**Release Date: December 12, 2014**

**IN THE PROVINCIAL COURT OF MANITOBA**

**IN THE MATTER OF:** ***THE FATALITY INQUIRIES ACT***

**AND IN THE MATTER OF:** **BRIAN LLOYD SINCLAIR, Deceased**

**APPEARANCES:**

Mr. D. Frayer, Q.C. and Ms M. Murray, Inquest Counsel

Ms B. Owen, Inquest Coordinator

Messrs. W. Olson, Q.C., R. Olson and Ms C. Tolton, for the Winnipeg Regional Health Authority

Messrs. M. Trachtenberg and V. Zbogar, for the Family and Estate of Brian Lloyd Sinclair

Mr. G. Smorang, Q.C., for the Manitoba Nurses Union

Mr. T. Kochanski, for Drs. Waters, Perez, Araneda and Minish

Ms E. Hill and Ms C. Big Canoe, for the Aboriginal Legal Services of Toronto

Mr. M. Balfour, for the Assembly of Manitoba Chiefs

Ms L. Spillett, for Ka Ni Kanichihk

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## HOLDING OF INQUEST

[1] On January 10th, 2009, the Chief Medical Examiner of the Province of Manitoba called for an inquest to be held for the following reasons:

1. To determine the circumstances under which Mr. Sinclair's death occurred;

2. To determine what, if anything, can be done to prevent similar deaths from occurring in the future with regard to, but not limited to, the following:

    (a) reasons for delays in treating patients presenting in Emergency Departments of the Winnipeg Regional Health Authority (hereinafter referred to as "WRHA") hospitals; and

    (b) measures necessary to reduce the delays in treating patients in Emergency Departments.

[2] As the Provincial Court Judge hearing this inquest, I heard evidence from 82 witnesses over the course of 40 hearing days between August 6th, 2013 and June 13th, 2014. *The Fatality Inquiries Act* mandates that I prepare and provide a written report of this hearing to the Minister of Justice.

[3] *The Fatality Inquiries Act* grants me discretion to recommend changes in programs, policies or practices of the government and relevant public agencies of institutions and even in the laws of the province that, in my opinion, might help to reduce the likelihood of deaths occurring in similar circumstances. One of my tasks is to make findings of fact, including acts or omissions on the part of persons dealing with Mr. Sinclair. What I am not allowed to do is express any opinion or determine culpability in a manner that identifies anyone as a culpable party. Attempts by counsel during the cross-examination of certain witnesses to assess culpability cannot result in my finding any party culpable. In other words, the function of an Inquest is not to assign blame. The function of an Inquest is to tell the public what happened and why and to recommend practical, implementable change that might help prevent future harm or deaths.

[4] I would first acknowledge the absolutely invaluable assistance I have received from Ms Betty Owen, the Inquest Coordinator before, during and after the hearing. She was tasked, among other things, with the responsibility of organizing

1,033 legal and medical documents. Ms Owen has been a great help to everyone involved in the hearing. She was of vital assistance to me in the editing process of this report. I wish to thank Inquest Counsel Mr. Frayer and Ms Murray for their preparation and presentation of the evidence. I also wish to thank all counsel for their helpful contributions in the face of a tragic set of circumstances.

## INTRODUCTION

[5] At the time of his death, Brian Sinclair was a 45 year old Aboriginal man. He was a double amputee. Both of his legs had been amputated above the knee in 2007. After that, he used a wheelchair to transport himself. At 12:51 a.m. on September 21st, 2008, Brian Sinclair was pronounced dead in the Adult Emergency Department (hereinafter referred to as "ED") at the Health Sciences Centre (hereinafter referred to as "HSC").

[6] In fact, some hours prior to being pronounced dead, Mr. Sinclair had already passed away in the waiting room of the HSC ED. A full 34 hours earlier on September 19th, 2008 at 2:51 p.m., Mr. Sinclair had been transported by taxi, wheeled in and dropped off at the HSC ED. A little earlier that day, Mr. Sinclair had attended an inner city primary health care facility, the Health Action Centre (hereinafter referred to as "HAC"), complaining of abdominal pain and problems with his Foley urinary catheter. He was assessed by a physician, provided a letter from the physician and told by the physician to give the letter to the HSC ED staff upon his arrival there. When he arrived at HSC ED, he spoke to the Triage Aide at the ED reception desk. For the next 34 hours, until his discovery by another visitor in the ED, he awaited but did not receive assessment or treatment.

[7] This report will firstly provide a glimpse into the life of the young Brian Sinclair through the eyes of his sister. Mr. Sinclair's more recent history is then outlined, with a spotlight on his life after leg amputation surgery in early 2007 until his untimely death in the fall of 2008. The questions of how and why Mr. Sinclair died are then answered. The report goes on to examine the fundamental changes, both structurally and procedurally, that were made to the HSC ED as a direct result of the circumstances of Brian Sinclair's death. Following that, the report provides some historical perspective on the challenges of Emergency Medicine and then looks at reasons for delay in an ED. Strategies to reduce delay are assessed. The Nurses' Union provides its perspective. Finally, Emergency Medicine and Aboriginal health issues are examined through the lens of expert testimony. My recommendations are proffered throughout the report.

[8] This inquest literally had bird's-eye glimpses of 34 hours in the life and death of Brian Sinclair. Closed-circuit cameras captured and were silent witnesses to the last 34 hours of Brian Sinclair's life. Real-time video evidence starkly mapped out Mr. Sinclair's last journey.

[9] Brian Sinclair was a man with a number of serious health challenges. Part of this report will outline some of his prior visits to the ED. However, the acute peritonitis which caused his death was avoidable. Brian Sinclair died because he did not receive the initial treatment he required. Hopefully, the recommendations that I make, as a result of hearing from those people who cared for Brian Sinclair during his later years and experts in areas of Emergency Medicine, will help prevent anything like this from ever recurring.

## BRIAN SINCLAIR

[10] Brian Sinclair's elder sister, Esther Joyce Grant, who is now the Administrator of his Estate, told the Court about her "baby brother" Brian Sinclair's earlier life. Brian Sinclair was one of nine children born to Veronique Goosehead and Alfred Sinclair. Their mother Veronique hailed from Berens River First Nation. She attended residential school. After attaining her Grade 11, she moved to Fort Alexander First Nation, where she eventually met her husband Alfred Sinclair. Alfred Sinclair was of mixed origin, First Nation and European ancestry and did not have treaty status. Brian Sinclair's father was a good provider for his family. He was a commercial fisher and a logger. The Sinclair family grew up on the Fort Alexander First Nation. When Brian Sinclair was still a youngster, the family moved up to Powerview. Since they were not recognized as having treaty status at that time, the family lived "off reserve".

[11] Ms Grant described her brother Brian as a kind, helpful boy and an excellent student. In the early 1970s, the family moved to the North End of Winnipeg. By that time, Ms Grant had already moved out of the family home. Brian was about eight years old. Unfortunately, Brian and some of his siblings started sniffing solvents with some of the neighborhood children. When Brian was 12 years old, his parents separated. For about a year, the children were in care of the Children's Aid Society, but were then returned to their father. Ms Grant told the Court that at age 13, Brian became inseparable from his father. After his father passed away, when Brian was in his early twenties, Brian and his brothers Russell and Bradley moved into a rooming house and were looked after by their landlady. After the landlady sold the premises, the new landlord evicted Brian and his brothers. After that, Brian moved around quite a bit, but Ms Grant said that she and he kept in

touch by phone and she sent her brothers Christmas packages and birthday packages, via Brian. She told the Court that the young Brian once risked his life to save the occupants of a burning house. She considered him a hero.

[12] Ms Grant obtained her treaty status in 2003. Their mother, who now lives in a nursing home in British Columbia and who too was devastated by the news about her son Brian, also obtained her treaty status in earlier years. As far as Ms Grant knows, Brian Sinclair never put in an application for his treaty status.

[13] Ms Grant has lived in British Columbia for many years. In recent years, Brian and she lost touch. She was not aware, for instance, of her brother's amputation surgery in 2007. She was not aware that her brother was a Committee of the Public Trustee. She was horribly shocked to hear from her sister about Brian Sinclair's death. The day she found out about her brother's death was the actual day of his funeral. She was and still is overwhelmed and angry that her brother died in the way that he did. She told the Court that she would never forget what happened to him and, in her words, "My heart is scarred for life."

[14] Chaplain Ken McGhie knew Brian Sinclair since the late 1980s. At that time, Chaplain McGhie was responsible for a local shelter and soup kitchen. During his 14 year tenure there, he often encountered Brian and his brothers Russell and Bradley. He told the Court that Mr. Sinclair struggled with a solvent abuse issue. The Chaplain described the young Brian Sinclair as a very quiet person: not a troublemaker, a humble man, never angry and never one to raise his voice. He described Brian as a patient man who always waited his turn. He did find Brian Sinclair very hard to understand. He had to pay close attention when he was trying to converse with Mr. Sinclair.

[15] More recently, the Chaplain encountered Mr. Sinclair through his work at HSC. He was shocked to see that Mr. Sinclair's legs had been amputated. He later brought books for and visited a few times with Brian Sinclair at his home. He told the Court that he never saw Brian Sinclair intoxicated on those occasions. The Chaplain assumed from media reports after Mr. Sinclair's death that Brian Sinclair was homeless and that he had lost his accommodation by the time of his death. His poignant and creative recommendation was that the new wristbands that have been issued at HSC to all incoming emergency patients should be called a "Brian band".

[16] Detective Sergeant John O'Donovan of the Winnipeg Police Service told the Court about Brian Sinclair's very dated detentions from 1993 to 2002 under the *Intoxicated Persons Detention Act* (hereinafter referred to as "IPDA"). An IPDA

entry is kept when a person has been picked up by the police due to intoxication by a substance and brought to the ED. A person classified as IPDA is assessed by a physician, tagged with a wristband and held in the ED under the supervision of Security Services until released, usually to the Main Street Project, a local shelter. Brian Sinclair had never been brought to HSC ED on this kind of detention.

[17] There is no evidence the Brian Sinclair was under the influence of any volatile substance when he attended HSC ED on September 19th, 2008.

[18] It was repeatedly reported in the media, even as late as 2013, that Brian Sinclair was "homeless". It was even asserted by Mr. Zbogar, co-counsel for the Sinclair family, at an Inquest Standing Hearing before then Chief Judge Wyant on June 15th, 2009 (a full 18 months after the incident) that Brian Sinclair was a "homeless" person. Although various personnel at HSC ED also assumed he was homeless, nothing could have been further from the truth. Brian Sinclair lived in The Quest Inn, a WRHA-funded, assisted-care residence in downtown Winnipeg. The Quest Inn is a personal care home with nursing staff, ordinarily servicing short-term stays from remote communities for medical appointments in Winnipeg. The Quest Inn became Brian Sinclair's home.

[19] Brian Sinclair's WRHA "Integrated Support Worker" Mr. Darwin Ironstand painted a more recent picture of Brian Sinclair. Mr. Sinclair was, by Mr. Ironstand's account, relatively contented during the last year of his life. Mr. Ironstand spent a few hours a week with Mr. Sinclair, during the day, both at his room in the personal care home and out on the street for medical appointments, shopping, going for coffee and other regular activities. Mr. Sinclair chatted to Mr. Ironstand about articles from the newspaper or the T.V. news. Gestures were a part of his conversation. Although he was generally polite, Mr. Sinclair was not afraid to ask people to move aside because he was in a wheelchair. Mr. Ironstand described him as "not particularly passive".

[20] According to his Quest Inn Home Care workers, during the summer of 2008, on any given day, Mr. Sinclair typically left his apartment early in the morning in his wheelchair and travelled to the Siloam Mission, where he enjoyed doing volunteer work and socializing with friends and his two brothers. He always wanted to be back in time for supper at the Quest Inn.

[21] More than one witness described Brian Sinclair as fiercely independent. Yet, it is clear that services that were listed on the "home care services as provided" for Mr. Sinclair were not, in fact, provided as time went by. As one home care support

worker framed it, “He let every one of us know what he wanted to do for himself.” Home Care staff told the Court that he enjoyed looking after himself as much as he could. He very much enjoyed his times at the Siloam Mission. He enjoyed bringing occasional gifts of fruits and vegetables to Home Care staff. Home Care worker Clarissa Immaculata told the Court that Mr. Sinclair liked to do things for himself, but if he was feeling weak, she helped him with his transfers from the wheelchair to other places. Home Care attendant Sylvia Lone told the Court that Mr. Sinclair routinely shaved himself, cleaned himself, dressed himself, combed his hair and put clean clothes on. She added that on occasion at the Siloam Mission, he would literally give his shirt or jacket to someone in greater need than he. She thought that his lifestyle was changing – definitely, for the better.

[22] Yet, according to witnesses who formally assessed Mr. Sinclair, he did not fully appreciate his own vulnerability.

## BRIAN SINCLAIR’S MORE RECENT MEDICAL HISTORY

[23] The Court heard a great deal of evidence about the more recent medical care that Brian Sinclair had received on prior visits to the HSC ED. Brian Sinclair was no stranger to the HSC ED. He had been triaged and treated at the ED, admitted and released from HSC on many prior occasions. He could fairly be described as a frequent user of the ED. Nurse Laura Johnson explained that the term “frequent flyer” is used among ED staff to describe patients who frequent the ED for medical reasons or non-medical reasons (people seeking shelter, for instance). In fact, Brian Sinclair had benefited from an array of medical services in recent years prior to his death. From 2003 to 2008, Brian Sinclair attended the HSC on 31 occasions.

[24] In 2003, he visited HSC ED twice by ambulance for seizures. In 2005, he visited the ED on eight occasions: he was conveyed by ambulance seven times and once as a “walk-in” (that is, without the aid of medical personnel). Four of those occasions were as a result of a seizure, for a blunt-force trauma, for a minor facial trauma and for substance abuse. The “walk-in” was for suture removal. In 2006, he visited the ED five times, all via ambulance and all seizure-related. In 2007, he visited the ED seven times. He was conveyed five times by ambulance, once by a nurse from the Health Action Centre (a nearby clinic that I will mention later, hereinafter referred to as “HAC”) and once on his own without the aid of medical personnel. One visit was as a result of frostbite, two were for seizures, one was an abrasion to the head, one was a urinary complaint, and once with blurred vision and that was when he was conveyed in the company of a nurse from HAC. The last one was a walk-in for a head injury. In 2008, he attended the ED nine times: seven

times by ambulance and twice by wheelchair as a "walk-in". One was for facial laceration, one was for motor weakness, one was for chest pain, one was for back pain and five were for urinary tract complaints.

[25] On January 31st, 2007, Brian Sinclair was brought to the HSC ED by ambulance and admitted to hospital with hypothermia and with severe frostbite to both legs. He told the medical staff that he had been evicted from his rental accommodation about three days before. He had tried unsuccessfully to gain access to a church and collapsed. He was found, literally frozen to the wall of the church. As a result, he required a bilateral amputation of both legs above the knee. That surgery took place on February 4th, 2007. The evidence the Court heard from the WRHA team that managed Brian Sinclair's recovery from surgery, his rehabilitation and his transition to the Quest Inn established that Brian Sinclair was given excellent care by the WRHA team.

[26] Dr. Maria Araneda has worked at the Department of Internal Medicine at HSC since 2002. She treats patients who have what the doctor described as "sub-acute medical issues" which include end-of-life care, dementia and catastrophic illness. Her contact with Brian Sinclair began after his legs were amputated.

[27] During her testimony, she referred to the HSC "Integrated Progress Notes" which she described as a "working body" of a patient's medical chart. Entries consist of the medical team members' notes. The team included social workers, physiotherapists, psychiatrists, occupational therapists, nurses and Aboriginal resource workers.

[28] Matilda Patrick is one of those Aboriginal Resource Workers, employed at HSC since 2002 under the auspices of WRHA Aboriginal Health Services, acting as a communicator to and for Indigenous patients and as a liaison between the patients and service providers. Ms Patrick spoke to Brian Sinclair from very early on in his surgery-recovery process until his discharge from HSC. According to Ms Patrick, he was always awake and alert and her visits with him were about 10 to 15 minutes at a time. She described Mr. Sinclair as very soft-spoken. At times he was hard to hear, but she did understand him. They spoke in English. He told her of how he lost his limbs. She spoke with him about his medical predicament and his family. He was not extremely talkative. He was very concerned with housing in the early days of his recovery. She reassured him that it would be taken care of, because she knew other service providers were trying hard to find housing for him.

[29] Since 2007, Beverly Swan has been the WRHA Regional Discharge Planning Coordinator with Aboriginal Health Services at the HSC. She has worked in the health care field for 25 years. She is Ojibway and fluent in that language. She grew up on Lake Manitoba First Nation. In her work, she provides support for the Aboriginal population within the WRHA for complex discharge situations. She confirmed that Brian Sinclair did not have treaty status; in other words, he did not have access to service through non-insured benefits. He had coverage through other government programs and social agencies. She first met with him on April 20th, 2007. He was difficult to hear and understand, so she crouched down to get closer to him, but he got angry and hit her in the arm. She was able to calm him down. During her time with him, he initially told her he did not want to stay at the Quest Inn because he did not want to go back to an unhealthy lifestyle. He pointed to his legs and said "That is why I am like this." Ms Patrick and Ms Swan did not confer with each other about Brian Sinclair.

## BRIAN SINCLAIR WAS DECLARED A COMMITTEE (WARD) OF THE OFFICE OF THE PUBLIC TRUSTEE

[30] Unfortunately, while recovering from surgery, Brian Sinclair developed a bladder infection on February 16th, 2007. He was unable to urinate. A urinary catheter was inserted. Then on February 20th 2007, he was diagnosed with deep-vein thrombosis and needed to be treated with a powerful anti-coagulant. During the month of March of 2007, all attempts by medical staff to remove the urinary catheter failed: Mr. Sinclair was unable to void naturally. By late March of 2007, the urologist diagnosed Brian Sinclair's bladder as "hypotonic", which meant the bladder muscles were not working. From this point on, Brian Sinclair would need an indwelling Foley catheter to allow him to pass urine. Parenthetically, a Foley catheter is usually inserted by nurses, not physicians.

[31] During his recuperation from surgery, in recognition of his vulnerability and in anticipation of his discharge back to the community, the HSC team, which included his physician Dr. Araneda, a social worker, an occupational therapist and a psychiatrist, assessed Brian Sinclair to determine his competency.

[32] In her one-on-one dealings with Brian Sinclair, Dr. Araneda found him to be soft-spoken, not talkative, not amenable to open-ended questions, so in her words, she "focused down to yes and no questions" with him. He was very difficult to understand, due to "mumbling articulation". She concluded from her formal assessment of his demeanor and his behavior on the ward that he was "not obviously incompetent".

[33] Danielle Harling is an Occupational Therapist and as such, she looks at how people manage their daily activities in the home and in the community, including recreation and finances. Since 2006, she has worked in Acute Medicine at HSC. Her realm is safe patient discharge: how to ensure safety and supports when a patient reenters the community. She assesses how people manage personal care tasks like dressing, going to bed, bathing, meal preparation, chores and general cognition. She had contact with Brian Sinclair in February of 2007. She too was immediately concerned about Mr. Sinclair's vulnerability.

[34] She administered a screening tool to assess Mr. Sinclair's ability to perform everyday tasks. She did not have difficulty communicating with him and understanding his responses. Mr. Sinclair's score put him into the "partially independent" category. She assessed that **he was at risk of having difficulty with interpreting when a situation may be unsafe to him**: even something as basic as meal preparation. He struggled with the concept of financial management, shopping and transportation. His immediate recall was good, but **his delayed recall was very impaired**. He required support in some areas. For instance, he knew how to get home but he did not know his street address. He identified the wrong medications for times of day. He could not complete the basics of the financial management portion of the assessment. **He could not identify safety hazards**. The identified concerns for her were his difficulty with daily tasks that involved interpretation and his personal safety. In short, he was a vulnerable person.

[35] Her recommendations for Brian Sinclair in her report:

- home care to assist in tasks such as laundry and cleaning;
- home care to assist in administration of medication and reminders for medical appointments;
- "Meals on Wheels" for food;
- occupational therapy for life skills and community management; and
- a minimal number of appointments requiring access to transportation.

She offered the results of her assessment to the team as one piece of the puzzle.

[36] By the end of March of 2007, Dr. Araneda was also quite concerned that Brian Sinclair did not appreciate how vulnerable his urinary catheter made him. She tried to speak to him about risk-reducing behavior. She concluded he was vulnerable, but in her opinion competent. By "vulnerable" she meant that he was a fiercely independent man with limited insight into his functional capacity. Her concerns were borne out by the occupational therapist's assessment.

[37] Social Worker Leonard Koberstein worked with the HSC multidisciplinary team in an effort to plan for safe discharges into the community for patients on the sub-acute ward. From March of 2007 through to Brian Sinclair's discharge on May 2nd, 2007, Mr. Koberstein saw Mr. Sinclair almost daily. He told the Court that it was not easy to have conversations with Mr. Sinclair because he was difficult to understand: he would mumble a lot, he would not stay on topic, there were no straightforward answers, he would not follow through on requests and sometimes the conversations did not really go anywhere. He agreed with Sinclair family counsel that Brian Sinclair was quiet, not one to initiate conversation and generally passive. Family contacts were Mr. Sinclair's brother Bradley through the Salvation Army Booth Centre housing facility and his brother Russell at Main Street Project shelter. It was noted in Mr. Koberstein's file that Brian Sinclair's mother and sisters lived in Vancouver, but Brian Sinclair was not in contact with them.

[38] Mr. Koberstein was trying to find wheelchair-accessible housing for Brian Sinclair. It was a challenge to find appropriate housing for an Aboriginal man with complex medical needs, a strong desire for independence, occasional aggression towards caregivers and very low income. In early 2007, several housing options were explored and denied. Finally, Employment and Income Assistance (hereinafter referred to as "EIA") workers approved funding for the Quest Inn. The Quest Inn was quite costly in relation to other accommodation. The stay at the Quest Inn was presumed to be temporary. In fact, the first approval was for three months.

[39] Mr. Koberstein also wrote to the Chief Provincial Psychiatrist outlining Brian Sinclair's background and assessment. He described Mr. Sinclair as "a simple, vulnerable person requiring support upon discharge". If Brian Sinclair were to return to independent living, he would benefit from a support worker, as it was felt by the team that Mr. Sinclair would have difficulty following through with plans, such as booking transportation for medical appointments. In fact, a psychiatric evaluation of Mr. Sinclair in March of 2007 concluded that Brian Sinclair was **not** competent to make medical decisions for himself, manage his own finances or his own disposition (discharge) plans.

[40] Dr. Araneda did not want Brian Sinclair to go to a nursing home and preferred not to "panel" him for placement in such a facility, because she did not wish to take away his fierce independence. She recognized how much he valued his independence. She observed and heard Mr. Sinclair express that desire for independence and she wanted a plan in place that would support his desire as much as practically possible. During cross-examination, Dr. Araneda stressed that the team's goal was to match clients' social circumstances to their convalescent care. She confirmed that she has treated many Indigenous people. She and the health care team took into account Brian Sinclair's vulnerability and tried not to ignore his needs by providing him with individualized care. He required and was given, in her words, "more robust care". She wanted a proctor for tasks such as transportation, medical appointments, overseeing bloodwork, monitoring blood thinner. She outlined the number of challenges she faced to obtain a place for Mr. Sinclair at the Quest Inn, which was much more expensive than the regular accommodation. She wanted very much to meet his complex needs.

[41] The team concluded that the Office of the Public Trustee ought to get involved to manage Mr. Sinclair's affairs, since that would definitely be in Brian Sinclair's best interests. For instance, the powerful blood thinner that he now required meant constant monitoring. Given that he could not properly interpret what was on a medicine vial and could not monitor his own medication, the team concluded that Mr. Sinclair really did not understand the implications of being on a blood thinner. A support worker would definitely be assigned to help Brian Sinclair with everyday tasks, such as booking medical appointments, helping him with public transportation and so on. To that end, Dr. Araneda completed a "Certificate of Incapacity" form, pursuant to Provincial mental health legislation. She described Mr. Sinclair as: "An unfortunate 43-year-old man who had the misfortune of losing both of his legs. He is a simple man who **does not appreciate the degree of his disability and dependence** and he would not allow help and would lack the capacity to arrange, organize for his care needs." (Emphasis mine.) Meanwhile, the social worker wrote a letter to EIA outlining that Mr. Sinclair would require the "Health Coordination Project", a care program which would make him eligible for assisted living.

[42] Keri Lynn Ranson is the Deputy Public Trustee. The Office of the Public Trustee provides services to Manitobans who have been declared mentally incompetent or are vulnerable persons. In effect, the office takes care of the person and their property. In her words, they are an office of last resort. Brian Sinclair's Order of Committeeship was pronounced on April 7th, 2007. A certified copy was provided to Brian Sinclair, and a copy was provided to his brother Bradley. On

May 24th, 2007, the Office of the Public Trustee wrote to the Director of the Mental Health Program at WRHA delegating to the WRHA the responsibility to provide personal supervision to Brian Lloyd Sinclair. Ms Ranson explained that the WRHA became the Public Trustee's "eyes and ears".

[43] Here is what was delegated to the WRHA:

- identification and facilitation of an appropriate residence for the client;
- identification and facilitation of appropriate day services;
- facilitation of the provision of regular mental and dental care;
- facilitation of the planning of leisure time for the person;
- coordination of the provision of individual support services; and
- communication with the person's family members.

[44] Here is what was not delegated as WRHA authority:

- financial affairs;
- legal affairs;
- consent to psychiatric or medical treatment;
- consent to release contents of confidential files or criminal records; and
- decisions affecting the client's human rights.

[45] The letter of delegation outlined that in all cases, the delegate of the Regional Health Authority (hereinafter referred to as "RHA") will report "as soon as reasonably possible" the hospitalization of a client, the death of a client or client's family member, the move from one residence to another, any legal claim of entitlement or any criminal charges.

[46] The Office of the Public Trustee made the formal application to EIA on Brian Sinclair's behalf.

[47] Ms Ransom made it clear to the Court that the Public Trustee's office does not always get contacted when one of their clients visits a hospital ED. The Office of the Public Trustee is most often contacted well after the fact. After Brian Sinclair became a Committee, he had a number of hospital visits. The Public Trustee does not expect a call each time a Committee goes to the hospital. A call from the hospital would occur if a patient cannot consent to treatment. If a doctor is satisfied with the level of capacity of a patient, even if that patient is a Ward of the Public Trustee, the Public Trustee will probably not be consulted.

*I therefore recommend:*

*1. That the Office of Public Trustee and the RHAs review their policies and procedures to ensure the primary care giver and service providers of any Committee of the Public Trustee are made aware of the Committeeship.*

[48] By April 18th, 2007, Brian Sinclair's prognosis was improving and he was being weaned off painkilling narcotics. The Home Care discharge plan was taking shape. Home Care was advised by a note from the hospital team that the indwelling Foley catheter needed to be irrigated or flushed as needed, and changed monthly or as needed. In other words, if the catheter needed to be changed after a few days, so be it. Upon discharge, there was to be a referral for occupational therapy, physiotherapy and bloodwork to be taken every two weeks. Prior to Mr. Sinclair's discharge, Dr. Araneda consulted with Diane Kubas, who was the Home Care Case Coordinator in the community.

[49] The day before she retired, Diane Kubas testified at this inquest. A social worker by profession, she had been a Home Care Case Coordinator with the WRHA for 22 years. Since 2006, she had worked with their Home Care and Mental Health Specialized Services Program. Ms Kubas was the intermediary between the doctors (and specialists) and Brian Sinclair. In March of 2007, she received an e-mail from the discharge planner at the hospital for a "problem" discharge. This was a common occurrence: her team met weekly to review these types of referrals. The referral was Brian Sinclair. She reviewed his chart on April 3rd, 2007. Brian Sinclair had been the recipient of home care services since April of 2004. She duly noted the latest assessment about his lack of insight and competence to make medical decisions, manage finances or disposition plans.

[50] In July of 2007, Ms Kubas put together a proposal for permanent accommodation for Mr. Sinclair through an agency which specialized in trying to find foster homes for vulnerable persons requiring 24-hour supervision in their

home. It was hard to find a home where Brian Sinclair would be both managed and happy. This type of accommodation was found and confirmed, but unfortunately Brian Sinclair refused to move on the day he was to move (September 6th, 2007), despite the fact that the agents had met with him many times and showed him the apartment. He was aggressive with the agency representative and made it clear that his brothers had advised him to move into the "North End" of the city and that he had no desire to live with "a white man". The following day, Mr. Sinclair was again aggressive with a caregiver.

## BRIAN SINCLAIR IS MOVED TO THE QUEST INN

[51] Ms Kubas was aware that Brian Sinclair was a Ward of the Public Trustee. His care plan was individualized. With the assistance of the HSC social worker Mr. Koberstein, Ms Kubas was able to secure accommodation for Brian Sinclair at the Quest Inn. She made a request of her team manager to order a fully-electronic, hospital bed because the need for such a bed, in Mr. Sinclair's case, was permanent. It had bedside rails and a specialized mattress. She also arranged for a commode. A direct service representative was to administer Mr. Sinclair's medication daily.

[52] Ms Kubas prepared a care plan for Brian Sinclair in August of 2007. Mandated services included a health care attendant visit three times a day, an integrated support worker visit twice a week, an assigned worker to do laundry once a week and a registered nurse visit every other week. She needed approval for an "over cost" from her manager, because Mr. Sinclair's monthly expenses were over the allowed budget - by $3,864.63. His total monthly expenses were $5,316.63, including his personal allowance of $258.

[53] Back in May of 2007, Ms Kubas had made a request for an integrated support worker to work with Mr. Sinclair in order to assist Mr. Sinclair in his day-to-day living. It took a few months, but eventually Darwin Ironstand was hired. He assisted Brian Sinclair from September of 2007 to July of 2008. Mr. Ironstand is a Health Care Aide currently employed at Valley River First Nation with the Dakota Ojibway Tribal Counsel Health Services, in the area of suicide prevention. Prior to that, he was the Coordinator of Residential Services for vulnerable adult males at Life's Journey, an agency that cares for FASD-affected clients.

[54] Mr. Ironstand worked with a number of other vulnerable clients during the time he assisted Brian Sinclair. He described himself not so much a chaperone as a support. He worked once a week for a few hours with Brian Sinclair at the Quest

Inn. He helped with Mr. Sinclair's hygiene, sometimes washing his hair and his hands, helping him get dressed but he was very careful not to take away what Brian Sinclair wanted most of all, which was his independence. He had the combination to Mr. Sinclair's medical lockbox that contained his medications. He helped Mr. Sinclair drain his catheter bag. Mr. Sinclair was missing appointments: he was not around when the nurses arrived to examine or change his catheter. He reminded Mr. Sinclair to wait around so the nurse could take care of him. At the beginning, Mr. Sinclair was out and around before Mr. Ironstand arrived at 8:00 a.m., so Mr. Ironstand changed his schedule so he could help Mr. Sinclair.

[55] Mr. Ironstand told the Court that the two of them often went out, because Mr. Sinclair had too much money in his account and he needed to spend some of it on things like haircuts, toiletries and coffee. Diane Kubas confirmed that Brian Sinclair's personal funds tended to accumulate. A trust account was set up at the Quest Inn. If any client had more than $4000 in their personal account, the EIA would claw back any excess, so often the client would be contacted to see what they wanted to spend the excess money on.

[56] In fact, at the time of his death, Brian Sinclair had over $4,600 in his account.

[57] After discussion with her team, Ms Kubas requested a further occupational therapy "behavioural mapping" assessment, partly because Brian Sinclair had a history of hitting out at caregivers but mainly because of his needing assistance for the activities of daily living. The referral documentation noted Brian Sinclair's difficulty with community living skills, a history of poor judgment, poor financial management and referred to his having a history of striking out when questioned about sniffing or alcohol abuse or when staff performed personal care tasks he did not want. Ms Kubas requested the referral to the Easy Street Rehabilitation Program at the Misericordia Hospital in July of 2007 for a post-rehabilitation program, in order for Brian Sinclair to receive speech therapy and occupational therapy. Mr. Ironstand recalled accompanying Brian Sinclair to Easy Street.

[58] The Court heard evidence from two occupational therapists from Easy Street who worked with Brian Sinclair. Kathryn Harrison explained that her work at Easy Street was to help reintegrate clients to the community and to promote independence in those individuals who had experienced "a life-impacting" change. She assessed Brian Sinclair at Easy Street in an effort to focus on helping him with his daily living activities and building on his independent skills. She concluded that Mr. Sinclair was **cognitively impaired**. He was very difficult to understand.

His speech was very low in volume, he mumbled and his sparse responses were quite limited. She attempted to discuss short and long-term goals with Mr. Sinclair, but that was difficult. He seemed to have some memory difficulties. She described him as a happy, cooperative, quiet-spoken person who seemed interested, but unable to voice any goals of his own: it was hard to tell if he really understood why he was there.

[59] Jodi Bachmier has her Master's degree in Speech Language Pathology and has worked in the area for 21 years. She worked at Easy Street with Brian Sinclair in the early months of 2008 to try and help him communicate better. Her first consultation with Brian Sinclair was on January 24th, 2008. She noted that Mr. Sinclair recalled recent events of the day. Even though it is not in her notes, she told the Court that she diagnosed dysarthria, a motor speech disorder which significantly affected his ability to communicate. For instance, he left off consonants which decreased his intelligibility. It was difficult to understand him. More importantly, he did not seem to understand that people were having difficulty understanding him. He wanted things repeated and had difficulty with time and memory. He had difficulty reading. He had no precise articulation. He would drop consonants and mix up sounds. He spoke at a very low volume. Her conclusion was that both his speech and his understanding were impaired. His communication skills were assessed as "significantly impaired". She tried having him use a "Chattervox" which amplified his voice. The device included a headpiece with a microphone and an amplifier in a box which attached to the waist. However, the amplification device did not improve the quality of his speech. The amplification box was an easy and effective option, if it was used.

[60] Meanwhile, Ms Harrison's second meeting with Brian Sinclair was in early December of 2007 and he was accompanied by Mr. Ironstand, who was very helpful. They were using the ChatterVox. The three of them were trying to discuss nutritional concerns. She observed that Brain Sinclair seemed to have deteriorated physically. She tried to complete a social assessment, but she felt that Mr. Sinclair's responses were neither coherent nor connected to her questions. She very much doubted whether Brian Sinclair could take advantage of talk therapy because of his cognitive impairment. However, she was pleased that he was able to use and enjoy the amplification device.

[61] Ms Bachmier's second consult with Brian Sinclair was February 25th, 2008. She attempted to formally assess Mr. Sinclair. Although he was cooperative and pleasant, he was confused about the assigned tasks. He did not want to practice any task, nor did he want any treatment. Her third consult with Mr. Sinclair was in

March of 2008 to discuss the use of the amplification device. She recommended that Mr. Sinclair have his hearing tested. No further meetings were scheduled. The team at Easy Street concluded that Mr. Sinclair was not an appropriate client for the program. He was formally discharged from their program by a letter dated April 30th, 2008.

[62] Diane Kubas also told the Court about the communication challenge that Brian Sinclair faced. She observed that he spoke quietly and rapidly. He mumbled and did not complete all his words. One needed to listen carefully. Similarly, Mr. Ironstand told the Court that communication with Mr. Sinclair was at first very challenging. He had to ask Mr. Sinclair a number of times to repeat himself and he really had to listen because there was a lot of murmuring or mumbling. Mr. Sinclair was generally quiet, but he could be boisterous. Mr. Sinclair was usually happy to see him and in a good mood. Mr. Ironstand confirmed that he helped Mr. Sinclair with his ChatterVox: "I made sure he used it and I helped him switch it on because he did like it." Mr. Ironstand was not sure if Brian Sinclair knew people found him hard to hear. He was shy about the headpiece. Mr. Ironstand told the Court that he accompanied Mr. Sinclair a couple of times to the HAC and Mr. Sinclair wore the headpiece. Mr. Ironstand did not really want Brian Sinclair to travel to the Siloam Mission with the headpiece on, in case it got stolen.

[63] Mr. Ironstand personally never witnessed Brian Sinclair under the influence of any volatile substance. He was aware that Mr. Sinclair had hit his former aide. Mr. Ironstand is a tall, stocky man; it was not altogether surprising that Brian Sinclair did not act out physically in his presence. The only aggression from Mr. Sinclair that Mr. Ironstand ever observed was verbal. Mr. Sinclair sometimes got mad about noise in the hall or about people being intoxicated. Mr. Ironstand thought of Mr. Sinclair as a friend. He saw him as physically disabled, but not mentally incompetent. He felt that Brian Sinclair was able to learn and able to follow directions. For instance, Mr. Sinclair was able to show Mr. Ironstand his medical appointment reminder cards.

[64] In October of 2007, Home Care was concerned that Brian Sinclair may be sniffing again: he had punched a worker. Also around that time, he was violently attacked. He was hit over the head with paving blocks. Fortunately, the assailant was caught. Ms Kubas accompanied Brian Sinclair to Court in April of 2008. His attacker entered a guilty plea and Brian Sinclair did not have to testify.

[65] The Court heard from WRHA Home Care workers who looked after Brian Sinclair during his stay at the Quest Inn. Each of them wanted the Court to know

about the warm relationship that they developed with Mr. Sinclair. Each of them was visibly upset to describe losing Mr. Sinclair. Each of them outlined that as time went on, Mr. Sinclair wanted to try to take care of himself to a greater extent, in areas such as dressing and washing himself and for the most part, they let him.

[66] Clarissa Immaculata is a Home Care worker employed at the Quest Inn. Brian Sinclair was not specifically her client. She took care of him about once a week. In fact, she told the Court that on September 18th, 2008, she spent 15 minutes with Brian Sinclair, caring for him as part of her evening duty, making sure he took his medications and checking to see if she needed to empty his urine bag. He told her that he had some pain and pointed to his abdomen, but he said that he would wait until the morning to have it checked out. She was aware that he often had urine infections.

[67] She was one of a number of caregivers to Brian Sinclair who told the Court that when she first encountered him, she could not understand his mumbling. However, after he was attacked in 2007, he spoke much better. She never witnessed substance abuse. He told her he was happy to volunteer at the Mission and he offered her tomatoes that he received from the Mission. She had no issues with him: he was an independent guy. To her observation, he was always clean in the mornings when she saw him. "Not that pleasant", as she put it, by the time he came home. He ordinarily came back for supper.

