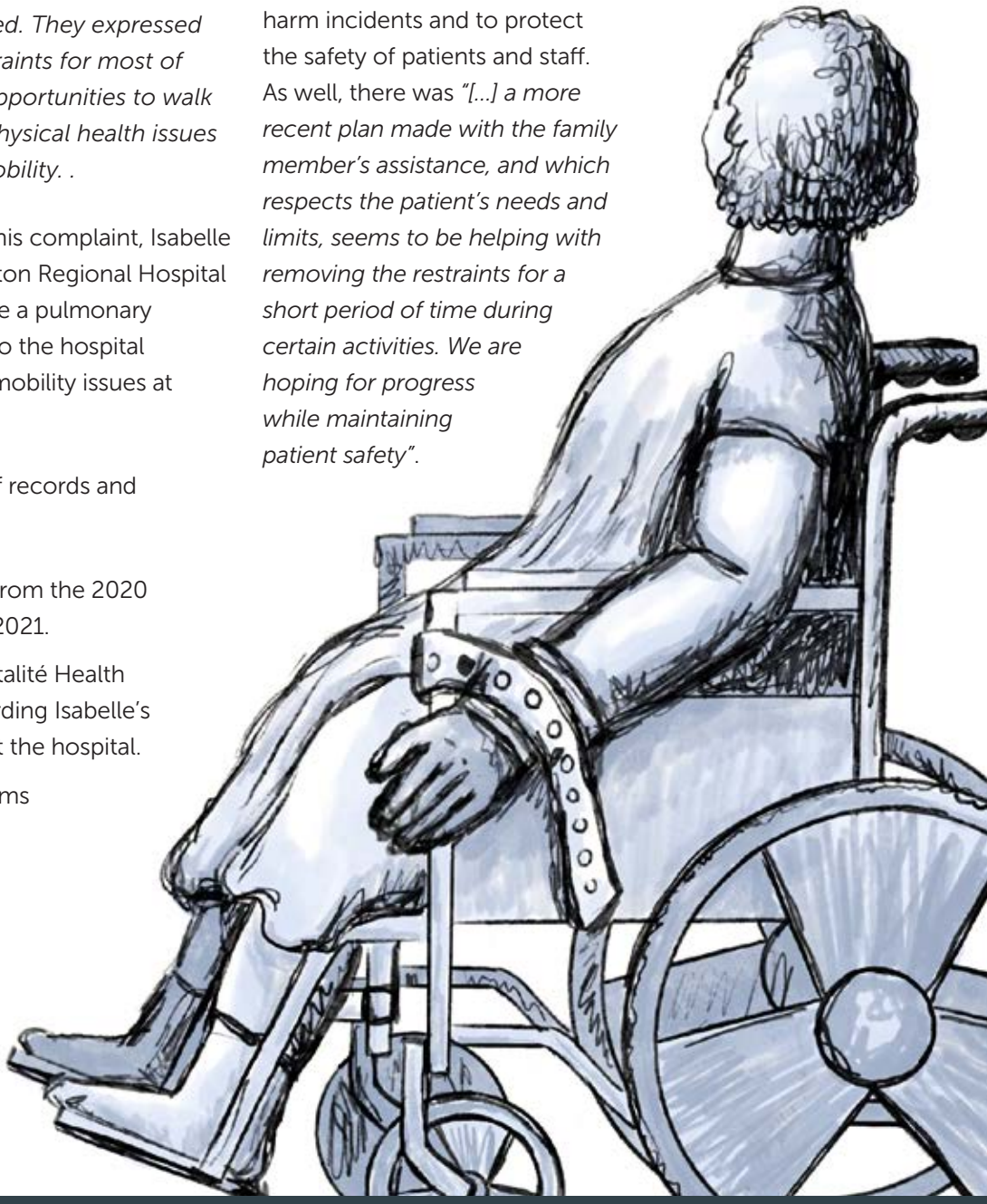
Shortly after our office received this complaint, Isabelle was hospitalized at the Campbellton Regional Hospital for a four-week period to examine a pulmonary condition. The admission report to the hospital also confirmed that Isabelle had mobility issues at admission.

Our office requested a number of records and information such as:

- Treatment plans and file notes from the 2020 calendar year and a portion of 2021.
- Emails exchanged within the Vitalité Health Network (Vitalité) facilities regarding Isabelle's care before and after her stay at the hospital.
- Medical orders and consent forms authorizing the use of physical restraints.
- Policies regarding the use of seclusion and restraints.

During our review, we noted that her file contained 80 medical orders over a 15-month period between 2020 and 2021, but it did not appear to contain the proper consent forms for the use of restraints.