[68] Esther Oyes is a certified Home Care worker and Health Care Aide. She has 8 to 10 clients or more at any one time. She empties urine bags for catheter patients such as Mr. Sinclair. It is clear that she provided services for Mr. Sinclair on September 14th and 15th, 2008, but those services were "cancelled" on September 16th and 17th, 2008. Services would be cancelled if Mr. Sinclair had gone to the hospital or he was not on the premises. She would let her supervisor know. She thought Brian Sinclair was a very nice client and had no difficulty with him. He only swore at her when she asked him to repeat things. He gave her fruits and vegetables that he got from the Mission. He was not very demanding: he was independent and tried to do everything himself. This included washing himself. The only time they washed him was when he first got there, because he was very weak. When she first met him, he was difficult to understand. She too said that she was better able to understand him after he was assaulted.

[69] Robert Cox has been a Home Care Attendant since 2003. He provided laundry and bathing services for Brian Sinclair on a weekly basis. His last bath as noted was September 8th, 2008. His last laundry was September 16th, 2008. His

bath on September 15th, 2008 was recorded in his notes as "C" for cancelled. Mr. Cox described Mr. Sinclair's initial form of communication as stammering and muttering: he was hard to understand. Yet Mr. Cox too said that after Mr. Sinclair was the victim of a bad assault, he became much easier to understand. Mr. Sinclair had shared with him how lucky he felt. Mr. Sinclair also told him that he was monitoring the door at Siloam Mission and was very proud of that job.

[70] The media portrayal of Brian Sinclair as homeless really upset Mr. Cox, because, as he said, "I knew the truth. He had a home and people looked after him."

[71] Ms Kubas explained that she had a caseload of 20 to 25 high-risk clients with cognitive or functional deficits. In Brian Sinclair's case, she was trying to preserve as much independence for him as possible and balancing that with his complex needs. At the beginning she saw him often, but by the summer of 2008, it was only every few weeks, because she felt he needed less care. She was aware he had deep feelings for his brothers but she concluded that he had no idea where his sisters and mother were living, other than in British Columbia.

[72] Ms Kubas outlined that Mr. Ironstand resigned before Brian Sinclair and he could find alternate housing. She agreed that it is very difficult to find accommodation for disabled people, mentally challenged people and substance-addicted people. In answer to the question of whether there is Aboriginal-specific housing, she replied that Mr. Sinclair needed specialized healthcare. His needs exceeded the capacity of otherwise available, Aboriginal-specific housing.

[73] Ms Kubas firmly believed that by 2008, Brian Sinclair was happy, relatively free and cared for. To describe Brian Sinclair as "homeless" was not accurate at all and to all of his caregivers, very disturbing to hear. She had a real relationship with him. He knew her and they had a number of discussions. She was aware that he was volunteering at the Mission and that he had empathy for unjustly treated individuals. She felt he had untapped potential. By January of 2008, she was comfortable with his attending his medical appointments by himself. This was one medical decision that he could handle.

[74] This can be contrasted with the assessment of Mr. Sinclair as a "high risk" in his HSC discharge care plan of early 2008, which outlined "a greater risk of negative outcomes if services were interrupted or withdrawn" and "cognitive impairment". Ms Kubas agreed that in a letter to Income Assistance dated June 16, 2008, Ms Kubas described Brian Sinclair as "medically very fragile". She

explained that when he was not feeling well, his coping skills were worse. Ms. Kubas agreed that his need for other people to make medical decisions for him continued until his death. Her care plan for him for 2008 bore that out. In short, she agreed that Mr. Sinclair was still a very vulnerable person in 2008.

[75] Ms Kubas listed Brian Sinclair's care plan requirements:

1) he was dependent on healthcare since he had no home supports;

2) meals had to be provided;

3) medications had to be provided;

4) laundry had to be done;

5) **he needed to be accompanied for appointments;**

6) **he needed to be transported to various facilities;**

7) **he needed an integrated support worker; and**

8) **he needed nursing services for catheter change and biweekly visits for drainage and skin care and supervision.** (Emphasis mine)

[76] Ms Kubas framed the events of the summer of 2008 as Brian Sinclair not wanting to take the time to get his catheter taken care of and preferring to do his own routine while also attaining a little bit more independence through the care plan.

## BRIAN SINCLAIR'S HEALTH SCIENCES CENTRE HOSPITALIZATIONS IN 2007-2008

[77] Linda Davidson is employed by the WRHA as a "Hospital-Based Case Coordinator" at HSC. She helps patients transition into the community to ensure appropriate care, support and resources: this is an interdisciplinary process. She assesses care plans for patient discharge from HSC and provides information to the community case coordinators, which in Brian Sinclair's case was Ms Kubas. She told the Court that she believed solvent abuse was taken into consideration in Brian Sinclair's care plans. She did not formulate the initial plan. Ms Davidson outlined to the Court some of Brian Sinclair's hospital stays during 2007-2008.

[78] It is clear that although Brian Sinclair maintained a positive outlook during this time, he still faced numerous, chronic struggles.

[79] Late in 2007, Mr. Sinclair was admitted to HSC as a result of an overdose of dilantin, his anti-seizure medication. In her summary of his admission to HSC, Ms Davidson noted that his cognitive and problem-solving abilities had declined since the time of his last discharge. He was admitted February 26th, 2008 to HSC ED because his catheter balloon was inflated in his urethra rather than his bladder, so the catheter was changed. He was transported by Emergency Services (in other words, by ambulance), so he did not have his wheelchair when he arrived in the hospital, so arrangements had to be made for a stretcher service. He stayed an extra night in hospital until the stretcher service was approved by EIA. The Discharge Fact Sheet from July 24th, 2008 outlined a stay at HSC ED on July 17th and 18th, 2008. Mr. Sinclair had admitted that he had been sniffing glue. The diagnosis was "metabolic acidosis, secondary to lacquer-sniffing". On September 2nd, 2008, when Brian Sinclair was admitted to HSC ED because of his leaking catheter, he was again brought in by ambulance, assisted by paramedics.

## HOW DID BRIAN SINCLAIR DIE?

[80] Dr. Travis Minish has been an Emergency Physician since 2003 and has been working fulltime at the HSC Adult ED since 2005. He was on duty September 21st, 2008 in the early morning hours. A Code Blue was called for the "Resus team to the Resus Room": in other words, the assigned nurses, respiratory therapist and emergency physician were to proceed immediately to the Resuscitation Room. When Dr. Minish arrived, a security guard and a nurse were laying Brian Sinclair on a stretcher. Mr. Sinclair had no pulse. He was not breathing. The doctor tried to insert an instrument into Brian Sinclair's mouth to get a tube into his trachea for intubation, but Mr. Sinclair's jaw was clenched closed and the doctor could not open it. Chest compressions were initiated. The resuscitation attempt lasted 90 seconds. His torso was "cool to the touch". Dr. Minish concluded that Mr. Sinclair had been dead for a long period of time: "at least hours". Rigor mortis had set in. He could not estimate the time of death. At 12:51 a.m., the doctor pronounced Mr. Sinclair dead. The doctor diagnosed cardiac arrest. He undressed Brian Sinclair and saw purple discoloration on his buttocks – lividity - the pooling and coagulation of blood as a result of the passage of time in someone deceased.

[81] Dr. Minish's told the Court that in his opinion, rigor mortis starts to set in approximately three hours after death, but that is a rough estimate, since it is not

his area of expertise. This was a sudden, unknown cause of death, so he notified the Chief Medical Examiner. He wanted an autopsy, because he did not know why Mr. Sinclair had died. Dr. Minish does not remember who found the HAC letter from Dr. Waters in Mr. Sinclair's possession, but he read it at the time. Letters of this nature are not uncommon.

[82] Dr. Thambirajah Balachandra is the Chief Medical Examiner (CME) for the Province of Manitoba. The CME is in charge of implementing *The Fatality Inquiries Act*. Dr. Balachandra ordered that an autopsy be performed at a different hospital than HSC because, as Dr. Balachandra put it, "We knew something was wrong with the way the patient was handled at HSC."

[83] Dr. John Younes is a Forensic Pathologist. He performed the autopsy on Brian Sinclair at the St. Boniface General Hospital. He is now the Deputy Chief Medical Examiner. His Preliminary Autopsy Report was dated September 22nd, 2008. Dr. Younes diagnosed severe acute cystitis, which is an infection of the bladder severe enough to be accompanied by obvious, thick pus. Fully half a litre of pus was found in Brian Sinclair's abdominal cavity. The abdominal cavity lining and the external lining of the bowel were an "angry" red, which meant they were engorged with blood. His bladder was almost empty and contained 50 cubic centimeters of very thick pus. It appeared that the remainder of urine had escaped from the bladder into the abdominal cavity. On the floor of the pubic region was thick, frank pus which indicated that infection had been present for some time. Since the bladder is in close proximity to the peritoneal cavity floor, the infection in the bladder spread to the peritoneal cavity, causing an infection: acute peritonitis. Acute peritonitis is an inflammation of the abdominal cavity and is life-threatening. It requires immediate treatment.

[84] Brian Sinclair had a neurogenic bladder. As Dr. Younes explained, a neurogenic bladder is a dysfunctional, nerve-damaged bladder, prone to infection. Nerve damage can be caused by trauma, injury, surgery, drugs or disease. Lack of neurological control can result in a chronically distended bladder, full of stagnant urine, leading to infections in the bladder and even in the kidneys. In this case, urine was stagnant. It was not voided.

[85] Dr. Younes described the catheter used by Brian Sinclair. The smaller end of the catheter travels through the urethra into the bladder and a balloon at the tip of the catheter is then inflated with a saline solution to secure it in the bladder. The other end drains from the urethra into a collection bag. Brian Sinclair's collection

bag was empty. The bulb was still in his bladder, but the openings were plugged with dead tissue and pus. The catheter definitely required replacement.

[86] Dr. Younes sent specimens for a toxicological examination of Mr. Sinclair's body. There was no evidence of alcohol or solvents in Brian Sinclair's system. Urea and creatinine readings were significantly elevated, indicating a degree of renal impairment. However, the doctor could not say if the impairment was chronic or recent. Electrolyte levels, drawn from the vitreous humour in the eye, were normal, which meant that Brian Sinclair was not dehydrated. On cross-examination, Dr. Younes agreed that Brian Sinclair had a history of kidney failure and that his kidneys were not functioning at the time of death, but he could not say if it was a chronic condition.

[87] Dr. Younes also diagnosed a diffused degeneration of the white matter in the brain, meaning that connections between various parts of the brain had degenerated, which is characteristic of chronic inhalant abuse. He incorporated this finding, "chronic solvent abuse", into his final autopsy report November 12th, 2008 as a contributing cause of death.

[88] In the opinion of the CME Dr. Balachandra, the immediate cause of death was acute peritonitis. The peritonitis was a consequence of severe acute cystitis or inflammation of the bladder. The bladder was inflamed as a consequence of it being neurogenic. Other significant underlying conditions contributing, but not causally related to the death, or what the CME referred to as co-morbidities, were narrowed heart arteries (arthrosclerotic coronary heart disease) and damage to the nervous system due to chronic solvent abuse. In fact, Dr. Younes opined that Mr. Sinclair's left anterior descending coronary artery was almost completely occluded and could have predisposed him to heart arrhythmia and sudden death.

[89] Dr. Younes testified that chronic solvent abuse causes neurological damage. Dr. Balachandra explained that these co-morbidities prevented Mr. Sinclair from "fighting harder" to stay alive. He stressed that Mr. Sinclair was not at the ED as a result of either of those issues. As I have stated, there is no evidence Brian Sinclair was intoxicated or under the influence of solvents.

[90] Infections entering the bloodstream require immediate intervention. Brian Sinclair's catheter was blocked well before he even attended the HAC, so it is difficult to determine when the period of deterioration began. Most likely what happened, according to Dr. Younes, was that the catheter was blocked, urine was retained, infectious organisms multiplied invading the bladder wall, causing

inflammation and pus, which spread throughout the bladder and even outside the bladder. Pus formed to fight the infection. There was no rupture seen, but pus was found in the bladder. Infection then spread to the bowel walls. The infection entered the bloodstream, which put Mr. Sinclair into septic shock and functionally immobilized him. His blood pressure would drop precipitously. As the infection continued to spread, sepsis, which is the infection of the whole body through the bloodstream, resulted in his death. This was a gradual process.

[91] As was previously stated, by the time Brian Sinclair's death was pronounced, rigor mortis had set in. He was pronounced dead at 12:51 a.m. on September 21st, 2008. The CME explained that time lengths for rigor mortis are approximate, but it takes about 12 hours to fully set in and remains as such for longer. If there is a fever or a seizure, rigor mortis sets in faster. Dr. Younes opined that rigor mortis under normal conditions results in the fingers and jaws stiffening within a couple of hours of death, 8 to 12 hours for larger muscle groups. It can change with temperature, muscle mass or physical activity. The time of death is very imprecise. If Brian Sinclair's body temperature could have been taken at the time death was pronounced, the CME may have been able to give a better estimate of the time of death.

[92] The CME confirmed that Brian Sinclair had been dead in his wheelchair in the HSC ED waiting room for a few hours before he was pronounced dead.

[93] The CME agreed that Mr. Sinclair's vital signs were fine when he was assessed at HAC on September 19th, 2008. He probably went into shock sometime after he vomited on September 20th, 2008. The CME testified that vomiting could be and likely was a result of infection. The clear vomit could be a sign of infection or the body going into shock. The CME explained that Mr. Sinclair would neither be able to talk or move after a certain point. Dr. Younes verified that Mr. Sinclair would have experienced abdominal pain as a result of acute peritonitis. Fever was likely. In septic shock, the blood pressure drops precipitously because of bacteria in the bloodstream. Bloodflow to the organs decreases, with serious consequences for all the major organs, resulting in loss of consciousness.

[94] It was impossible for either doctor to provide a time line as to when Brian Sinclair actually passed away.

[95] The CME opined that for Brian Sinclair's initial medical issue of a blocked and possibly infected catheter, treatment in this context would be relatively straightforward. It might include the removal of the catheter, the taking of urine

samples and blood tests, the measuring of blood pressure and pulse, hydration if called for and the flushing of the bladder if necessary.

[96] Dr. Balachandra is of the firm opinion that Brian Sinclair's medical issues were treatable and his death was preventable, had he been treated at HSC ED. Brian Sinclair's complaint at the HAC was that he was not passing urine and his bag was empty, so in the opinion of the CME, Brian Sinclair needed a new catheter tube and antibiotics. If the catheter had been changed and antibiotics administered, he likely could have survived, had he been treated within a reasonable time of presentation. A bladder infection like this is an emergency, but is treatable. The CME estimated that treatment time would have taken approximately half an hour to an hour.

[97] The Foley catheter is an in-dwelling tube that drains urine from the bladder and it has to be cared for, maintained and/or changed on a regular basis. This catheter was plugged by pus and tissue debris, caused by deterioration of the inside of the bladder wall.

[98] The CME classified the manner of death as "death by natural causes". As the doctor explained, "natural" in this context does not mean "inevitable" or "unpreventable", nor does it necessarily mean that appropriate care was given. In his closing submission, co-counsel for the family Mr. Zbogar urged the Court to classify the manner of death as a homicide. This was somewhat surprising, since no questions were put to the CME by counsel for the family on the issue of Mr. Sinclair's manner of death. I am not persuaded that Mr. Sinclair's manner of death was a homicide, nor would I consider altering the CME's expert conclusion.

[99] Dr. Younes concluded that the cause of death was due to a neurogenic bladder. He too consulted an expert. Dr. Marc Del Bigio is a neuropathologist, a medical specialist concerned with the diagnosis of diseases of the brain, spinal cord, nerves and muscles. His examinations rely on microscopic analysis of tissues. Dr. Younes sent the preserved brain and spinal cord of Brian Sinclair to Dr. Del Bigio for examination and expert opinion. That examination took place October 15th, 2008. Dr. Del Bigio has completed research in the area of brain damage caused by solvent abuse. The active chemical in solvents is toluene which can cause permanent brain damage. The circumstances of Brian Sinclair's death are not related to solvent abuse but in Dr. Del Bigio's opinion, Brian Sinclair's bladder was damaged because his brain and spinal cord were damaged by solvent abuse.

[100] He discussed in detail Brian Sinclair's medical history through the 1980s and his presentations at HSC as "tremulous". In 2005, an anti-epileptic medication was prescribed for seizures. A July, 2005 CT scan showed diffuse cerebral atrophy, which indicates that his brain was shrunken all over, which resulted in motor and cognitive dysfunction.

[101] Dr. Del Bigio explained to the Court that the motor control part of Mr. Sinclair's brain was more dysfunctional than the cognitive, thinking part of his brain. However, when admitted to the HSC in April of 2006 for a seizure, Brian Sinclair was documented to have "resting tremor", which meant that he shook at rest and his body was somewhat rigid. He also was documented to "confabulate", which meant that he was filling in gaps in his memories. All of this indicated to Dr. Del Bigio a fairly wide range of brain dysfunction. By April of 2006, Brian Sinclair's CT scan showed diffuse, moderate atrophy with "ischemic" changes; in other words, brain degeneration more likely seen in a much older person. Dr. Del Bigio concluded that the brain dysfunction as shown by this examination was toluene-related; in other words, as a result of solvent abuse.

[102] In October of 2007, when Mr. Sinclair was admitted to HSC for a seizure, he demonstrated resting tremor and was disoriented to time and year. Dr. Del Bigio concluded that this was a worsening of his condition. The doctor agreed that by 2007, there had been a progressive decline which is shown by his disorientation to time and year as opposed to his earlier being alert and oriented. A 2008 CT scan again showed brain atrophy. Dr. Del Bigio's examination of Mr. Sinclair's brain and spinal cord revealed severe brain damage that the doctor concluded had existed for many years prior to his death. It is likely that Mr. Sinclair continued to have that brain dysfunction. Dr. Del Bigio agreed that by the time of Brian Sinclair's arrival at HSC ED on September 19th, 2008, Mr. Sinclair's documented dysfunctional memory processes would likely not have improved. Although he agreed it is dangerous to generalize on cognitive function due to solvent abuse, he firmly concluded that Brian Sinclair had clearly documented cognitive problems. The doctor agreed that nothing in these reports documented chronic alcohol abuse after the early 1980s.

[103] When he examined Brian Sinclair's brain, Dr. Del Bigio concluded that one of his neuropathological diagnoses was "axonal injury". The axon is the "wire" between two nerve cells. If the axon is stripped of myelin, which is an insulation-like covering, the axon can degenerate. The doctor explained in the most basic way he could that the "wiring" of Brian Sinclair's brain was still present, but the "insulation" was no longer present, due to solvent abuse. Therefore, his brain was

not functioning properly. The doctor found toluene-related damage in many parts of the brain. Mr. Sinclair's entire brain was shrunken: not just a specific area that might be caused, for example, by a stroke or a head injury or a brain tumor. Brian Sinclair's various CT scans through the years documented the same brain damage. The white matter degeneration in his brain is characteristic of chronic inhalant abuse. A neurogenic bladder has been attributed to toluene abuse in rare cases. This was his conclusion. Brian Sinclair's neurogenic bladder was a consequence of solvent abuse. The doctor freely conceded that he is not an urologist and he deferred to Dr. Younes's conclusions regarding the bladder.

[104] In Dr. Del Bigio's opinion, his conclusions were tempered because Brian Sinclair was suffering the overwhelming, untreated effects of "sepsis":

> With respect to the axonal injury…, it should be noted that this patient was in uncontrolled sepsis for some time prior to death. Sepsis with hypotensive shock could contribute to the axonal injury.

[105] Sepsis or severe infection results in a blood pressure drop, causing less blood flow to the brain, which can cause axonal damage. Sepsis also affects the brain, because the infection causes inflammation. Mr. Sinclair's abdominal cavity was inflamed and his blood pressure had dropped. There was inadequate blood flow to the vital organs. It was uncontrolled, which means it was untreated. The brain is dependent on oxygen and nutrients and if deprived of same, this affects consciousness and causes the death of brain cells. The untreated, severe infection resulted in Mr. Sinclair's body going into hypotensive shock.

[106] If prolonged, hypotensive shock symptoms can affect the brain and can cause damage to brain cells. Doctor Del Bigio did not observe damage to Mr. Sinclair's nerve cells. He concluded that the axonal injury was caused by loss of myelin, but he could not say it with any certainty.

## WHAT HAPPENED?

[107] In this section, I will analyze the chain of events which led to Brian Sinclair's death. An overview of the events shows that when one tries to weave the events together, one finds a number of dropped stitches.

[108] In this context, it is essential to view each component of the health care system starting with the patient Brian Sinclair, the personnel looking after him, the environment in which Brian Sinclair found himself and the organization of the

medical institutions controlling the actions. Human error can apply to individuals singly or collectively. One error does not necessarily cause what counsel for the WRHA, Mr. Olson, aptly referred to as "the perfect storm". Adverse outcomes evolve. Individuals contribute through their action or inaction, which can be triggered or compounded by working conditions that harbour system flaws.

## 1. Brian Sinclair was medically vulnerable

[109] Context is important here: I heard evidence from a number of health care professionals that Brian Sinclair was medically fragile and that the maintenance of his ongoing care was crucial. Brian Sinclair's pre-existing medical conditions made him vulnerable. He had a limited awareness of his vulnerabilities and his communication skills were compromised.

[110] Alexandra Komenda is a WRHA hospital-based, Home Care Case Coordinator. She prepares individuals for discharge planning, assessing the care needs and working with the multidisciplinary team to secure the appropriate services. She works very closely with the community-based home care case coordinators. Each activity in the home care program is mandated by protocol. The mandated, allowed activities can be exceeded by getting the approval of the Program Manager.

[111] Each time Brian Sinclair was admitted as a patient to hospital, the WRHA Home Care Coordinator would be notified. Mr. Sinclair could not be discharged until the community Home Care plan was in place. His discharge information was sent to the community physician and the Health Care Coordinator in the community. Ms Komenda coordinated the continuation of Brian Sinclair's Home Care plan in March of 2008 after his admission for a blocked catheter and fever. The diagnosis was, inter alia, a bladder infection and bacteria in the blood. He was quite ill when he was admitted. Incidents of his aggression towards hospital staff were noted on March 8th and March 11th of 2008. Ms Komenda confirmed that the home care coordinator in the community (in this case, Ms Kubas) was able to access or interface the hospital's Integrated Progress Notes. She agreed that a client should always have a backup plan: for instance, family resources. If a client is not competent or did not have any family supports for a backup plan, she agreed with Mr. Trachtenberg that the Public Trustee needs to formulate a backup plan in conjunction with the home care coordinator.

[112] Ms Komenda's interaction with Brian Sinclair at that time was limited to a 15 to 20 minute, one-time contact with him. She found him very difficult to

communicate with because of his lack of enunciation and his mumbling. It was difficult to problem-solve and plan with him or to even obtain a history from him. From her perspective, he had no support structure outside of the home care system. She assessed him as fairly independent, but in her opinion he probably required quite a bit of supervision. She assessed him as a "high risk", which in this context meant that Brian Sinclair was at risk if home care were to be interrupted. On Ms Komenda's objective summary at the end of her assessment, she identified goals for him to focus on. For instance, taking medications as prescribed and living in a safe and sanitary environment.

[113] Ms Kubas made it clear in her Home Care plan for 2008 for Brian Sinclair:

- he needed to be accompanied for appointments;
- he needed to be transported to various facilities;
- he needed an integrated support worker; and
- he needed nursing services for catheter change and bi-weekly visits for drainage and skin care and supervision.

[114] Sylvia Lone was employed as a Home Care Attendant by WRHA since 2000. She retired in 2011. Her duties were dependent on the client's needs. Brian Sinclair needed a lot of care when he first moved in after surgery, including administering medications, bathing, dressing, being helped in and out of bed and being wheeling around. Brian Sinclair was her third client in the morning. She started around 6:00 a.m. A male attendant gave him a bath. As time went on, Brian Sinclair did his own morning care, dressed himself and wheeled himself. In Ms Lone's opinion, again echoed by others, Brian Sinclair was doing really well at the time of his death. She too confirmed that Mr. Sinclair's communication skills, which were difficult to understand at first, improved after he was assaulted. By September of 2008, Brian Sinclair was doing his own toiletry. She recalled that Mr. Sinclair was already up when she arrived at his apartment on September 19th, 2008. As part of her duties, she usually emptied his catheter bag. His night-time bag contained very little urine and it was dark and smelly. "It did not look good." She told him so. He felt like something was wrong, so she talked to him about his going to the hospital to get it fixed. When she saw him in the lobby she said "Don't forget to go to the hospital." He wanted to go to the Mission and they would give him money for a cab, is what she recalled. Later on, she thought that he meant the HAC maybe and not the Mission. She did not think it was an emergency, but the

catheter definitely needed to be changed. If it was an emergency, she would have called 911. She had sent Brian Sinclair to hospital on a couple of prior occasions. His appearance, she recalled, was fine. This evidence is difficult to reconcile with the testimony of the medical staff at the HAC, all of whom testified about Mr. Sinclair's disheveled and malodorous state when he arrived at HAC not much later that same day.

[115] The theme echoed by each of the home care workers who cared for Brian Sinclair at the Quest Inn was that he wanted and accepted less and less care from them as time went on.

[116] The net effect of all this was that the people tasked with looking after Brian Sinclair were starting to loosen their grip on him.

### 2. A decision was made by the attendant Home Care Nurse to withhold Brian Sinclair's medically-mandated catheter irrigation and catheter change

[117] Lisa Blanchette is a Registered Nurse. Her contact with Brian Sinclair was as his visiting nurse, assigned to change his catheter in his home at the Quest Inn. The Home Care Plan was for Nurse Blanchette to visit him every two weeks to irrigate the catheter and every four to six weeks to change the catheter. It took approximately 15 to 20 minutes to change the catheter. Nurse Blanchette agreed that if a catheter is not changed, there is a risk for infection or blockage.

[118] She told the Court that Brian Sinclair often missed his appointments with her. On July 11th, 2008, she changed his catheter, but noted in the Integrated Progress Notes "the client's noncompliance by being over a week late".

[119] It is apparent that Nurse Blanchette was not being kept apprised of Brian Sinclair's attendances at hospital for problems with his catheter. She was not aware that Brian Sinclair spent May 1st - 5th, 2008 at HSC to have a catheter reinserted. She was not aware that he attended HSC on June 20th, 2008 where his catheter was changed. She had changed his catheter on July 11th, 2008. She was also not aware that he was admitted July 17th - 18th, 2008 for a substance abuse issue. Nor was she aware that he was admitted to HSC on July 20th, 2008 for a urinary infection.

*I therefore recommend:*

*2. That WRHA Home Care review its policies and procedures to ensure that Home Care updates service providers concerning any hospitalization of their clients.*

[120] By August of 2008, after becoming frustrated with trying to track Brian Sinclair down to change his catheter, Nurse Blanchette decided to "put a hold" on her duty. She explained how she categorized Brian Sinclair as "noncompliant": she continually left messages with the health care aides at the Quest Inn to direct Brian Sinclair to stay home for her arrival, but he did not stay home. The Integrated Progress Notes entry for August 7th, 2008 outlined that Home Care had been trying to find Brian Sinclair for "almost a week". Her notes also referred to this as a trend and stated: "The client is very noncompliant. The writer saw the client on the street and told the client to go home so she could see him, but the client just smiled and carried on in the direction he was going."

[121] Nurse Blanchette phoned the Home Care Case Coordinator Diane Kubas, to discuss with Ms Kubas about putting the client on "hold", as in her words, "Home Care is not designed for tracking down noncompliant clients." She told the Court that she then spoke to the nurse practitioner at Siloam Mission and the nurse practitioner was agreeable to taking over Brian Sinclair's catheter maintenance, when Mr. Sinclair attended there. She testified that Ms Kubas was aware of that.

[122] Ms Davidson, the HSC Discharge Coordinator confirmed that putting a patient on "hold" meant the suspension of a direct service provider. The direct services provider would consult with the home case coordinator: it was a judgment call. Ms Davidson told the Court that in her opinion, it is desirable to regularly review a hold or look at other options to provide care.

[123] Nurse Blanchette agreed with Counsel for the family that dealing with Brian Sinclair was frustrating and irritating. She had no further dealings with him after August 7th, 2008. She told the Court that she put him on "indefinite" hold. She agreed with counsel that the word "indefinite" (in relation to the hold on her catheter-changing duty) does not appear in her notes. She also agreed that she did not follow up to see if the nurse practitioner was in fact irrigating and changing Brian Sinclair's catheter. She agreed that if the catheter did not get changed, blockage or infection would result. She was not aware that in fact Brian Sinclair attended the emergency room on September 1st, 2008, brought in by ambulance because of a leaky catheter. On that occasion, Quest Inn home care had called

EMS, the paramedical emergency services, because Brian Sinclair's pants were saturated in urine. She opined that a leaky catheter is a common event: it may just need irrigation.

[124] In short, she did not revisit her decision to put Mr. Sinclair on hold. She was not aware if the Public Trustee was ever advised of her decision.

*I therefore recommend:*

*3. That WRHA Home Care review its policies and procedures to ensure that each service provider is made aware of the specific care plan for each Committee.*

*4. That WRHA review its policies and procedures to ensure that when a medical service is put on hold, suspended or withdrawn from any client for any reason, that there is an alternate plan in place or that the hold be reviewed on a regular basis.*

[125] Ms Kubas told the Court that she did not hear about Nurse Blanchette's frustration with Brian Sinclair until August 8th, 2008. She recalled speaking to Nurse Blanchette to "problem-solve". Ms Kubas told the Court that after Nurse Blanchette told her that she was putting Brian Sinclair on hold for his catheter change, Ms Kubas was told by Nurse Blanchette that Brian Sinclair was going to go to the Siloam Mission to get his catheter changed. She classified all this as "a work in progress".

[126] After speaking with Nurse Blanchette, Ms Kubas made no entry into the Integrated Progress Notes about any of this. It was not until after Brian Sinclair died that Ms Kubas updated the Integrated Progress Notes. On September 22nd, 2008, the day after Mr. Sinclair's death, Ms Kubas made a "Late Update" in the Integrated Progress Notes. In her late entry, Ms Kubas noted that in mid-August, she met with the Siloam Mission nurse, who said that she would get the Director of the Mission, who was also a nurse, to do the catheter change, because she, the Siloam Mission nurse, was leaving. It was "an interim solution". It was "a plan in progress", not put into place. Ms Kubas told the Court that she did want to meet with Brian Sinclair to try to sort it out. She was aware that on September 1st, 2008, Brian Sinclair's catheter had been changed at the HSC ED.

[127] Lori Lamont, the WRHA Chief Nursing Officer, also told the Court that in an instance of non-compliance such as this, the home care case coordinator would look for other options in the community. Ms. Kubas agreed that, prior to

Mr. Sinclair's death, she did not revisit Nurse Blanchette's decision to withhold the catheter change service. She confirmed that her office was the Public Trustee's delegate, the agent assigned to fulfill their duties. She did not advise the Office of the Public Trustee about the hold. Ms Kubas agreed that she did not send anything in writing to the Siloam Mission to confirm the arrangement. She also agreed that she did not discuss this arrangement with the Director at Siloam Mission. A subsequent police investigation found no record of a medical chart for Brian Sinclair at the Siloam Mission. Winnipeg Police met with the Mission Manager and confirmed that there was no record of Brian Sinclair ever having received medical treatment there. Police were unable to locate and speak to the Nurse Practitioner from that time frame.

[128] Ms Kubas told the Court that Brian Sinclair did not have an answering machine: it was always preferable to speak to him in person rather than try to listen to him on the phone. They did play phone tag. She had been trying to connect with Brian Sinclair for two weeks. Sadly, on September 19th, 2008, she and her coworker attended the Siloam Mission to try to speak to and connect with Brian Sinclair. She did not see him there, so they went to the Salvation Army building nearby. Ironically enough, one of the reasons she was trying to track Mr. Sinclair down was to get him to spend some of his excess money because he had over $4000 in his account.

[129] She spoke on the phone later that afternoon to Nurse Connolly at HAC. Nurse Connolly advised her that Brian Sinclair would be transported to HSC ED for a catheter change. Ms Kubas told Nurse Connolly that she would see Brian Sinclair on Monday at 8:30 a.m. In fact, she arrived at the Quest Inn at 8:45a.m. to meet her client, who had by then passed away.

[130] Ms Kubas confirmed that she and her staff were very fond of Brian Sinclair. He had a wonderful smile. They cared about him very deeply. They met to console each other after his death. He generally showed compassion towards others and was empathetic towards anyone who suffered injustice. He liked to treat his brothers on their birthdays and "hang out" with them at the Siloam Mission. They forgave and tolerated any of his misbehavior such as when in December of 2007 Mr. Sinclair was aggressive to a nurse and refused to have his catheter changed.

### 3. The Public Trustee was not aware that Brian Sinclair's prescribed catheter change was put on "hold"

[131] Nurse Blanchette claimed that she did not know that Brian Sinclair was a Ward of the Public Trustee. She does not recall ever dealing with a Ward of the Public Trustee, but she knew that it meant that a person was not able to manage their own care. She agreed that it was an important component of her relationship with a client to assess the client's competence. At her first visit with Brian Sinclair, she needed to satisfy herself that he was consenting and competent to consent. She said she did both. She told the Court that she understood Brian Sinclair's gestures and his moods, but it was difficult to understand his words. She saw Brian Sinclair as competent and in her opinion, able to make safe decisions. She described him as competent, but not extremely competent. In her opinion, he could decide if he wanted to get his catheter changed. He understood the repercussions. In fact, he called about catheter problems to solve them. Nurse Blanchette's perspective was not shared by any other member of Brian Sinclair's health caregivers.

[132] Nurse Blanchette was shown a document which was the "plan for the visiting nurses" for Brian Sinclair from the Public Trustee. She testified that she would not have seen this document. She got her schedule from a different computer system. Nurse Blanchette was frustrated, in hindsight, by the lack of background information that service providers such as she were given from Home Care. At the time, she was simply task-oriented.

[133] Service providers were not being given all the information they needed. It is vital that the service providers for vulnerable patients such as Brian Sinclair be provided with specific notification of each client's care needs and challenges. Expert witness testimony made it clear that electronic charting not only is a cost-saver, but a life saver, since the most up-to-date medical information can be shared amongst all service providers.

*I therefore recommend:*

*5. That WRHA Home Care reviews its policies and procedures to ensure the provision to service providers of relevant background information of their vulnerable clients.*

*6. That the RHAs and the Office of the Public Trustee continue to review the feasibility of compatible electronic charting of all relevant medical information for clients of the Public Trustee.*

## 4. On September 19th, 2008, Brian Sinclair had no Integrated Support Worker

[134] Mr. Ironstand, the Integrated Support Worker, who looked after Mr. Sinclair and often accompanied him to medical appointments, moved to another job in August of 2008. This coincided with the timeframe of Mr. Sinclair being put on hold for his catheter change. Mr. Ironstand had not been replaced by September 19th, 2008. Brian Sinclair's home care plan included the need for him to be transported and accompanied for medical appointments. Mr. Ironstand helped Mr. Sinclair to not only remember his medical appointments but sometimes accompanied Mr. Sinclair to them. Mr. Ironstand agreed that navigating the health system in general was difficult for people like Brian Sinclair. That is why he ensured reminders, facilitated or otherwise helped him with logistics. Had a support worker accompanied Mr. Sinclair to HSC ED, effective contact would inevitably have been made by Mr. Sinclair with the staff at HSC ED.

## 5. Brian Sinclair's complete medical chart was lost at the Health Action Centre

[135] The Health Action Centre (HAC) is an inner-city, community health care centre. The HAC clinic attended by Brian Sinclair boasts a team of Doctors, Nurse Practitioners, Community Health Workers (referred to as "the eyes and ears of the community", doing home visits and looking at the needs of clients), a Speech Pathologist, a visiting Psychiatrist and an Obstetrician. HAC also has a number of different clinics for inner-city patients, including dentistry, midwifery, primary care and home care. Lab technicians work at HAC on and off during the week. HAC is open from Monday through Saturday. The centre is not a walk-in centre *per se*, but HAC will always take care of emergent, walk-in clients. The HAC outreach worker described team meetings at HAC as "picturing" a client, not just medically, but looking at their entire environment to help them lead a healthy life and to help them navigate systems, be they nutrition, housing, pension or medical systems.

[136] Brian Sinclair's first visit to the HAC was in 1997. He was a frequent visitor. He was often a walk-in client. He also missed a lot of appointments. Veteran nurse Kathy Christenson has been the Clinical Coordinator at HAC since 1994. Her duties are to oversee the nurses, dietitians and social workers. She also works as a nurse one day a week. She told the Court that she knew Brian Sinclair from her former work as an ED nurse and from his ED visits as a solvent abuser. On May 15th, 2007, Brian Sinclair's medical chart went missing. It was reported as

missing on June 15, 2007. A temporary, duplicate chart was made until the original chart could be found. Oddly enough, the duplicate chart also went missing. According to Ms Christenson, this is an uncommon occurrence. Ms Christenson told the Court that back in 2008, she was not aware that Brian Sinclair was a Ward of the Public Trustee.

[137] Around 2:15 p.m. on September 19th, 2008, Brian Sinclair wheeled himself from the Siloam Mission to the premises of the HAC and presented himself to the receptionist Sylvia Chidlow at the front desk. Ms Chidlow had only been working at HAC for two weeks. She had no medical training. Her responsibility was to greet the client, get their demographics, find out who their doctor was, pull their medical chart, check their prescriptions and get the chart to the doctor. She does not recall the exact time when Mr. Sinclair came in, but as she sat behind her desk, which she could not see over, she told the court that she heard "moaning". She stood up and saw the top of Brian Sinclair's head. Mr. Sinclair did not have an appointment. She went around the reception desk to ask why he was there. He looked visibly uncomfortable. He motioned to his groin. He was mumbling. She wheeled him in his wheelchair around to the side of the desk, dealing with him quite differently than she would in other circumstances. She quickly located his chart, flagged down a nurse and told the nurse that she had "Brian Sinclair is here and he seems to be in pain". Ms Chidlow told the Court that she had no difficulty understanding what the general problem was and saw that it was a situation that needed a prompt response. Although he did not have an appointment, she immediately got him to see a nurse. He was obviously in distress. He seemed to have a speech impediment, but she understood what was happening because he pointed to his groin. He responded appropriately to her questions. Ms Chidlow's testimony conflicts in some respects with the two nurses and the doctor who actually treated Brian Sinclair.