Vitalité officials clarified in their response that there was a medical order on file for Isabelle for partial restraints to the wrists at night and during the day to help reduce the number of self-harm incidents and to protect the safety of patients and staff. As well, there was *"[...] a more recent plan made with the family member's assistance, and which respects the patient's needs and limits, seems to be helping with removing the restraints for a short period of time during certain activities. We are hoping for progress while maintaining patient safety"*.



## ISABELLE

Isabelle's typical routine involved being dressed and placed in her geriatric chair around mid-morning. As she was prone to wanting to remain isolated in her room, she was brought to a small room off the common living space near the nursing station that was set up specifically for her in an attempt to reduce her isolation. Isabelle spent her days mostly inside the room, with the half-door locked, watching her favorite television shows. However, contact with her peers remained limited.

Isabelle's case, as a long-term patient at RHC, raises a problem of a different nature than many of the others we reviewed in this investigation. Isabelle spent most of her days with her wrists and waist restrained to a geriatric chair during the day and to her bed at night. This practice occurred for an extended period during Isabelle's decades-long hospitalization. Although other methods to manage her tendency for self-injurious behaviours were attempted (i.e. the use of mittens to protect the patient from self-harm), there did not appear to be a consistent effort to assist her in developing new habits.

During our investigation, the RHC eventually initiated steps with the Department of Social Development to identify a community placement that could provide care for her complex needs. After decades at the RHC, Isabelle was finally placed in a community facility. Once there, she was able to enjoy more social interactions with her family and peers and spend some time without restraints. Isabelle was even able to perform some of her personal care on her own, such as brushing her teeth and eating, things she had not done for some time.

Unfortunately, Isabelle passed away a few months following her transfer in the community. Nonetheless, her family was grateful for an improved quality of life in her final months. They were also able to be by Isabelle's side in her final moments.

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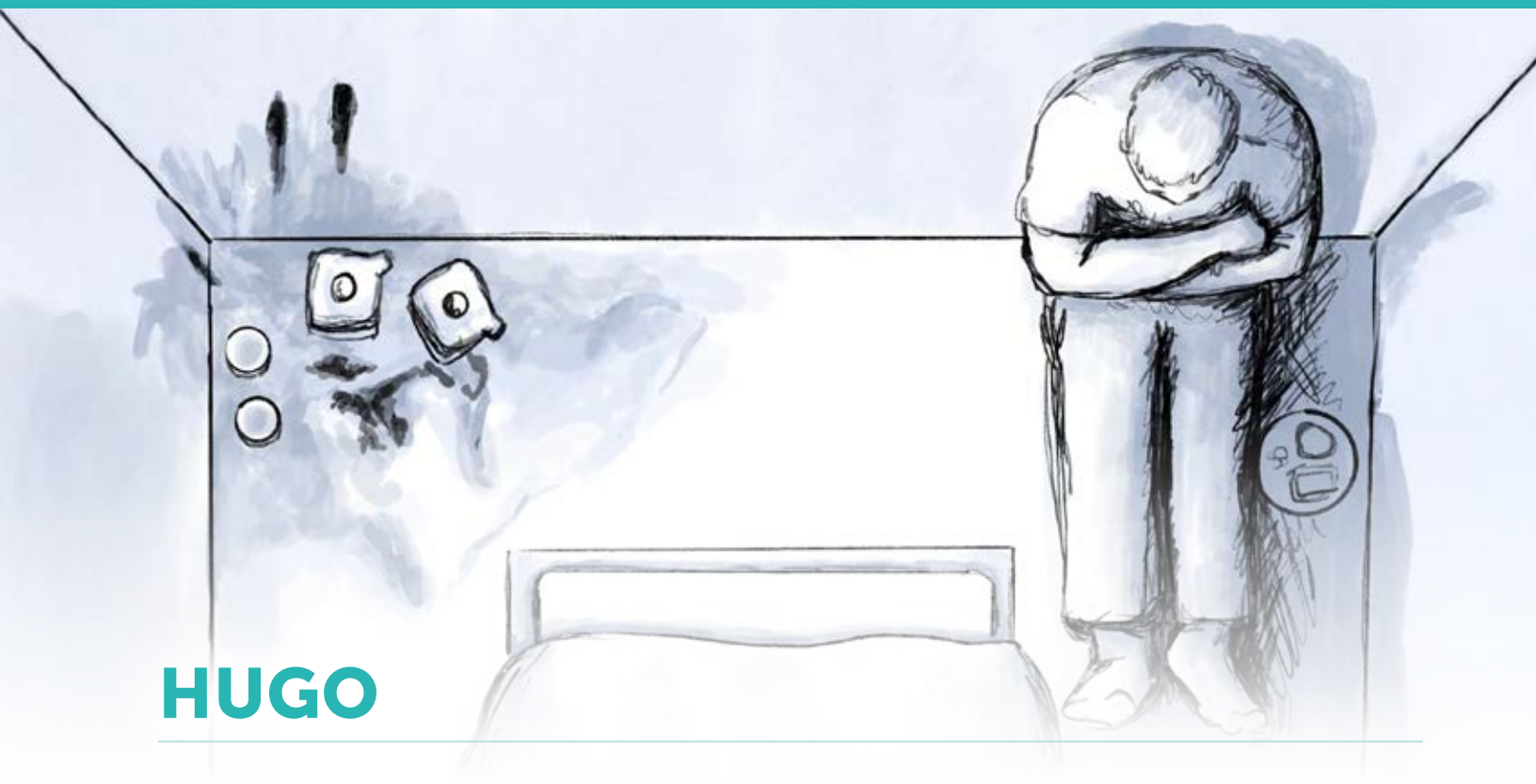