[138] Dana Connolly graduated as a nurse in 1989. Ironically, her expertise as a Nurse Clinician is in the area of dialysis. She currently works at HSC Renal Clinic. She assesses patients for dialysis and advocates on their behalf. In her line of work, she has a great deal of experience in changing catheters and has seen numerous bladder infections. She was one of the two attendant nurses who took care of Brian Sinclair at HAC on September 19th, 2008. She was told by the receptionist that Brian Sinclair needed to be seen. She was given the chart. At that time, patients' charts were kept in a separate room. (HAC charts are now electronic.)

[139] Nurse Connolly told the Court that Brian Sinclair's chart as it then existed had no Home Care contact numbers, no immediate family listed, nor any "alerts"

or “cautions”. The “issue” list was brief. Solvent abuse was one of the issues charted. Nurse Connolly saw nothing on the chart about memory problems. There was no indication on the chart that Brian Sinclair was a Ward of the Public Trustee. She readily agreed that those issues were important missing pieces.

*I therefore recommend:*

*7. That the Office of the Public Trustee and the RHAs review their policies and procedures to ensure that when a patient is a Committee of the Public Trustee, the patient’s Committeeship status is clearly flagged on that patient’s medical chart.*

[140] Nurse Connolly reviewed the chart for a few minutes. Brian Sinclair was waiting in a wheelchair at the reception desk. She called his name and he said “That’s me”. She told him that she would be the nurse looking after him and she offered to wheel him into the examination room. He replied: “No, I can do it.” He wheeled himself into the examination room. He told her his penis was sore, that he had pain and that he didn’t feel well. His blood pressure was normal, his pulse was normal and his temperature was 37.5 Celsius, which is a normal temperature for most individuals. She phoned the contact number which was on the chart: it was the number for the Quest Inn. She left a message for them to call her back because Brian Sinclair was with her. She meanwhile asked another nurse to accompany her because she would be examining Mr. Sinclair’s genitalia. It hurt Brian Sinclair to move his catheter. There was discharge at the end of his penis and there was no urine in the bag.

[141] According to Nurse Connolly, Brian Sinclair was disheveled, malodorous, had crusting feces up his back, his clothes were dirty, there was feces on his wheelchair and his Foley catheter bag was almost on the ground. His bottom and scrotum were sore and red and there were broken areas of skin there. She agreed that although Mr. Sinclair was wheeling himself around, and was oriented to the occasion, he did look ill. In her eyes, he was competent and not confused. He spoke appropriately and was able to discuss his concerns with her. After he talked about his pain and showed her his genitalia, he told her that his health care assistant tried to drain the catheter two times in the last day and nothing was coming out. He was not wearing any underwear. He said his Foley catheter was due to be changed. He had missed seeing his nurse for his catheter change. His penis was sore to the touch and there was a yellowish, pus discharge at the urethra. He moved his catheter in and out, showing that it hurt to do this. His testicles were red and sensitive. He was shaky and sweaty but not hot to the touch. His speech was garbled. He had difficulty hearing her, so she got close to him.

[142] Nurse Connolly arranged for a doctor, Dr. Marnie Waters, to examine him, which she did. They both concluded that the depth of care he required demanded a visit to HSC ED. His bladder was distended. There was urine in his bladder. His temperature might in his case indicate a low-grade infection. He was in her words "on a bad road". She concluded that he was at the outset of a urinary infection, which if not treated could lead to sepsis. Dr. Waters told him he was too ill for their facility and asked him if he agreed to go to the HSC to be treated there. He did. After Dr. Waters left the examining room, Nurse Connolly, as she put it, cleaned Brian Sinclair up. She wanted him to show her what he was going to do when he got to HSC and asked him to do that. He took out a letter that had been given to him by Dr. Waters and told her he was going to give it to the Nurse.

[143] By 2:45 p.m., there had been a discussion with Diane Kubas, the Home Care Case Coordinator, who told Nurse Connolly that Brian Sinclair had refused to stay home for his scheduled catheter change and that Ms Kubas has been unable to find him. Ms Kubas advised her that Brian Sinclair frequently missed seeing his Home Care attendant, because he was not in his room or on the premises when they came to attend to his care. He was frequently on the go and a busy person. Nurse Connolly told Diane Kubas that she believed Brian Sinclair to be ill with a urinary tract infection and that they were sending him to HSC.

[144] Ms Kubas asked Nurse Connolly to tell Brian Sinclair to be at his room on Monday, September 21st at 8:30 a.m. and she would go see him. Nurse Connolly took the opportunity to reinforce with Mr. Sinclair the necessity of being at home for his Home Care nurses, so they could provide care to him and thereby reduce the number of emergency visits to HAC and HSC. Mr. Sinclair agreed to be home at 8:30 a.m. Monday September 21st, 2008 to meet Ms Kubas.

[145] Nurse Connolly told the Court that Brian Sinclair conversed with her. He told her how important it was to him to spend time at the Siloam Mission. He liked to volunteer. He told her that when he went to the Siloam Mission, he liked to wipe tables there. He also told her that he had earlier passed his nurse on the street. He had started to feel unwell at the Mission and he was on his way, wheeling himself to HSC, but he got tired, so he came in to see his doctor, Dr. Perez. Nurse Connolly told him that it broke her heart to see him this way. She agreed with him that it was important to volunteer and she understood that he had a big heart, but he had to look after himself first. In her opinion, he seemed to understand. She maintained that Brian Sinclair also told her on that day that sometimes, the Siloam Mission would change his catheter. I heard no evidence that that had ever occurred.

[146] She maintained that it was not safe to change the catheter at HAC because:

- the clinic did not have a lift to get Mr. Sinclair properly placed on the narrow patient bed;
- it was impossible and unsafe to try to do it without taking Mr. Sinclair out of his wheelchair, because the catheter may have dislodged;
- there could be a trauma to the client while removing it;
- he could go into shock with a blood pressure drop and a possible cardiac arrest and they did not have resuscitation capacity; and
- he required other, further tests that they could not provide and any blood test results would not be sent to them for 48 hours.

[147] Nurse Connolly confirmed that after Mr. Sinclair's death, Dr. Brian Postl, the then WRHA Director, issued a Directive that a phone call must be made in advance before a patient is sent to an ED.

[148] Shireen Loat has been a Registered Nurse since 1970 and has been working at the HAC since 1998. She was the second nurse in the examination room with Nurse Connolly, while Nurse Connolly examined Brian Sinclair's groin. She was present for no more than ten minutes. She had seen Brian Sinclair wheeling himself down the hall to get into the examination room. She recalled that he answered the questions they asked. She asked him when he last "peed" and he answered "Yesterday". She recalled his complaint being abdominal pain. The area where the catheter entered the end of the penis looked dirty. She was concerned about blockage or infection.

[149] She concluded that Brian Sinclair was well aware that the catheter should be draining because she had direct, past experience with Mr. Sinclair and problems with this catheter. She had dealt with Brian Sinclair on May 5th, 2007 because his Coumadin levels were very low. At that time, he was not able to tell her much about his medication, so she spoke to a nurse at the Quest Inn. She also left a message with his Case Coordinator, Ms. Kubas. On April 12th, 2008, she had seen Brian Sinclair for a complaint that he needed a catheter change, but in fact he was asymptomatic and she told him that the catheter was draining fine and sent him away. She knew he had a speech impediment, so Nurse Connolly and she asked

him simple questions and received brief responses. They were patient with him. He was polite and forthcoming with answers. Nurse Loat told the Court that Mr. Sinclair did not look like he was in any undue distress. He was not writhing. Nurse Loat agreed with Nurse Connolly that HAC did not have the capacity to deal with potential trauma to Mr. Sinclair if they had removed and reinserted the catheter. Given that the catheter itself was encrusted and cloudy, it may have been caused him a lot of pain. In her opinion, Mr. Sinclair definitely needed follow-up.

[150] I would otherwise have recommended that HAC review the feasibility of electronic charting, but I heard evidence that this has already occurred.

*I therefore recommend:*

*8. That the RHAs review the feasibility of electronic charting for all their facilities.*

**6. The Attendant Physician gave Brian Sinclair a letter to give to the Health Sciences Centre Emergency Department staff, but did not call the Emergency Department to alert them of Mr. Sinclair's pending arrival.**

[151] Dr. Marnie Waters is a family doctor who has worked at several clinics in Winnipeg. She has practiced Family Medicine at the HAC since 2002. Dr. Waters explained that HAC clientele come primarily from the core area of Winnipeg. They are often poor people, facing huge issues around education, housing, employment, addictions, mental health, literacy, English as a second language and a variety of cultural challenges. If a walk-in client such as Brian Sinclair has a regular doctor and that doctor is not available, then another doctor may be able to fit them in. This is what Dr. Waters did. She was fully booked on Friday September 19th, 2008. She knew of Brian Sinclair because of weekly team meetings that took place at HAC where "challenging" cases were discussed. So on that Friday afternoon, she knew he was a man who had faced many challenges, but who was "on the right track".

[152] Nurse Connolly approached her to see if she could assess Mr. Sinclair. He told Nurse Connolly that he had wheeled his way from Siloam Mission and detoured into HAC on his way to the ED. He had missed his last catheter appointment with Home Care and Home Care had lost track of him. Dr. Waters explained that the attendant nurse often gets a good feel for a patient, but if that nurse cannot deal with the complaint on her own, a doctor is consulted. However, the patient plan is definitely collaborative.

[153] Because she had never dealt with Brian Sinclair and he was coming in on a walk-in basis:

- she was inclined to collaborate quite a bit with the Nurses, given their historical knowledge and their sensitivity to red flags or alarm bells;
- the "issues list" on the chart is the most important document for the doctor seeing another doctor's patient because that will tell you what the issues are for that patient and you are reviewing the chart for the problem at hand;
- she might take a look at lab results;
- she usually skimmed through recent encounters in the chart; and
- she looked at the demographics portion of the chart at the front: name, address, health number, social services and next of kin.

[154] She was shown a May 15th, 2007 occurrence report from HAC saying that Brian Sinclair's chart was "not locatable" and that was dated July 10th, 2007. When she treated Brian Sinclair on September 19th, 2008, she had no idea the chart was missing: not once, but twice.

[155] When she spoke to Mr. Sinclair, she asked: "Why are you here?" He told her: "My dick hurts. The tube fell out. There's no piss in the bag." He pointed in the direction of downtown and told her "I live in a room." She told the Court that he provided his Ellice Street address. She concluded on the basis of this conversation that he was reasonably oriented. The content of his "issues" list was not voluminous, but in her assessment, quite compelling because she saw several medical illnesses. "Cognitive Impairment" was not noted as one of the issues on the chart's "issues" list. Similarly, there was no entry that Brian Sinclair was a Ward of the Public Trustee. Normally these important facts would be on the issues list. She did not question the issues list, or the relatively thin chart: she had confidence in her colleague Dr. Perez. Also, her immediate concern was the catheter.

[156] She then examined Mr. Sinclair with his consent. She told the Court that his responses were basic, audible, intelligible and sensible. Nurse Connolly had previously advised her that Brian looked good and his vitals were stable. He was malodorous.

[157] Nurse Connolly had done a "dipstick urinalysis test" on the urine from the bag. Dr. Waters was not surprised by the presence of leukocytes, because they were often present in an irritated bladder with an in-dwelling catheter. There was protein in the urine, which indicated to her some degree of kidney dysfunction. Kidney dysfunction was not on Mr. Sinclair's "issues" list and it did not seem relevant for his presenting issue. There was a little bit of blood, which is often present with in-dwelling catheters. Again, this was not a cause for concern because the plan was that Mr. Sinclair was going to be sent to HSC ED for catheter re-insertion.

[158] Dr. Waters told the Court that Mr. Sinclair's groin area was soiled and he was generally unkempt. However, Dr. Waters testified that the fact that he was unkempt was not of medical significance. She added that it is not uncommon for her patients to be either unkempt, smelling of urine or having fecal incontinence. Her other observations were a little different than Nurse Connolly's observations. She noted fecal matter in the crotch area but, unlike Nurse Connolly, noted no lesions, bumps or scratches around the genital area. There was a drop of clear fluid on the tip of the penis where the catheter exited. It looked like fluid from an inflammation or else urine. She did not observe Mr. Sinclair to be "diaphoretic" (sweaty) and "tremulous" (shaky). She also did not observe any "yellowish pus-y discharge at the urethra end" of his penis.

[159] There was no red flag in her mind. There was scant urine in the bag, a couple of millilitres. Mr. Sinclair was not agitated or pale or vomiting. His skin tone was fine and his skin was warm and dry. She palpated his abdomen. His bladder was sitting four to five centimetres above his pubic bone, which meant that it was somewhat distended, but this again was not seen as urgent. Her assessment was that his catheter was blocked and it needed changing. She asked if Nurse Connolly could do the change. Nurse Connolly felt it would be unsafe to perform at HAC.

[160] According to Dr. Waters, Brian Sinclair needed a "good, general clean up" and maintained that they could not lift him and he needed timely lab facilities. She was concerned that the sterile technique would be compromised if they did the catheter change at HAC, because fecal soil can compromise the sterility of the field. The most appropriate place to get his catheter changed was HSC ED. She told Brian she was going to send him to HSC for a Foley catheter change and he said "Okay". She told him that she was going to write a letter for him and he said "Okay". She said she was going to organize a ride for him. The examination took about five to ten minutes.

[161] She left and looked at his medical chart. She wanted to try to find the source of his bladder infection. She read a letter written by Nurse Tanis Olson for Dr. Perez that Brian Sinclair had previously taken to the ED. She did not notice WRHA progress notes specifically, because she was "skimming the chart" for information pertinent to the problem. In Court, she was shown an entry on Mr. Sinclair's chart that he was a "questionable reliable historian". She told the Court that she was only skimming Mr. Sinclair's chart that day. She typed a letter, which took about three to five minutes. The letter read as follows:

> Friday, September 19th, 2008
>
> Re: Brian Sinclair, Date of Birth 24/06/1963
>
> To Whom it May Concern
>
> Brian is a patient of my colleague, Dr. Perez. He has bilateral BKA's and an in-dwelling catheter (I'm unaware of the reason for it but I presume it is neurogenic). He presented to our clinic this afternoon with supra pubic pain and a history of "tube falling out". His examination reveals a firm, distended bladder and a loose Foley. There is clear discharge from his glands. His Foley bag is empty and he says it has had no urine for 24 hours. He is unkempt and he has had fecal incontinence.
>
> We have been unable to contact his home care provider at this time. He is transient, and home care has had trouble finding him for regular Foley care. My concern is that he is likely obstructed, possibly due to a dislodged Foley. I am unable to provide adequate Foley care here and ask that he be seen by nursing at your facility to ensure adequate Foley placement and urine output.
>
> Thank you very much, Marnie Waters, M.D., C.C.F.P.

[162] She placed the letter in an envelope from HAC and printed on the front "HSC ER".

[163] When she returned to speak to Brian he was calm and coherent and she held up the letter and told him to give the letter to the person at the front desk of the Emergency Room because it would help him to be seen quickly. He reached out his hand and said "Okay, doc." and took the letter and placed it in his breast pocket

and then he started to wheel himself out and she said "No, Brian, we're going to get you a ride up there." and he said "Okay", so she said goodbye and dismissed herself.

[164] She did not make a phone call to the HSC ED. She confirmed that she made phone calls to the ED for the majority of her patient transfers for patients who are experiencing unstable vital signs or clinical distress. She makes a "courtesy call" to the emergency room and to the ambulance. Those are the urgent calls as far as she is concerned. She told the Court that she would only call if it were a complex medical issue or if the person had a complex social or medical history. She concluded that day that Mr. Sinclair's medical needs were clear-cut. He needed a catheter change. He was motivated. She felt he was capable of both handing the letter over and giving his history to the staff at HSC ED. She concluded that "Brian Sinclair was capable of providing reliable historical information."

[165] Dr. Waters told the Court that calling an emergency room ahead of a patient's arrival is good practice, but there are some challenges:

- she heard from patients that after they arrive at the emergency ward, the triage nurse did not know who they were;
- a client has not shown up until 24 hours later;
- a client is sent by ambulance but taken by that ambulance to another hospital; and
- a colleague at HAC had phoned the ED regarding an elderly, demented client to have them admitted to hospital because they were unsafe in the home, but that patient was seen and discharged.

[166] On cross-examination, it was suggested that the better practice of referring a patient to HSC ED is to call and provide a letter. In other words, to make a phone call to the ED prior to the patient's arrival. Dr. Waters response was that generally when she has called the ED, she has only actually connected directly to the ED physician or the triage nurse once or twice. She tries to make a note of who she speaks to and make an entry on the patient's chart. She agreed that such a call represents the sharing of information to try to ensure a safe hand-off and to help the emergency room understand the medical information. In her opinion, a letter is much more satisfactory and an effective, reliable tool.

[167] Counsel pointed Dr. Waters to the Integrated Progress Notes that were part of Brian Sinclair's HAC medical chart that outlined: "No chart. Attend on May 4th, 2007. Client has known cognitive issues due to substance abuse." She told the Court that she did not look this far back in his chart when she skimmed it. Even if she had seen this note, this note does not tell her that Mr. Sinclair was not capable to do what she told him to, even if he was a Ward of the Trustee. She has dealt with many Public Trustee Wards and it is not uncommon for them to attend without an escort. 40 to 50% of her patients have some history of substance abuse. There was no evidence of Brian Sinclair being under the influence of any volatile substance. The team had advised that Mr. Sinclair had essentially kicked his bad habits. Dr. Waters maintained that in 2008, it was not uncommon to have Wards of the Public Trustee attend HAC alone. If she knew they were Wards, she may decide they need an escort, but not necessarily. Mentally and physically challenged patients were sent from HAC to the ED, sometimes with a letter and sometimes alone. She agreed that these people are vulnerable, but she stressed that they too can be sent to the ED by themselves. It is patient-specific, as to whether the particular patient would find it difficult to navigate the ED. She eventually agreed it was more likely that these people may have challenges in the ED environment and she did agree that there ought to be a system at EDs to assist the vulnerable.

[168] Counsel for the WRHA showed Dr. Waters the new WRHA policy of August 16th, 2013 for the transfer of patients from Primary Care to Acute Care facilities. The doctor responsible for the transfer must notify the ED in advance by phone. So a call must be made to the ED physician (or the clinical resource nurse or the triage nurse if the ED physician is unable to accept the call) to inform the ED of the reason for transfer, the acuity of the patient and mode of transport. There will be a discussion of the urgency of the problem so that the patient can be triaged and managed appropriately on arrival at the ED. Dr. Waters said this is now her practice. Dr. Waters wanted it made clear that she was not trying to criticize her ED colleagues, but she expressed a concern that if a referring physician is now mandated to make telephone calls to the ED prior to sending patients, she still finds a "lack of reliability" in those calls.

[169] Nurse Loat was not involved in the decision to transport by wheelchair taxi, but she told the Court that when a patient is stable, an ambulance is not usually necessary. Patients are only sent by ambulance if they are medically unstable. A phone call to the ED from the HAC doctor to the emergency physician is also in most cases part of the protocol, but there was no written policy that the emergency room be phoned before a patient arrived there. From her perspective on that day, Brian Sinclair was stable and it was logical for him to go via taxi. Nurse Loat had

heard HAC doctors complaining about waiting on the phone to speak to emergency physicians. In her observation, doctors were phoning the emergency physicians and often being put on hold for a long time before they got through, so the letter was another way of making that communication.

[170] The Court heard conflicting evidence from HSC ED staff about notes or letters provided to patients from primary care physicians to be given to emergency physicians. These notes or letters were sometimes delivered to the triage nurse, sometimes delivered to the triage aide and if the latter, the notes or letters were sometimes placed inside the "triage list" notepad. There was no defined policy to ask a patient whether they have a note from a doctor or even what to do with it when they do. It was not unusual for a patient to hold on to the note, if so instructed, until he or she saw a doctor.

[171] Dr. Del Bigio, whose research has focused on solvent abuse, stressed that Brian Sinclair's solvent abuse had an irreversible, toxic effect on his brain. Dr. Del Bigio had no desire to judge Mr. Sinclair. He asked the question of whether Mr. Sinclair was dealt with in an appropriate manner as a vulnerable person. He acknowledged that the admission process has been corrected, but he was firm in his opinion that a phone call from a primary health care unit to an ED is not enough for someone with brain dysfunction. Professional assessments referred to earlier in my report also concluded that Mr. Sinclair did not appreciate the degree of his disability and lacked the capacity to understand and arrange for his own care needs.

[172] What Dr. Del Bigio did not know at the time he shared his concerns publicly (prior to the commencement of the inquest) was that because HAC had lost Brian Sinclair's original chart, Dr. Waters was not alerted by her perusal of his "issues" list on his threadbare chart of either his status as a Ward of the Public Trustee or of his cognitive impairment. Dr. Del Bigio was also not aware that Mr. Sinclair had arrived at HSC ED on two prior occasions in 2007 and 2008, once with a letter from HAC and once unaccompanied, both occasions as a result of referrals from HAC to HSC ED.

[173] In the CME's opinion, Dr. Waters acted appropriately based on the letter she gave to Brian Sinclair, because from Dr. Balachandra's perspective, Mr. Sinclair was able to communicate and move around in his wheelchair. From the CME's perspective, Mr. Sinclair understood his medical condition and was able to verbalize it. However, even the CME conceded, when pressed in cross-examination, that it might be difficult for Brian Sinclair to **fully** appreciate his

medical predicament, due to his cognitive difficulties, which included a poor long-term memory**.**

*I therefore recommend:*

*9. That the protocol that requires primary care physicians sending patients to an ED to notify the ED in advance by phone be maintained, including verification of whether a letter has been given to a client to present to the ED staff.*

*10. That the RHAs continue to review their policies and procedures to examine the feasibility of letters from primary care physicians to EDs being sent electronically.*

## 7. Brian Sinclair was sent by the Health Action Centre unaccompanied without an advocate to the Health Sciences Centre Emergency Department

[174] Dr. Waters told the Court that they made a decision to transport Mr. Sinclair via taxi because his vital signs were stable, he had no clinical distress, nor was he "decompensating". Dr. Waters concluded that an ambulance transfer was not necessary. Often in this type of case, the family can give a ride. Mr. Sinclair was unaccompanied, so a taxi was called. HAC Community Outreach did not have the means to transport a client in a wheelchair. Dr. Waters did not speak to the "Handi-Transit" cab driver. Nurse Connolly told the Court that she cleaned Brian Sinclair as best she could. She then asked the HAC Outreach Worker Elaine Hawkins to arrange transportation for Brian Sinclair. The decision to send Mr. Sinclair by taxi was made collaboratively by both doctor and nurse. From Nurse Connolly's perspective, they had concluded that Mr. Sinclair's health issue was non-emergent, he was stable and he was not critically ill.

[175] HAC Coordinator Kathy Christenson said that patient transfers go something like this: if clients can make it to hospital on their own, they go on their own. If family can take them, family takes them. If they need a taxi or "Handi-Transit", then that is what they get. There were various modes of transportation. If a patient were acute, an ambulance was the option. Mr. Sinclair's condition was not acute. He was not critically ill, so that option was not pursued. A "non-emergent" ambulance could be booked, if a patient is not acutely ill. The third option was for the outreach worker to transport a patient, but in this case, a wheelchair taxi was necessary because the HAC transport vehicle was not set up for wheelchairs. The last option was self-guided: the patient could transport him or herself. In fact, Mr.

Sinclair was prepared to wheel himself to HSC and offered to do it, but Nurse Connolly told him that he could not do that. HAC had no written policy regarding transportation.

[176] Brian Sinclair's Home Care plan included the need for him to be transported and accompanied for medical appointments. The Home Care plan was not readily available on Brian Sinclair's HAC chart as it then was. On September 19th, 2008, HAC staff did not make arrangements for anyone to accompany Mr. Sinclair after he arrived at HSC ED.

[177] Nurse Loat confirmed the obvious: if a relative or caregiver had been with Mr. Sinclair, it would have been fine for the relative or caregiver to wheel or drive Mr. Sinclair to HSC ED. Nurse Loat also confirmed that the outreach worker could only accompany ambulatory patients in her motor vehicle.

*I therefore recommend:*

*11. That WRHA review its policies and procedures to ensure that primary care facilities develop a uniform protocol for the transportation of clients with mobility or cognitive challenges to other health care facilities.*

[178] Dr. Waters prepared her letter and told Brian Sinclair to take it to the HSC and give it to the Nurse at the triage desk. Mr. Sinclair put the letter in his right breast pocket. Dr. Waters told the Outreach Worker that he had to go to HSC ED and that he needed to go directly to the triage desk with the driver.

[179] Elaine Hawkins has worked at HAC since 2003 and is a Community Health Worker. Basically, she is a liaison between the client, the various community agencies and the medical field. She was shown documents that confirmed that on November 21st, 2007, it was she who arranged transportation for Brian Sinclair. The Nurse's Note for that date specified: "Outreach is arranging transport to HSC ER and the letter has been given to Brian Sinclair". Ms Hawkins told the Court that from her experience, giving a letter to a client is a common occurrence. Those letters are for handover at the triage desks. Doctors will also phone to let the ED know that the client is on the way. If she is transporting a client herself, she will make sure the Triage Nurse gets the letter.

[180] Ms Hawkins recalled that on September 19th, 2008, she had been told either by the Doctor or the Nurse to call EIA and arrange for transportation for a person needing "wheelchair escort" to HSC ED from HAC as soon as possible.

Somebody, she does not remember who, put the letter in Brian Sinclair's jacket and said "Make sure you give this to the Nurse" and he nodded.

[181] Ms Hawkins also had dealt with Brian Sinclair before. She described him as "a busy boy" and "fiercely independent". She had difficulty understanding Brian Sinclair, but he could understand her. For instance, Brian Sinclair understood her when she told him to put his wheelchair brakes on, so that he did not slip off the curb when the taxi van was approaching. She can often understand people with speech deficits, but with Brian Sinclair, she could not understand him, so they ended up communicating by gesture. From her perspective, this was not an urgent call. If it was urgent, an ambulance would have been called.

## 8. Brian Sinclair was never assessed by hospital staff after he arrived and while he sat at Health Sciences Centre Emergency Department

[182] When a person needing medical attention enters the ED of a hospital, the "triage" process is the method by which a presenting person's medical condition is assessed and prioritized. Veteran Clinical Resource Nurse (hereinafter referred to as "CRN") Susan Alcock explained that to "triage" literally means to "sort". A triage nurse is trained to obtain details about a medical complaint and to decide how to prioritize the patient and where they need to go. Basically the triage nurse talks to a patient, looks over the patient and takes the patient's vital signs. Ideally, a triage nurse has at least two years experience in the ED environment and specialized triage training. The principles of triage, being rapid assessment and appropriate categorization of acuity, are well-developed.

[183] 2008 WRHA triage policy guided the practice of the triage nurse. Included in the responsibilities of the triage nurse were: rapid identification of patients with urgent, life-threatening conditions, initiation of treatments and investigations, determination of the most appropriate treatment site or area for patients presenting to ED, ongoing assessment of waiting room patients, revision of information and reassurance to patients and families regarding services, expected care and wait times.

[184] Veteran Nurse Elizabeth Franklin spent 32 ½ years nursing in EDs. She described the triage process as it existed in 2008. If the triage nurse was available, he or she recorded the presenting person's name, health number, presenting problem and vital signs. A "CTAS" score was then assigned by the triage nurse. The Canadian Triage and Acuity Scale (hereinafter referred to as "CTAS") is the assessment of emergency patients dependent on their level of acuity - the severity

of their medical situation. CTAS levels 1 through 5 run the gamut from someone needing immediate care (CTAS1) to someone in a non-urgent situation (CTAS5). I will speak more of the CTAS guidelines later in my report.

[185] Exhibit 15 is a diagram of the triage admitting area of HSC ED as it was when Brian Sinclair attended on September 19th, 2008. (See below).


[186] On the right (east) side of the diagram is the triage desk. The waiting room chairs face the T.V. with their backs to the triage desk. The aisle between the security camera (camera#6) and the chairs adjacent to (north of) the camera is where Brian Sinclair spent the final hours of his life. Though situated in the aisle, Mr. Sinclair also faced away from the triage desk.

[187] On September 19th, 2008, 134 patients were triaged from midnight to midnight. On September 20th, 2008, 138 patients were triaged from midnight to midnight. The average number of patients triaged daily was 120. The Court heard and watched video evidence that after his arrival at HSC ED, Brian Sinclair was neither entered into the hospital system nor assessed medically by hospital staff during his 34 hours in the ED.

[188] Major Crimes Detective Sergeant John O'Donovan of the Winnipeg Police Service told the Court that he reviewed the closed-circuit television images of the HSC ED waiting room that captured the 34 hours that Brian Sinclair spent there. The Detective Sergeant estimated that he had spent about 500 hours reviewing several cameras and had watched each camera's images in their entirety. From his viewing of the video, he concluded that Brian Sinclair did not leave the premises of the waiting room that entire 34 hours.

[189] The Court heard evidence that the cameras were there in the ED waiting room for **security** purposes only. The video monitoring process focused on what was perceived by the Security Staff Monitor as a potential security risk, so for the most part, ironically, the camera is ignoring Brian Sinclair, who of course posed no security threat whatsoever.

[190] The Detective Sergeant testified that he watched the video of Brian Sinclair's arrival and his interaction with the Triage Aide Jordan Loechner. After interacting with the Triage Aide, Brian Sinclair is seen wheeling himself into the corner behind the security desk, pulling out the letter from Dr. Waters and putting the letter back in his left inside jacket pocket, twelve seconds later. The Detective Sergeant confirmed that at that point, mid-afternoon on Friday September 19th, 2008, Brian Sinclair looked alert, aware of his surroundings and was looking around the waiting room.

[191] At 3:15 p.m., Brian Sinclair is seen moving in front of the security desk, wheeling himself past the triage desk area and then wheeling himself to park his wheelchair very close to the security desk. At 3:37 p.m., Brian Sinclair is caught on video coming back from the washroom area of the waiting room. At about 3:40 p.m., Mr. Sinclair is asked by Security Patrol Officer Howard Nepinak to move from the security desk area and Mr. Sinclair immediately complies. Two hours later at 5:37 p.m., Brian Sinclair seems to be watching T.V. He approaches and seems to chat with security around 6:00 p.m. By 8:01 p.m., he is slumped in his wheelchair. At 38 minutes past midnight on September 20th, 2008, Brian

Sinclair has his head slumped to the left. By 2:00 a.m., his head is slumped a little more to the left.

[192] At 3:41 a.m. on September 20th, 2008, Brian Sinclair is captured wheeling himself back into the waiting room from the washroom and vending machine area. Seven minutes later, he is seen with his head slumped to the side in the area of the T.V. At 4:15 a.m., Triage Nurse Wendy Krongold passes by Brian Sinclair. His head is facing forward, slumped over. At 4:39 a.m., Brian Sinclair is seen once again wheeling himself out of the washroom area and he passes Security Patrol Officer Ed Latour. There are very few people in the waiting room. At 5:11 a.m., Brian Sinclair is slumped to the left with his wheelchair facing the television, directly below the camera. At 7:39 a.m., the camera scans and catches Brian Sinclair in his wheelchair, moving slightly. At 9:43 a.m., Brian Sinclair is in front of the television, with his head facing down. At 11:39 a.m., his head seems upright. By now, Saturday morning, there are more people in the waiting room. By 1:02 p.m., Mr. Sinclair is seen in the aisle, at the end of the second row of chairs in front of the T.V., with his head slumped forward. Four minutes later his head is moving slowly from right to left, but he is still slumped over.

[193] The cameras do not capture images of Mr. Sinclair vomiting, but they do show the aftermath in the early afternoon of Saturday, September 20th, 2008. Housekeeping cleans up around Mr. Sinclair and a concerned citizen alerts security. Hours later, at 4:37 p.m., a metal washbasin, which now appears to be empty, can clearly be seen in front of the Mr. Sinclair's wheelchair. Mr.Sinclair is still in the same location, now with his head slumped forward. He is caught in the frame in exactly the same location at 5:52 p.m. At 5:55 p.m., Brian Sinclair is still in exactly the same location. His head is slumped to the left and the metal washbasin is still in front of his wheelchair. By 7:14 p.m., the waiting room has thinned out yet again and Brian Sinclair is still slumped over. No head movement is visible. The same image of Brian Sinclair is captured at 7:39 p.m. and 9:02 p.m. By 9:38 p.m., his head appears to be slumped down even more to the left. It is not possible to say whether his head has moved voluntarily or whether the force of gravity is at work. As the waiting room population thins out again, Mr. Sinclair is captured in exactly the same position at 9:53 p.m., 11:24 p.m., 11:26 p.m., 11:29 p.m. and 11:35 p.m. The final video image of Brian Sinclair captured at 11:45 p.m. shows him in the same location he has been in since his image was captured at 4:37 p.m.

[194] There exists no video image of the first intervention by HSC ED staff in the early morning hours of September 21st, 2008, when the lifeless Mr. Sinclair was wheeled into the Resuscitation Room of the ED.

[195] During his testimony, the CME Dr. Balachandra bluntly assessed the situation when he told the Court that Brian Sinclair was not appropriately triaged and even if not triaged, a number of things should have been done which were not done.

[196] Detective Sergeant O' Donovan, who did a thorough investigation of the incident, agreed with Counsel for the family that Mr. Sinclair seemed to do what he was supposed to do when he arrived at the triage desk of the HSC ED, which was interact with the triage aide and then wait. The Officer agreed that Mr. Sinclair was told by the staff at HAC not to leave the ED until he saw a doctor. Detective Sergeant O'Donovan confirmed that 150 other people were triaged during the germane timeframe of 2:50 p.m. on Friday September 19th, 2008 to 1:00 a.m. on Sunday September 21st, 2008. All 150 of them were triaged and assessed by Triage Nurses and all were treated or voluntarily left without being seen.

[197] This question remains unanswered: why did Brian Sinclair not ask anyone on the afternoon and evening of September 19th, 2008 for an update on his place in line or his status in general? Why did he not advocate on his own behalf at any time? After all, he was a frequent user of the HSC ED and he had advocated for himself on previous occasions. Indeed, staff at the HAC earlier that afternoon testified that they had little difficulty understanding his medical issue. The CME stated bluntly that Brian Sinclair should have spoken up.

[198] Why he never spoke up on his own behalf is perplexing. He was capable of doing so on other occasions. He was not in unfamiliar terrain. Part of the explanation may be that Brian Sinclair would have been aware that wait times at HSC ED were lengthy and he was initially prepared to wait. He may have not wanted to intrude on staff during those initial peak hours.

[199] Part of the answer is that Mr. Sinclair had no one with him, be it family, friend or support worker, to advocate on his behalf.

[200] Part of the answer was that his vulnerability, which was well documented, put him at dire risk for not understanding the harm he could do by simply waiting. After all, he had been assessed as having difficulty interpreting when a situation may be unsafe to him. Also, his cognitive disability had an impact on his ability to

communicate. Certainly, however, as the clock ticked, he became more and more ill and less able to communicate.

[201] Dr. Del Bigio very much exhorted the Court to ensure that the triage process be reasonable for a vulnerable person such as Mr. Sinclair. Court heard evidence that as a result of what happened to Mr. Sinclair, there has been a fundamental revamping of the triage process at HSC ED, which I will review later in this report.

*I therefore recommend:*

*12. That all RHAs review their policies and procedures to ensure that vulnerable persons, including persons with mobility issues, are assisted by staff with the triage process immediately upon their arrival at an ED.*

## 9. The registration process for triage was subject to human error

[202] Persons arriving at HSC ED for medical care were supposed to see a triage nurse. The triage nurse would see them immediately if able to do so. However, if the triage nurse was busy with a patient, persons presenting with a medical issue would in theory be approached by either a triage aide or a security guard. This process of having a variety of staff tasked with the responsibility of registering a patient made it difficult to verify, let alone oversee and was thereby subject to error.

[203] Jordan Loechner worked as a Unit Assistant, or Triage Aide, at HSC ED from July of 2007 to September of 2009. He told the Court that he completed a three-month course at a community college in 2006 and claimed that he received on-the-job training by "shadowing someone for the day". He outlined his duties as including helping the nurses in the ED, taking names of people arriving for assistance at the ED when the triage nurses were otherwise occupied, escorting patients from the ED waiting room to the ED interior areas, answering questions at the Reception Area and stocking the ED Minor Treatment Area. He reported to the triage nurses and they directed him.

[204] He told the Court that ongoing assessment of waiting room patients was **not** in his job description. He claimed that he received no guidance from his boss, the Manager of Patient Care. His performance was monitored by nurses and the Unit Manager. No complaints about his job performance were ever brought to his attention.

[205] During his testimony, he was shown a Triage Aide job description. He was shown the duties of a Unit Assistant which included "assist with patients in the waiting room". He claimed that he was not familiar with the description: it was never shown to him at work. The job description specifies that his main function, under the delegation of the Triage Nurse, is to assist in escorting patients to treatment areas, to assist in tracking patients in the Department and to assist in monitoring the activities and interactions of patients and relatives while they are in the ED. An illustrative example of his position is to "alert Triage Nurse if patient family appears to need attention".

[206] On both days, September 19th, 2008 and September 20th, 2008, he was the ED Unit Assistant at the Triage Desk for twelve hours each day, from 10:00 a.m. to 10:00 p.m. He agreed that if the triage nurses were occupied, his duties on both those days included taking the name, time of arrival and chief complaint of a new arrival. He was tasked to write down on a notepad, also known as the "triage list", the presenting person's name, time of arrival and chief complaint. He would then put the notepad down beside the triage nurse at the Triage Desk. Mr. Loechner confirmed that it was very important for him to record information from an incoming person accurately. He also confirmed that he would **never** direct a presenting person to the waiting room without first recording their name, time of arrival and chief complaint.

[207] In fact, video evidence shows Brian Sinclair arriving at HSC ED September 19th, 2008 at 2:53 p.m. Brian Sinclair presents himself to Mr. Loechner. He is greeted by Mr. Loechner. Mr. Loechner is seen to interact with Mr. Sinclair. He leans down towards Brian Sinclair and, as Detective Sergeant O'Donovan told the Court, there is no doubt Mr. Loechner is seen addressing Brian Sinclair. Mr. Loechner holds the triage list in his hand. He appears to converse with Brian Sinclair for about 30 seconds. He is seen to bend over to get closer to Mr. Sinclair. About five minutes later, he is seen on the video setting down the triage list on the triage desk.

[208] Mr. Loechner was shown video evidence of his interacting with other people, shortly after his interaction with Mr. Sinclair, in a manner similar in duration (about 30 seconds) and content (what appeared to be conversation, while holding the triage list) to his interaction with Mr. Sinclair. Each of those people was triaged shortly after their interaction with him. He is seen on video picking up the triage list, interacting with the other people as he had with Mr. Sinclair and walking around with the triage list in his hand.