# HUGO

*Hugo was admitted to the RHC as part of a court ordered assessment. He contacted our office in May 2021 to make a complaint about his time in a seclusion room and in restraints while on the Legal/ Forensic Psychiatry-Evaluations Unit and the Legal/ Forensic Psychiatry-Stabilization Unit. He stated he was put in the seclusion room frequently, with and without physical restraints, and that staff were not responding to his needs to the point that he had to urinate and defecate on the floor.*

Our office requested documentation and video footage for the time he spent in the seclusion room. There was 339 hours of video footage.

We read in the patient's notes, and were told by the RHC staff, that Hugo was monitored during isolation and that the policy was followed. Our investigation found the opposite.

We were able to observe on the video footage that the staff did not respond to his basic needs or acknowledge his requests for assistance. After indicating that he was thirsty, he went 12 hours without hydration because no one returned to the seclusion room to offer him water.

After his second day in seclusion, Hugo expressed to staff that no one was responding to his requests for assistance. Hugo was observed wrapping a sheet around his neck on several occasions, hitting his head and throwing himself off the bed. Staff eventually intervened and gave him a security blanket.

Hugo was also not given an opportunity to go to the bathroom on a regular basis. He relieved himself on the floor and was left in the seclusion room with his feces and urine for approximately 20 hours before it was cleaned. Although staff finally supplied him with urinals, he still spent more than 16 hours in the seclusion room with full urinals.

As he had very limited access to a shower, to wash his hands or use disinfectant before meals, to toilet paper or a change of clothes, Hugo had to remain soiled for long periods.

Several days later, Hugo was placed in the seclusion room again, during which time he was observed spending 13 consecutive hours overnight in a five-point physical restraint without any intervention or assessment by staff. On several occasions, Hugo was screaming and yelling for help that never came.

# SIMON

*Simon was admitted to the RHC as part of a court ordered assessment. He contacted our office in February 2022, complaining that he was left in five-point physical restraints in the seclusion room on the Legal/Forensic Psychiatry–Evaluations Unit from about 8:00 a.m. until about 1:00 p.m. the next day.*

We observed that Simon did spend 34 hours in the seclusion room and confirmed he spent a little over 27 consecutive hours in some form of physical restraints (three-, four-, or five-points).

In addition, Simon was not given the opportunity to use the bathroom to relieve himself during this entire period, even after he kept begging staff to let him go to the bathroom with dignity. At one point, a staff is heard telling him to, *"shit in the piss jug"*. He eventually used his pillowcase to defecate.

Simon challenged staff's decision to restrain him for covering up the camera, questioning whether his actions were sufficient to justify being restrained, stating: *"That is why you're tying me up? You got to have a better reason than that"*. Our office observed him being difficult, but he eventually complied and stated that he would not cover the camera again. We further observed a missed opportunity to de-escalate the situation instead of using restraints.

We also observed Simon ask if staff could give him his sweater so he could cover up because he was bare from the waist up. He was not given his sweater and was left shirtless, in restraints, until the next day – more than 24 hours later.

While Simon was in restraints, staff did not offer him the opportunity to go to the bathroom. As a result, he urinated in empty foam cups that were left behind after his meals, which he placed around him on the side of his bed. The cups filled with urine were left there for several hours on two different occasions. At one point, he was heard telling staff that, *"there's no way to call, there's no communication"*.