[209] When asked repeatedly, in a variety of ways, during his testimony, about having a conversation with Mr. Sinclair and bending over, he claimed that he does not know why he bent over, close to Mr. Sinclair. He agreed that there appeared to be some conversation, but he does not recall it. He testified that he did not "recall or remember" taking down Brian Sinclair's name. "I don't remember taking his name. I talked to many people." His repeated response to counsels' questions of him was: "I do not remember".

[210] Mr. Loechner was tasked with the duty to record Mr. Sinclair's name, time of arrival and chief complaint. Unfortunately, he appeared to have done none of these things.

## 10. The process for compiling the list for persons needing to be triaged was subject to human error

[211] At HSC ED on September 19th, 2008, the "triage list" consisted of handwritten entries on a notepad. An entry was made either by a security officer, a triage aide or a triage nurse. The notepad was handed back and forth, ideally ending up on the triage nurse's desk. In theory, when a name on the triage list was called and the person was spoken to by the triage nurse, that person's name was struck off the list. Mr. Loechner told the Court that once a page of the triage list was filled with names and all the names were struck off, generally that page was tossed in the garbage, usually by the nurse. In other words, no verifiable record was kept of the names on the triage list. Mr. Loechner explained that the triage list was on paper and would never be committed to memory. Nor was the list itself compiled in any order of priority. Mr. Loechner maintained that in these circumstances, keeping track of whether a person has been triaged is not possible. He did not keep track of Brian Sinclair.

[212] The triage patient list tracking process was flawed. Mr. Loechner told the Court that generally, the triage nurse would simply call out a person's name for triage. Sometimes the patient was paged on the PA. Veteran ED Nurse Elizabeth Franklin explained that the pager in use for the ED waiting room was a PA located between the two triage desks, mounted on a pillar. If a person on the triage list did not respond, the time of the call was put above the name and they were called two more times. The third call for the person on the list was usually made by a staff member in the ED waiting room itself. If there was still no response, the person's name was struck off the list. The list was eventually thrown in the garbage. There would be no follow-up for a person who was struck off the list.

[213] In 2008, there was no defined practice about how to search for missing persons before those persons were struck off the list. There was also no defined policy about how that triage list was created and maintained. It is very difficult to follow on the video exactly which staff member has the triage list at any given time. It is clear that other people were being triaged at the point when Brian Sinclair had arrived.

[214] Immediately after he heard about Brian Sinclair's demise, Security Patrol Officer Peter Van Den Oever took it upon himself to try to look for the missing triage list. He told the Court that he looked in the confidential waste bin and saw all kinds of old triage lists, along with the usual discarded coffee cups, et cetera. He looked at the triage lists extensively and found the previous days' lists. He could not find Brian Sinclair's name on any list from the relevant days. He put all the lists in a plastic bag and put the bag back into the wastebasket, assuming that someone else would look at these during a formal investigation. The bag appeared to have been removed as part of regularly-scheduled waste management.

*I therefore recommend:*

*13. That paper triage lists at any ED be eliminated and that each presenting person's information be entered electronically into a hospital registration system upon first point of contact by ED staff.*

## 11. Many persons in the Health Sciences Centre Emergency Department waiting room were not accounted for and there was unlimited public access to the Health Sciences Centre Emergency Department waiting room, with multiple points of access and entrance to the Health Sciences Centre Emergency Department

[215] The Court heard evidence from all HSC staff that back in September of 2008, access to the HSC ED was basically unrestricted: completely open to the public. There was a front door. There was a back door. There was access to the waiting room from other areas of the hospital. No one restricted the flow of pedestrian traffic through or in the waiting room. The general public, and that included people who might have simply been seeking shelter, were allowed to access the waiting room and often remained there. HSC ED has the highest patient volumes in the WRHA. Congestion was compounded by family, friends and various visitors. There was no "pre-triage" area assigned for persons to wait near the triage desk before being triaged.

[216] Norman Shatz, Head of Security for the entire HSC complex, agreed that at times, the ED waiting room was chaotic. He readily agreed that it was hard to gauge whether a person in the waiting room was a patient, a family member, a visitor or a sleeper. He confirmed that nurses sometimes allowed people to stay in the ED waiting room and the nurses would feed them. As he put it, included in the "chaos" were people sleeping, people vomiting, people screaming or moaning in pain or people intoxicated by various volatile substances. Security Patrol Officer Robert McKendry outlined that triage nurses occasionally encountered verbal or physical abuse from people in the waiting room. He would step in to attempt to de-escalate the situation. He agreed that the waiting room could be chaotic, populated by all kinds of people.

[217] Ronald Galbraith has been a Security Patrol Officer for 21 years. He described the HSC ED in 2008 as a place for people to come in off the street for medical treatment mostly, but also for warmth, shelter or food. Sometimes patrol officers and sometimes nurses gave food or blankets or drinks to persons seeking shelter. He also confirmed that there were always lots of people in wheelchairs.

[218] Veteran ED Nurse Susan Alcock outlined the problem from the ED nurse perspective: "endless traffic" through the front door, which included family, friends, strangers, police officers and security guards. It was all extremely disruptive. She pointed out that there was a second, back exit, "invisible to the Triage Nurse, way down the hall, past the washrooms" over which the ED nurses had no control and through which people had unrestricted access. In short, it was a huge concern that there was free access to the general public. The ED was not a controlled environment. Nurse Alcock confirmed that the waiting room often had "less fortunate people" sleeping or sheltering from the weather outside.

[219] Veteran ED Nurse Cathy Janke told the Court that it was common for people from the street to come to the HSC ED to have something to eat. The ED staff dealt with many poor, homeless, hungry people with diverse and complex medical problems, sometimes simply seeking shelter and warmth. There was never a formal policy on helping out people who needed food and shelter "but we were all aware it was ongoing".

[220] "Order" in HSC ED waiting room was a relative concept.

[221] The current Director of Patient Services, Laverne Sturtevant, confirmed that HSC management was aware that nurses were concerned that the triage system was not set up properly. She agreed there were many flaws, including the paper

triage list and the paging process, which could result in an incoming client becoming responsible for their own journey to triage registration, instead of keeping the onus for triage on the triage staff. She agreed that there was no policy on keeping track of who was in the waiting room. Nurses were responsible for patients and a patient was someone who had been triaged and had a chart. People were allowed to sleep in the waiting room and sometimes given a bus ticket home. Shelter and food and bus tickets were ongoing acts of kindness, which management knew about.

[222] People who had been triaged were given wristbands. People who were assessed by a physician as intoxicated and detained for transfer with the police or an agent connected with Main Street Project were also given a wristband. The rest of the ED waiting room population was completely unmonitored, barring any misbehavior or other commotion.

[223] Brian Sinclair was one of those unmonitored people.

## 12. The "new" (March, 2007) Health Sciences Centre Emergency Department waiting room design was problematic

[224] The "new" ED was 8 to 10 years in the making. In the early millennium, HSC Administration ensured that medical staff had input into the layout of the ED. The Critical Services Redevelopment Project (CSRP) was announced in 2003. Two senior nurses were involved in that project. The "new" ED was unveiled at HSC in March of 2007. Veteran ED nurses were consistent in their testimony at this inquest when they described their reactions to and experiences with the "new" 2007 version of the waiting room at HSC ED. These same nurses told the Court that they had raised their concerns with WRHA administration in a variety of ways prior to the opening of the new ED.

[225] After Brian Sinclair's death, an Administrative Review took place. The report, dated October 27th, 2008 was prepared by the Chief Nursing Officer, the Director of Patient Services and the Director of Human Resources of the WRHA. The Review said this about the staff reaction to the physical layout of the "new" ED:

> Shortly before moving into the new building, staff expressed concerns about the physical layout of the space, including the location of the triage desk and the configuration of the waiting room. In particular, staff were concerned that the waiting area was not visible to the Triage Nurses sitting at the triage

> desk and that some of the chairs were facing away from the Triage Nurses and Security, due to the location of the television at the back of the waiting room. During the interview process, considerable anger was directed towards Management for not addressing staff concerns regarding configuration of the waiting room.

[226] Although the authors of the Administrative Review concluded that it did not appear that physical space issues were causally connected to Mr. Sinclair's death, this opinion was not shared by the ED nurses. Veteran ED Nurse Elizabeth Franklin testified that she attended planning meetings prior to March of 2007, where these concerns were raised. She told the Court that concerns about the design of the new ED were voiced to Management, listened to, but not acted on, which the nurses found frustrating and somewhat demoralizing, but mostly very worrisome because of the risk to patient safety.

[227] Nurse Franklin asserted that when the triage nurse was seated at the computer at the triage desk, the view to the waiting room was obstructed. Patients and other persons in the waiting room were seated with their backs to the triage desk. However, she did agree that that if there was no other obstruction, a staff member would be able to see, from the triage desk, Brian Sinclair in the aisle, sitting with his back to the triage desk, as he was for hours.

[228] Nurse Franklin went on to explain that it was very important for nurses to see the patients in the waiting room to see if their condition changed, to see who was coming and going and to ensure everyone was safe.

[229] Nurse Susan Alcock is a CRN, the nurse in charge on any given shift at HSC ED. Nurse Alcock, a 29 year veteran ED Nurse, testified that she wrote to Management with her concerns about the proposed "new" triage and waiting room layout. In the correspondence, she critiqued the move into the new ED in March 2007. She testified that she became quite active around staffing issues and physical space issues. She felt strongly that the physical layout of the new ED would cause problems. The pre-2007 ED was smaller, but the patients were much more visible to the Triage Nurse, who used to sit in front of patients, much as a teacher would sit in front of a classroom. The entire waiting room was visible to the triage nurse.

[230] Nurse Alcock outlined her frustrations. In October of 2006, the committee she was a member of discussed a concern that patients in the new waiting room would be facing away from triage. She recalled being told, when they moved in to the new ED, that they needed to "live with it for about a year". She took that to

mean that concerns could be raised, but substantive changes would not occur. She stressed that the nurses wanted the pre-triaged population separated from the triaged population.

[231] In cross-examination, Nurse Alcock said that she was not aware that the design of the new waiting room at HSC ED centered on the comfort of the patient. She told the Court that she and her staff had safety concerns about the new ED, in part because of the obscured line of sight. The triage desk was on the extreme right. The first triage nurse sat with a limited view of the patient's backs and the second triage nurse really had no sight line to the waiting room and was in a cubbyhole in the corner. The location of the triage desk was directly in front of the police holding room, where there were often loud and disruptive patients. A pillar between the two triage desks prevented the second triage nurse from seeing into the waiting room and the pillar also limited dialogue between the two triage nurses. The security desk, manned by Security, sometimes completely obstructed a good view of the waiting room. She told the Court that she shared these concerns with Management. In fact on February 28th, 2007, there was a meeting with ED staff and the Executive that identified the physical issues, including visual issues between triage and the waiting room: patients getting lost while queuing or going to sit down or waiting to be triaged. She explained that in early 2007, attempts were made to create a pre-triage area that was roped off, but really there was no one to police it and it did not work out.

[232] Veteran ED Nurse Lori Stevens confirmed that because of ED nurses' concerns, a meeting was struck in February of 2007 between staff and Management. The ED nursing team felt that they had no input into the design of the building of the new ED. When the new ED was revealed, Nurse Stevens' reaction was: "Oh my gosh, you've got to be kidding me." From her perspective, the waiting room was "as long as a football field". There were places in the waiting room where people could be lost or hide or not be found. As she put it: "In the old department we could see everyone. We needed to see everyone because of the lack of flow. Management gave us a pat on the back and told us it would be okay. The high-backed chairs were above our sight level. We wanted people to be safe and we expressed concerns. The sight lines were not changed and that weighs on my mind….The waiting room became a multi-purpose room and we couldn't keep track." She too wanted an area roped off for pre-triaged patients. In cross-examination, she claimed not to recall a number of meetings through 2004 to 2008 between the Nurses' Union, the Nurses' Counsel and Management. She also did not recall seeing an invitation poster in 2006 asking for input from ED staff and

inviting them for tours. She did concede that there were opportunities to make suggestions to management.

*I therefore recommend:*

*14. That RHAs review the floor plan of all EDs to ensure that no persons in the ED waiting room requiring medical care face away from the triage desk.*

## 13. The Health Sciences Centre Emergency Department was understaffed

[233] Each veteran ED nurse who testified spoke of a chronic issue of understaffing in the ED. For instance, in 2006, veteran CRN Susan Alcock was part of a committee that eventually decided not to staff the Observation Area of the ED, due to the chronic issue of being short-staffed in the ED. One the recommendations of a 2004 ED Task Force as an immediate implementation was the hiring of additional nursing staff in all Winnipeg EDs. Nonetheless, I heard evidence that on a daily basis in 2008, ED nursing staff were working with only 80% capacity at HSC ED. So each day in 2008, the HSC ED nurse commenced work with baseline needs which were 20% short.

[234] Veteran CRN Susan Alcock contended that back in 2008, it was not part of any nurse's duty to completely inventorize the entire waiting room. Reassessment Nurse Todd Torfason explained that the role of a reassessment nurse in an ED is to reassess the medical condition of a person who has **already** been triaged. Nurse Alcock explained that the Emergency Care Task Force, whose final report and recommendations were made public in 2006, felt very strongly that the reassessment role following triage was crucial, since people are at risk when they wait, **after** being triaged, in the waiting room of an ED. Nurse Alcock agreed that people who have been triaged need ongoing assessment while awaiting treatment. The ED is a high risk area. Nurse Alcock pointed out that waiting without any contact by medical personnel accentuates a patient's anxiety and can lead to adverse outcomes.

[235] Nurse Franklin testified that a the reassessment nurse was set up at the entryway to the Minor Treatment Area, still within the vicinity of the ED waiting room, across from the security desk. However, in 2008, a reassessment nurse was not assigned on a regular basis. In fact, there was no reassessment nurse in the HSC ED on September 19th, 2008 when Brian Sinclair arrived at HSC ED. When no reassessment nurse was assigned for a shift, in theory, the ongoing reassessment responsibility of the waiting room rested with the triage nurse. Reassessment was

done from the triage desk when there was time. If the triage nurses were busy, no reassessment of patients in the waiting room would take place.

[236] Nurse Alcock has been a nurse for 29 years, with 21 of those years spent at the 42 bed, tertiary care HSC ED. Since 2006, she has been a CRN. In her capacity as CRN, she allocates nursing resources based on patient care needs. She acts as a mentor. She is there as a resource to answer questions and resolve conflicts. She is a conduit to management. She leads daily ED patient rounds. She also attempts to manage patient flow for the HSC ED. In other words, she tries to prevent backlog. She was the go-to person, the problem solver, ensuring everyone was doing their jobs properly. She trusted her nurses and looked to them to come to her to report a problem.

[237] As the CRN, Nurse Alcock moves around constantly. The only time she left HSC ED would be for lunch or coffee in the cafeteria. She would often walk through the ED and brainstorm with triage staff and check on how they were coping. She also helped with patients. She checked the Minor Treatment Area. She often walked out to the waiting room and called for a patient. She attended the ED waiting room to call for patients and to ensure nurses and patients were safe. On both September 19th and 20th, 2008, she worked the day shift from 7:00 a.m. to 7:00 p.m. She recalled that both shifts were, in her assessment, "horrendous", very busy with very sick patients. There were six patients waiting for beds in the main hospital and one long-stay patient who was in the ED for 59 hours. She worked hard with the hospital wards to try to move the ED patients to a ward.

[238] Nurse Alcock confirmed that short-staffing was a daily issue. She communicated both to Management and the Nurses' Union about her inability to provide enough staff or enough experienced staff. She told the Court that her practice was to try to sort out staffing issues 10 minutes before her shift commenced, make adjustments for people who had called in sick and generally deal with staffing issues that involved some reassignment. That, she said, was fairly typical. She confirmed that on September 19th, 2008, the nurse assigned to reassessment was unassigned from 3:30 p.m. to 10 p.m. She was short-staffed that day by three nurses.

[239] Nurse Alcock has definitely heard the HSC ED referred to as a "war zone". However, she could not recall any incident when a person has reported to triage and been completely overlooked. She recalled occasions where people have been overlooked, but staff has picked it up and remedied it.

[240] Cathy Janke, the Nurse in charge of the evening shift on September 19th, 2008, outlined that the shift commenced with no reassessment nurse and no nurses in the Observation Unit. She also confirmed that if there was no reassessment nurse, the triage nurse had that responsibility and it was dictated by time. Therefore, it was a problem. After 10:00 p.m., the triage nurse covered the reassessment function. In Nurse Janke's opinion, that became a risk factor to public safety.

[241] Emergency Physician Dr. Minish confirmed that there was a chronic short-staffing of Nurses and the emergency room was frequently short-staffed. In his opinion, this created a lot of stress. The Observation Area was closed, meaning six patients had to be moved into other beds, meaning six fewer treatment spots and meaning increased wait times for people in the waiting room.

## 14. Incorrect assumptions were made about Brian Sinclair's presence in the Health Sciences Centre Emergency Department waiting room

[242] Darwin Ironstand, Brian Sinclair's Integrated Support Worker, pointed out that for Brian Sinclair, barriers that affected his mobility were compounded by other stereotypes. When WRHA counsel, Mr. Olson, acknowledged a "perfect storm" occurring when Brian Sinclair sat for 34 hours in HSC ED, part of that event had to do with the working conditions at HSC ED. Part of it had to do with assumptions made about Brian Sinclair's continued presence in the waiting room. Not only was a treatable condition missed, but a treatable patient was missed.

[243] The Court heard from various expert witnesses.

[244] Dr. Balachandra, CME, was of the strong opinion that no doctor or nurse would lower their standard of care based on a patient's ethnicity. Doctors are focused on the medical condition. Doctors diagnose the medical problem that is presenting and decide what is in the best interests of the patient. Doctors are obliged as medical professionals to treat everyone. The CME has never encountered discrimination by doctors or nurses. He claimed that "Snow White" would have died in these circumstances.

[245] Counsel for the family and for the Aboriginal Legal Services of Toronto submitted that racism was at play in the health care system in general and at HSC ED specifically. Mr. Zbogar asked the Court to recommend that the Government of Manitoba call an Inquiry into the issue of how stereotyping, assumptions and attitudinal issues affect the healthcare of marginalized and Aboriginal people in

Manitoba. My report examines these issues in the context of the emergency room but the recommendations the Court suggests have a wider application. The Court will not be making a recommendation to the Government to hold an Inquiry.

[246] Dr. Janet Smylie gave expert evidence to the Court about best practices in healthcare for Indigenous persons in the ED context. Dr. Smylie attempted to make a link between what happened to Brian Sinclair and many of the factors that she is familiar with in her research. Dr. Smylie focused on individual acts of bias or stereotyping, not wishing at all to frame it as racism, because she had no desire to call it that. Dr. Smylie contended that the relationship between Brian Sinclair (the patient) and the ED staff (the medical caregiver) never really got started because of implicit associations and assumptions about Brian Sinclair.

[247] Dr. Smylie elucidated what is one of the trickier issues around stereotyping in the context of healthcare: all healthcare providers are trained and encouraged to recognize **patterns**. Experience is a great teacher. Experiential perspectives and pattern recognitions are encouraged as a huge part of the learning curve for medical staff. The Court heard evidence from a number of HSC ED staff who had prior encounters with Brian Sinclair. Some of these witnesses made assumptions about Mr. Sinclair based on past experiences with him at the ED. Dr. Smylie told the Court that assumptions based on experience and associations can sometimes result in harmful outcomes. Dr. Smylie recognized that on the one hand, there was an assumption made by some ED staff that Brian Sinclair was homeless. On the other hand, ED staff believed that they were performing a helpful service by allowing homeless people to stay in HSC ED and use it as shelter.

[248] Dr. Smylie in her evidence made an assumption about Brian Sinclair when she told the Court that she imagined that Brian Sinclair may not have spoken up to ED staff because he may have been intimidated by the ED process. The Court heard evidence from other witnesses who made it clear that Brian Sinclair was quite capable of articulating his needs in a variety of medical contexts, including at the ED.

[249] Dr. Catherine Cook is an Indigenous woman who has devoted much of her career to the development of effective and accessible health care for Indigenous persons. She was asked by the Court about assumptions that were made by staff at HSC ED about Brian Sinclair. Dr. Cook also spoke of past experiences informing present responses, but she warned of the danger of making any assumptions about a motionless or sleeping person in an ED waiting room:

> Q Doctor, we've heard evidence pertaining specifically to Brian Sinclair and how he was viewed or, or what assumptions were made about him, and I'll just give you a couple, okay? Just ask for your comment. One of the witnesses commented that Mr. Sinclair wasn't disturbed because that was the usual position you would find him in when intoxicated. So do you have any comment with respect to hearing something like that?
>
> A I guess the first thought that I would have was that assumptions were made based on, certainly, what appears to be past behaviour or situations….I think it's a very unfortunate statement…. One situation differs quite significantly from the other….And I guess that's where you start to wonder whether or not the perception or stereotypical image of Indigenous people would come to mind, rather than the actual situation itself.
>
> Q How about an assumption that Mr. Sinclair was homeless and just seeking shelter, any, any comment with respect to that? We have heard evidence that individuals did seek shelter in the emergency department. The assumption was made by a witness, at least one witness, that Mr. Sinclair was simply sleeping, seeking shelter?
>
> A Well, I think we have evidence that making those kinds of assumptions can result in critical mistakes….again, the stereotype of the Aboriginal person who was homeless within our inner city is one that results in assumptions being made and can be very critical….I think it's very important that we, regardless of our situation, I mean, there have been people who are diabetic and, you know, stumbling around with hypoglycemia, and people assume that they're intoxicated instead of approaching the individual and asking if they need help, so those kinds of assumptions are very dangerous.

[250] A number of incorrect assumptions were made about Brian Sinclair's continued presence in HSC ED waiting room.

1. <u>He was sleeping off his intoxication.</u>

[251] Gary Francis was the night shift Security Supervisor for the entire HSC complex throughout the relevant period. His shift was 7:00 p.m. to 7:00 a.m. He told the Court that he knew Brian Sinclair from his many visits to HSC over

several years. He had seen Mr. Sinclair being brought in by ambulance or on his own. He knew him to get loud in the waiting room on occasion. He told the Court that he had seen Mr. Sinclair intoxicated at times. He witnessed Mr. Sinclair yelling at nurses for blankets or food, or yelling at other people in the emergency room for looking at him. He witnessed Brian Sinclair "taking a swing" at a nurse who was trying to remove his backpack and place it somewhere secure on his wheelchair.

[252] On September 19th, 2008, his first encounter with Brian Sinclair was around 9:30 p.m. or 10:00 p.m. Security Officer Francis walked through the back door into the HSC ED waiting room and saw Brian Sinclair in the aisle near the T.V. He said hello to Mr. Sinclair, who nodded his head.

[253] He worked the same shift on Saturday, September 20th, 2008. He attended the ED security desk, which he often did during security rounds at busy times. Some time through the night, he saw Brian Sinclair there near the T.V., in the same spot in the aisle. He made no inquiries about Brian Sinclair's status. He concluded that Brian Sinclair was sleeping. He may have said hello when walking by him, but there was no interaction.

[254] A concerned citizen, Debbie MacPhail-Abraham, approached him around midnight and told him that she thought Brian Sinclair was dead. The Court can put it no better than Mr. Francis in his official report:

> While standing by in adult emergency a lady by the name of Debbie approached writer at the security kiosk and whispered that she thinks the person sitting in the black wheelchair in the aisle close to the front of the waiting room was dead. Writer looked over to see Brian Sinclair sitting there with his head slumped over as if sleeping. **I explained to Debbie that he is a regular patient and that is the usual position you would find him in when intoxicated**. Debbie stated that she was pretty sure he was dead because the back of his neck is a pasty white color and his catheter bag is not attached to the line and it is dry. (Emphasis mine)

[255] He agreed that Ms MacPhail-Abraham had to persist for him to take her seriously. He was reluctant to believe that Brian Sinclair was dead. He told Ms MacPhail-Abraham that that was the way Brian Sinclair normally slept. She said "No, he's dead." They both attended to Mr. Sinclair. He firmly tapped Brian Sinclair on his left shoulder and there was no response. Then he firmly pinched Mr. Sinclair's neck. Again, there was no response. When recounting this to the

Court, he explained that usually when people are intoxicated and they don't wake up easily, they tend to wake up when their neck is pinched. He pushed back Brian Sinclair's head with difficulty and noticed his eyes were black and his face was white. So he turned the chair around and pushed the wheelchair down the hall and spoke to the male and female nurses at the desk inside the Treatment Area of the emergency room and said he needed some help, because he thought this fellow was dead. They thought he was joking, but he explained that he was serious. Doctors commenced resuscitation after they were summoned. About a minute later, they pronounced Mr. Sinclair dead. The time noted was 12:51a.m.

[256] Security Officer Francis denied that Ms MacPhail-Abraham had to grab his jacket to get him to follow her. He did not think that Brian Sinclair was dead. He thought Ms MacPhail-Abraham was wrong and that Mr. Sinclair's catheter would still drain. That was when he made the "intoxicated" reference. When asked by counsel about the "intoxicated" reference, he told the Court that he had seen Brian Sinclair in an intoxicated state in the past. He added that "Always, they come in to get warm." Although he was quick to add that he is not suggesting that Brian Sinclair was intoxicated. And he agreed that he could not possibly tell if anyone was intoxicated by the way they sleep. He agreed that the night before, on Friday September 19th, 2008, he had observed Brian Sinclair and Brian Sinclair was not intoxicated.

[257] When he helped lift Brian Sinclair up onto a bed in resuscitation, Brian Sinclair was "stiff as a board". He agreed that the metal washbasin on the floor in front of Brian Sinclair's wheelchair was not the usual kidney-shaped basin. He had never seen that kind of bowl in that context before. He agreed it was unusual but he did not make any inquiries. After all this happened he spoke to Charge Nurse Janke and asked her where Brian Sinclair's chart was. She told him there was no chart made. The last chart was sometime earlier in September, 2008. She said they were going to have to make a chart after the fact for him.

[258] Security Officer Latour agreed that it was a common occurrence to see people sleeping in the ED waiting room and he tended to "let sleeping dogs lie", because they may have been intoxicated or under stress and they were often irritated when awakened.

2. He had been assessed on Friday, released and returned on Saturday.

[259] Howard Nepinak has been a Security Patrol Officer since 2002. Prior to that, he was a Band Constable at the Waterhen First Nation. On Friday, September 19th, 2008, he had two encounters with Brian Sinclair in the waiting room of HSC ED. Almost 18 hours later, at 1:39 p.m. on Saturday he is captured on video talking to fellow officer Peter Van Den Oeven when a concerned citizen, Dennis Grant, approaches them both to tell them that Brian Sinclair is vomiting in the waiting room. Officer Nepinak told the Court that he did not participate, since he was occupied with a "patient watch" as part of his security duty. He observed that Brian Sinclair was vomiting and appeared very weak and in pain. He agreed with counsel that his first thought was "Are you still here?" That was because he noticed that Mr. Sinclair was still in the **same** place he had been on Friday. His next thought was that Mr. Sinclair had been assessed and treated on Friday, had been discharged and then returned. He recalled discussing this thought with his security officer partner. He does not recall what his partner said.

[260] He did not explore why Mr. Sinclair was still in the same spot. He assumed his partner was in charge of the ED. His own "patient watch" continued. He finished his shift and had no further discussions. Unfortunately, he did not mention his observations about Brian Sinclair to the nurses. He assumed that Brian Sinclair had been triaged and everything was fine. The basin beside Mr. Sinclair was common. The vomiting was common. He confirmed that he saw the basin on the floor in front of Brian Sinclair with fluid in it.

[261] The CME was firm in his opinion that when an employee had seen Brian Sinclair in the waiting room on a previous shift, a day earlier and then when that employee returned to work the next day and saw Brian Sinclair in the same place, that employee ought to be concerned. Brian Sinclair ought to have been questioned, as in "Are you okay?" or else nursing staff ought to have been alerted.

[262] Similarly, Dr. Araneda was asked what she would do if she left her shift and saw a patient and then returned the next day to begin her next shift and saw the same patient in the same place. She told the Court that she would approach the patient and ask what the matter was, because that would be commonsensical. She quickly added that common sense is not as common as one would like it to be.

3. He was homeless or seeking shelter.

[263] Student Nurse Janelle McRae worked the night shift 7:30 p.m. to 7:30 a.m., September 19th - 20th, 2008 in the Minor Treatment Area of the HSC ED and she recalls it being very busy. She is seen on video briefly stepping into the waiting room to call for a patient to bring the patient to the Minor Treatment Area. She does not recall needing to go to into the waiting room. Late on Saturday evening, she had a conversation with a patient's mother, Debbie MacPhail-Abraham, who told her that she had seen a person in a wheelchair in the waiting room whom she thought had been there since the night before. Ms MacPhail-Abraham's stepdaughter, Deanna, said that it was probably someone drunk and sleeping it off. Student Nurse McRae's response to Ms MacPhail-Abraham was that sometimes people are treated and go to the waiting room because they have nowhere else to go, so they sleep or sometimes they are without a home or cold and they come in to warm up.

[264] She was thinking that there could have been more than one reason why the man was there. She thought the shelters may have been full. She had witnessed or been told about patients being discharged with nowhere else to go. She assumed that the person who had been in the waiting room "since the night before" was either homeless or had returned for shelter. She did not alert anyone about Ms MacPhail-Abraham's concerns. She told the Court that she had witnessed people sleeping over after treatment or having no place to go or people being called back to the ED after leaving. She agreed that she could have directed Ms MacPhail-Abraham to speak to the triage nurse. She assumed the information was not medically significant. She was not aware whether Mr. Sinclair had come and gone and returned or whether he had been there the whole time.

[265] She is seen on video walking past Brian Sinclair. She told the Court that she has no recall of seeing Brian Sinclair in a wheelchair with a metal washbasin in front of him.

[266] She had a second, more dramatic, conversation with Debbie MacPhail-Abraham, who told her that the person Ms MacPhail-Abraham had been concerned about earlier was not breathing and he had "lividity". Nurse McRae immediately went to the triage desk to get a senior nurse. She spoke to Triage Nurse Robert Malo (after waiting a few seconds, because he was triaging someone) and told him that there was a concern that a man in the waiting room was dead. The security guard at that point was already wheeling Brian Sinclair around. The video shows

this moment with the Triage Nurse Robert Malo at September 21st, 2008 at 12:46 p.m.

4. He had been seen by medical staff and was sleeping or seeking shelter.

[267] In fact, Triage Nurse Robert Malo had worked on the previous night, working a twelve hour night shift from 7:30 p.m. on September 19th, 2008 to 7:45 a.m. on September 20th, 2008. He readily agreed that around 4:00 a.m. to 5:00 a.m., in the early morning hours of September 20th, 2008, there were perhaps at times only seven to fourteen persons in the HSC ED waiting room. One of those persons was of course, Brian Sinclair. Nurse Malo told the Court that it was "non-stop triaging until the early morning". He checked periodically on persons in the waiting room to verify if they had a wristband. If they did have a wristband, they had been assessed by a nurse and if so, he would then check their status and ensure their chart was up to date. He did not pay much, if any, attention to the other persons in the waiting room who had no armband, because it was common for persons, other than patients waiting to be seen, to stay overnight in the waiting room.

[268] When he was shown video evidence from 4:26 a.m. on September 20th, 2008 which showed him checking to see if persons in the waiting room were patients and had wristbands on, Nurse Malo told the Court that in fact he checked Brian Sinclair's wrist to see if he was wearing a wristband. It was not unusual for him to do "a walk-through" to check that every patient was accounted for. He did not speak to Brian Sinclair. He was sleeping and he was not wearing a wristband. He made no effort to awaken Mr. Sinclair. In the seconds that he dealt with Mr. Sinclair, he assumed that Mr. Sinclair had possibly been seen and discharged earlier and was waiting for a pickup, or he was homeless and seeking shelter or perhaps IPDA, but he made no inquiry of either his fellow staff or Mr. Sinclair. As I just stated, Nurse Malo worked the same shift the following evening and was the nurse that spoke with Student Nurse McRae, but I will speak of his evidence about that encounter later in the report.

5. He was waiting for a bed in another area.

[269] Nurse Laura (Ferguson) Johnson has been a nurse since 1997 and is currently an ED Nurse Practitioner. She has taught at the University since 2008 and since August of 2011 has worked on a casual basis in HSC ED while working full-time at the Faculty of Nursing. She does consultancy work with Aboriginal treatment centres, advising or consulting about "process issues": in other words,

issues around capacity-building and how the centres are run. She has been well-trained in Aboriginal awareness courses and cultural awareness courses.

[270] On September 20th, 2008 she was a nurse practitioner in the Minor Treatment Area on a twelve-hour shift from 10:00 a.m. to 10:00 p.m. Her work there allowed her to independently assess, diagnose, prescribe and run tests and consult a doctor if an issue were beyond her scope. She recalled September 20th as being a "regular, busy day". She did not previously know Brian Sinclair. She had two contacts with him during her shift.

[271] She recalled seeing Mr. Sinclair as she stood at the entrance to the Minor Treatment Area, when she was calling a patient. Mr. Sinclair sat in the first row near the T.V. at the end of the aisle. His back was to her and she did not see his legs. She did notice a large, stainless steel washbasin in front of him and thought that quite odd and unusual. Such a washbasin had to be obtained from the clean supply room. Normally, if someone is sick in the waiting room, that person is given a kidney basin, not a washbasin. She concluded that somebody must have already been attending to him and made an effort to help him.

[272] Later in the day, she passed Brian Sinclair, and at that point she noted he was a bilateral amputee. She walked past him and noticed his head was down to the side and he looked like he was sleeping. It was all less than a minute. Her assumption was that he was "not minor treatment material" and that he was simply waiting for a bed in another area. She assumed his chart would be at the triage desk. She assumed someone had already taken care of him.

6. <u>He was awaiting medical attention from another nurse.</u>

[273] Nurse Tasia Menell worked the night shift at HSC ED on both September 19th and 20th of 2008, 7:30 p.m. to 7:30 a.m. On September 19th, 2008, she was working in the Minor Treatment Area. She received or retrieved patients' charts from the triage nurse and then called for those patients, either in person in the waiting room or using the intercom at the Minor Treatment Area station, adjacent to the ED waiting room. Although her memory of it was foggy, she did recall that she knew Brian Sinclair by name and was pretty sure that she had looked after him before.

[274] On September 20th, 2008, she was working in the acute care bed area, assisting patients with respiratory, abdominal or cardiac issues. She testified that she was "tied down" to her area. She was shown a series of video clips of her

attendance in the waiting room on a number of occasions during her shift. At 2:53 a.m., she is seen checking on a patient in a wheelchair in the aisle and then checking on a second patient in a wheelchair in the aisle before going out of camera range towards Brian Sinclair.

[275] In fact, she told the Court that she tried to speak with Brian Sinclair in the early morning hours of Saturday, September 20th. There was not much conversation. Mr. Sinclair looked at her after she said "Hi, Brian." between about 3:00 a.m. to 5:00 a.m. She agreed in cross examination that Brian Sinclair made some response, but she could not understand it. She said he was awake, located to the left of the Minor Treatment Area, near the water fountain. She does not remember it being excessively busy in the waiting room. Her memory was fuzzy: she does not remember now, but in October of 2008, she told her interviewers that she may have shaken Brian Sinclair's wheelchair to wake him up. Mr. Sinclair did not flag her down nor reach out to her. She agreed she may have said "Hey, Brian. What's up?" The notes of her early interview say that a kidney basin was in his lap. She does not remember it now. She remembered he was in a wheelchair, had a Foley catheter and he mumbled, with what she described as garbled speech.

[276] She had told the interviewers that Brian Sinclair had seemed "lethargic", but she could not attest to whether he was sick. She did not check to see if he had been triaged. She did not have a chart for him. She says there was no reason to look at other people's wristbands. She agreed that the kidney basin in Brian Sinclair's lap was certainly a sign of nausea. She did not ask Mr. Sinclair how he was feeling or if he had seen a doctor or if he needed anything, nor did she look at or ask about his catheter. She was just being pleasant. She was not worried about Brian Sinclair because of her fleeting interaction. She did not really think about why he was there. It was not really her area to check his vitals. She was not trained as a reassessment nurse. She confirmed that another nurse was responsible for patients in the waiting room: the reassessment nurse.

7. <u>He was not a security risk, so he drew no attention to himself.</u>

[277] Norman Shatz is the Coordinator of Investigations and Staff Development of the Security Department of HSC. He testified as to the perspective of HSC security personnel in general. He opined that a sleeping, disheveled Brian Sinclair would be assumed to be no security risk: he drew no attention to himself. He was not a security risk – he was a medical concern.

[278] Robert McKendry has been a Security Patrol Officer at HSC since 1999. He described his primary duty as providing a safe environment for staff and visitors. On September 19, 2008 he worked at HSC ED from 7:30 p.m. to 1:30 a.m. He witnessed Mr. Sinclair during that time wheeling himself from the second row of chairs in the waiting area to the water fountain, returning and remaining in the second row aisle, not drawing attention to himself in any way, nor asking for assistance, nor motioning for help. He would have no undue concern about somebody waiting six or seven or eight hours on a busy night. That person may simply have been watching T.V. He did not assume Brian Sinclair was intoxicated. He made no particular assumptions about Brian Sinclair being there that whole time.

8. He was sleeping, intoxicated and homeless.

[279] Alain Remillard has been a Security Patrol Officer since 2003. On September 20th, 2008, he worked the day shift in HSC ED from 7:15 a.m. to 2:30 p.m. He remembered "the double amputee" but he did not know him. There were no security issues that day, as far as he was concerned.

[280] At 12:42 p.m. on September 20, 2008, he is shown on video at the time when a concerned citizen, Dennis Grant, came up to him and told him that a man was vomiting. He told the Court that he walked part way towards Mr. Sinclair, whose head was slumped over, and he saw a pool of clear liquid at the base of Mr. Sinclair's wheelchair, so he turned back to the security desk to look for a number to call Housekeeping, to get someone to clean up the mess. He told the Court that he was not even sure if Brian Sinclair had, in his words, puked. It could have been urine. Yet he agreed that in his Incident Report that he had made a note that the patient was "puking on hospital floor" and he agreed that his report made at the time is "probably accurate". Watching the video, he agreed he could see Brian Sinclair as he walked towards him and he saw a pool of liquid at the base of the wheelchair and he could see his head slumped forward. The fluid was in plain view.