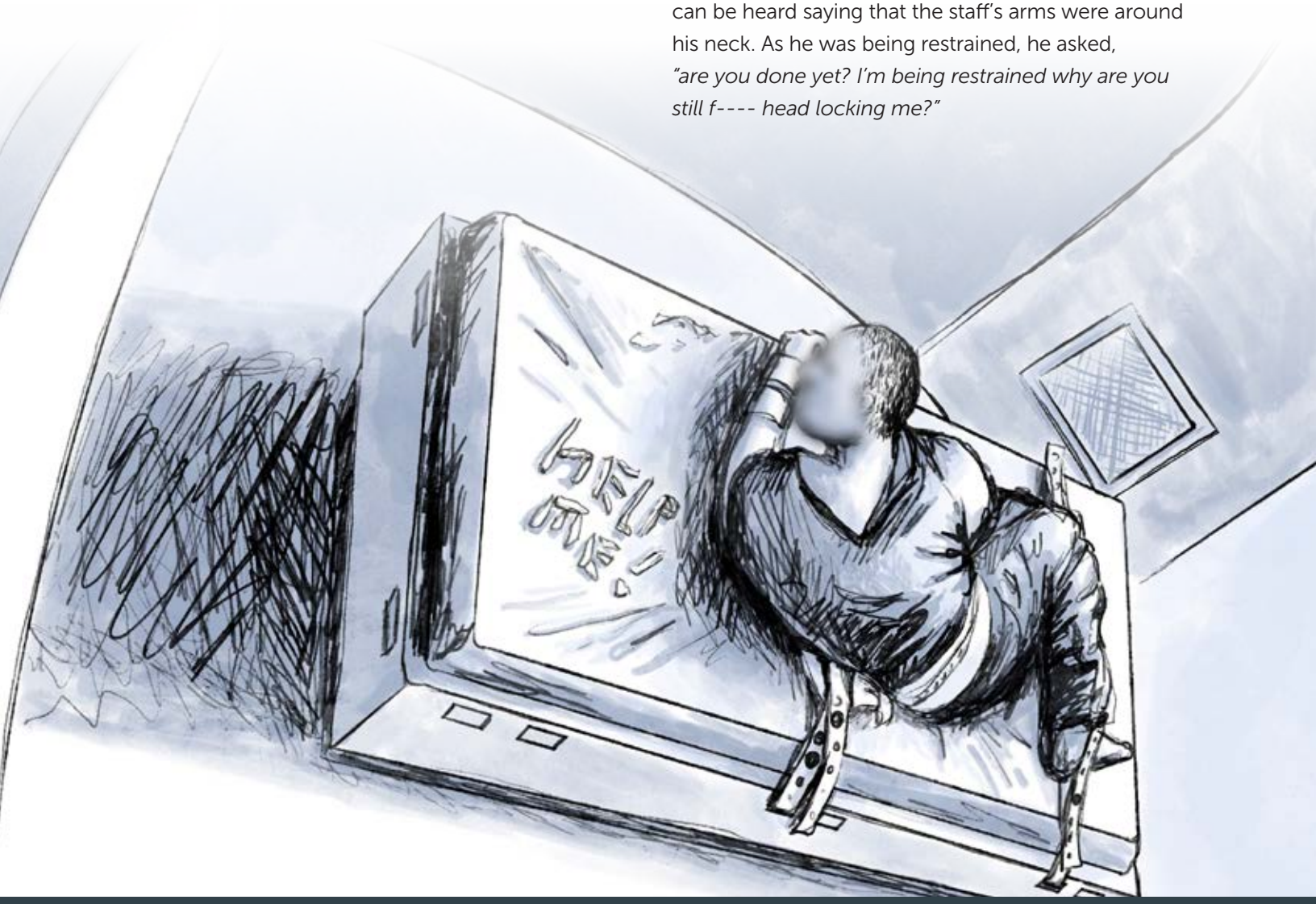
Simon continued to remove his restraints and at one point staff entered the room to re-apply them. During this intervention, a staff member applied pressure by holding Simon's head and neck while his colleague re-applied the restraints on his right wrist. This pressure was used for four minutes while Simon was already in a submissive position in four-point restraints. Additionally, once the restraint was secured, the staff member continued to apply pressure on his neck for an additional minute while he was in total restraints. When staff members exited the room, they tossed a blanket over Simon that covered his head and face, but his feet remained exposed.

# DAVID

*David was admitted to the RHC as part of a court ordered assessment. He contacted our office in June 2022, after leaving the RHC, to share his experiences in the seclusion room on the Legal/ Forensic Psychiatry–Evaluations Unit. In total, he made four allegations: that he was denied a physical health assessment; that he spent long periods of time in five-point restraints without the required interventions; that he needed to urinate and defecate on the floor because his requests to go to the bathroom or take a shower were not responded to; and that staff used excessive force (he was placed in a headlock).*

Following our review of the video footage, we observed that David spent 60 hours in seclusion over a two-week period. In addition to this, David spent significant consecutive periods of time in physical restraints on three separate occasions: 17.5 hours; eight hours; and another period of five hours.

At one point, David was forcibly taken by five staff members into the seclusion room and repeatedly resisted, saying that he didn't want to go. He was escorted in a headlock and placed on the bed. David said that he couldn't breathe as staff applied pressure around his neck area. The camera view was obstructed because staff were positioned in front of it, but David can be heard saying that the staff's arms were around his neck. As he was being restrained, he asked, *"are you done yet? I'm being restrained why are you still f---- head locking me?"*



## DAVID

While in restraints, appropriate interventions were not respected. There was no offer of washroom use, water or food, the ability to stretch his limbs, verification of skin integrity and adequate position of restraints. At one point, he yelled for staff to help him as he chewed on his restraints: *"I'm going to have a f---- heart attack"*.

RHC staff offered him urinals on a few occasions while he was in five-point restraints, although it is almost impossible for patients in restraints to use them. David urinated on the floor several times and defecated in a pillowcase but had nothing to wipe himself. He was not offered disinfectant or an opportunity to wash his hands regularly.

He told staff on a few occasions that the restraints left marks on his limbs. His hands appeared to be discoloured at one point, but the restraints were not readjusted as policy requires them to be.

David had difficulty eating his meals and taking his medication while in physical restraints and in a semi-recumbent position. For example, he had only one hand free when he ate, which made this task almost impossible, especially considering the types of food he was offered such as oranges that he peeled with his teeth, yogurt cups, packaged cheese, etc.

On one occasion the restraints were not properly positioned. While David was moving around, the abdomen restraint ended up around his knees, having pulled down his underwear along the way. RHC staff entered the room to fix the right wrist restraint while David laid half-naked.

Staff then removed the mattress from under him and placed it on the floor. David was now on the bare multi-point-restraint bed half-naked. They did not check or fix the other points, nor cover his genitals. They left the room, leaving him naked and restrained, without his mattress and with the abdomen restraint still positioned around his knees.

# ADAM

*Adam was an involuntary patient at the RHC, under the Mental Health Review Board's authority. In August 2022, he made a complaint about his time in a seclusion room and in restraints while on the Legal/ Forensic Psychiatry-Evaluations Unit when he was admitted.*

*He alleged staff sexually assaulted him by pulling down his pants while he was physically restrained in the seclusion room and conversed casually amongst themselves in French during the intervention (a language he does not speak). This made him uncomfortable because he thought they were laughing at him. He alleged he had been placed in the seclusion room for what felt like a week and had been physically restrained for what felt like three days. He said he had to urinate and defecate on the floor of the seclusion room since staff did not take him to the washroom.*

Our office requested video footage of the entire time he spent in the seclusion room and other paperwork related to Adam. The footage reviewed showed a sequence of experiences that speak to every deficiency discussed in our report.

Over a period of 16 days, Adam spent about 324 hours alone in the seclusion room. This included a period of 285 consecutive hours (approximately 12 days).

While in the seclusion room, Adam spent a total of 102 hours and 20 minutes in three-, four- or five-point restraints on the bed. At one point, he was in restraints for about 58 consecutive hours, then two periods of about 19.5 consecutive hours, and one period of about five consecutive hours.

## ADAM

Adam spent 60 consecutive hours in a seclusion room soiled by urine and feces. Video footage shows Adam urinating at least 20 times and defecating into a cup inside the seclusion room because he was not provided an opportunity to use a toilet. RHC staff were aware of the state of Adam's room and took no action to ensure cleanliness.

On five separate occasions, Adam did not receive meals and was not offered water at regular intervals as dictated by policy. His requests to wash his hands (often before a meal), to take a shower or use the washroom were often unanswered. Although empathetic and amicable interactions between staff members and Adam were observed, some other staff members lacked professionalism and tact in their interventions.

The allegation of sexual assault resulted from an incident where staff tried to restrain Adam's hands after he had removed himself from restraints. RHC staff pulled Adam's pants down and he remained naked below the waist for seven minutes in front of six staff members. During this time, Adam's limbs, waist, and neck were restrained. A spit hood had been placed on his face for the duration of the incident. At one point, while an employee was kneeling on the patient's restrained leg, another employee was sitting on the floor and pulling down on Adam's arm. During this time, staff were conversing and chuckling in French; a language Adam does not understand. During this incident, employees also expressed concern that Adam would be injured. For example, staff were heard saying:

*"We're going to break a finger... We're going to get charged", "It's too tight", "If he puts his hands in like that a second time... there are more chances of us hurting him than anything else", "Well, I thought we were going to break his arm."*

We also heard an employee express that he was afraid of hurting Adam. The employee holding Adam's head/neck asked the supervisor if the spit hood was to be left on his face, to which the supervisor responded that they can't, because some of their patients are so ill that they could start eating them and choke.