[281] Officer Remillard told the Court that he did not approach or speak with Brian Sinclair because Brian Sinclair was motionless and had his eyes closed. He assumed Mr. Sinclair was sleeping and that he did not pose any security risk. He did not fetch a kidney basin. He did not inform medical staff about the incident. He did not think it was worth contacting the medical staff over. He did not think it was a medical issue. He has witnessed people soiling themselves and vomiting. He did not smell any liquor. Nor did he pass on any information about Brian Sinclair to

the next security officer. When he returned to HSC ED waiting room to relieve his partner on supper break at 5:00 p.m., he noticed Brian Sinclair in the same position. Mr. Sinclair had not moved. Officer Remillard did not recall seeing a bowl at that point. He presumed that the mess had been cleaned up.

[282] In his briefing at the start of a shift, he would be informed of problem patients, IPDAs and "patient watches". He maintained that it was not his job to identify everybody in the emergency room. His task was to maintain the peace. Patients, once triaged, got an armband. He did not look to see if Brian Sinclair had an armband. It was not part of his job description. The emergency room was not particularly busy that day. He was on the lookout for disruptions. He observed Brian Sinclair as the Aboriginal, double amputee, sleeping in the wheelchair, looking disheveled. He told the Court that this type of thing was not infrequent. There was nothing unusual about an Aboriginal patient, a patient in a wheelchair, a patient vomiting, a patient sleeping.

[283] Video evidence shows a nurse coming out of the Minor Treatment Area, looking in the direction of Brian Sinclair. At 12:46 p.m., the cleaner arrives. Officer Remillard agreed that he watched as the housekeeper cleaned up the area around Brian Sinclair. At 12:49 p.m., his partner Peter Van Den Oever arrived to relieve him. He told the Court that he may have told Officer Van Den Oever that housekeeping was cleaning up a mess and he may have told Security Officer Van Den Oever that someone had been sick.

[284] When pressed by counsel, he agreed that vomiting is a medical problem. He was loath to agree that he even saw Brian Sinclair vomit. He never reported the incident to anyone. If he thought it was a medical issue, he would have reported it. He confirmed that he would report to a nurse if he saw anyone in distress. He did not consider Brian Sinclair to be in distress. He assumed Brian Sinclair was intoxicated and "sleeping it off". Brian Sinclair looked to him like someone who was intoxicated.

[285] He told the Court that when he returned to HSC ED at1:45 p.m., he was not advised by the relief security officer that Brian Sinclair had been sick again. There was no conversation about it. During his watch from 1:45 p.m. to 2:30 p.m., Brian Sinclair sat quietly, but he does not recall if Mr. Sinclair remained in the exact same position. He returned again at 5:00 p.m. to relieve a fellow officer. Again he saw Brian Sinclair in the same general location, with his head slumped in the same position. The camera at 5:55 p.m. catches Officer Remillard walking by Brian

Sinclair, who is sitting in his wheelchair at the end of the row of chairs, in the aisle. The metal washbasin can clearly be seen.

[286] When asked about what he thought about seeing Brian Sinclair at that time, Officer Remillard told the Court that he assumed that Brian Sinclair was simply in the same spot at the end of his 12 hour shift. He confirmed that he did not know for sure whether or not 12 hour waits in the ED waiting room were common. He has not personally observed people staying there that long. He told the Court that "once in a blue moon", he has finished his night shift, gone home and seen the same people sitting there the next morning when he returned to work.

[287] In his Incident Report, he noted Brian Sinclair as "no fixed address". He told the Court that he was under the impression that Brian Sinclair was homeless because no one was able to provide him with an address. He guessed that he probably spoke to someone in the medical staff, maybe a nurse, who said Brian Sinclair was homeless.

[288] This Officer made a number of assumptions. He assumed the vomit may have been urine. He assumed Brian Sinclair was sleeping off a drinking event. He assumed Brian Sinclair was homeless. He assumed this was not a medical issue even though he put in his report that Brian Sinclair was "puking".

9. <u>He was perhaps intoxicated.</u>

[289] Triage Nurse Wendy Krongold was the night shift Triage Nurse on September 19th to 20th, 2008. She was on duty from 7:30 p.m. to 7:30 a.m. She explained that when she starts on duty as a triage nurse, she goes through all the charts for all the patients, discussing acuity, discussing who was in the waiting room and also discussing who still needs to be triaged. When she arrived on September 19th, 2008 she said there were "one and a half pages of triaging" left to do and several stretchers in the hallway. She also worked with the team in the Minor Treatment Area. There were ambulances arriving throughout her shift. Indeed, she is noted as being the triage nurse for a "stabbing victim" at 3:11 a.m.

[290] She noticed Brian Sinclair around 4:00 a.m. for the first time. She saw the back of him and he appeared to be sleeping, because his head was to the side. She did not see his face, because he was facing the television. She had been in the waiting room prior to this on a number of occasions looking for patients. She very briefly observed Brian Sinclair. She observed he was a male and Aboriginal. She

did not recall observing that he was an amputee. She did not know Brian Sinclair from his previous visits to the HSC ED.

[291] When she was interviewed by the police on July 25, 2011, she told the police: "I think my initial thought unfortunately….he probably was an IPDA." She told the Court that she did not know why she thought that. She made no inquiries about it. It was a very brief encounter. She moved on and dealt with other patients. No one had told her that Brian Sinclair was an intoxicated person. No one had said there was an IPDA person in the waiting area.

[292] She was shown video from September 20th, 2008 at 4:15 a.m. She is seen checking on a patient in a wheelchair in the aisle directly behind Brian Sinclair, holding what appear to be charts and trying to find patients who matched the wristband to the chart. She then walks towards the washroom a few seconds later, passes Brian Sinclair and then goes back to a person covered with a blanket, appearing to try to wake the person or check for a wristband. At 4:15 a.m., she is looking for a specific patient. Shown directly in front of Brian Sinclair is another patient in a wheelchair. She speaks to neither of them. In fact, she checks on 2 of the 11 people in the waiting room, because they do fit the description of the patient she is looking for. At 5:32 a.m., she is seen chatting with a gentleman in a wheelchair. She checks for a wristband on another gentleman in a wheelchair and takes him into the Minor Treatment Area at 5:33 a.m. At 6:23 a.m., she leaves the triage desk carrying charts to look for patients, either to reassess or to match them up with their chart.

[293] Although she agreed with Counsel for the family that if Brian Sinclair was in fact IPDA, he would still be her responsibility, other ED nurses were adamant that once a person has been seen by an ED physician and diagnosed as an IPDA patient, the person then becomes the responsibility of security staff, eventually to be turned over to the police. ED Nurse Penner testified that if she came on shift and there was a person already designated IPDA, she **may** be briefed by the prior triage nurse. There was no set IPDA checklist or process. Before police arrived, the patient would be handed to security. There was no designated area for them to be held.

[294] Robert Garcia, a Supervisor of Security at HSC, outlined his understanding of the IPDA process. A person who is classified as IPDA has been so classified by an Emergency Physician and has been cleared medically. Security officers were then tasked with the duty to take care of IPDA patients, for the patient and others' safety, to ensure that they not leave the HSC until the police or another agency

escorted them to a safe shelter. Security was responsible for keeping an eye on them until the police or the agency arrived. If the IPDA patient needed to be segregated from the rest of the people in the waiting room, the IPDA patient would be held in a holding room.

[295] In 2011, policy on IPDA was clarified by the WRHA. The person is triaged, assessed, seen by a physician or emergency nurse practitioner. If the patient is not intoxicated, they can be discharged as usual. If the patient is intoxicated and determined to be a danger to self or others, Winnipeg Police Services are notified via the non-emergency line and the patient is transferred to the ED waiting room. Security services are alerted and the triage nurse has a handover report. Ongoing care of the patient in the waiting room is shared between the security service, the Community Service Worker and the triage nurses. The discharge can occur by transfer to the police or by security, in discussion with the triage nurse, determining that the patient no longer meets the criteria.

[296] Nurse Krongold was asked to comment on the fact that the HSC ED waiting room was quiet during her night shift. She stressed that a relatively empty waiting room definitely did not mean a lack of work for the triage nurse. Their work proceeds unseen. Patients are often brought in via ambulance. Police or Security needs assistance. Family members need assistance.

[297] Her initial thought about Mr. Sinclair did not change before she left her shift. The fact that he was in a wheelchair did contribute to the initial thought, because she said that drunken patients are often put in a wheelchair to protect them from falling. The fact that he was male was not a factor. The fact that he was amputee was not a factor. The fact he was Aboriginal was not a factor. She did not smell alcohol on him. She simply made a quick assumption at four o'clock in the morning on the basis that "most people are at home" at 4:00 a.m. She did concede however that at 4:00 a.m., it is just as likely that someone in that area needs medical attention. She did not recall calling in any IPDA persons that night and no one else said they had. She stressed to the Court that it would not matter what race he was. Race would never be a factor affecting her level of care given to any patient.

10. <u>He was waiting for further medical attention after being attended to by medical staff.</u>

[298] Peter Van Den Oever has been a Security Patrol Officer at HSC since 1991. He knew Brian Sinclair. He recalled that Mr. Sinclair was brought in sometimes by

paramedics in an intoxicated state. He had witnessed Mr. Sinclair become verbally aggressive and upset about a month or so earlier. At that time, Officer Van Den Oever was able to calm Mr. Sinclair down. He did not view Mr. Sinclair as a violent person. He said that Brian Sinclair was "not on our radar".

[299] Brian Sinclair was pointed out to him at the beginning of his shift on September 20th, 2008 in these terms: "The gentleman right there is sleeping and obstructing the walkway". He was on relief duty at HSC ED for part of his shift. When he was relieving an officer at HSC ED later on that afternoon, a concerned citizen, Dennis Grant, approached him and told him that Mr. Sinclair was vomiting and needed help. Mr. Van Der Oever **immediately** alerted medical staff. Officer Van Den Oever assumed that Mr. Sinclair would at that point receive some medical attention. Unfortunately, his alert did not have the desired effect.

[300] Later that evening, he noticed Brian Sinclair again as he walked by at 9:30 p.m. Mr. Sinclair seemed to be sleeping at that point. He had his head down and he was not moving. He assumed that Brian Sinclair was at that point waiting for **more** medical attention.

[301] Detective Sergeant O'Donovan confirmed that part of his investigation had to do with dispelling some of the assumptions made about Brian Sinclair.

[302] He checked the weather records to dispel the notion that Brian Sinclair was seeking shelter that weekend. On September 19th, 2008, the high temperature was 21.6 C and the low was 7.3 C with zero precipitation. On September 20th, 2008, the high was 14.2 C and the low was 3.4 C with zero precipitation. On September 21st, 2008, the high was 25.1 C and the low was 8.5 C with zero precipitation.

[303] He checked IPDA records to dispel the notion that Brian Sinclair was intoxicated. There were no entries for Mr. Sinclair for six years prior to his death and no entries ever recorded from the HSC. In other words, the police were never called to remove Brian Sinclair from HSC ED. He also checked previous ED attendances by Brian Sinclair to examine and confirm the reason for the medical visits, in order to dispel the assumption that Mr. Sinclair attended HSC ED for anything other than medical reasons. He also made an inquiry of the Main Street Project, the shelter for IPDA detainees, and found that there were no records of Brian Sinclair having ever been brought there by the Project's voluntary pickup. He confirmed that the police attended twice on September 20th, 2008 to HSC ED for removal of intoxicated people from the emergency room. Neither of those people was Brian Sinclair.

*I therefore recommend:*

*15. That RHAs review their policies and procedures to ensure that persons in ED waiting rooms are awakened at regular intervals.*

## 15. Brian Sinclair was never assessed or questioned by hospital staff after he vomited

[304] As I stated, in the early afternoon of September 20th 2008, while he sat near the T.V. in the HSC ED waiting room, Brian Sinclair began to vomit. By this time, Mr. Sinclair had been in the waiting room the entire afternoon and evening of his arrival day, the entire night of September 19th - 20th, 2008 and the entire morning of September 20th, 2008. No one from HSC had checked on his well-being. He was becoming more and more unwell as the hours passed.

[305] Dr. Smylie expressed the opinion that "compassion fatigue" on the part of medical staff is an important factor to consider. Dr. Smylie told the Court that it is important to recognize the existence of compassion fatigue in the ED environment. She defined "compassion" as the act of listening and sharing with patients to help with their issues.

[306] Compassion fatigue can occur virtually anywhere in a society that is inundated with images of trauma and human suffering. In the emergency room context, where coping with trauma is constant, compassion fatigue can be one of the by-products of managing other people's trauma. It has been referred to as "vicarious trauma" or "secondary traumatic stress". Ironically, it can arise after persons are being empathetic, giving of themselves or striving to do their best. The price of caring for others can sometimes result in compassion fatigue. A number of ED nurses testified that in 2008, there was chronic understaffing of nurses, the workload was onerous and everyone felt under pressure, all of which contributed to stress and low morale.

*I therefore recommend:*

*16. That the RHAs review the feasibility of secondary traumatic stress training for all ED staff.*

[307] The Court heard evidence that employees in the ED stayed busy in their own "silo", performing their assigned tasks and not necessarily directing their attention to other persons who were not already "patients", as defined by their system.

Emergency personnel are trained to be specialists and ED nurses are trained to take care of their **registered** patients. The unfortunate consequence can be that the **unregistered** person who is in need of medical care is not looked after.

[308] After he vomited, Mr. Sinclair was given a small "kidney basin" to use at first. When he vomited again, he was given a large, metal washbasin which was placed immediately below his wheelchair. Housekeeping also placed a yellow, "CAUTION" sign near the wet area where Mr. Sinclair's vomit had landed and had been cleaned up. The metal washbasin remained directly in front of Mr. Sinclair's wheelchair as the many hours passed and as many HSC staff passed him by.

[309] Many witnesses told the Court that HSC ED medical staff ought to have intervened after Mr. Sinclair vomited.

[310] The CME stated bluntly that the appropriate response to a person vomiting in an ED waiting room is for staff to speak to the person vomiting, ask what is going on, check his pulse and do something. Doing nothing is not the appropriate response. Multiple vomiting increases the need for intervention, because it is a sign of trouble.

[311] Reassessment Nurse Todd Torfason explained that it is not uncommon to see people in the waiting room with a kidney basin on their lap or a basin on the floor. He confirmed that were he the Reassessment Nurse on shift and saw someone vomiting in the waiting room, he would make an inquiry, in his role as the Reassessment Nurse. He would want to ensure that vital signs were taken and that there was charting of the vomiting.

[312] Veteran ED CNR Susan Alcock agreed that if a nurse were to observe that there was a metal washbasin on the floor next to a person, Nurse Alcock would expect that nurse to inquire about the well-being of the person. If someone was vomiting, it should be drawn to the attention of a nurse. If a triage aide was told that someone has vomited or there is any similar concern, a triage aide should advise the triage nurse, because vomiting is a mark of a medical issue and that requires investigation and possible treatment.

[313] Veteran ED Nurse Cathy Janke confirmed that if someone knew Brian Sinclair had vomited, it is something she as the nurse in charge would want to know and be briefed about at the start of her shift. For unexplained vomiting, the triage nurse is the go-to person and it is a cause for assessment.

[314] Nurse Practitioner Laura Johnson agreed it was odd and unusual to see a metal washbasin in the ED waiting room. That washbasin could only have been obtained from the clean supply room. If someone was vomiting, you would expect to see a kidney basin. Normally, if someone is sick, that person is given a kidney-shaped basin, not a washbasin.

[315] Dr. Araneda, an Internal Medicine Physician, opined that vomiting is the sign of a medical problem and the appropriate response to vomiting would be to expect assistance and assessment, such as taking vital signs or speaking to a doctor. Dr. Minish, an ED Physician, listed off the possible causes of vomiting in an ED: pain, stress, intestinal disorder, infection, concussion, diabetes, ulcers, cancer, psychological stress, toxins or alcohol. Vomiting, the doctor agreed, is illustrative in that it tells a health care provider something is medically wrong. It can be serious or not, but the doctor agreed it warranted some investigation as to why a person has vomited.

[316] Robert Garcia has been a HSC Security Patrol Supervisor since 2001 and was the day shift Supervisor of Security Patrol from September 19th through to September 21st, 2008 from 7:00 a.m. to 7:00 p.m. He was in charge of the entire HSC complex, with about 10 or 12 officers on each shift at that time. On September 19th and 20th, 2008, there was a "book off" in the camera monitoring room, so he sat in the second chair in that room most of the time. In his words, on his watch, he responded to "curveballs", which meant any kind of security issue. He recalls nothing "earth-shattering", except for Sunday, early morning. He says he noticed "one or two or three bowls" around Brian Sinclair, "towels and blankets and such". It was not, to Officer Garcia, an unusual circumstance and he did not pay it any particular attention. Officer Garcia told the Court that he has had plenty of experience as a security patrol officer at HSC ED. Vomiting is not uncommon. He may bring it to the attention of staff if it is "out of the norm" or if there is an escalation or elevation of a person's distress. As for who he would contact, it could be a unit assistant or a triage nurse for an immediate set of eyes. This is in fact what Officer Peter Van Den Oever did.

[317] Norman Shatz, HSC Security Services Supervisor was questioned about what a security patrol officer's responsibilities are if someone is vomiting in the waiting room. He confirmed that there is no policy around this issue. He stated that it should just be a human response. Vomiting in the ED was not uncommon, but was not something an officer may necessarily be drawn into. Security may contact Housekeeping to render the area safe. When he was questioned as to whether the security officer should pass information about vomiting to medical staff, he said it

would depend on the situation. If it deviated from the norm, he said it is still a judgment call. The officer would not necessarily alert the medical staff.

[318] Dennis Grant, a visitor to HSC ED on the morning of September 20th, 2008, certainly thought that Brian Sinclair required medical attention. Mr. Grant and his wife attended HSC ED around noon with their adult son, who had an infection. The Grants' son was triaged almost immediately upon their arrival. Mr. Grant and his wife sat in the waiting room in the first or second row of chairs facing the T.V. Mr. Grant noticed an Aboriginal man (Brian Sinclair) in a wheelchair in the aisle at the end of their row of chairs. He noticed Mr. Sinclair right away because he seemed distressed, fidgeting and rolling back and forth in his wheelchair. Mr. Grant explained what happened next.

> I thought he was blind because he didn't seem to be focusing on anything and his eyes were glazed over. I watched him vomit on two occasions. On the first occasion after he vomited all over the floor, my wife moved to the back wall and I went to the security area and spoke to security and said "My buddy is having a problem up here. I think he is sick. He needs some help. Can you do something about it?" They brought him a kidney basin. I sat down beside him. The second time he vomited he had a bowl. He didn't even try to contain it. It just spewed all over the place same as before. I think the bowl was on his lap but the vomit ended up on the floor.

[319] He was asked why he referred to Mr. Sinclair as his "buddy". His caring and trenchant response was this:

> **"I was being his advocate. He didn't have anyone with him. I was his buddy for the moment."** (Emphasis mine)

[320] In Court, Mr. Grant watched video evidence of the vomiting incident that occurred at 1:39 p.m. Mr. Grant recalled Mr. Sinclair as continuing to seem agitated, moving his wheelchair back and forth and looking around with a "vacant stare". He confirmed that after security gave Mr. Sinclair a bowl, no one but Housekeeping approached Mr. Sinclair. He recalled no conversation between the security guard and Brian Sinclair.

[321] He agreed with WRHA Counsel that security and housekeeping responded quickly, that the waiting room was extremely busy that day and staff was not at all rude. He felt it was difficult to try to get the attention of the triage nurse. He told the Court that because of the design of the waiting room, he observed that triage

was at a huge disadvantage to see everyone. That was why he approached a security guard. Mr. Grant told the Court that in his experience, HSC staff behaviour was usually exemplary.

[322] Mr. Grant's wife Evelyn also witnessed Brian Sinclair vomiting. She did not smell anything coming from Brian Sinclair. She heard him groan and throw up. His vomit shot out. She moved away, because she did not wish to have anything spill on her. Mr. Sinclair backed up his wheelchair to help housekeeping clean up. She tried to see if he had a wristband, to determine if he was a patient. She could not tell, because of his long sleeves. She did not converse with him. From her prior visits to HSC ED, in her opinion, the staff in the HSC ED waiting room was excellent to everyone and very respectful.

[323] Helen Principe has been a Housekeeper at HSC since 2007. Her various duties include collecting garbage, dusting, washing the floor and cleaning up spills. She is not medically trained. She worked on September 20th, 2008 from 7:45 a.m. to 4:00 p.m. On that day, a security guard called her to clean up vomit. The security guard showed her the site. She cleaned it up with her mop and she washed the floor and put her yellow "CAUTION" sign up. She did not converse with the person who had vomited. She says the vomit was clear. Video evidence recorded this event at 12:46 p.m. She then told the Court of a second call from the security guard about the same thing. She put her sign down again. The vomit was watery again. The video recorded this event at 1:42 p.m. She did notice it was the same person. On the second occasion, she suggested to security that they needed a bigger vomit container, given how much vomit there was, so they retrieved a large washbasin. That was the only time she had ever done that.

[324] No one had to direct her to the person who had vomited. It was obvious. She saw where it happened. When asked whose job it is to bring the kidney basin, she said it was not her job: it was the triage aide's job.

[325] Security Patrol Officer Peter Van Den Oever explained the incident from his perspective. At 1:39 p.m. on September 20th, 2008, Security Officer Van Den Oever and his colleague Security Officer Nepinak were manning the security desk in the HSC ED waiting room, when Mr. Grant approached them both and told them someone had been sick in the waiting room. Officer Van Den Oever immediately went to the triage desk, opened the triage door to retrieve a kidney basin, then walked over to Brian Sinclair and offered Brian Sinclair the kidney basin, saying, "Here you go, buddy". He observed Brian Sinclair's eyes to be open and he appeared alert, but Mr. Sinclair grimaced as if he was in some discomfort.

Officer Van Den Oever saw clear liquid on the floor in front of the wheelchair and saw that Mr. Sinclair had soiled the front of his jacket. He definitely thought the clear fluid was odd so he wanted to alert staff at the triage desk. He was concerned. He wanted the medical staff to know what had happened. He thought it was a legitimate medical issue.

[326] Officer Van Den Oever then headed back towards the triage desk to get medical staff's attention. He believed that Triage Aide Jordan Loechner could see Brian Sinclair from where they both stood. Officer Van Den Oever told the triage aide about Mr. Sinclair.

[327] In his Incident Report, he wrote that his conversation with Mr. Loechner pertained to "a male who did not look too good". He could not recall the response he received from Mr. Loechner. In his Incident Report, he said that the triage aide nodded when he told the triage aide about the male who did not look good. When he testified at the inquest, he was unsure whether Mr. Loechner nodded. However, he believed that Mr. Loechner heard him and he assumed that Mr. Loechner would follow up. Their conversation ended at 1:41 p.m.

[328] Housekeeper Principe was cleaning up around Brian Sinclair. She advised Officer Van Den Oever that Mr. Sinclair needed a larger basin because he had filled the kidney-shaped basin. He deposited the dirty kidney basin in the Dirty Equipment Room, which is in the Minor Treatment Area. On his way back, he recalled that he remarked to both the housekeeper Ms Principe and the triage aide Mr. Loechner that it was the triage aide's duty to provide and dispose of kidney basins. He recalled that Mr. Loechner had responded that he was busy at the time.

[329] Officer Van Den Oever brought Brian Sinclair a metal washbasin about five minutes later and he said to Mr. Sinclair, "Here, let me trade with you". He handed Mr. Sinclair the bowl. Brian Sinclair said nothing, but Officer Van Den Oever did remember his grimacing. He confirmed that washbasins were not stored at the triage desk but in the Clean Equipment Room.

[330] In cross-examination, Officer Van Den Oever readily agreed that there was a need for a medical person to look into Mr. Sinclair's situation. He thought it was a legitimate medical issue. He definitely thought the clear fluid was odd and that is why he wanted to alert staff at the triage desk. That was why he saw fit to draw it to Mr. Loechner, the triage aide's attention. He recalled the triage aide looking in Brian Sinclair's direction. Officer Van Den Oever assumed that Mr. Loechner saw Brian Sinclair. Had Officer Van Den Oever known Brian Sinclair had been there as

long as he had been and was now vomiting, he would have had even greater concern about Brian Sinclair getting medical attention.

[331] So, Officer Van Den Oever had indeed alerted the medical staff. Mr. Loechner, the triage aide, agreed that if he received medical information about an incoming person, his job was to report it to a triage nurse and then it was the triage nurse's responsibility to take care of the medical problem. Mr. Loechner agreed that he would report anything of medical significance to the triage nurse. If someone was vomiting in the waiting room, he would generally report it.

[332] Mr. Loechner confirmed to counsel that he has no memory impairment. He recalled that he had contact on September 20th, 2008 with Officer Peter Van Den Oever. He recalled that he was taking a patient somewhere and Officer Van Den Oever asked him to grab a kidney basin and he told Officer Van Den Oever that he would get it on his way back. By the time Mr. Loechner returned, Officer Van Den Oever told him not to worry about it and said: "I already got it."

[333] That was the only conversation he remembered having with Mr. Van Den Oever. He was then shown Officer Van Den Oever's written report, wherein Officer Van Den Oever reported telling Mr. Loechner: "This male does not look good." In fact, video evidence verified that at 1:39 p.m., Mr. Van Den Oever is seen fetching a kidney basin from the triage desk and returning shortly to the triage desk where Mr. Loechner is located.

[334] Mr. Loechner recalled a conversation taking place with Mr. Van Den Oever in the entranceway to the main area across from the security desk, but he did not recall the content of the conversation. Nor did Mr. Loechner recall the officer pointing anyone out to him. Nor did he recall if he reported the officer's conversation about the kidney basin to the triage nurse. Mr. Loechner was asked in cross examination to explain why he is noted as telling WRHA counsel in October of 2008 that Officer Van Den Oever said to him: "That guy over there needs a kidney basin." His response in Court was that the officer did not gesture to him. The WRHA interview notes also indicated that Mr. Loechner remembered seeing someone of Brian Sinclair's description around the time Mr. Sinclair was given a kidney bowl. He was also asked to explain why it is noted that he told the interviewers: "I glanced over there and saw Mr. Sinclair." His explanation to the Court was: "I do not recall. This was a long time ago."

[335] When questioned about his interaction with Officer Van Den Oever, Mr. Loechner maintained that he did not recall the security guard asking for a patient to

have a kidney basin because of vomiting. He remembered simply being asked: "Can you get me a kidney basin?" When it was pointed out to him by counsel that the only use for a kidney basin is for someone who is vomiting, his answer was: "I'm not sure if I understood that." When pressed, he conceded: "I would have made that inference. He never gestured to me. All he asked was he needed a basin. I didn't know who needed it." When confronted that he is also noted as telling his interviewers shortly after the incident, "I glanced at him, Brian Sinclair, again." he contended that he does not recall saying any of this to WRHA counsel, nor does he recall it happening that way. He told the Court that he could not be sure he gave those responses either way. He did not remember telling the WRHA interviewers any of this, nor did he recall the exact conversation with Mr. Van Den Oever.

[336] He did agree that in his duty as a triage aide, he is expected to bring an incident of vomiting in the waiting room to a nurse's attention. He did not recall if he reported the vomiting to a triage nurse, or indeed doing anything about it. When pressed about whether he passed this information on, he answered: "Maybe, maybe not." When accused of indifference to Brian Sinclair's plight, he responded: "I am not sure if I reported it. It was a busy day." He also claimed there was no reassessment nurse. When it was pointed out to him that Lori Stevens was the reassessment nurse on duty that day, he cannot recall having any conversation with her. When it was suggested to Mr. Loechner that there is no evidence he told anyone about the vomiting, Mr. Loechner was loath to speculate or draw conclusions.

*I therefore recommend:*

*17. That the RHAs review their policies and procedures to ensure that staff intervenes when a person is vomiting in an ED.*

## 16. Brian Sinclair was never assessed by a nurse during his 34 hours in the Health Sciences Centre Emergency Department waiting room

[337] WRHA Chief Nursing Officer Lori Lamont agreed that the riskiest patient in the entire hospital is the un-triaged patient in the ED.

[338] As part of the WRHA ED implementation guidelines for the emerging role of the reassessment nurse, it was recognized that emergency care must be initiated as soon as possible after a patient enters the ED. The waiting room in the ED is a high-risk area. The role of the reassessment nurse was set up to address risk management issues. The expectation was to enhance communication between

patient and nursing staff, to facilitate patient flow, to enable implementation of care and comfort measures, to allow for flexibility within the nursing unit and ultimately to enhance patients' satisfaction. The stated proviso was that "the demands of the ED may affect the ability to consistently meet the CTAS guidelines." Reassessment Nurse Todd Torfason opined that the stated goal of changing the ED culture did not succeed. The goals of reassessment are still difficult to achieve.

[339] CTAS involves the assessment of emergency patients dependent on their level of acuity; the severity of their medical situation. The more ill a patient, the more frequently he or she ought to be assessed. As I stated earlier, CTAS levels 1 through 5 run the gamut from someone needing immediate care (CTAS1) to someone in a non-urgent situation (CTAS5):

- a CTAS1 patient requires constant care;
- a CTAS2 patient requires reassessment every 15 minutes;
- a CTAS3 patient requires reassessment every 30 minutes;
- a CTAS4 patient requires reassessment every 60 minutes; and
- a CTAS5 patient requires reassessment every two hours.

[340] Nurse Torfason readily agreed that these times are ideals. The CTAS implementation guidelines are objectives for optimal situations. In a perfect world, patients would immediately see a doctor, not a nurse.

[341] He explained that the reassessment nurse at HSC ED worked from a workstation in the Minor Treatment Area, adjacent to the ED waiting room. He confirmed that in 2008, the only shift for reassessment nurses was from 10:00 a.m. to 10:00 p.m. Thus, from 10:00 p.m. to 10:00 a.m., the ED triage nurses were *de facto* reassessment nurses. However, reassessment nurses were assigned to replace the triage nurses on their breaks. Furthermore, Nurse Torfason told the Court that he was often pulled off his assignment to relieve other areas of the ED.  he ability to reassess was often interrupted. Reassessment Nurse Lori Stevens agreed, telling the Court that when the reassessment nurse relieves other nurses for their breaks, or is pulled to other areas of the ED such as the Resuscitation Room to help out, all these other duties can eat up easily five hours of a twelve hour shift.

[342] On September 19th, 2008, Nurse Torfason had an office day from 7:30 a.m. to 3:30 p.m., but because of the fact that the ED was short-staffed, he became the reassessment nurse at 10:00 a.m., working in the ED. By 1:30 p.m., he was caught up and quite happy, because that seldom happened. He had reassessed all the

triaged patients. It is rare to be caught up. In fact, at about 2:30 p.m., he was reassigned to the ED Resuscitation Room. He worked overtime that day, from 3:30 p.m. to 7:30 p.m. in the Resuscitation Room, with patients of the highest acuity.

[343] On September 19th, 2008, he recalled seeing a woman sitting in the waiting room with her leg up on a chair. He asked her if she was waiting to see a doctor and she said she was waiting for a cast change. He does not recall seeing Brian Sinclair on September 19th, 2008 when he was working. He had been reassigned prior to Brian Sinclair's arrival.

[344] He agreed that prior to 2008, he occasionally discovered people in the waiting room who had not been triaged. He recalled that it was less than ten occasions. If he saw someone he thought is not moving through the system, he would check it out, even though they were not his patients *per se*. He agreed that if patients show signs of distress, as the reassessment nurse it is his job to pay attention to them and if patients are **not** vocal, they need to be reassessed in the same manner.

[345] Lori Stevens has been at HSC since 1976. She has been at HSC ED since August of 1997. From 2004 to 2008 she was a reassessment nurse. She became a charge nurse in 2008. Nurse Stevens explained that she helped develop the role of the reassessment nurse around the time of the ED Task Force of 2004 because of the exceptionally long wait times in ED. She described her work location at HSC ED in 2008 as adjacent to the waiting room in "a cubbyhole" with a desk, a computer and charts. She eventually agreed with WRHA counsel that there were lots of discussions with Management and attempts to accommodate nurses' concerns, including the reassessment location. But she wanted the Court to know that the ED nurses still had concerns, because they felt the layout was not safe.

[346] If she took a chart to reassess someone, she left the patient's ID sticker to indicate that she had the chart. She would call a patient into her space and take vital signs and discuss concerns about the presenting complaint. Acuity levels were assessed and assigned at triage. By reassessing a triaged person, she could obtain a more current acuity assessment and adjust patients in order of priority. A reassessment ticket is put on the medical chart each time a patient is reassessed, which is a visual cue that the patient has been reassessed and when the patient should be reassessed again. Nurse Stevens said that if the ED was busy, it was possible for her not to attend the waiting room throughout her shift. Patients were simply called to her work space.

[347] On September 20th, 2008, Nurse Stevens was assigned as the Reassessment Nurse for the usual day shift of 10:00 a.m. to 10:00 p.m. She proceeded to the triage desk and met with the triage nurses, who were in her words "going full speed all of the time". She was updated by the triage nurses.

[348] Nurse Stevens did not know Brian Sinclair from any previous encounter. She recalled seeing Mr. Sinclair once during her entire 12 hour shift. She attended the waiting room to look for a patient. She told the Court that around 2:00 p.m., she observed Brian Sinclair: "I saw a person with no legs" She observed him in the first row of chairs facing the T.V. in a wheelchair, wheeling himself over the top of a metal washbasin. She watched as he was able to clear the washbasin, because he had no legs and he wheeled himself towards the back hall. This of course was Brian Sinclair. No red flag was raised in her mind because she recalled that the washbasin was empty and the person, in her words, was "mobile". Nurse Stevens told the Court that all of this is disturbing for her to think about it now. She explained that if the basin had something in it, she would never leave it there. She agreed that it was not common to see such a washbasin, which comes from the clean room, accessible only by HSC staff.

[349] As stated, the role of a reassessment nurse is to reassess patients after they have been triaged and registered in the system. Brian Sinclair was never triaged. Nurse Stevens was on duty on September 20th, 2008 during the time that Brian Sinclair vomited. She readily agreed in Court that vomiting is a sign of illness. She stressed that as a Reassessment Nurse, if she had been aware of someone vomiting, she would check on that person. She would mention the vomiting to the triage nurse if she could not follow up herself.

[350] On cross-examination, she agreed that when she was interviewed in October of 2008 by WRHA Counsel, she was being truthful and she may have had a better recall. In October of 2008, she seemed to have told the WRHA interviewers that she had seen fluid on the floor beside the basin in front of Brian Sinclair's wheelchair and she recalled security saying that they had called someone to clean up a couple of spots. She has no recall of making the statements and she has no recall of it actually happening in that fashion.

[351] From the Court's perspective, it is unfortunate that the notes taken by the interviewers back in 2008 were not initialed or somehow authenticated by the interviewees at the time the notes were taken. Inquests often take place long after the critical incident in question has occurred. This issue is not new to the inquest process.

*I therefore recommend:*

*18. That the RHAs review their policies and procedures with respect to interview notes taken on behalf of hospital Administration after the occurrence of critical incidents, with a view to having the notes dated and initialed or otherwise authenticated by the interviewee.*

[352] Nurse Stevens adamantly denied that there was any fluid on the floor or fluid beside the basin adjacent to Brian Sinclair. She had no recollection that someone had seen fluid on the floor. She stressed that she would have done something had she known someone was vomiting. She was not aware that someone had vomited. She was shown video evidence of Brian Sinclair in the wheelchair on September 20th, 2008. This did not refresh her memory as to his being there on her shift. She was shown video of herself coming out of the Minor Treatment Area and surveying the waiting room on more than one occasion. After watching a number of video clips showing her walking near and past Mr. Sinclair, she readily agreed that she might have seen Mr. Sinclair, but it did not register with her.

[353] Ms Hill pointed out to Nurse Stevens that in the video, one can see a large, yellow, "CAUTION" sign on the floor near Brian Sinclair. Nurse Stevens confirmed that the sign could indicate any number of spills: a beverage spill, a vomit spill or a blood spill. She agreed that seeing the sign might clue her in to make some inquiries. She agreed that if someone was in medical distress, whether they have a chart or not does not matter. Whether they are triaged, it does not matter: she would help them.

[354] On September 21st, 2008, she was working when she found out about Brian Sinclair's death. She does not remember discussing it with a security officer that day. When confronted with the fact that Security Patrol Officer Van Den Oever testified that she approached him on September 21st, 2008 and initiated a conversation at the security desk, telling him that the day before, she had seen Brian Sinclair wheeling himself around and Brian Sinclair had vomited, she finds that very hard to believe. She told the Court that she does not recall the conversation ever taking place.

[355] The Triage Aide Mr. Loechner was on duty for two shifts of ten hours duration while Brian Sinclair waited for medical attention: September 19th and September 20th, 2008. During those two day shifts Mr. Loechner can be seen on video occasionally in the vicinity of or walking past Brian Sinclair. Mr. Loechner agreed that if you stand near the triage desk, as he did during his shifts, one can see

most of the waiting room area, including the area where Brian Sinclair sat. He agreed that Brian Sinclair was potentially in his line of sight, "along with everyone else". When shown video that Brian Sinclair had basically been in the same place in the waiting room for hours, he maintained: "At the time, I don't recall seeing him." When asked if part of his job was to keep track of the people he has pre-triaged, his answer was "I do not recall seeing him." He pointed out that he was seldom seen on the video because he was busy performing other duties up front and in the back.

[356] Valerie Penner (nee Hiebert) has been a nurse since 1998. She has worked at HSC ED since 2002 and became a CRN in 2006. Since 2010 she has been the Clinical Education Coordinator in the Interlake region of Manitoba. Her testimony pertained to a conversation Edward Latour, the security patrol officer said he had with her, when he pointed out that Brian Sinclair did not look good.

[357] Edward Latour commenced his work as a Security Officer in 2001. He retired in 2009. He described his duty as "keeping the peace". On Friday, September 21st, 2008 he worked the night shift from 7:30 p.m. to 7:30 a.m. He was on duty in the ED from 7:30 p.m. to 1:30 a.m. He recalled seeing Brian Sinclair. He described Brian Sinclair as one of many who would come and go. He had dealt with Mr. Sinclair a number of times over the years. He did not note any disturbance by Brian Sinclair. On Friday evening, he was on a "patient watch" with a potentially violent young man, with whom he stayed in the holding room all night.