This incident was referred to the Royal Canadian Mounted Police (RCMP) by the unit manager, though no charges were laid as a result.

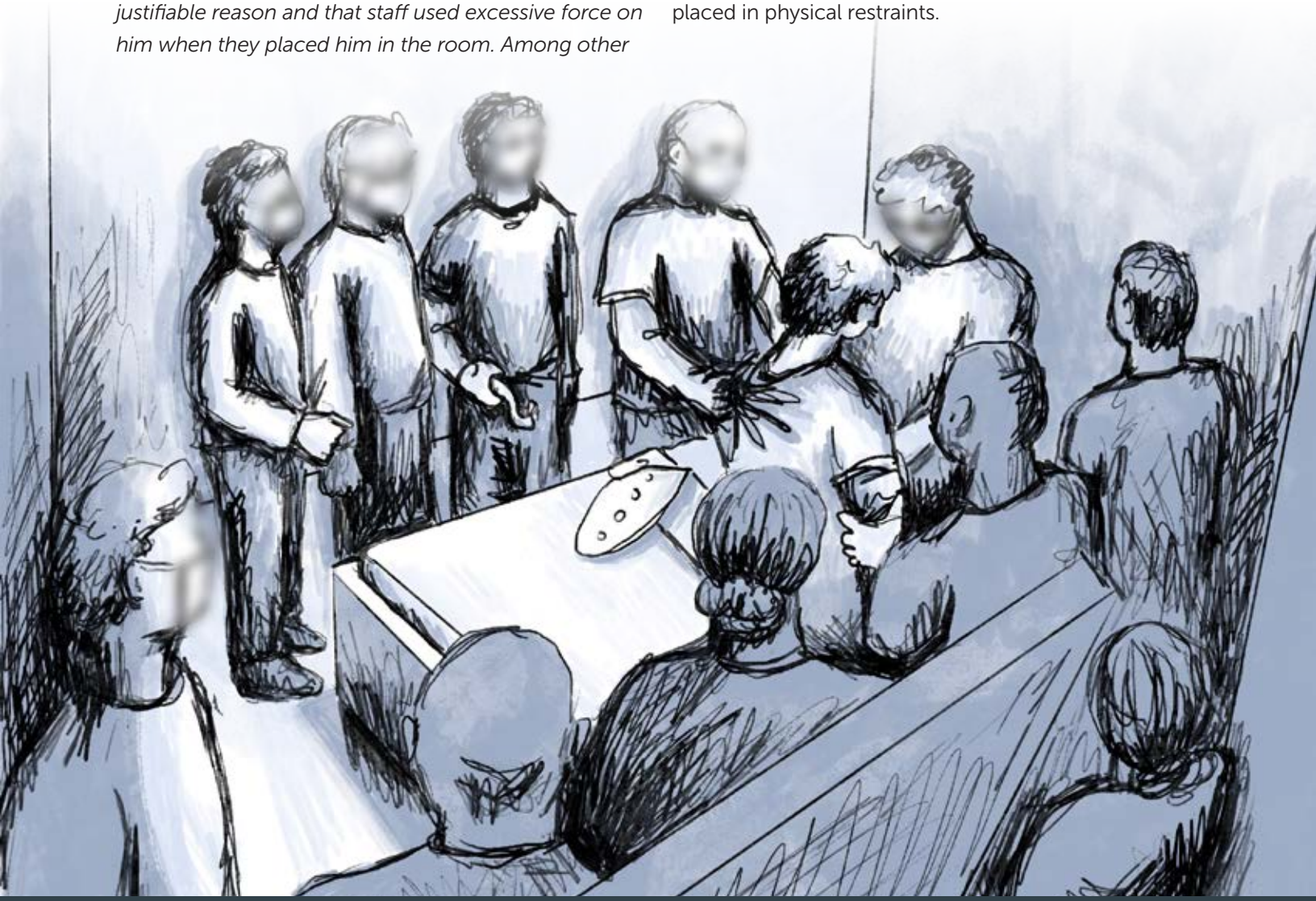
There are instances where the events documented by staff in reports did not correspond to the video surveillance footage. For example, in the incident described above, the file note stated that staff removed Adam's pants because he was *"suicidal"*. However, staff are not heard articulating any concerns for Adam's personal safety in relation to his pants, and there is no corresponding documentation of this concern.

# NICHOLAS

*Nicholas was admitted to the RHC as part of a court ordered assessment. In November 2022, several days after his time in the seclusion room, Nicholas contacted our office to share his concerns about his treatment during this period on the Legal/Forensic Psychiatry-Evaluations Unit. He acknowledged that his behaviour on the unit deserved a consequence, but that he did not think that his actions justified placing him in physical restraints because he was not aggressive and did not have a history of injuring himself.*

*Nicholas' complaint alleged he was physically restrained upon his arrival in the seclusion room for no justifiable reason and that staff used excessive force on him when they placed him in the room. Among other things, he said he was pushed roughly against the wall; he spent about three hours in physical restraints; his requests to use the washroom were not granted so he had to urinate on the floor; and his request for incident reports about the events was denied.*

Our office reviewed nearly 17 hours of footage and requested documentation from his file. Our review confirms that Nicholas was in fact placed in five-point restraints while in seclusion for two hours and 33 minutes consecutively. Vitalité also confirmed that based on the information they reviewed, they were of the opinion that the behaviors observed on video in the seclusion room did not justify Nicholas being placed in physical restraints.



## NICHOLAS

RHC staff entered the seclusion room at intervals of about 15 minutes during the first hour to speak with him, which demonstrated an improvement when compared to the other situations observed in our investigation. In that first hour, physical restraints were not always checked, as is required by policy. However, there were hourly in-person checks afterwards. Nicholas was not always offered water and was not given the opportunity to move his limbs after being in restraints for two hours. Despite the improvements recorded, staff did not comply with the policy in its entirety.

Nicholas expressed the need to urinate and defecate while physical restraints were being applied and was not offered a urinal or the opportunity to go to the washroom. At one point, staff members entered the room and asked Nicholas to lift his buttocks so they could put a basin under him to defecate. He refused and told staff that he would defecate in his underwear instead. The staff did not seize the opportunity to negotiate with him and take him to the washroom.

Nicholas was heard asking repeatedly why he was placed in physical restraints, he stated he was *"strapped down for nothing"*. He cried several times and seemed anxious while in restraints. He expressed that he had difficulty breathing, that he was going to vomit, and appeared in despair. Eventually, RHC staff attended to him and during this interaction, Nicholas cried hysterically asking to have his restraints removed and saying he couldn't breathe properly.

The staff told him they were going to check with the supervisor, and they would come right back. About an hour later, the nurse in charge had a clear, calm exchange with Nicholas explaining that she would remove his restraints if he remained calm (no shouting or crying) for another thirty minutes. He appeared to be more cooperative and calmer afterwards.

# EMMA

*In the fall of 2023, our office had not received any complaints related to restraint or seclusion room use at RHC in almost a year when we were contacted by Emma, a patient on the Legal/Forensic Psychiatry-Rehabilitation Unit.*

*Emma contacted us the day after she was released from the seclusion room alleging to have spent four days there; to have been placed in physical restraints for about eight hours; to have been refused access to the washroom during this time; and to express concerns about the force that was used on her by staff intervening in a particular code white incident during this time. She also alleged that staff members had pulled her hair and slammed her head against the floor during the intervention and that her injuries were not assessed by a doctor afterwards.*

Emma was brought to the seclusion room after having been found self-harming in her room and remained there for the next four days. While our review found many meaningful improvements to the interventions from a number of staff members, we remained concerned by the force that was used during a particular response to her self-harming behaviour.

During her time in the seclusion room, we observed her self-harming or threatening to do so on multiple occasions. She was also uncooperative in many instances, would direct threatening or derogatory comments towards staff and would constantly request medication for pain management or to help her sleep (she did not have medical orders for some of the medication she was requesting). We observed multiple staff members enter the seclusion room alone to talk with Emma or provide her things she had requested, all while she was unrestrained.

After a multitude of de-escalation tactics were unsuccessful, she was getting increasingly agitated, continued to self-harm, and was placed in physical restraints. Our review did not find concerns related to staff's response to this code white and subsequent use of physical restraints. Staff checked on her regularly and physical restraints were completely removed 3 hours and 52 minutes later. We note that this intervention was done under the supervision of the unit manager, which appears to have contributed to a more coordinated effort on the part of the responding staff.