[358] On Saturday, September 20th, 2008 he was patrolling the outer perimeters but went into the ED as a backup. Quite late in his shift, at approximately 11:00 p.m., he saw Brian Sinclair in the ED waiting room. He recalled seeing Brian Sinclair the previous night. He observed that Brian Sinclair was **still** in the same location, in the aisle leading to the washrooms, near the T.V., slumped over, head bowed - that concerned him. In his Incident Report to Management, he wrote that because he was assigned to HSC ED the previous night, he remembered the patient from the previous night. Being "suspicious", he returned to the triage desk and raised concern with the triage nurse. He in fact spoke with Nurse Penner. He told the Court that he entered the triage area itself to speak to the triage nurse privately. This was captured on camera, shortly after 11:00 p.m. on September 20th, 2008. The conversation was about his general concern that a patient was still in the waiting room. He recalled the man from the night before and he expressed a concern as in, "Is he okay? Is he going to be seen?" He recalled Nurse Penner responding to the effect of "Yes, he has been treated, and he has gone home and

returned." In his report, he recalled that the nurse told him that the patient had been released "earlier in the day".

[359] He accepted Nurse Penner's response as reasonable and left the ED for his duties outside. When he was speaking to Nurse Penner, he wanted to keep it private and discreet and so he pointed in the direction of Brian Sinclair and told her that he still seemed to be in the same position. The whole conversation took about 14 seconds. He recalled that he identified Brian Sinclair as the gentleman amputee in the wheelchair. He could see Brian Sinclair from where he was pointing and he believed that Nurse Penner could see Mr. Sinclair also, because Brian Sinclair was at the end of a row of the chairs, in the aisle leading to the washroom. He told the Court that the triage nurse gave him her full attention, was not distracted or irritated and did not seem to be brushing him off.

[360] Officer Latour agreed that the chairs and wheelchairs in the ED waiting room faced away from the triage desk. He calculated the distance from the triage desk to the television as about 100 feet: possibly not that far. He agreed it was a brief conversation. He agreed that Brian Sinclair was about 80 feet away from the triage desk, facing away. He agreed that he could not recall exactly what he said to Nurse Penner. He agreed in cross-examination by WRHA counsel that it is possible that Nurse Penner made a more general statement that "people are often treated, go home and come back the next day".

[361] Officer Latour told Counsel for the family that the word "suspicious" was written by him in his report because he felt some responsibility for Mr. Sinclair. It was a matter of common sense that some inquiry should be made. He checked with the triage nurse, because she is charged with the responsibility for patients in the emergency room. He had no doubt she fully understood that Brian Sinclair had been there in the same place as the previous night. There were no other amputees in wheelchairs and he does not recall seeing any other wheelchairs in the line of sight.

[362] Nurse Penner had no recall of the conversation with Officer Latour. On September 19th, 2008, she was on an office day and she did not recall going into the waiting room that shift. On September 20th, 2008, she was working the night shift as a triage nurse. She recalled that most of her time would have been at the triage desk. She remembered the ED traffic being steady, with what she called "the usual busy-ness". She knew Brian Sinclair from his prior visits to the HSC ED, but did not know him by name. She does not recall seeing Brian Sinclair on September 20th, 2008.

[363] She was shown video from September 20th, 2008 at 11:00 p.m. which shows her at the triage desk being approached and spoken to by Security Patrol Officer Ed Latour, who points somewhere to his left. She too looks to her left after he points. They are seen to converse. When asked about all this, she recalled neither the conversation nor the encounter. She stated that from her vantage point at the triage desk, her line of sight was blocked from looking down the entire length of the waiting room.

[364] She was asked what she ought to do if a security officer had expressed to her a concern that a person was in the waiting room who was there the night before. She responded that she would investigate.

[365] Counsel for the WRHA took Nurse Penner through the records and video of a patient who was triaged and seen by a doctor for stab wounds. The patient had attended HSC ED on September 20th, 2008 at approximately 3:14 a.m. and was discharged at 12:30 p.m., when she was not on duty. However, she was on duty at 10:45 p.m., when the patient returned and was triaged by her for approximately eight minutes at 10:43 p.m. At 10:56 p.m, the patient's girlfriend is seen on video wheeling him out of the front door of HSC ED while Ms. Penner triages the next person. At 11:00 p.m., Officer Latour is seen coming through the front doors, walking towards the washroom. The patient and his girlfriend come back through the front door and the patient gets up out of his wheelchair and both of them go outside for a while. Approximately a minute later is when Mr. Latour opens up the triage desk door and comes in to chat with Nurse Penner.

[366] Watching all this, Nurse Penner agreed with Counsel for the WRHA that when Officer Latour expressed the concern to her about a guy being there the night before and "he is still here", her response that "the patient had been released earlier in the day and returned feeling ill" makes much more sense in reference to the patient who had been stabbed earlier in the day and returned feeling ill. The wheelchair occupied by Brian Sinclair is over to her left, down the aisle leading to the washroom. The unoccupied wheelchair is over to the left but much closer to the security desk. This was the wheelchair that had been occupied by the stabbing victim 30 seconds earlier and would be occupied by him again very shortly. She agreed that the wheelchair used by the stabbing victim was right beside where the security officer was pointing and both she and Mr. Latour were looking in the direction of the wheelchair of the stabbing victim.

[367] She stressed that she actually had no recall of her interaction with Officer Latour, even though she agreed that the explanation suggested by counsel for the

WRHA did make the most sense to her. She does not even recall triaging the stabbing victim, but she would have known from his chart that he had been there earlier in the day.

[368] Cathy Collis has nursed since 1993 and has worked in various locations and EDs in Canada and Saudi Arabia. She has worked at HSC ED since 2003, first as a General Duty Nurse, then in 2005 as a CRN. She is currently a Nurse Educator of Adult Emergency Department Nursing and Orientation. On Saturday, September 20th, 2008, she was working in the Resuscitation Room of the ED. The first time on her shift that she saw Brian Sinclair was when he was brought into the Resuscitation Room. She did not know him. She documented the resuscitation record as a "Code Blue" which meant the patient had no pulse. The record created as a result of this event indicated that there were "no interventions prior to the event".

[369] She agreed with counsel for the Sinclair family that if an ED nurse is told that a patient has been in the ED for 24 hours, the response should be, "Why is he waiting? Shelter? Bed? Triage?" In other words, some inquiry is necessary and it should not be ignored. It is not routine for someone to be there for 24 hours so someone should try to find out why. If she was advised that someone was worried about a person in the waiting room, she would check.

[370] Triage Nurse Robert Malo was one of the two triage nurses who worked the HSC ED evening shift, from 7:30 p.m. on September 20th, 2008 to 7:45 a.m. on September 21st, 2008. He had worked the previous evening shift and recalled momentary contact with Brian Sinclair during the middle of the previous night. Brian Sinclair had been sleeping. However, he maintained, as he put it, that he did not notice "a double amputee" throughout this second evening shift. He did not notice Brian Sinclair until he saw him in the Resuscitation Room.

[371] He did recall that Student Nurse McRae had told him sometime during that second evening shift that that a security officer had told Student Nurse McRae that "someone in a wheelchair needed help". He did not recall her pointing to anyone in particular and he recalled no urgency in her voice. Since he concluded that there was no urgency in her request of him, he told Student Nurse McRae that he would be there as soon as he finished triaging the current patient. Once he finished triaging the patient, he looked out into the ED waiting room and saw "no commotion", nothing of note as far as he was concerned, so he did not follow up on Student Nurse McRae's request of him. Minutes later, Nurse Krongold told him that they had found Brian Sinclair dead. He went to the Resuscitation Room and

saw the same gentleman that he had seen the previous shift – Brian Sinclair – and that indeed, Brian Sinclair was dead.

[372] He watched video evidence that clearly showed Student Nurse McRae speaking with him at the triage desk at 12:47 a.m. on September 21st, 2008, pointing toward where Brian Sinclair was slumped in his wheelchair. Nurse Malo told the Court that he could not recall if she pointed or not.

[373] He told the Court that he was not aware of any occasion when a person had been missed by the triage process. He stressed that most people tended to voice their concerns if they had not been seen. He maintained that he had not seen Brian Sinclair during that second evening shift. If he had noticed Brian Sinclair, it might have raised a concern, but he added that it was not unusual to see the same person in the ED on consecutive days or nights. Court was shown a video image of Brian Sinclair captured at 11:24 p.m. on September 20th, 2008. Mr. Sinclair is in the same position he was the previous evening when Nurse Malo had checked his arm for a wristband. Nurse Malo did agree with Counsel for the family that it was not typical to be in the same spot on two consecutive nights.

[374] Nurse Malo watched video evidence from the second evening shift showing him at 11:00 p.m. walking past what was then a deceased Brian Sinclair. The metal washbasin was still beneath Mr. Sinclair. Nurse Malo reiterated that he did not recall seeing Mr. Sinclair that shift until he saw him in the Resuscitation Room.

[375] Court heard from Cathy Janke, another veteran ED nurse, who graduated in 1992. Since 2000, she has worked part-time at HSC ED. Since 2005, she has worked as a CRN in a .3 position, working 12-hour shifts. As a CRN, she is responsible for overseeing the assignment of staff and the movement of patients through the ED. She is the most senior nurse on shift, with a desk in the large main area. She described herself as on the move constantly. She carries a phone and receives constant calls from ambulance, flights and clinics. When she comes on shift, the prior CRN gives her a verbal and written report about all the patients in the emergency room. After that, she does a physical round throughout the ED to view the patients. She then proceeds to the triage area to view the charts and to assess the prioritization. She defined rounds as “a fresh set of eyes” and repeats this process throughout the shift. Generally speaking, none of this takes her into the waiting room. During rounds, she did not travel through the waiting room to look at anyone. From her perspective, the waiting room had lots of visitors and sitters and there was a back door and a steady flow of traffic, so there is no point.

[376] She worked the night shift from 7:30 p.m. to 7:30 a.m. on September 19th and 20th, 2008. The September 19th shift was busy. There was a shortage of three nurses. From 11:30 p.m. to 7:30 a.m., the observation room was closed and there was no reassessment nurse.

[377] Nurse Janke told the Court that September 20th was also very busy. They were taking lots of ambulance calls and there were six to eight people waiting in the ED to be admitted to a hospital ward. At the commencement of her shift on September 20th, 2008, nobody had made her aware that someone had been vomiting. She was aware of a patient who had been in on Friday with shortness of breath and that patient was back in on Saturday for the same medical issue. She knew the patient (Deanna Abraham) because she was a Health Care Aide. Nurse Janke talked to the patient's father (Glenn Abraham) who in Nurse Janke's words was "not happy". To Nurse Janke, the father seemed focused on the fact that it was very busy and he seemed unfriendly. His wife worked in health care and she had seen a fellow out in the waiting room. Both he and his wife thought the fellow looked sick. Nurse Janke told them: "There are many return patients." No alarm bells sounded during this conversation.

[378] Charge Nurse Janke told the Court that she was not advised when she arrived on shift on September 20th, 2008 that Brian Sinclair had vomited. She agrees vomiting is a medical problem and she agrees that vomiting in the ED means it is important to find out why it is occurring and you do check it out. If someone knew he had vomited, it is something she would want to know and be briefed about at the start of the shift. For unexplained vomiting, the triage nurse is the "go-to" person and it is a cause for assessment. She agrees it is uncommon to provide a patient with a washbasin. She is shown the video of Brian Sinclair at 11:25 p.m. on September 20th, 2008 with a large metal bowl in front of the wheelchair. She testified that she did not observe the washbasin: she does not remember seeing Mr. Sinclair or the bowl. If she had seen the washbasin, she would have taken note of it and would have looked at the patient to see if it was connected to him. It would have triggered an intervention. In other words, she would have spoken with the person. It would merit an inquiry.

*I therefore recommend:*

*19. That the RHAs review handover policies in the ED to ensure that the oncoming triage and reassessment nurses are fully briefed on the status of persons present in the waiting room.*

[379] In cross-examination, she agreed that the father said "This person has not moved since the previous day." She claimed there was no urgency in his voice or his request. There was no "call for help". Even knowing that a patient had been there the night before and was there now, the following night, would not necessarily ring alarm bells to her. She testified that such an event was quite common. She stated that if a third party draws her attention to a particular patient, she intervenes on the basis of urgency and action required. If the request to look a patient is, in her words, "vague", she may not give it her immediate attention. The father did not say words to effect of "Quick! Come with me – look at this person."

[380] She was questioned by Ms Hill as why she did not try to make it less vague with follow-up questions like "Who are you talking about? Where is this person? What makes you think he's sick?" Her answer was that third parties are not in the best position to assess urgency. She did not agree with the suggestion that patients can be intimidated by nurses. Nurse Janke did agree that nurses have more power than patients in this context. She was loath to agree with the suggestion that nurses can and do shut patients down. She readily agreed that a cognitive disability can impact the ability of a person to communicate a concern.

[381] She told the Court that she did feel that Mr. Abraham's concern was odd, so she looked in the waiting room from the Minor Treatment Area. She saw no one in immediate distress. She did not see anyone that needed immediate care. She concluded that the father was angry about what was happening with his daughter. She concluded that the person the father was referring to (who was of course Brian Sinclair) may have been discharged the day before and had simply returned to the ED. She felt she acted prudently. She agreed with Counsel that she told the father that they were busy and they would get to him. She does not recall that the father raised this issue twice.

[382] She was shown a video from September 20th, 2008 around 8:30 p.m. on, which she agreed might have been when she checked the waiting room in response to the father's concern. She told the Court that nothing caught her attention. She "did not see anybody who was in immediate need of assistance". She saw no one "clutching their chest, dropping over, falling, screaming, wailing, crying…." She saw no "projectile vomiting".

[383] She agreed with counsel that cues of distress can often be subtle. She said she was not given a description of the patient the father was referring to. She was pressed by counsel and asked if she did not notice anyone who was ill or dead. She

said she did not. When she was asked why she never noticed Brian Sinclair, who was, by that time, probably dead, she answered:

> "A dead person doesn't move."

[384] She agreed that ordinarily, when she was scanning the waiting room looking for a specific patient, she often tried to avoid direct eye contact or interactions. She explained that this was not because she was intimidated or did not care, but because she had no time. Interaction with people in the waiting room prevented her from doing her job, which was patient flow through the ED. However, if she saw that a waiting room person needed immediate medical attention, she would definitely get involved.

[385] When she attended the Resuscitation Room after the Code Blue was called, she was shocked to find no chart accompanying Brian Sinclair. Somebody gave her a letter retrieved from Mr. Sinclair. She went to search for a chart to make sure it had not been misplaced or misfiled. Obviously, she could not locate a chart. She found from his records that he was last at HSC ED on September 1st, 2008. After that, someone created a new chart on her instructions. When there was no record of his being triaged, she wondered if he had been dropped off, already dead. She said that this had happened before. She asked the security guard to look at the video, to see if anyone had simply brought the body into the waiting room.

[386] She maintained that all ED nurses are always vigilant, especially at HSC ED. It was important to see patients' faces. She agreed that nurses had the responsibility to monitor the waiting room but she explained that the ability to check on people, one-on-one, in the waiting room depends on the busyness of triage or reassessment. She maintained that triage nurses would wake people up to check on them.

[387] Nurse Janke told the Court that the Security Officers and other staff are there to explain issues. Unreliable information can waste their time. People can sometimes be rude, abusive or threatening and can sometimes be an interruption. When asked to agree if HSC ED was a war zone, she said that there are a multitude of problems and diagnoses: it is a very diverse area. "You are under constant attack" if there is a surge of unpleasant people. The waiting room in her opinion is not generally an appropriate place to be talking about health care. Patients are told at the triage desk to "report as needed and come back if you don't feel well".

[388] Veteran Nurse Collis agreed with Nurse Janke about the abuse, physical or verbal, that nurses sometimes experience from persons in the waiting room. Nurse Collis explained that any comments she received from patients are made in crisis: some persons use totally inappropriate language or gestures. Nurses rely on Security for protection and put only their first name on their badge.

[389] Nurse Janke agreed that concerns by people in the waiting room about other people in the waiting room should be taken to the triage nurse. She agreed that the concern can be valuable. It also depends on the description. There is a need to tell someone that there is an emergency. However, she recognized that some people are more aggressive and some are shy. She said many people that night were in urgent situations. It is a process of prioritization. A 12-hour wait in the waiting room, she agreed, is abnormally long. If she had seen a person in the same spot 12 hours later, it would warrant intervention.

[390] Nurse Janke told the Court that when she observed Brian Sinclair being wheeled into the Resuscitation Room, he had a waxy, pale look and he looked extremely ill. To Nurse Stevens, he looked dead. Nurse Janke told counsel that on September 21st, 2008 after learning about Brian Sinclair's death, she did a walk through the waiting room and spoke to triage staff to ensure that they had checked the waiting room and spoken to all the people present. She agreed that it was appropriate to perform this task.

[391] One person present in the HSC ED waiting room the night of September 20th, 2008 had immediately observed Brian Sinclair to be in grave distress.

[392] Debbie MacPhail-Abraham is a Health Care Aide by profession. She has worked for 35 years at a Nursing Home and currently cares for patients affected by dementia. She told the Court that she has encountered deceased persons in her line of work. She freely admitted in cross-examination that she was unclear and mistaken about exact times and exact words said by her and others in her recounting of the incident from her perspective. She took no notes of any of this. For instance, her recall of how Mr. Sinclair's catheter and bag looked did not conform to the evidence of the resuscitation team. What is clear is the extent to which she went to try to alert HSC staff to Brian Sinclair's predicament and her frustration that no one seemed to be responding to her concerns.

[393] She and her husband Glenn Abraham had accompanied her stepdaughter, Deanna Abraham, to HSC ED on September 19th, 2008. Shortly after their arrival, while Ms MacPhail-Abraham sat in the HSC ED waiting room in a chair against

the back wall, she noticed a male double-amputee (Brian Sinclair) in a wheelchair. He was across from them at the end of a row of seats, in the aisle, in his wheelchair, facing the television. She and her husband left around 2:00 a.m. on September 20th, 2008, after visiting and supporting her stepdaughter. The hospital had initially decided to keep her stepdaughter overnight, but later released her at 4:44 a.m.

[394] However on Saturday, September 20th, 2008, her stepdaughter was called back to the ED because of test results. Ms MacPhail-Abraham was mistaken about her time of re-arrival: it was 9:26 p.m. While she sat once again in the HSC ED waiting room, she observed that the same male, whom she now concluded appeared to be Aboriginal, was still there, in the very same spot, wearing the very same clothes: she had a funny feeling about that. She became "fixated", as she put it, on **looking** at Mr. Sinclair. She was waiting to see him move, but saw no motion. He was in the exact same position as the night before and had his head slumped towards his chest. Video evidence showed her moving around to different areas of the waiting room from 9:47 to 10:00 p.m. She told the Court that she was trying to have a different look at him, to try to figure out what was happening with him.

[395] She recalled that it was around 11:00 p.m., when she was with her stepdaughter at her bedside in the ED Minor Treatment Area. Her stepdaughter was talking to a student nurse and Ms. MacPhail-Abraham said to the nurse something like: "There's a man out in the waiting room. He was here last night. I think someone should take a look at him." The Nurse did not ask any questions of her such as "Who are you talking about? Where is he? What does he look like?", so she told her husband to talk to someone. Her husband came back and said that he had gone to the nurses' desk and someone said they would have a look at him as soon as they could get to him. She remembered going back out into the waiting room: no one had come to see Brian Sinclair as far as she could tell. She readily agreed on cross-examination that she was in fact with her stepdaughter in the Minor Treatment Area most of the time on Saturday night.

[396] She had a second conversation with the student nurse, telling her something like: "I'm dead serious. Someone needs to go out there. There's a patient who needs help." She agreed that Student Nurse McRae's recall of their conversation is pretty accurate. However, when she was asked about a comment attributed to her by Student Nurse McRae that she said of Brian Sinclair "He has lividity", she asked Mr. Smorang what lividity meant. It seems that neither party recalled the

exact words spoken. Certainly, the student nurse took Ms MacPhail-Abraham's concern very seriously on this second occasion.

[397] Meanwhile, when Ms MacPhail-Abraham was back in the waiting room, she saw two police officers whom she wanted to speak to, but her husband told her not to. She recalled approaching another security guard outside the ED when she was "on a smoke break" and said to the security guard something like: "Someone should check on him". She recalled the security guard saying: "I think he's here to just watch T.V.". She recalled pointing out to the guard that the fellow in the wheelchair sitting next to the water fountain needed to be checked on. She told the security guard that she had been there the night before and the fellow had been there then.

[398] She was unsure as to what the officer's exact response was or whether she was recalling what her husband had told her about his recall of what the officer said. Her husband may have informed her about something about the "guy being a regular" or "too much paperwork", but she cannot be sure. Her husband did tell her that he had spoken to the Charge Nurse and the Charge Nurse said that she would go and look at the gentleman when she had the time. After that, she sat in the waiting room. No one attended to Brian Sinclair.

[399] Meanwhile, her stepdaughter was admitted to a hospital ward. After visiting her stepdaughter and on her way out of the main hospital, she told her husband that she wanted to go back to the waiting room. She sat in front of Brian Sinclair, because she wanted to see him breathe or move. He did neither. She then spoke to a security guard, saying words to the effect of: "Would you please check on that man over there? There is something really wrong." She followed and watched the security guard tap Brian Sinclair on the shoulder and she said to the guard: "Tapping won't do it. You need to face him." The security guard attempted to lift Brian Sinclair's chin. She recalled that his face was purple or blue. His entire body started to slide. She watched as the security guard wheeled Mr. Sinclair away. She was told that she should stay to give her name.

[400] She says she was frustrated because no one believed her and she felt she was not being heard or taken seriously. That is why she told them she was in the health care field:

> "I couldn't leave without someone looking at him."

[401] Her husband Glenn Abraham told the Court that he noticed an Aboriginal man, a double amputee in a wheelchair with his head down, sitting in the aisle near the back three rows of the waiting room on the evening of September 19th, 2008. When they left in the early morning hours of September 20th, 2008, the man was in the same position. The next night, September 20th, 2008, he arrived between 9:00 p.m. and 10:00 p.m. and saw the same man. He walked around to see if the man was okay. He looked like he was sleeping. He recalled expressing his concern to the nurse (Student Nurse McRae) that was talking to his daughter's boyfriend with words to the effect of: "Would you like to look at this gent? I think there's something wrong with him." Brian Sinclair was the only person in the waiting room in a wheelchair slumped over and that was how he described the man he was concerned about to the student nurse. He told the Court that the student nurse did not check on Mr. Sinclair. He added that it was not that busy in the waiting room. A little later on, he told another nurse (Nurse Janke) that there was a gent in the waiting room and would she mind checking on him because he thinks something is wrong and her response was to the effect of: "When I get a chance, I'll go check on him".

[402] He readily agreed he took no notes of any of these events. He described an encounter with a security guard outside the complex around 11:00 p.m. He asked the guard to check on the gent in the wheelchair, to which he recalled the security guard telling him something to the effect of it takes too much paperwork and that people come in all the time to watch T.V. and that person was one of the regulars.

[403] On cross-examination, it was suggested to Mr. Abraham that he was not conveying his message to staff about Mr. Sinclair with any urgency. Mr. Abraham responded that both he and his wife were concerned. The staff did not seem to understand his concerns. He wanted them to take it seriously and it was frustrating. They had a funny feeling that the man had passed away because he was not moving. As Mr. Abraham put it:

> "It was like the person was frozen in time."

[404] He was just hoping that someone would check on Mr. Sinclair. He agreed that he did not tell anyone in the waiting room to look specifically at Brian Sinclair. He did not remember the conversation with the student nurse. He recalled speaking to the Charge Nurse (Janke) at the desk in the Minor Treatment Area. He did not remember her saying "We do get a lot of return patients." He did not recall her response. He recalled a general response by everyone that the place was very busy and he agreed he too may have said the same thing to them.

[405] Nurse Nicholas Wendel graduated in 2004 and commenced work at HSC ED. On September 20th, 2008, he worked the night shift from 7:30 p.m. to 7:30 a.m. He was "Resuscitation Nurse #2", which meant that he was on call for resuscitation duties. He was busy at one of his assigned beds in the ED when he was told by Officer Francis, who was wheeling Brian Sinclair in: "We have a problem. This man is dead." He saw that Brian Sinclair indeed looked dead. He immediately called for the Resuscitation Team over the intercom. Everyone arrived very quickly and he and another staff member moved Brian Sinclair onto a stretcher. Mr. Sinclair was stiff and cool. Nurse Wendel commenced CPR.

[406] When questioned by counsel about Patrol Officer Francis' statement that he, Nurse Wendel, thought Officer Francis was joking when he wheeled Brian Sinclair in, Nurse Wendel did not recall that at all. He just remembered being shocked, because this was very unusual. He was definitely surprised. He knew Brian Sinclair and had seen him before in the ED. However, he had not seen him on September 20th because he did not attend the waiting room that night. Brian Sinclair's eyes were open, his pupils were fixed and his skin was pale and waxy-looking. Nurse Wendel agreed with counsel that it was obvious that Brian Sinclair had been dead for some time. Although he was obviously dead, it was mandatory that they attempt resuscitation.

## OBSERVATIONS OF BRIAN SINCLAIR BY OTHER MEMBERS OF THE PUBLIC

[407] The Court heard from a host of civilian witnesses who testified that they had been in the HSC ED waiting room and remembered seeing Brian Sinclair. Some of them interacted with him. The Court will not recount every person's testimony in this regard. Some witnesses remembered details clearly. Some witnesses were clearly mistaken about details. The theme from each of them was that they could and did clearly observe Mr. Sinclair, the double amputee, in his wheelchair in the waiting room of HSC ED. From their various vantage points, they observed very little interaction by staff with patients and visitors in the waiting room, unless the persons were being called for triage. They observed no interaction by staff with Mr. Sinclair.

[408] Lakhwinder Pannu is a Home Care worker employed by the WRHA. She was at HSC ED with her daughter on September 19th, 2008. Her daughter was triaged at 10:33 p.m. She thought she was there a long time before that, but video evidence confirmed that her daughter was in the waiting room for 2 ¾ hours. Initially, she and her daughter sat in the waiting room in the second row. She

recalled seeing Brian Sinclair close by. She observed that Mr. Sinclair's pants were wet and there was a urine smell. She recalls his pants being folded upwards because his legs were amputated and he had a "pee bag" hanging on his wheelchair bar, one third or less full. She concluded he had not been clean for a while. She moved to the back wall. She recalled Brian Sinclair wheeling his chair to the vending machines, buying chips and using the phone. She was not paying close attention to him. She wondered to herself whether she should ask anyone to wash Brian Sinclair or speak up about him. She feared she may be told it was none of her business or they could handle it. She also did not want to make a fuss for fear that her daughter to be mistreated. She does not recall anyone talking to Brian Sinclair.

[409] Her daughter was discharged from the ED at 1:28 a.m. on September 20th, 2008 and transferred to the hospital ward. Later that early morning, she recalled seeing Brian Sinclair still sitting there in the waiting room when she visited the ED washroom on her way out to go home. She returned to the HSC on Saturday and Sunday during the day to see her daughter. She recalled seeing Brian Sinclair in his wheelchair, in the same location. It bothered her. She noticed that his pants had dried. She recalled him leaning his head on his hand with his eyes closed. She agreed in cross-examination that her recollections were a little off: she was quite mistaken about times and dates. What she wanted the Court to know was that Brian Sinclair was visible seated in the aisle.

[410] Cynthia McKillop arrived at HSC ED at 4:49 p.m. and was triaged at 4:56 p.m. on September 20th, 2008. As with most people, she was called to the triage desk after sitting in the waiting room. She told the police she recalled that she had her blood pressure checked while she was in the waiting room. When she first sat down she was sitting in the same row where Brian Sinclair had parked his wheelchair. She noted that his legs were missing. There was a strong odor of urine and a bad body odour. She moved to get away from his "sour smell". Mr. Sinclair's eyes were closed and his head was bowed a little. She could not recall if he moved, but she did recall that he was stationary in his wheelchair. She was not paying too much attention. She heard no sound from him. No one interacted with him. He appeared to be sleeping.

[411] Dr. Nadir Kharma, at that time an Internal Medicine Physician, was a patient in the HSC ED waiting room on September 20th, 2008 at 9:46 a.m. and was discharged at 1:23 p.m. He did not think the waiting room was busy in the morning. He waited, by his recall, about an hour to an hour and a half after being triaged, was seen by a medical student and then by a doctor. He then waited in the

waiting room for blood work results and he recalled the waiting room as getting much busier.

[412] Brian Sinclair caught his eye as soon as he arrived. He observed a gentleman who was a double amputee in a wheelchair. To Dr. Kharma, the man looked Aboriginal, he had facial hair and "dirty, low quality clothing". From the doctor's perspective, Mr. Sinclair was not in "acute distress". His definition of acute was that Brian Sinclair was not sliding off the chair or comatose or breathing fast or shallow. He looked chronically ill, not acutely ill. He did look like someone having a problem that needed looking into. He had not witnessed Mr. Sinclair vomiting, however. He has never witnessed vomiting in an ED. He recalled that "a janitor" cleaned up fluid or urine around him. He does not recall the fluid. It may have been yellow or beige, but there was no blood in it. He does not recall a smell, although he did notice people close to Brian Sinclair moving away from him.

[413] He agreed with counsel for the family that Mr. Sinclair looked like someone who needed to be attended to. He did not see any staff approach Brian Sinclair. He saw staff calling names, but not scanning the waiting room. He assumed that Brian Sinclair would be seen by someone and assumed that he had been registered. It was his first visit to HSC ED.

[414] Adrienne Martin attended HSC ED with her husband very late on September 20th, 2008. They entered the emergency room through the front door, gave their name and sat in the waiting room. One minute after midnight on September 21st, 2008, her husband was triaged. She noticed Brian Sinclair. He was slumped over. He was not moving. Nobody stopped to check on him and she thought that was "weird". She did not think it was that busy in the waiting room. She was not close enough to smell him and did not notice any bowl. She agreed with WRHA counsel that it looked like he was sleeping. She did not conclude that he was dead. Other people were sleeping in the waiting room. No one checked on them either.

[415] Diane Bell attended with her son, who had burned his legs. They arrived on September 20th, 2008 at 2:59 p.m. and her son was triaged at 3:15 p.m. After triage, Ms Bell sat down in the second last row on the aisle, next to her son, who was in a wheelchair. That day, she was worried about her son and feared his wounds may become infected. She is seen on video trying to get somebody's attention at the entrance to the Minor Treatment Area. She told the Court that she noticed a man in a wheelchair with no legs, who looked very weak. There was a very bad smell like feces emanating from him. There was a basin beneath the wheelchair. She did not see anyone interact with Brian Sinclair, who remained slouched in his wheelchair.

[416] This was her first time in HSC ED. Video shows her at 2:23 p.m. heading to triage to try to get some help for her son. She is seen speaking to the Triage Aide, whom she recalled as saying something like "We are doing the best we can." A few minutes later, she is seen speaking to a Nurse (Lori Stevens) and four minutes later, Nurse Stevens comes to get her son, to take him into the Minor Treatment Area. About 20 minutes later, she and her son come out of the Minor Treatment Area, back to the same location in the waiting room. Ms Bell then stands outside the Minor Treatment Area, trying to get somebody's attention. She agreed that her son was reassessed at 4:49 p.m. At 4:55 p.m., her son is returned to the Minor Treatment Area. Her son was discharged at 6:23 p.m.

[417] Ms Bell was quite vocal on behalf of her son. She was anxious to make the ED staff know that she was concerned about him. She was concerned because she thought that her son was not sitting in a sterile area. She was upset and she communicated that upset and frustration. She agreed that the nurse she spoke to did not get angry at her for being assertive. She was advocating on behalf of her son. Not everyone has an advocate. She felt she needed to take on the role of advocate. Until she did this, they were just sitting there waiting.

[418] Even though she was concerned about her son, Brian Sinclair caught her eye and her nose: she noticed the man in a wheelchair, very weak, saying nothing, slumped over with a pan under him. In her words, "It kind of concerned me." Although she told the police in April of 2011 that she saw Brian Sinclair when she left HSC ED, she did not recall that during her testimony.

## HEALTH SCIENCES CENTRE EMERGENCY DEPARTMENT 2008-2013

[419] HSC ED has the highest patient volumes in the WRHA. On any given day, approximately 150 people are triaged at HSC ED and approximately 23 people are admitted to the hospital. However, most wards in the hospital are full to capacity. As a 2013 accreditation noted, "There is constant pressure on all programs to provide care over capacity and provide resources that are not funded or staffed."

[420] After Brian Sinclair's death, a Critical Incident Review was undertaken. The Review inevitably noted that the congestion in the waiting room at HSC ED was compounded by the added presence of patients' friends, family and various other visitors or people seeking respite or shelter. "Confusion and turbulence" was created by the congestion in the waiting area for both patients and visitors. There was "limited staff interaction" with most of the people in the waiting room. There was "limited proactive behaviour" on the part of the ED staff, except when looking

for patients who had already been triaged. It appeared that during the night when things were quiet and volumes were lower, there was still limited proactive interaction from staff to the occupants of the waiting room. People were allowed to continue to sleep for a couple of reasons: firstly, because they were left to rest while they waited and secondly, because waking people was sometimes disturbing, both to the person being awakened and the staff doing the waking up. There was no assigned space for patients to wait at the front entrance before being triaged. The area was too small.

[421] The Review pointed out that some form of security presence at the entrance to most EDs is important in order to provide clear direction to anyone entering. A security presence also ensures both patient and staff safety. Unfortunately, there are people trying to access the ED who are inappropriate for a variety of reasons.

*I therefore recommend:*

*20. That all RHAs review the feasibility of a security presence at the entrance to an ED.*

[422] It was also pointed out by the Review that the ED security guards had no ED specialized training. As important as non-violent crisis intervention training is in this area, it is also important for a person in that position to have training to deal with vulnerable persons.

*I therefore recommend:*

*21. That ED Security staff receive training in the areas of substance abuse and dealing with persons with physical or mental challenges.*

[423] The Critical Incident Review Committee made five recommendations:

1. Put a system in place to ensure that anyone arriving at an ED needing care is registered electronically before entering the waiting room;

2. Develop an alternate point of entry to deal with non-medical clientele;

3. Clarify roles and responsibility for staff and reinforce same on an ongoing basis;

4. Communicate directly with each person in the waiting room at least once every four hours; and

5. Rotate the Triage and Reassessment Nurses to other positions every four hours, with full reporting to any staff substituting for them.

*I therefore recommend:*

*22. That all RHAs review the feasibility of implementing the recommendations of the Brian Sinclair Critical Incident Review Committee.*

[424] The Court heard from a number of witnesses that culture change in medicine is difficult. Often, huge resources are expended to maintain the status quo. On the other hand, change can be very expensive. Any meaningful shift in the culture of an institution starts with the Administration. As part of that process, administrators must gather ideas from frontline service providers. Laverne Sturtevant is the current Director of Patient Services at HSC ED. Veteran nurses who had been critical of Ms Sturtevant's predecessor were united in their high praise and respect for Ms Sturtevant. Ms Sturtevant agreed that when she arrived in March of 2008, nursing staff morale was low. The nurses felt there was a lack of communication between staff and Management. The other two Nurse Managers on her team left shortly after her arrival. She readily agreed that her management style is collaborative, not "top-down". The current Nurse Managers share her collaborative philosophy.

[425] Ms Sturtevant told the Court that one of the first issues she dealt with in 2008 was the frontline ED staff outlining their frustration to her in their attempts to communicate with the hospital administration. She initiated a series of meetings with staff and administration. For the next couple of years, she met and worked with them, collectively tackling ongoing issues. From Ms Sturtevant's perspective, when she assumed the position of Director of Patient Services, she very quickly encountered what she termed as "a climate of blaming and a little bit of learned helplessness". It was all laid on her desk. The journey was a difficult and often emotional one. Her attitude was "Tell me what the issue is and give me two solutions." In other words, she was asking for the direct, pragmatic assistance of frontline staff and their participation in solving issues. She was happy that the nurses' representative was comfortable enough to share concerns. From Ms Sturtevant's perspective, this process was part of the bumpy ride to culture change and there were trust issues that needed to be ironed out. She wanted feedback.

[426] One of the issues was to monitor a "Triage Process Improvement Initiative" at HSC ED. Included in this working group were a Nurse Practitioner, a CNR (Susan Alcock) and two Triage Nurses. Ms Sturtevant welcomed ideas or

information for this project. She made sure she was keeping ED staff updated on the installation of the appropriate computer software. The objective was to develop a strategy for implementing the necessary changes to registration and triage prior to activating the new triage system. Her meeting notes for April of 2008 indicate: frontline staff was looking forward to "structured change" and would be supportive of changes in triage; the current space was not set up properly; visibility was poor; and the HSC Executive was supportive of the project. This was in recognition that staff sending patients to the waiting room to wait to be triaged constituted a critical patient safety issue.

[427] In fact, at the precise time that Brian Sinclair arrived at HSC ED on September 19th, 2008, Ms Sturtevant was in a meeting with senior Management, discussing ED renovations. The meeting was with WRHA Capital Planning and the Clinical Program Leadership Team. The Capital Projects team was also present because she was looking for an expanded scope of the project, beyond simply reconfiguring the triage desks.

[428] Very shortly after Mr. Sinclair's death, a project was initiated to look at the **entire** front end process of the ED. The goal was to redesign processes, through a patient's eyes, to ensure timely patient registration and triage and ensure safety in the waiting room. The project was overseen by a Project Manager and a Process Engineer. ED staff was asked to participate.

[429] Ms Sturtevant is able now to look back on part of Brian Sinclair's legacy as her being given the power to make changes, but at the time she learned of his death, she and her ED team were devastated. She met with the nursing staff and together she and they came up with quick recommendations:

- Turn the lights up in HSC ED waiting room;
- Move the T.V. and turn all the chairs around in the waiting room;
- Move the large chairs to the back to improve visibility for the triage nurses;
- Consult the Triage Nurses (for instance, the triage nurses and Ms Sturtevant looked at sight lines and arranged to have holes cut so that the triage nurses could see **through** the triage desk bulkhead, which at the time contained electrical systems);

- Get the triage aide to stand at the door to vet people, to make sure they were in the ED for medical care;

- Put a computer on wheels at the door, with the registration clerk; and

- Lock the back, west door.

[430] The weekend after Brian Sinclair's death, Ms Sturtevant attended a local "Dollar Store", bought green armbands, brought them to the ED and instructed the unit assistant to direct persons arriving at HSC ED to the registration clerk, who was directed to register the patients and give each of them a green armband.

[431] Short-term recommendations were put into play by the WRHA by September 28th, 2008:

- Identify people seeking care and enter the basic information into the EDIS electronic patient registration system;

- Attach a green armband to people seeking medical care, prior to their being triaged;

- Ensure a dedicated Triage Nurse on the night shift;

- Reconfigure the waiting room at HSC so everyone faces the triage desk;

- Implement a round-the-clock Triage Aide;

- Identify persons who were not in the ED for medical care, redirect them and thereby reduce traffic;

- Accelerate patient flow;

- Ensure a persistent Security presence;

- Clarify the roles of Triage Nurse, Reassessment Nurse and Triage Aide;

- Rotate nurses' duties every four hours (which has met with limited traction);

- Place chairs directly in front of the triage desk for easy access for patients; and

- Improve signage and visibility.

## THE 2013 VERSION OF THE HEALTH SCIENCES CENTRE EMERGENCY DEPARTMENT "FRONT END"

[432] A brand new "Front End" of the HSC ED has been constructed and is now open to the public. Ms Sturtevant was one of the drivers of change, both structurally and administratively, at HSC ED. In collaboration with her Directors and frontline staff, Ms Sturtevant has worked tirelessly to problem-solve the front-end issues in the HSC ED. She established an Emergency Nursing Practice Committee to review ongoing issues.

[433] A full-time social worker has been hired at HSC ED to help identify complex- or special-needs clients or frequent users and partner them up with social service providers in the community. The Community Support Worker follows the patient through pre-triage, triage and treatment. The Management Team has partnered with the Siloam Mission Management Team. Now, HSC ED is made aware by the Siloam Mission of available bed space at the shelter. No patient is allowed to sleep in the waiting room. Patients are woken up. The ED nurses are encouraged by her to engage in a "team huddle", a couple of times per shift, in order for them to assess their own well-being and the patients' well-being. She has recommended a formal scan of the entire ED waiting room at least every four hours to check on each patient. The present goal is to reassess each patient 90% of the time, once an hour. (The current best reassessment time at HSC ED is 70-75% of the time, each hour.) Although reassessment is a top priority and another reassessment nurse had been funded, "due to high volumes and acuity in the department, this (reassessment) nursing role has been absorbed into the triage and resus (resuscitation) teams". So Ms Sturtevant has requested funding for an additional nurse for 24 hours a day.

[434] HSC had a hiring push in 2009. The Observation Room, which was closed at the time of Brian Sinclair's death, is now open. Also in 2009, end-of-shift reporting guidelines were mandated. Mandatory training includes a two-day Aboriginal cultural awareness workshop and non-violent crisis intervention. Community Service Workers have spoken to her recently about the need for more of an Aboriginal presence of Elders in the waiting room at HSC, so she contacted Spiritual Services to ask if an Elder could be there more often.

[435] Ms Sturtevant looked at the HSC ED Front End Project through the eyes of patients and the family and their advocates. She invited Ms Mowat of the MNU to come to the team meetings. That invitation was declined because the MNU felt that their Nurse Representative on the team sufficed to provide the input that was needed. As an example of that input, the "internal waiting room" which is now the Reassessment Area, was Nurse Alcock's idea: patients can sit in the internal waiting room and wait for lab results, for instance, which leaves six beds available. A 24-hour Reassessment Nurse position was funded. In April of 2009, a Community Service Worker position was funded. In July of 2009, another position created was for a Nurse Practitioner, up to 16 hours daily in the Minor Treatment Area.

[436] Ms Sturtevant was proud to show the Court a nine-minute video of the new, wholly rebuilt, Front End of HSC ED. She noted that prior to each section of the ED becoming operational, an Aboriginal Elder attended to perform a smudging ceremony.

[437] Some of the changes to HSC ED front end:

1. There is now only one entrance and exit. There are no side or back entrances;

2. A security officer sits directly in front of the main entrance in order to secure the point of entry and the first question to everyone entering is "Are you here for medical care?" If a person is not at HSC ED for medical care, that person is redirected to another part of the hospital;

3. A Community Support Worker is present to provide ongoing support for everyone in the waiting room. The Community Support Worker checks each person in the waiting room at least once an hour;

*I therefore recommend:*

*23. That all RHAs review the feasibility of the presence of a Community Support Worker for EDs, where deemed appropriate.*

4. There is a separate, pre-triage area directly across from the triage nurses;

*I therefore recommend:*

*24. That all RHAs review the feasibility of creating a distinct pre-triage area for EDs, where deemed appropriate.*

5. The Minor Treatment Area waiting room is separated from the general waiting room (for CTAS4 and CTAS5 patients);

6. There is a separate and distinct area for the higher-acuity CTAS2s and CTAS3 patients; and

7. The triage procedure is completely different. The security officer now directs a newcomer to the triage desk. However, if the triage nurse is occupied with other patients, the new person is directed to be registered by the registration clerk. The person's information is entered into the hospital's computer system, the person is given a green armband and made to sit opposite the triage desk in the pre-triage area. The triage nurse regularly "walks the line", checking the pre-triage patients. Once triaged, the green armband is cut off and a white armband is put on. If a patient has been assessed CTAS4 or CTAS 5, that patient is given a blue armband and immediately directed to the Minor Treatment Area waiting room.

[438] One of the new initiatives is a surge protocol, known as a "Code 10", which means that when there are 10 people lined up for triaging, it is "all hands on deck", using a portable triage unit, with the registered nurses helping out with the triage process, to reduce the patient waiting line to zero. When a surge in persons attending the ED, either in-person or via ambulance occurs, the Community Support Worker desk can also be used as a triage desk. Triage desks are located in the Minor Treatment Area waiting room and in the middle of the general waiting room. There are six stretchers in the Minor Treatment Area. There is a Reassessment Zone, which includes cardiac monitors. There is a round-the-clock Emergency Psychiatric Nurse available. A separate psychiatric consulting room has been built. There are two monitored "Mental Health" rooms for patients in crisis. Those rooms have rubber on the walls to protect any person who may be acting out. The "family" room, the room set aside for loved ones of the patient, is close to both the Resuscitation Room and the Triage area, for easy access. The entire space is well-lit.

[439] Certain types of patient numbers have decreased. The number of CTAS2 patients has decreased, because there are fewer ambulance drop-offs at the HSC and there have been a number of initiatives to "regionalize" patients to other hospitals. There are fewer CTAS5 arrivals, because the new Crisis Response Centre, (which I will speak of later) and other nearby community clinics effectively "decant" those patients.

[440] The average time from registration to triage was 23 minutes and is now just under seven minutes. There is an additional 16 hours of coverage for the "Offloading Nurse", who transfers patients brought in by ambulance to the ED, in order to allow the offloading nurse the time for a focused attempt to find a spot within the unit, so the incoming ambulance patient can be transferred from the ambulance paramedic to the hospital.

[441] Ms Sturtevant ideally wants more nurses dedicated to triage and reassessment; either a second reassessment nurse from 10:00 a.m. to 10:00 p.m., or a dedicated resuscitation nurse who can do other tasks. She believes that the hiring of an extra reassessment nurse would bring the HSC ED closer to meeting CTAS guidelines. She would like to gain a second CRN to add another overseeing critical eye. Ms Sturtevant is confident that HSC administration has taken the right course of action. Even though the volume has increased, crucial wait times have decreased.

[442] In September of 2009, triage nurses' activities were tracked as part of a project. 63% of their time was spent triaging. One-third of their time was spent doing other tasks, albeit important tasks, such as finding beds, EDIS trouble-shooting, waiting for patients, waiting for the registration clerk, retrieving drugs, answering the phone, arranging transport for consult patients.

*I therefore recommend:*

*25. That all RHAs review the feasibility of replicating the HSC ED front-end procedures throughout the system, where deemed appropriate.*

## DELAY AND WAIT TIMES IN AN EMERGENCY DEPARTMENT

[443] The next part of my report will examine reasons for delay and measures necessary to reduce delay in treating patients in EDs.

[444] The CME did not mince words. Dr. Balachandra exhorted the Court not to simply look at whether or not someone has been triaged, but to look at all aspects of the ED and to make recommendations to try to rectify the persistent problem of delays in EDs. The CME blamed delays at HSC ED on the fact that HSC ED, by default, treats many non-emergent patients, who crowd the ED. The CME also cited a lack of both beds and doctors in the hospitals as a cause of delay in the ED. His desire is to improve access to treatment in EDs. From his perspective, it is a wait-time problem and this Inquest needs to address the issue.

[445] In June of 2009, Hay Group Health Care Consulting completed a review of emergency services at HSC and St. Boniface General Hospital. Their overview of the issues has been very helpful to the Court, since some of what the Hay Group analyzed corresponds with the subject matter of this phase of the Inquest.

**Some historical perspective**

[446] The issue of delay in EDs is **nothing** new. As a result of public concern over the issue of backlog in EDs in Winnipeg hospitals, recommendations were made to the Provincial Minister of Health by the Emergency Care Task Force, appointed in January of 2004. The Task Force was called as a result of a series of documented delays in EDs, including a woman who died after waiting six hours in an ED without being seen by a physician and without being reassessed from the time of her initial triage and a young woman who suffered a miscarriage after waiting almost four hours without seeing a doctor and without being reassessed following her initial triage. These were not isolated incidents.

[447] Soon after its formation, the Emergency Care Task Force recommended adding a Reassessment Nurse role in each ED, piloting a Nurse Practitioner Minor Treatment Stream, formalizing the process to open temporary beds at each hospital as needed and enhancing training for ED staff. Other recommendations included a computerized triage system for each ED, an electronic patient tracking system for all Winnipeg EDs, a "fast-track" minor treatment system at each ED to reduce wait times for less urgent patients and ED waiting room enhancements to "promote patient comfort". The Task Force pointed out that "Challenges being faced in emergency departments are very much the product of routines and processes; attitudes and beliefs built up over time in the health care system and that are now entrenched." Both process and attitude influenced outcome.

[448] It was noted by the 2004 Task Force that many patients accessed the ED for non-urgent reasons: residents from care homes who were ill, where doctors were

not readily accessible; people who could not otherwise access other primary care; referrals from primary care physicians for more rapid access to treatments, therapies, tests or specialists. In short, a significant number of non-emergent patients were accessing the ED because of their inability to access health care services elsewhere. Ironically, the Task Force recognized the need for significant changes to the HSC ED waiting room, not only to improve comfort, but also to improve the sight line from the triage desk.

[449] One of the recommendations was for a computerized triage system. By 2005, an electronic triage system, the Emergency Department Information System (EDIS) was initiated in the WRHA hospitals to become the regional standard. By 2006, each ED had two E-triage terminals, allowing both the triage nurse and the reassessment nurse access to the system at any one time. Another recommendation was that social work services in the ED should be redesigned to improve patient care, such that the social worker would become an integral part of the ED team and introduce the entire team to a more broad-based approach to complex social issues. At that time, social workers were working Monday through Friday only during the day. Although social workers were assigned to ED, they typically had responsibility in other parts of the hospital. Because of their limited ability to follow up on a patient's psycho-social needs after discharge, those patients often returned to ED.

[450] As I stated, the most recent review of Winnipeg Hospital Emergency Services was undertaken by the Hay Group Health Care Consultants in June of 2009.

## REASONS FOR DELAY

### 1. Overcrowding in the ED

[451] Overcrowding in the ED is a direct result of system-wide issues. The Court heard evidence from a variety of health care witnesses and experts, all of whom described the root cause of delay in the ED as the problem of "flow" or "throughput" of patients in and out of the hospital. I heard from witnesses who spend their entire professional life trying to understand and manage that flow of patients through the hospital system. Each of them in their way candidly admitted that the system is still not flowing smoothly. The Court's perspective is an outsider's perspective. Any recommendation in this area needs to be filtered through that lens.

[452] If one thinks of a person presenting at the ED as the front end of the hospital, and a person being discharged from hospital after admission as the back end, the problem of delay or wait time at the front end is caused by the delay at the back end. From the perspective of the ED health care providers, delay commences in the ED waiting room. Persons wait to be triaged. They are waiting because the Triage Nurses are fully occupied with other patients. Persons who have been triaged are waiting to be seen by a physician. Physicians are waiting because there are no spaces or beds for incoming patients in the Emergency ward. Patients who have been triaged, seen by an ED physician and are in a bed in the ED cannot be admitted to a ward in the hospital. There is no room for them in the hospital wards. Many of the beds in the hospital wards are occupied by persons awaiting discharge from hospital and placement in personal care homes or other long-term care facilities.

[453] The assumption that the cause of long wait times in the ED is the huge number of people accessing the ED is incorrect. Research suggests that the real bottleneck in the ED is in the delay in admitting patients to hospital, once a patient has been admitted to the ED. Admitted patients are forced to stay in the ED until a hospital bed becomes available. A hospital typically has a limited capacity to absorb emergency patients requiring admissions to the hospital. The result is an inability to accommodate non-urgent cases in the ED in a timely way.

[454] Dr. Alecs Chochinov, the Medical Director of the WRHA Emergency Program, outlined for the Court some of the causes of overcrowding in the EDs. He told the Court that 15% of the population coming to the ED does not have a regular primary care physician. He observed that primary care physicians in the community are loath to perform non-routine procedures. Moreover, there is a general expectation in the community of entitlement to rapid access to medical care at an ED.

[455] At the time of Mr. Sinclair's death, Dr. John Sokal was the Program Director of the Continuing Medical Education Program of the Department of Emergency Medicine at the University of Manitoba. In 2010, he became the Medical Director of the HSC ED. In that capacity, he is responsible for facilitating the planning and coordination of ED service delivery, based on a system-wide model which includes collaboration with other site Program Managers and Directors. He too is an Administrator who embraces input from front-line staff. He collaborated with Ms Sturtevant on the HSC ED Front End initiatives.

[456] Dr. Sokal told the Court that ideally, health care ought to be safe (minimize risk or harm), effective (evidence-based improved outcomes), patient-centered (culture, social context and specific with patients playing an active role in decision about their care), accessible (timely), efficient (constantly seeking to reduce waste, cost and time) and equitable (equal access). Various quality improvement techniques have been used, including "LEAN thinking", a system imported from the aerospace and auto industry, which seeks to reduce "waste". Waste in this context means the attempt to improve wait times, prevent people leaving the ED without being seen and ultimately reduce the length of stay in the ED.

[457] Dr. Sokal provided the Court with an overview of the recent and current state of affairs. Patient visits to the HSC ED have increased. In 2003-2004 there were 40,815 patient visits to HSC ED. By 2012-2013, there were 51,298 patient visits or what Dr. Sokal referred to as "a lot of unmet demand in the system". At HSC ED, there are 25 acute care beds and six observation unit beds. The ED has on average 150 visits per 24-hour period. Approximately 23 patients are admitted each day. Since the Front End changes, the number of persons leaving the ED without being seen has dropped from13% to anywhere from 4% to12% some weeks. There used to be more than a three-hour wait in the waiting room for people awaiting minor treatment, which Dr. Sokal agreed was unacceptable. That waiting time has been reduced lately by up to an hour on some days. It has been proven statistically that reducing wait times reduces the number of people leaving without being seen.

[458] The average stay for a non-admitted ED patient is 5 hours.The average stay for a non-admitted patient occupying a bed in the ED is 12 hours. The average stay for a patient admitted to the hospital and occupying a bed in the ED is 19 hours. There has been 100% increase in the past seven years for CTAS1 patients and a steady increase of CTAS2 patients.

[459] Dr. Sokal referred to the Canadian Association of Emergency Physicians' analysis of ED overcrowding, published in November, 2013. Their Executive Summary is as follows:

> Emergency Department overcrowding is defined as a situation where the demand for emergency services exceeds the ability of an Emergency Department to provide quality care within appropriate time frames. Emergency Department overcrowding has been a key issue in emergency medicine in Canada for more than 20 years. Despite increased political, administrative and public awareness, Emergency

> Department overcrowding situations continue to rise in frequency and severity. Patient suffering, prolonged wait times, deteriorating levels of service, adverse patient outcomes and the ability to retain experienced staff in an Emergency Department are all ill effects of this ongoing problem. The inability of admitted patients to access in-patient beds from the Emergency Departments is the most significant factor causing Emergency Department overcrowding.

## 2. "Boarding"

[460] The ED patients who have been admitted to hospital but who still occupy a bed in the ED are "boarded". Boarded patients are stuck in the ED because of the lack of "flow through" in the hospital. Flow through is a chronic issue.

[461] Dr. Chochinov explained the problem from his perspective. He told the Court that the length of stay of an ED patient will not change until the "boarding" issue is tackled. These boarded patients are admitted to the hospital, but have nowhere to go: no hospital ward or doctor will admit them into the hospital and take care of them on a ward because they do not fit the admission criteria or there is no room for them on the ward, so they take up a valuable and scarce space in the ED.

[462] Dr. Sokal explained the historical backdrop to the acute care bed shortage:

> Back in the early '90s, there was the downsizing of health care and our department actually had a primary care unit attached to it with physician compliment where we would send our low acuity cases, and these doctors actually provided primary care to a lot of the downtown core population, homeless population; part of the downsizing that was moved off site to Health Action Centre. And our visits dropped from I believe it was about the 50,000 range to 36,000.... Over time, each year, there was a successive additional patient volume of 500 to 1,000 and that just continued to add. And that likely had to do again with some of the restructuring because there was a shift away from training of primary care to more specialist care. And as you're well aware, not everybody has primary care physicians. They're very hard to access. So a lot of that population ended up coming to the emergency department, and we became the catch all for that and physicians would direct their patients to come to the emergency department after

> hours, on weekends. And that led to a large, well, the progressive increase.
>
> At the same time, the inpatient beds decreased. So, such that by 2009-10 year, if you look at the organization of economic cooperation and development stats, we're down to 33rd out of 34 developed countries in terms of number of acute beds per thousand population - we're at 1.7. United States is at 2.6. That doesn't necessarily mean we need more acute care beds but it did put stresses on the system back then through the '90s and early 2000s, such that there wasn't the bed availability for internal medicine and for surgery.

[463] Patients whose length of stay in the ED is over 24 hours account for at least 40% of total patient hours in the ED. The impact on patient flow is huge. Boarded patients constitute the equivalent of a 53-bed medical ward, fully occupied and situated in the ED. These patients constitute a mere 3% of total ED visits, but they account for 16% or more of total patient hours. Boarded patients in the ED can result in ED Nurses providing nursing care in non-assigned areas such as hallways. If a patient is admitted in the ED, the assigned physician is actually on another ward, so the ED nurse is assigned to care for the boarded patient, which not only increases risk but is an inefficient use of the ED nurse.

[464] Most often, all hospital units run at 100% occupancy. Dr. Sokal readily conceded that after two years of a four-year plan to reduce "boarding", there is not much of an improvement on the number of boarded patients.

[465] Veteran ED Nurse Susan Alcock maintained that from her perspective, the most significant cause of delay in the ED is "through-put". Once a patient arrives in a treatment area, a nurse does a more thorough assessment, often prior to the arrival of an emergency physician. The physician assesses the patient and regularly seeks a "consult" from a specialist on a hospital ward. This kind of referral takes time. That ED bed remains occupied. If the patient is admitted to the hospital, the patient remains "boarded" in the ED bed, awaiting a hospital bed. Once a patient is admitted to the hospital, the ED needs to get that patient streamed out of the ED and into a hospital bed. The corresponding and frustrating outcome is the delay and wait-time for persons in the ED waiting room. Nurse Alcock hastened to add that this is happening nationally. HSC is not unique.

## 3. Nursing vacancy rates

[466] As I have explained, Nurse Alcock has a great deal of respect for the Director of Patient Care, Ms Sturtevant. The two of them had met in March of 2008 and Nurse Alcock had shared with Ms Sturtevant the nurses' concerns that something needed to be done soon: the nurses believed that the ED situation was critical. Ms Sturtevant told the Court that in 2008, HSC ED was "desperate" for nurses to work for them. Back in 2008, the HSC ED struggled with a daily vacancy rate of 16% to 22%. By April of 2010, they were still short-staffed. As of September 24th, 2013, the vacancy rate had been reduced to 8%.

[467] After Brian Sinclair's death, the discontent that ED nurses felt was expressed in a variety of ways. Nurse Alcock told the Court that after his death, the ED nurses still felt that nothing had changed in terms of the **chronic** ED understaffing. During a conference for ED nurses, "Nursing Week" at the HSC, the ED nurses displayed a poster, which was filed at the Inquest as an Exhibit. The poster's message was clear: "ER wait times: why so long? ER overcrowding is a symptom of a system failure". The poster outlined that there were 45,000 visits to the ED annually, 30% by ambulance. The poster proclaimed causes of ED overcrowding as analyzed by ED physicians:

- lack of beds for admitted patients;
- lack of primary care, specialist physicians and nurse practitioners;
- shortage of nursing and physician staff;
- complexity and acuity of patients presenting to ED;
- large volume of patients with non-urgent problems; and
- lack of alternative advanced diagnostic testing facilities.

[468] In June of 2009, Nurse Alcock and five of her charge nurse colleagues co-wrote a letter to the Chief Nursing Officer, the Director of Patient Care, the Manager of the Adult ED and the Medical Director to formalize the concerns of the ED nurses. Their main point was their objection to the closing of the six beds in the Observation Room. The Nurses felt it was vital to keep those beds open.

[469] Ms Sturtevant told the Court that she agreed with much of what she was hearing, except for an assertion that Administration was not making staffing a priority. She agreed that there was a staffing shortage the weekend Brian Sinclair died.

[470] Sandra Mowat, President of the Manitoba Nurses Union (MNU) told the Court that since the 1990s, Manitoba has experienced a shortage of nurses. Statistics have charted 1000 vacancies in the City of Winnipeg alone. By 2013, there were 700 vacancies outside of the city. A nurse's average age is 47, two years older than the national average age. 25% of nurse graduates leave the province. There has been a huge drive for recruitment and retention by the joint committee struck between the RHAs, the MNU and the government Department of Health for strategies and incentives. She agreed that there are now a lot of younger faces at the HSC ED. She maintained that every nurse mentors and all nurses learn by experience.

[471] Lori Lamont is the Chief Nursing Officer of the WRHA. Ms Lamont lamented that there is a chronic shortage of ED nurses: nursing vacancy rates at EDs vary from site to site, from 3% to 10%, but these vacancy rates persist in Manitoba.

[472] I heard evidence that in Alberta, there is no nursing vacancy problem. Clearly, more nurses are needed in Manitoba, young or old.

*I therefore recommend:*

*26. That the RHAs continue to review, create and implement long-term strategies for the recruitment and retention of nurses.*

[473] The Court heard evidence that emergency nurses prefer to work 12-hour shifts and are resistant to working fewer hours per shift. On the other hand, I also heard evidence of the difficult and demanding work that emergency nurses are required to do during those 12 hours. The Court heard from the experts that fatigue is a live issue.

*I therefore recommend:*

*27. That the RHAs continue to review a rotation of roles and hours of work for ED Nurses in an effort to reduce fatigue.*

## 4. The "patient flow" issue

[474] In order to understand the delay in the ED, it is necessary to turn a spotlight on the process of patient discharge from hospital. Clearly, available hospital beds are scarce. Court heard evidence that as soon as a patient is admitted to hospital, a discharge plan is initiated. Yet for a variety of reasons, discharges can be delayed.

[475] Since 2002, Patricia Bergal has been the WRHA Regional Director of "Utilization". Generally, "utilization" in the health care realm refers to the systematic measurement of available health care services. In this WRHA context, utilization refers to an electronic management system employed to achieve the optimal use of acute-care beds in hospitals, personal care homes and long-term care homes in Manitoba. Ms Bergal described herself as a broker, a facilitator and an agitator. Ms Bergal works with all of the RHAs and their service providers. Flow is her priority and her challenge. According to Ms Bergal, a huge hurdle to better flow is the Manitoba matrix of devolved and non-devolved hospital facilities, all with different operating agreements. Dr. Chochinov made exactly the same observation.

[476] From the Court's perspective, hearing evidence that there is no standardized operating agreement is concerning. It would seem a step in the right direction for operating systems in publicly-funded hospitals to be eventually standardized.

[477] In early 2008, Ms Bergal undertook an evidence-based project to try to improve the flow of patients occupying high-acuity beds. Manitoba had a longer "length of stay" of patients in hospital beds than the Canadian average. This was perplexing, given that the WRHA had more hospital beds per population than some other jurisdictions, so capacity was not the problem. The strategy was to implement an electronic "utilization" management system. The management system was only one piece of the puzzle: Ms Bergal explained that there needed to be an acknowledgement of both the complexity of the task and the need for a cultural shift amongst the health care providers.

[478] In her work, Ms Bergal initiates daily conference calls to monitor flow throughout the region. For instance, early each morning, she monitors the status of EDs to decide if and where capacity (available acute-care beds) exists. The target is that no patient be in the ED for more than 24 hours. The "utilization" management system kicks in if the estimated length of stay is exceeded, by establishing a date of discharge and developing an action plan for patients, including those with complex needs.

[479] She chairs the Regional Integrated Services Council (RISC) which has overall decision-making responsibility in the WRHA for operational issues related to the integration of health care services. It is a forum for senior staff to consult with each other and review these issues. The goal is to create a hub of integrated services at one location. One of her initiatives was the "hospital home team", whereby a nurse practitioner provides health care in community care homes, thereby helping to avoid needless ambulance transports and hospitalization. The Court agrees that this type of administrative initiative is a huge step in the right direction for the future. The health care system has to not only contemplate integrated community-based services but also to create them.

*I therefore recommend:*

*28. That RHAs, health care site Directors, Nurse Directors and MNU representatives continue to convene ongoing meetings focused on an interdisciplinary, integrated health care model for Emergency Medicine.*

[480] After Brian Sinclair's death, Ms Bergal visited St. Michael's Hospital in Toronto to examine the work they had done in terms of vulnerable populations in the ED context. St. Michael's Community Advisory Panel had been in place for about 14 years, with two-thirds membership from the community and one-third membership from the hospital. The panel's mandate was to recommend how to provide better services to a marginalized population. She immediately noted that the advisory panel had helped create an ED "transition centre": a six-bed unit for vulnerable patients discharged from the ED in the middle of the night without a home to go to. The reasons for the lack of accommodation varied: shelters not accepting residents in the middle of the night, patients barred from shelters, patients refusing to go to a shelter. In fact, the Hay Project recommended that the directors of ED and site leaders meet to consider the development of "decongesting follow up clinics for discharged patients".

*I therefore recommend:*

*29. That the WRHA review the feasibility of establishing Transition Centres for vulnerable patients discharged from urban EDs, where deemed appropriate.*

[481] As I stated, Dr. Chochinov is the Medical Director of the WRHA Emergency Program. He is also the Academic Head of the Department of Emergency Medicine at the University of Manitoba. He is also responsible for the

"LEAN" transformation program at another Winnipeg hospital to try to improve efficiencies in that hospital system.

[482] Dr. Chochinov provided a pragmatic perspective of the "flow" issue in Manitoba EDs. He challenged and deconstructed a common misconception that less urgent cases, that is CTAS4 and 5 patients, who account for 40% of all patients at EDs, are responsible for the log jam in an ED. He maintained that those less acute patients have less of an impact on flow, because they take less time to assess and take up less bed space. The group least likely to flow speedily through the ED is the CTAS3 group: these patients are often not ambulatory, often need to stay longer and therefore are most at risk. Dr. Chochinov referred to part of this group as "can't go home patients", patients not able to be admitted to the hospital with length of stays in the ED over 24 hours. This group comprises only 2.5% of total ED visits, but up to 25% of total patient hours in the ED.

## 5. "Access block"

[483] Dr. Chochinov outlined the corollary issue of hospital bed "access block": there are no available beds in the hospital wards due to the number of "alternate level of care" (hereinafter referred to as "ALC") patients in the hospital. Discharge of ALC patients remains a huge problem. After their acute issues are resolved, the vast majority of ALC patients cannot be discharged, because the alternate level of care they need is not immediately available. A care facility is often not available for the ALC, even after identification and acceptance. As Dr. Sokal told the Court, in a 2009 study, Canada ranked 33rd out of 34 OECD (Organization for Economic Cooperation and Development) countries for the number of acute care beds per population. The lack of acute care beds means very high and unsustainable occupancy rates in hospitals, resulting in overcrowding and bed shortages. Many of these acute care beds are being occupied by patients who require an alternate level of care. Almost half of the ALC patients are awaiting placement in personal care homes; about a quarter are awaiting home care services and the rest are awaiting other kinds of placements or services. They only constitute 3½% of the patient population, but they account for 16% of patient days in hospital. ALC patients are blocked by lack of access to long-term care beds and community services. Bed access block causes hospital-wide boarding.

[484] In short, Dr. Chochinov agreed with the Canadian Association of Emergency Physicians that the primary and definitive cause of ED overcrowding is hospital overcrowding due to access block.

[485] At present, Ms Bergal has also been tasked to spearhead the Panel Process Improvement Project. The project is attempting to reduce the time it takes to "panel" a person. Paneling is the process by which applicants for personal care homes are screened by a Long Term Care Panel Review Board and eventually placed in an appropriate facility. The challenge for a hospital is multilayered. Wait lists for ALC hospital patients for personal care homes can vary from a few days to months or years.

[486] The Court endorses the intention of this project. The Court need not make a specific recommendation in this area.

[487] Dr. Sokal echoed Dr. Chochinov when he explained the thorny issue of "flow" from his perspective. Dr. Sokal told the Court that in the HSC hospital wards, 5% of patients take up one-quarter of bed hours. HSC ED needs twice as many beds as they have in terms of bed time. There are blockages all the way up the system, because 20% to 30% of hospitalized patients are ready to be discharged, but not yet discharged. Ironically enough, approximately 11% of hospital beds have remained empty at any given time, because of bed cleaning or patient movements. Dr. Sokal assured the Court that the hospital is actively working out efficiencies to cut down this last time.

[488] The most recent statistics have shown that the daily average number of beds in the ED continuously occupied with admitted patients who are waiting for in-patient hospital beds is 6.5 beds, again because of the bed constraints in the hospital itself.

[489] During his testimony, Emergency Physician Dr. Minish also shared a concern about flow-through as a chronic issue. He too pointed to the problem posed by patients in hospital beds who are simply waiting for Home Care, blocking access for any new patients needing to be admitted to the hospital. Dr. Minish told the Court that he often admits up to 15 patients daily from the ED. The admitted patients must wait in the ED until another patient has been discharged from a ward. Dr. Minish stressed that at HSC, the Home Care Case Coordinators who organize the discharge and transfer of ALC patients to care homes are only available Monday through Friday, 9:00 a.m. through 3:30 p.m. No patient can presently be discharged from the hospital and be placed in a care home on the weekend. Ms Bergal readily agreed that if Home Care Case Coordinators worked weekends, flow would be better.

[490] Dr. Sokal recommended the implementation of an "overstay reduction team" at the HSC. Long-stay patients can account for more than 20% of hospitalized patients. The team has collaborated with home care specialists, occupational therapists and social workers, working on earlier discharge to free up beds which helps to ease the burden of those patients being boarded in ED. A Regional Patient Flow and Transition Support team already exists to support inter-disciplinary, cross-program teams to improve patient flow.

## 6. Staffing ratios do not match demand

[491] Dr. Grant Innes is a Professor of Emergency Medicine at the University of Calgary. He provided the Court with expert evidence in the area of Emergency Medicine. He is not employed by the WRHA and as such brought another viewpoint. He echoed much of what was expressed by WRHA experts.

[492] Dr. Innes commenced by pointing out that overcrowding *per se* (too many people visiting the ED) is not the primary problem in an ED. Overcrowding is a symptom. The ED is overcrowded because a visit to the ED has become the safety net and the default position for a variety of reasons: many people do not have a primary care physician; family physicians make referrals to the ED; doctor's offices are closed after hours; a doctor's answering machine recommends that the client visit the ED; a person is misbehaving or deteriorating at a nursing home.

[493] Dr. Innes contended that the real issue in the ED is that people waiting in the ED cannot access emergency care within an acceptable time frame. This is the number one operational and safety concern in EDs across the continent. His recurrent theme: the ED waiting room is a very dangerous place. He echoed the other witnesses: the issue does not originate in the ED. The problem arises because there are no available stretchers or beds in the ED, because of the number of admitted patients "boarded" in the ED, who are waiting to be moved to hospital wards. The main cause of emergency access block is hospital ward access block, resulting in a compromised flow of admitted patients from the ED to the hospital wards.

[494] Dr. Innes made another assertion: low acuity patients are not the biggest problem in an ED. In fact, Dr. Innes maintained that it is risky to divert low acuity patients from the ED. His research found that doing so only frees up 2.7% of ED capacity, but causes a 7.3% missed rate for sick patients hidden in the low acuity assessment. Based on his research, diverting low acuity patients does not reduce access block. Low acuity patients represent approximately 8% of the inflow at an

ED and use only 2.5% of ED resources. He told the Court that studies showed that "extended-hours" primary care emergency clinics located near a hospital ED made no difference in reducing ED volume: these clinics resulted in fewer patients consulting their primary care physician. In his opinion, low acuity divergent strategies do not mitigate access block, because access block occurs as a result of high acuity patients. High acuity inflow has a much more profound effect on access block. Non-urgent ED patients use a small fraction of ED resources and only overcrowd the waiting room, not the treatment area. Dr. Innes contended that reducing ED walk-in patient volume is unlikely to reduce access block, because low-acuity patients do not occupy stretchers.

[495] Dr Innes reinforced what other witnesses asserted: research has shown that the lack of capacity of the hospital to receive admitted patients is the primary cause of access block and boarded ED patients. A two-year study in Australia showed quite clearly that the percentage of ED stretchers occupied by boarded patients almost completely co-relates with ED overcrowding. When the numbers are crunched for the "length of stay" of admitted patients "boarded" in the ED, Dr. Innes calculated that boarded patients in the ED account for 75% of all ED resources. He posited that the sum total of hours boarded patients spend in the ED annually is huge, relative to hospital size and capacity. Thus, even a one per cent improvement in hospital efficiency can solve a lot of the access block. Small improvements make big differences.

[496] In his opinion, based on his research, the higher the proportion of beds occupied in a hospital, the longer the length of stay for a person in the ED of that hospital. Risks are discernible when hospital beds are occupied at greater than 85% of capacity: regular bed shortages and crises are inevitable at 90%. His research found that ED length of stay increased dramatically when occupancy in the hospital is greater than 90%. Most urban Canadian hospitals are greater than 95% occupancy. Daily hospital bed demand varies and overcapacity periods are inevitable. As far as Dr. Innes is concerned, the dream target is 85% occupancy.

[497] Dr. Innes provided examples of how discharges from hospitals are delayed. Access block has many contributing causes. The population is aging. Patients present with complex medical issues. The ED is the default location for primary care. There are perennial staff shortages. Hospital discharges plummet on the weekend while patients continue to flow into the system, so by Monday, the hospital is overcapacity and the ED is gridlocked. Patients are discharged at a time too late to arrange home care services that same day and so the patient spends an extra day in hospital. Long-term care facilities only accept patients Monday

through Friday 9:00 a.m. to 4:00 p.m. Stable patients spend days waiting for diagnostic testing.

[498] It was his strong opinion that the ED should not be the default solution for gaps in care. One of these gaps in Winnipeg is what he called the "orphan patient", often frail or elderly: for instance, difficult to manage, personal care home patients sent to the ED without family support. The problem, of course, is that the hospital does not control personal care home protocols.

[499] Dr. Innes saw great benefit to overcapacity protocols, discharge planning and what he called "smoothing", which is matching staffing to demand, which would include elective and surgical work. One solution, for instance, is to schedule more surgeries into periods of lower demand and odd hours. In Dr. Innes' opinion, matching supply to need is a huge problem in hospitals. For example, evening shifts are needed to match evening demand. In other words, efficiency is as important as capacity.

[500] Dr. Innes is vitally concerned with "smoothing" out inefficiencies. He has observed that peak periods for hospitals are holiday times such as Christmas and summer, and yet that is when hospital beds are closed because of staff vacations, so obviously supply does not meet demand. Hospitals tend to schedule elective surgery Monday through Friday, which does not take into account the inevitable, unscheduled weekend demand. From his perspective, Monday is the worst day at hospitals because elective surgeries are "front loaded". Patients are not being discharged over the weekend. Transfers and discharges of patients occur after a shift change and not before. Also, a simple matter of Rounds in the morning can delay discharge decisions and interfere with the flow. Long-term care facilities do not accept patients on weekends or holidays. Hospital discharges plummet on the weekend, but inflow continues. Staffing levels are not matching the patient inflow.

*I therefore recommend:*

*30. That the RHAs identify staffing demands in all EDs and strategically plan to supply adequate staffing for all EDs.*

*31. That an ongoing review of staffing ratios for all EDs be undertaken by all RHAs to match supply to demand.*

[501] Other examples of inefficiencies as far as Dr. Innes was concerned include unnecessary diagnostic testing, unnecessary repetitive recitations of medical history and duplicated medical examinations by Nurse, Medical Student, Emergency Physician and Consultant.

[502] The doctor used a simple concept of "pull" and "push" to outline his contentions. A "pull" system of patient flow is one where service providers control the inflow: they "pull" the patient in **only** when the system is ready to receive the patient. In his contention, this becomes a self-fulfilling disincentive to enhancing patient flow. Dr. Innes contended that the pull process is based on a false assumption that medical providers will work harder to pull new patients in faster and increase their workload. It sustains a system's dysfunction in the sense that there is a huge incentive to reduce stress by blocking access. He labeled the pull process as a perverse allocation of resources: being accountable to one patient can lead to a denial of essential care to the many. He contended that from an ethical standpoint, it amounts to a provision of ineffective care and is morally indefensible, since the outcome is a denial or diversion of healthcare resources from patients in real need: the sickest patients needing acute hospital-based care should have top priority.

[503] Dr. Innes argued for accountability in the health care system. In his framework, accountability decreases the disproportionate risk existent in an ED. The solution, according to Dr. Innes, is the "push" system where patient's need drives the flow: the goal is to give the patient the correct care when they need it. He maintained that the best patient outcomes and the best efficiencies in the system happen when patients receive the right care from the right provider in the right place. In his opinion, EDs are not ideal places for managing surgical conditions, mental health problems and rehabilitation problems. "Accountability zones" require that all the parts of the system work together. He calls it an accountability framework, where accountabilities must be established for all zones, since every zone is interdependent. He likened accountability to an "evolutionary stressor" required to drive change. It is defined not only conceptually but also by time and flow targets. On a macrocosmic level, he says the Ministry of Health must drive accountability planning and develop strategic plans with RHA Directors and provide resources for measurement and reporting. Regional Managers and facility CEOs and hospital leaders all need to implement accountability structures, measurement and reporting systems.