## EMMA

The following day, much of the same behaviour was observed. Staff intervened in a few self-harming incidents throughout the day, the behaviours were managed by ensuring she was changed to an anti-ligature gown and removing concerning objects. A note was put on her file indicating that *"Should a subsequent code white be called she will be placed in mechanical (physical) restraints."*

On her third day in the seclusion room, a staff member entered the room, turned on the light and left a sandwich on Emma's bed. Emma had told them that she would not eat until she left the room. The staff member told her that she could discuss this with the nurse and left. Shortly after, Emma screamed and persistently asked for the light to be turned off. After not receiving a response, she wrapped her sheet around her neck then removed her shirt to do the same. A few minutes after she did this, voices were heard from outside the seclusion room, presumably from the code white team assembled outside her door. She got up and banged her head aggressively on the door multiple times.

About three minutes later, three staff members entered by opening the door abruptly and bringing Emma down to the floor. She was held to the floor, behind the bed, until physical restraints were placed on the bed. While we were unable to confirm it with certainty, it did appear as though Emma hit her head on the corner of the bed on her way down to the floor. Emma was not given any directives on what was required of her in that moment prior to the staff entering the room. De-escalation techniques were not attempted, such as responding to her request (which was to turn off the light in the seclusion room). These actions did not appear proportionate to her behaviour, particularly given that Emma had not been observed to be aggressive towards staff during her time in the seclusion room. The response could have led to serious injuries to the patient and/or staff.

Moreover, Emma remained agitated throughout the intervention and continuously asked staff why they hadn't turned the light off like she had asked and if she could receive medication. After not receiving a response for several minutes, she eventually pointed out the fact that there were a multitude of people around her, but nobody was responding. Staff were also observed placing a cloth over her face on two occasions during this intervention: once for 4.5 minutes and the other for 1.5 minutes. Unlike the code white that occurred the previous day, there did not appear to be any staff coordination this time, which undoubtedly lead to a needlessly disorderly intervention.

Emma remained in physical restraints for 1.5 hours and was released from seclusion the next afternoon after being calm and cooperative for most of the day. Despite complaints of neck pain after this intervention and a potential head injury, we did not observe staff (or a medical professional) checking her physical ailments. We did not observe a psychiatrist visiting her during her time in seclusion despite exhibiting numerous self-harming behaviours.

Despite this very unfortunate instance, we noted positive improvements in the other interventions that occurred during Emma's period in the seclusion room. These improvements were a marked difference with the observations we made in the almost 950 hours of video footage we reviewed for the previous complaints we received. We observed soothing music being played inside the seclusion room, a number of staff members kneeling by Emma's side or sitting with her for long periods of time trying to encourage her when she was visibly upset, staff encouraging her to shower and offering to do her hair to help boost her mood, and bringing her a book when she said she was bored.

Emma's story highlights the fact that, though there is still work to be done, there have also been improvements in terms of the frequency and quality of staff interventions with patients when placed in a seclusion room. It also demonstrates how strong leadership during stressful interventions can lead to better outcomes for patients and staff alike.

# GLOSSARY OF TERMS

| | |
|---|---|
| **Code White** | A code white is called when a response team is needed to assist in de-escalating a violent or aggressive situation. For example, if a patient exhibits aggressive behaviour that can potentially harm others or themselves. This may also require the response team to use force, but they are expected to use the least amount of force necessary to gain compliance and control. |
| **De-escalation tactics** | The primary function of de-escalation is to help the distressed person reduce the intensity of their problematic behaviour quickly and effectively while maintaining that person's safety and others. Examples: using a soft hand contact/smile, making reassuring comments, assessing if hungry/thirsty/warm/cold. |
| **Office** | Office of the Ombud for New Brunswick |
| **Restraint(s)** | The word "restraint" refers to any means used to stop or restrict capacity for mobilization in any form, whether it be physical, chemical, or environmental.<br><br>**Environmental restraint:**<br><br>Any obstacle or device that limits a patient's mobility, thereby confining him or her to a specific geographic area or location (e.g., half door).<br><br>In our investigation, the only environmental restraints we encountered were seclusion rooms, which is the term we use in this document.<br><br>**Physical restraint:**<br><br>Physical or mechanical means or methods that stop or restrict voluntary capacity for mobilization of the entire or a part of the body.<br><br>• Total physical restraints (e.g., wrists, ankles, and abdomen).<br>• Partial physical restraints (e.g., wrists or ankles or abdomen or chair with table and/or belt).<br><br>In this document, we use the terms restraint(s) or physical restraint(s) to describe the equipment used to restrict parts of the body such as the wrists, ankles, or abdomen. We may also use the term five-point restraints to describe someone who is in total physical restraints (both wrists, both ankles and abdomen restrained with the equipment). Similarly, we may use the terms three-point or four-point restraints to describe partial physical restraints (where three or four parts of the body have been restrained). |