*I therefore recommend:*

*32. That the RHA Directors, Site Directors, ED Directors and the Ministry of Health review the feasibility of strategic planning to implement accountability structures, including measurement and reporting systems.*

[504] Dr. Innes had some concrete suggestions for creating a "push" system in the ED:

- send the Emergency Physician directly into the ED waiting room;
- never send a CTAS3 patient who has been triaged back to the waiting room but go immediately to an intake area with a doctor at the front-end of the process who can rapidly determine the care resources needed. This would probably require replacing part of the waiting room with an intake area;
- create an overcapacity plan that reduces acutely ill patients left in the waiting room of the ED by moving stable patients to most appropriate units or wards;
- instantly divert CTAS4 and 5 patients to a low-intensity, Fast Track area of the ED; and
- in agreeing that staffing should match peaked demands, avoid the Monday to Friday, "9 to 5" mindset.

[505] Dr. Innes readily conceded that these recommendations represent the convergence of all his data and are ideals as much as objectives. Overcapacity protocols serve as accountability mechanisms. The overcapacity protocol is in fact an accountability strategy and a risk reduction strategy and a push strategy. He defined "waste" from the perspective of the patient: waste in this context is care that does not improve a patient's outcome nor reduce a patient's disability.

[506] Dr. Innes spearheaded accountability strategies in Alberta. December 2010 was the implementation of the Alberta Overcapacity Plan. Higher-acuity patients (CTAS1s, 2s and 3s) were moved, within 15 minutes, to an ED acute care space. If that space was full to capacity, the patients were moved to an assigned overcapacity space. When the ED is over capacity by 10%, based on acute stretcher capacity, the most stable, admitted patients were transferred, one by one,

on a “no refusal” basis within 15 minutes to intake care spaces on the most appropriate inpatient unit. When asked about the Winnipeg ED overcapacity protocol, Dr. Innes observed that the ability to push and mandatorily place patients elsewhere in the hospital is missing from the protocol. The HSC ED personnel are already “too overcommitted”. His sense is that Winnipeg does not yet have a demand-driven overcapacity protocol.

[507] The Alberta plan resulted in significant reductions in the length of stay of patients in the ED, an average of a 48% reduction in boarded patients and over half-a-million stretcher hours freed up at all existing sites, even though there was approximately a 10% increase in ED patients. Thus there was a reduction in hospital access block and boarded ED patients. Wait times to see a doctor were improved as were the number of people leaving the ED without being seen. There were also reduced ambulance-offload delays. Reduction in wait time leads to a corresponding reduction in people not leaving the ED without being seen.

[508] The doctor was cross-examined. He agreed with WRHA counsel that one of the hospitals in Edmonton where he has performed research actually has a higher length of stay than HSC ED. He also agreed that at the Calgary inner-city hospital ED, a much lower percentage of CTAS4s and 5s are present because of the existence of an urgent-care centre in downtown Calgary. In other words, statistics can vary because different hospitals have different resources.

[509] Dr. Innes also agreed that the fast-track renovations in the HSC ED are similar to the Minor Treatment Area in the Calgary hospital. He strongly endorsed very rapid triage. His “dream triage question” is: “How sick are you and what destination in the hospital are you going to?” He endorsed the HSC ED registration and triage process. He agreed with the concept of flexibility of nursing function and also contended that physicians ought not to be restricted to one area. In a good system, doctors ought to be flexible.

[510] Dr. Innes endorsed a “two consult” approach, whereby the ED physician selects a Consultant on a hospital ward and if the Consultant refuses to take the patient, an alternative Consultant is picked. If the second Consultant also refuses, the Medical Director is contacted to assign the patient to one of the wards.

[511] The doctor was asked about the WRHA “Patient Flow Action Plan” for 2012-2015. He saw the plan as a very good concept. However, because he too maintained that low-acuity patients (CTAS4s and 5s) are not the problem in the flow conundrum, he believed that the stated goal to “Reduce CTAS4 and 5 visits

as a percent of total ED visits to 20% by 2015" will not ease the pressure on patient flow. He did not see much value in that stated goal. He agreed that other targets are steps towards the right goal. He agreed that it is always a good idea to include frontline medical staff when change occurs. If frontline staff is not involved, Dr. Innes was of the strong opinion that "It's a guaranteed failure."

[512] In terms of an "output" strategy, Dr. Innes believes it is very important to connect with the long-term care facilities and meet with them to discuss patient transitions and queue management. He agreed that the presence of nurse practitioners in nursing homes is a very good idea.

[513] Dr. Innes was familiar with the MNU recommendations to the Health Minister, about which I will deal with later in the report.. He agreed that there ought to be a consistent, region-wide, overcapacity protocol. The Court agrees.

*I therefore recommend:*

*33. That the RHAs review the feasibility of creating a region-wide Overcapacity Protocol, such as the Alberta Overcapacity Plan, where deemed appropriate.*

[514] He agreed with the positions of a dedicated ED triage nurse and a dedicated ED resuscitation nurse, but he was hesitant to endorse a dedicated reassessment nurse position for all EDs because he prefers an aggressive mode of getting patients treated and placed in an appropriate care area. He agreed that baseline staffing discussions are always necessary.

[515] Dr. Innes agreed that home care services must be enhanced outside of the Monday to Friday regime. Rather than coverage around the clock, Dr. Innes recommended that peak periods be covered. He identified the peak periods as noon to 7:00 p.m., seven days a week.

[516] He agreed that it is important to educate doctors to avoid the ED as the default position. He thought that this ought to be confirmed with a policy. He also agreed with other witnesses that diagnostic services should be readily available in EDs.

*I therefore recommend:*

*34. That the RHAs review the feasibility of providing on-site diagnostic equipment in EDs, where deemed appropriate.*

## 7. Weekend staffing

[517] Emergencies know no timetable. An emergency can occur any hour of the day or night, any day of the week, including statutory holidays. Many witnesses, including Dr. Innes, decried the lack of available services on weekends and the resultant, predictable, manifest inefficiencies. The reality is far more problematic: not only are there always shortages of nurses, but the entire care home discharge system seems set up not to function on a weekend. Ms Lori Lamont, Chief Nursing Officer for the WRHA, recommended operating a central scheduling office for home care referral from hospital discharges seven days a week. She also recommended that the Home Care Coordinator position, currently a Monday to Friday position, excluding vacation time, become a seven-days-a-week position. She also recommended that the home care resource teams be staffed seven days a week. This Court can make similar recommendations, but until the nursing shortage is remedied and until the relevant parties fill the gaps created by weekend staffing decisions, the "weekend and statutory holiday" issue will continue to contribute to front-end delays in the ED. What is important is long-term planning and a recognition that in the realm of emergency medicine specifically and health care in general, the Monday to Friday workweek no longer suffices.

*I therefore recommend:*

*35. That the RHAs review the feasibility of a seven-day work week for the office of the Home Care Coordinator.*

*36. That the relevant Utilization representative(s) meet with the Ministry of Health, Housing and Healthy Living representatives to continue to review bed registry and guidelines for transfers and discharge of patients from hospital, including the feasibility of a seven-day work week.*

*37. That RHAs review the feasibility of the implementation of the delivery of primary care, after-hours, urgent services, where deemed appropriate.*

## 8. Frequent users

[518] Frequent ED users have complex health problems. Often, they have mental health issues. These individuals often belong to socially-disadvantaged groups. They also use a disproportionate number of other health care services. Frequent ED use has been attributed to many causes: those patients' unmet needs; a lack of or inaccessibility to other health care facilities or community resources for those

patients; a safety net or simply, a convenience. Frequent ED users, while making up only a small proportion, just over two percent of all ED patients, account for 13% of all ED visits. Brian Sinclair was a frequent user. Dr. Chochinov surmised that Brian Sinclair would have been assessed as a CTAS3 when he attended the ED for the last time on September 19th, 2008. Dr. Chochinov deemed Mr. Sinclair's presenting medical issue as urgent, but not critical.

[519] In May of 2008, the Manitoba Centre for Health Policy, Department of Community Health Services, Faculty of Medicine, University of Manitoba, did "An Initial Analysis of Emergency Departments and Urgent Care in Winnipeg." Among other issues, they attempted to categorize the idea of the "frequent user" of the ED. Intermediate users were two to six visits annually; moderately frequent ED users were people with more than seven visits annually. Frequent ED users were seven to 11 visits. Very frequent users were 12 to 17. Highly frequent users were people with more than 18 visits annually. As far as general trends, they found that the use of ambulance services had increased in recent years, a large portion of ED visits were for people who have fairly minor medical problems, and three-quarters of patients were discharged without being hospitalized. Researchers found that compared to single users, frequent ED users tended to be older (25 to 64 years old), impoverished and living in the core area of Winnipeg. A disproportionate number of them had co-morbid, chronic physical diseases. Many of these patients had been diagnosed in the past with mental illnesses. The study found that mental illness was the strongest determinate of frequent ED use. Included in the definition of mental illness, it should be noted, was substance abuse. A disproportionate number of frequent users arrived by ambulance, only to be triaged as less or non-urgent or to leave without being seen. 40% of ED visits by frequent users were triaged as less urgent or non-urgent. The study recommended that research be conducted to attempt to understand how a lack of primary care resources influences ED use for these patients.

[520] One of the group's recommendations was that the policy-makers should plan, from the perspective of both the patient and the health care system, to develop alternative services for select ED users. The caveat, however, was that alternate care strategies for frequent ED users may be costly and the study concluded that there was limited evidence to estimate the potential health care cost savings that could arise from the strategy.

[521] In January 2011, a WRHA project was initiated for trying to better manage "frequent users". The initiative is to identify the frequent users and triage them. If the matter is non-urgent, proactive community supports are put in place to try to

improve their quality of life. They do this by helping the frequent users manage their medical issues more effectively, by establishing reliable social supports and working collaboratively with other service providers, and in the process building up information about them for future reference. Dr. Chochinov pointed to a number of initiatives that are ongoing, but told the Court that "heavy users" are .33% of the population but account for 45% of hospital days. He confirmed that the frequent user tends to be traumatically sicker and/or older than other hospitalized patients.

[522] Dr. Sokal outlined for the Court the WRHA plans to divert frequent users from the EDs. The target is to reduce the use of the ED by frequent users by developing alternate supports in the community. Ideally, the goal is to safely care for people in settings other than the ED: a safe referral of the frequent user by a paramedic or a nurse practitioner from the ED to a Quick Care Clinic or a Crisis Response Centre or a Primary Care Clinic, **without** an ED physician's assessment. In January 2011, the Department of Social Work at HSC ED undertook a special project on frequent users to develop care plans for each patient, which has resulted in significant reductions in their visits. At the ED triage desk, there is now a list of frequent users.

[523] Back in 2008, a mere 97 patients accounted for 2,591 HSC ED visits that year. Those same 97 patients had an additional 797 ED visits at various other hospitals. Initiatives commenced to divert these patients to community resources. In November of 2009, an ED Community Liaison Social Worker position helped in this regard. Currently there are 16 hours per day social work coverage at the HSC ED. Permanent funding is in place for a social worker dedicated to frequent users of the HSC ED. This social worker is focused on developing comprehensive care plans for frequent users and stabilizing individuals within the community. The SWERL program (Social Work Emergency Room Links) has been created to allow social workers from different hospitals to follow the same frequent users, in order to develop individualized case coordination for them.

[524] It is estimated that approximately 80% of the people who go to an ED experiencing acute emotional or psychological distress do not need to be admitted to hospital. In June of 2013, a Crisis Response Centre, connected to the HSC complex, was opened to the public. It provides coordinated crisis services and is part of the strategy to divert patients from HSC ED. The Crisis Response Centre is open 24 hours a day, seven days a week. It offers walk-in assessment and treatment for those persons in mental crisis, along with referrals from other mental health services. It is designed for adults in distress. There is also a mobile crisis service

for adults. The team at the centre includes nurses, social workers, crisis workers, physician assistants and psychiatrists.

[525] As of January 2014, there are a number of initiatives existing for high-risk, complex-needs clients and patients who are frequent users. This includes the HAC and Nurse Practitioner services at the Main Street Project. There are also Paramedic services at the Main Street Project focused on assessment, care and service for individuals detained under the IPDA and also on primary and emergency care to clients in the rest of the facility. Funding for the round-the-clock paramedics at the Project was provided by WRHA effective April 1, 2011. There has been a resultant 50% reduction in ambulance transports from the Main Street Project to Winnipeg EDs.

[526] Another of the WRHA initiatives is the Modified Integrated Supported and Transitional Housing initiative (MIST) which is an integrated housing and support environment for individuals with complex medical and/or behavioural needs, providing 12 units of housing with on-site supports up to 24 hours a day (eight permanent housing units and four transitional assessment units). The WRHA has new initiatives to open Quick Care Clinics designed to treat CTAS3s and 4s, staffed by nurses and nurse practitioners. Currently, there are two such clinics in Winnipeg. Two more are expected to be opened this year.

[527] The problem still remains that the lower-acuity patient is still delayed in an ED. These patients may not account for or be responsible for the delay, but they certainly suffer the consequences. It is imperative that they be diverted from EDs if at all possible. The Court recognizes that recommending **any** alternative to the busy urban ED will require a commitment of time, energy, scarce resources and capital. Yet, it appears by all accounts that the **integration** of services in smaller, satellite community health centres that provide access for clients living in that area to a team of social workers, dieticians, physiotherapists, nurse practitioners and other health and social service professionals does serve to divert a number of people who would otherwise use the ED. While the wait time in EDs remains an issue, people remain at risk simply sitting in an ED waiting room.

*I therefore recommend:*

*38. That the WRHA review the feasibility of community health care facilities with integrated models of care.*

## VULNERABLE PATIENTS

[528] Almost one half of visits to EDs in the inner city are not urgent. Yet, framing these non-urgent visits as a "misuse" of the emergency room overlooks the fact that for the population served in the inner city, the emergency room can function as a medical harbour, a safety net for homeless, transient, poor or otherwise marginalized or vulnerable people. However, the use of the ED in this fashion represents a huge cost to the health care system.

[529] ED Nurse Penner told the Court that back in 2008, she often dealt with homeless people at HSC ED. She was made aware that the person was homeless because after the person had been discharged, she was told by the person that they had nowhere to go. At times, she would let the person stay till morning, because there was no social worker available after hours. Staff was given no direction from Management as to what to do in those situations. ED Nurse Collis confirmed that for the last 3 or 4 years, there is a social worker at HSC ED dedicated to the vulnerable patient population, Monday through Friday, 8 a.m. to 4 p.m. and every evening (seven days a week) from 3:30 p.m. to midnight.

### An Ottawa perspective on the homeless client

[530] Dr. Jeffrey Turnbull is a very busy person. Among other roles, he is the Chief of Staff of the Ottawa General Hospital, a Professor of Medicine at the University of Ottawa and the founder and Medical Director of the Ottawa Inner City Health Project which has been in existence for 12 years. This last project is an initiative to provide **integrated** services and care to homeless people in Ottawa with what he described as "an army of support workers, nurses, community outreach workers and doctors". This multi-agency initiative links health, social service, housing and legal sectors. More than 50% of the budget is contributed by partner organizations. Partners include an Aboriginal Health Centre, the Ottawa Police Department and the Canadian Mental Health Association. The project has also partnered with ED staff to create solutions for frequent users of the ED.

[531] Dr. Turnbull pointed out that the homeless in Ottawa are a diverse group including entire families, workers, refugees and the elderly. 17% are Indigenous persons. He has observed that this diverse, homeless group uses the ED inappropriately, excessively and often in crisis mode, resulting in bad outcomes and expensive and ineffective treatment. "They pay for their poverty with their health." Their life expectancy is 21 years less than average.

[532] He told the Court that the homeless are at the ED because:

- they are seriously ill;
- they have a greater exposure to trauma, violence, disease;
- they often present with a co-occurrence of mental illness, acquired brain injury or cognitive impairments, all of which impair the executive functioning of the brain;
- they experience a lack of access to primary care;
- they often lack health cards and other identification;
- they are seeking drugs;
- they are simply trying to relieve the symptoms of chronic illness; and
- they are intoxicated or rowdy on the street.

[533] This population represents huge challenges to hospital staff, in part because they may be poor historians, disruptive, complex or rowdy for a variety of reasons. They also represent a huge cost to the health care system. By Dr. Turnbull's reckoning, 2.5% of people use up to one **billion** dollars a year as frequent users of EDs and 43% of them are homeless. This is not a unique problem. There is a 7% growth in these types of hospital visits without the corresponding bed capacity.

## MEASURES TO REDUCE DELAY

[534] The 2013 accreditation of the WRHA made the following recommendations:

1. develop an over-capacity protocol that is activated when ED surges occur;
2. ensure appropriate staffing. At minimum there should be one dedicated triage nurse for all hours that the ED is open. Ensure each ED has a dedicated resuscitation nurse. Ensure that each ED has a dedicated reassessment nurse. Ensure a dedicated triage aide 24/7. Continue to expand nurse practitioners;

3. ensure safety and security by having a trained Security staff at each ED;

4. develop a Winnipeg Ambulance Service discharge protocol;

5. ensure diagnostic services are readily available; and

6. enhance home care service by allowing referral and implementation of services to be available seven days a week including evenings for direct discharge. It is currently limited from Monday to Friday, and limited after-hour care.

[535] Dr. Chochinov provided the Court with a number of practical recommendations to reduce delay in EDs. Dr. Turnbull concurred entirely with Dr. Chochinov's recommendations. Dr. Turnbull defined the ED as "the sharp edge of the wedge". He maintained that CTAS3s are the biggest challenge for the health care system.

[536] Dr. Chochinov firmly believed that nurse practitioners can reduce wait times for the ED, particularly in "fast-track" (Minor Treatment) areas for high-volume EDs. Nurse practitioners are currently located in four Winnipeg hospitals. Dr. Chochinov explained that in rural areas, nurse practitioners can supplement overextended physicians and allow Health Centres to remain open when they might otherwise have to close. With the addition of a nurse practitioner, whether in a minor injury unit in an ED or in a free-standing unit, wait times are reduced. Dr. Chochinov believed that nurse practitioners function best in the Minor Treatment Area. The WRHA controls a number of the hospitals, community health services and home care facilities but also has service purchase agreements with non-devolved hospitals and health facilities.

*I therefore recommend:*

*39. That RHAs continue to review the feasibility of incorporating more Nurse Practitioner positions in EDs, where deemed appropriate.*

[537] A variety of other jurisdictions have developed a model using a "Hospitalist" as the Admitting Physician in the hospital. Dr. Innes believes that hospitalists, who are physicians trained to specialize and work in a hospital setting and are responsible to the hospital, can help speed patients through. Dr. Innes worries that

primary care physicians are already scarce and are moving to become hospitalists. Hospitalists are a fast-growing specialty in medicine.

[538] A Hospitalist has Family Medicine or Internal Medicine training and assumes primary responsibility for all patients requiring admission, where the length of stay is more than 24 hours. This model does **not** exist in Manitoba yet. The Hospitalist assumes responsibility for the ED patient as the admitting physician. Dr. Chochinov ideally wants a Hospitalist for each hospital. If there is a round-the-clock Hospitalist, then there is a "one-way consult" from the ED into the hospital and the patient would be admitted through the Hospitalist and not simply bounced back to the ED after a specialist had been consulted. In practice, family physicians would be given an additional one year of training in a hospital to train as Hospitalists. This brings the Primary Care Physician back in to the hospital context. This is on the theory that no patient should stay in the ED more than 24 hours without direct access to an admitting doctor and bed space.

*I therefore recommend:*

*40. That RHAs review the feasibility of recruiting and retaining Hospitalists, where deemed appropriate.*

[539] Dr. Chochinov foresaw a solution to delay due to the time it takes for a Consultant to see an admitted ED patient. His target is to have round-the-clock access from the ED to Consultants with a response time from the Consultant within two hours. The doctor testified that his "one-way consult" recommendation has received some resistance, but he feels it is a necessity. This one-way consult process is endorsed in other jurisdictions.

*I therefore recommend:*

*41. That RHAs review the feasibility of the implementation of "one way consults" from the ED to the hospital ward, where deemed appropriate.*

[540] Numerous witnesses, from the entire health care spectrum agreed that "over-capacity protocols" are necessary at times of peak demand. Dr. Sokal told the Court that hospital administrators have a variety of competing issues to address within the system when trying to find a hospital bed for all ED admitted patients. For instance, Dr. Sokal pointed out that when HSC ED peak period overcrowding was analyzed, it was clear that part of the solution involved the development of an overcapacity protocol and the development and support of strategies to discharge

patients from the hospital during the weekend and at the beginning of the week. Part of the unsafe environment was that fully **25%** of the people arriving at the HSC ED during a recent peak period or "surge" left without being seen.

[541] Night volumes at HSC ED had been increasing such that there were up to 20 patients waiting to be seen at 4:00 a.m. Dr. Sokal wrote to the Chief Medical Officer of the WRHA in October of 2012 requesting additional night coverage by ED physicians and round-the clock Minor Treatment Area coverage, which was instated.

[542] Ms Sandra Mowat, President of the Manitoba Nurses' Union (MNU) concurred. The MNU recently recommended to the Minister of Health the development of a regional overcapacity protocol: a step-by-step protocol that is activated when surges occur in an ED. The protocol requires all staff in the ED to examine possible discharges, to make room for incoming patients from a disaster or other surge. Proper use of such a solution, from the MNU perspective, could include accelerating inpatient discharges to home with appropriate resources, discharging patients to a long-term care facility, transferring patients to non-acute care units and admitting patients who have already been admitted in the ED to other parts of the hospital.

[543] Dr. Chochinov confirmed that "frequent flyers" constitute 2% of patients but are responsible for 14% of ED visits. Efforts are underway to address these patients on an individual basis. Dr. Chochinov told the Court about the initiatives WRHA has used to address the issue, such as a full-time social worker, community supports and research. He claimed that the WRHA is "on the road to try to address this issue". Funding was obtained in April of 2009 for a dedicated social worker who focuses on frequent users and is thus focused on a very narrow population. The Community Service Worker at HSC interacts with the entire ED population. The Community Service Worker job description, dated December 17, 2013 outlines: "The Community Service Worker role includes hourly rounds within the ED waiting room, interaction with all patients, checking arm bands. If a green arm band is still on a patient, the worker must ensure that the patient has been triaged, including checking IPDA patients to wake them up and have them state their name. They advocate for patients in the waiting room, informing the triage nurses of any concerns."

[544] Each ED now has a "pre-triage waiting area". Dr. Chochinov was quick to point out that different solutions work at different hospitals. There is now a green wristband used at the HSC ED and at the Grace Hospital in Winnipeg, to identify

patients not yet triaged, but at other EDs, the nurse "walks the line" to check on the patients not yet triaged. Solutions for one site may not suit another because of different populations. I have already made a recommendation in this regard.

[545] Dr. Chochinov discussed the WRHA "Patient Flow Action Plan for 2012-2015". As I stated, one of the targets is to reduce CTAS4 and CTAS5 visits by 20% by 2015. One potential strategy is to develop processes to enable the safe referral of CTAS4 and CTAS5 patients from the ED to "Quick Care Clinics", or the Crisis Response Centre or Primary Care Clinics, without first requiring a physician assessment. The WRHA supports the recent training and addition of "Physician Assistants" who are regulated and licensed health care professionals. There is a high demand for them and Dr. Chochinov supports the hiring of more of them for EDs to improve patient safety and flow.

*I therefore recommend:*

*42. That the RHAs review the feasibility of hiring and retaining Physician Assistants to work in EDs, where deemed appropriate.*

[546] As I stated, Dr. Jeffrey Turnbull is, among his other roles, the Chief of Staff of the Ottawa General Hospital. He testified that in his hospital, the problem of "boarding" never happens. Patients are tracked by the hour. The algorithm they use dictates that when an ED patient is admitted to the hospital, a ward is chosen, such as internal medicine. If internal medicine refuses to take the patient, then a second ward is chosen. If the second ward refuses the patient, then he, as the Medical Director, forces one of the wards to take the patient. A 24-hour deadline commences from the point of admission. So the outcome will always result in an assigned attending physician.

*I therefore recommend:*

*43. That the RHAs review the feasibility of creating a process to establish a deadline for admitting a "boarded" ED patient to a hospital bed, where deemed appropriate.*

[547] The 2013 Accreditation of the WRHA congratulated the EDs on their dedicated work to address the issues of flow and patient safety. They are all described as "challenged" to address the patient flow issues and congestion in the EDs. The Accreditation concluded that substantial improvement of patient flow will demand fundamental system change in the WRHA:

> There is no obvious resolution...regional initiatives can be slow and cumbersome and local initiatives can interfere with regional strategies and services.
>
> Improving client flow may require evaluating and improving triage processes; adding or shifting bed capacity or having surge capacity policies and procedures, including thresholds for creating extra capacity; improving bed cleaning turnaround times; improving the transfer of information between departments or service providers; establishing which clients or cases have priority for beds and protecting beds for those that are prioritized; or balancing the surgical schedule with elective and non-elective surgeries so that there is room for flexibility in carrying out unscheduled or emergency surgeries.

[548] In short, the Accreditation recommended that the organization's leaders assess and improve client flow throughout the organization. Focus has to be on the specific impact that innovations are likely to have on patients, staff and the system. One of the recommendations is that the WRHA continue to make investments in community and long-term care in order to ensure adequate capacity to accommodate a shift away from the overuse of acute care. The Court has made a recommendation to this effect.

[549] Dr. Sokal referred the Court to a discussion paper prepared in June of 2013: "Getting to the Source of the Patient Flow Problem: An Analysis of Flow-related Initiatives in the Winnipeg Health Region". System-wide, emergency wait times appeared to be increasing and in-patient length of stay showed no significant decline. The author of the paper conducted in-depth interviews with 62 Senior- and Middle-Management representatives. There are 3 paradoxes of patient flow: a small part of the system may have been improved but the underlying system problems remain; rules that improve the organization at one site or location may create obstacles at another site; initiatives can originate from either hospital sites or programs, but conflict may arise when both try to be the initiators of change. Improving flow demands that the entire trajectory of patient population care must be analyzed. A consistent process must be established to better meet patient population needs, whether this means revising an existing service model or creating a new one.

[550] Recommendations that arose from the 2013 report included establishing who is responsible for revising the existing service model and holding the leaders accountable for their progress, having a more centralized, systematic and proactive

approach to the deployment of regional resources and **continuing to make investments in community and long-term care in order to ensure adequate capacity**: all this in order to accommodate the shift away from the overuse of acute care. In other words, there needs to be a fundamental, structural shift.

[551] Dr. Sokal endorsed some of the recommendations to reduce overcrowding in EDs that the Canadian Association of Emergency Physicians made. These solutions are echoed by other witnesses. On the "input" side of the equation:

- Improve primary care access. Create a robust primary care system to give Canadians reasonable access to a primary care provider;

- Improve ambulance offload coordination. Ontario provided funding for Nurses to take over care of patients arriving by ambulance from Paramedics, so that Paramedics are able to get back on the road. Dr. Sokal confirmed that there has been a slight decrease in ambulance arrivals at EDs more recently because of diversions to the Main Street Project (approximately 40 patients a month) and movement of lower-acuity patients from personal care homes to facilities other than EDs.

On the "through-put" side of the equation:

- Engage in process improvement with techniques such as the "LEAN" technique;

- Invest in improved staffing of the EDs;

- Utilize "Rapid Assessment Zones" by organizing staffing in the ED for specific needs of patients. This involves fast-tracking non-emergent patients with a low risk of admission, who can be cared for in non-traditional care spaces: for example, patients who are stable enough to wait in a chair for the initial assessment;

- Establish formalized intake policies and processes; and

- Establish a short stay area or an observation area.

The HSC ED is engaging all these strategies. "Output" solutions:

- Implement overcapacity protocols; and

- Formalize hospital-wide flow policies. In other words, create a hospital length-of-stay committee to monitor and optimize patient flow.

The Court endorses these measures.

*I therefore recommend:*

*44. That the RHAs create a Hospital Length-Of-Stay Reduction Committee to monitor and optimize patient flow in RHA hospitals.*

[552] Dr. Sokal noted that it appeared that media campaigns that attempt to dissuade ED use and divert patients to walk-in clinics have been shown to be fairly ineffective. Ironically, Dr. Sokal also pointed to a study that concluded that none of the models currently used to measure ED workload can be relied upon to accurately predict the number of staffed hours necessary. When he looks at the WRHA Flow Action Plan for 2012 to 2015, he has a concern that the reduction of long-stay patients by 5% is not high enough. His wish-list recommendation is the concept of "no-wait ED". In other words, he wants to immediately move admitted ED patients out of ED beds into an internal hospital ward.

## OTHER STRATEGIES TO SMOOTH THE FLOW

[553] Lori Lamont is the Chief Nursing Officer of the WRHA. She is the Chair of the Nursing Leadership Council, which consists of Chief Nursing Officers and Program Directors. She is also the Chair of the WRHA Professional Advisory Committee regarding standards and guidelines in clinical practices. Ms Lamont outlined for the Court various targets that the WRHA is trying to meet. She confirmed that a number of strategies have been implemented as a result of the WRHA Patient Flow Action Plan 2012-2015 in an attempt to move patients through the hospital system, including strategies to reduce the utilization of the ED.

[554] Targets include:

- reduction of ambulance offload times to 30-60 minutes;

- reduction of ED length-of-stay: the target is to have 90% of non-admitted patients treated and released within four hours and 90% of admitted patients treated and moved to an in-patient area within eight hours;

- increasing personal care home capacity;

- increasing long-term care facility capacity;

- streamlining the paneling process;

- reduction of CTAS4 and 5 visits to the ED by 20% by 2015; and

- a Nurse Practitioner as the on-site primary care giver for WRHA personal care home residents.

[555] At **any** point in time, 60 to 80 people in WRHA hospitals are waiting for personal care home beds and an equivalent number of people are in the process of being paneled. Also, there are approximately 300 people at any time in the community awaiting personal care home admission. In other provinces, once a person is paneled, that person is moved to the next available bed in a personal care home. There is little choice for the patient. Not so in Manitoba.

[556] Ms Lamont explained that part of the push for increased capacity in the personal care home realm is a function of demographics: the recognition that the "baby boomer" generation is aging and will require beds in personal care homes, supportive housing or expanded home care. The estimated wave of aging population growth is projected to crest until 2036 (Manitoba Centre for Health Policy did the projections in November 2012). Funding has been received from Manitoba Health for two 120-bed long-term care facilities. The **hope** is that they will be built in 2016.

[557] In Winnipeg, over 50 percent of those persons being admitted to a personal care home had come from a hospital after being paneled. Those persons have remained in a hospital bed prior to being admitted to a personal care home bed. If more beds were available in personal care homes, in-hospital wait times would be reduced. The Court agrees with Ms Bergal's recommendation that building the infrastructure for our long-term care needs is hugely important. The players at the table are the Government and the Health Authorities and the task is to try to help

match demand with capacity by committing to capital infrastructure in a timely fashion.

*I therefore recommend:*

*45. That the WRHA engage in strategic planning with the Ministry of Health and Manitoba Housing for the funding and construction of more long term care facilities.*

[558] The majority of personal care homes are privately run. Ms Lamont agreed that even though nurse practitioners are the most expensive option, the WRHA would like to hire them for personal care homes. Currently only five of 39 personal care homes in Winnipeg receive some level of nurse practitioner service. Ms Lamont agreed that there needs to be ongoing discussions about attracting more nurses into geriatric nursing specifically and training more nursing staff in general to meet the demand. She described the efficacy of the nurse practitioner in this context:

> The Nurse Practitioners have been demonstrated to have a very positive affect in the primary care system. They are educated to, to deliver primary care. The Nurse Practitioner education program at the University of Manitoba, which is the only one we have in the province, focuses on educating Nurse Practitioners so that they can take on a role in primary care. They become expert at working with people around their health needs, both in terms of treating illness, you know, minor illness, acute illness, but also I think, importantly, in looking at chronic disease management and health promotion and prevention. The presence of a Nurse Practitioner in the long-term care system has significantly reduced the number of people from personal care homes that are sent to the ED.

*I therefore recommend:*

*46. That WRHA continue pursuing the feasibility of the recruitment and retention of more Nurse Practitioner services in personal care homes.*

[559] She was asked about the communication between health care and home care to ensure that both sides have access to past and current patient data. For truly collaborative care to occur, she told the Court:

> One of the key components in that is ensuring that team members are communicating clearly, and ensuring that the plan of care is well understood by everyone. And where we see that being very important as well is also in the transitions of care and so what we think of as a transition in care is when someone leaves a hospital or, or another kind of institution and goes to community … that it's clear what the plan is, what the needs of the individual are… who the community partners are that they are working with.

[560] Currently, there exists no single electronic health record. Home Care and Health Care do not currently have the same computer systems. She agreed that being able to generate information that could be sent "from the hospital to the community to the home care office or to the personal care home and vice versa, ensuring that the appropriate information goes back and forth with the person when they transition from one part of our health system to another would be important." Work needs to done to make it possible to access information about an individual regardless of where they are in the health system. There is a necessity for better communication between the health care and the home care to access all past and current data on a patient. Presently the computer systems cannot interface electronically.

*I therefore recommend:*

*47. That the RHAs review the feasibility of the creation of a single electronic health record accessible to all health care facilities.*

[561] Ms Lamont outlined a number of strategic initiatives (some of which have already been mentioned) that have been or are soon to be implemented in an effort to improve flow. It is not necessary to itemize them all in this report. Suffice it to say that the focus of many of these programs is access to health care in the community, **away** from the hospital setting. Strategies include:

- opening the Crisis Response Centre in June of 2013; and

- opening six Community Health Access Centres in Winnipeg.

  These centres are in effect "one-stop community health centres" tailored to the needs of area residents, with expanded hours, making it more convenient for people to receive care closer to where they live. The centres deliver a range of social services to the community under

one roof. More are planned. Dr. Brian Postl, formerly the CEO of the WRHA and currently the Dean of the University of Manitoba Faculty of Medicine, was quoted in a recent Winnipeg Free Press article as follows: "The growing literature is that health care that is delivered by teams of professionals tends to be both safer and more effective than by professionals working in individual silos." Basically, physicians who still are paid on a fee-for-service basis work collaboratively with other health professionals supplied by the Health Authority. This is a Primary Care Network, being health care tailored to the immediate needs of any particular community. These Primary Care Networks are being established throughout the Province.

*I therefore recommend:*

*48. That the Ministry of Health and the RHAs review the feasibility of the expansion of Primary Care Networks.*

- initiating specialized case management services led by community mental health services who take their services on the road to the client;

- creating 500 supported housing spaces for persons who have mild to moderate dementia, are physically independent, but who need an environment that provides 24 hour supervision for them;

- creating a pilot project, Emergency Paramedics in the Community (EPIC), to try to avoid ED visits by vulnerable persons in distress;

- creating a pilot project of the Hospital Home Team, providing a cluster of health services, mainly to the elderly who might otherwise use the ED;

- creating a transitional lodge on the HSC campus with 14 suites for trauma victims without housing; and

- establishing two "Quick Care Clinics" (more are planned) where people can go to have relatively minor illnesses or injuries addressed, seven days a week with extended hours of operation.

[562] The WRHA has various partnerships in the community. One of the initiatives bears special mention. "Chez Soi", originally a federally-funded initiative, is now a WRHA initiative. It has capacity for 300 homeless individuals (280 are currently enrolled) with the "Housing First" model partnered with inner city agencies (Mount Carmel Clinic, Ma Mawi Chi Itata Centre and Aboriginal Health and Wellness Centre), providing permanent housing, along with itinerant support services by the three agencies. Sustainability issues are of grave concern because of the cost of the specialized contracts, which continues to escalate because of the complex needs of the clients.

[563] The Court commends all these initiatives.

*I therefore recommend:*

*49. That the WRHA review the feasibility of the expansion of Nurse Practitioner-operated Quick Care Clinics to help ease wait times at EDs and Primary Care Physicians' offices*.

*50. That the WRHA and the Ministry of Health continue to create strategies to educate the public about the existence, function and location of community health care centres.*

## TAKING IT TO THE STREETS

[564] Dr. Turnbull told the Court about Ottawa's Targeted Engagement and Diversion (TED) Progamme, initiated by Dr. Turnbull in 2013, which has quickly become a measurably successful strategy to provide the equivalent of hospital services at places where the homeless gather. Throughout Ottawa, there are five shelters. The TED team brings the health care to the shelters in partnerships with the shelters. This program has core funding from the Ministry of Health. In their first 8 months of operations, TED avoided 756 visits to the ED. They saved the system an estimated $378,000 at an operating cost of $170,000. In 2013, about 96% of the 650 people assisted were diverted from the ED. According to their data for the first year of operation, only about 4% of the individuals who otherwise would have been taken to the ED actually required the level of care most appropriately provided at an ED.

[565] The TED team consists of outreach workers, frontline shelter workers, a nurse coordinator, a physician, a mental health nurse, an intensive case manager, a primary care nurse practitioner and a psychiatrist. Whereas ambulance and police

resources used to be diverted to respond to calls to take people to a shelter, now dedicated paramedics **look** for homeless clients and bring them to the shelter. There are designated beds for those who are not in a fit condition to either engage in the program or consent to engaging in the program but are trying to engage. 45 beds are set aside for acute cases.

[566] At one of the shelters, for example, nurse practitioners run a primary care clinic which is open six days a week, from 9:00 a.m. to 5:00 p.m. and includes a dental clinic and HIV response centre.

[567] From Dr. Turnbull's perspective, **billions** of dollars in saving are possible. He considers investment in the social determinants of health to be a fiscal imperative. He estimated that addressing the social determinants of health can decrease health costs by 25%.

[568] Dr. Turnbull suggested a few concrete, short-term strategies for the ED.

1) The Triage Nurse has a very complex role and ought to be the most qualified Nurse in the ED, since the Triage Nurse assesses the most complex medical patients. In Dr. Turnbull's world, once the Triage Nurse has assessed a patient as either CTAS4 or a CTAS5, (low-acuity), that patient is streamed to an urgent care department which is proximate to but not part of the ED and is staffed by another group of doctors;

2) The observation area of the ED, where ED patients are monitored, requires a "Float" Nurse around the clock to take care of those patients;

3) There needs to be an "E-Board", an electronic whiteboard, to monitor where all patients are at all times in the ED;

4) There needs to be a patient advocate to give a voice to the marginalized; and

5) Social workers need to liaise with community agencies.

[569] For longer-term strategies, Dr. Turnbull contended that the ED is not the place for these marginalized populations. The community should create integrated, case-managed, team-based care to manage the chronically ill and complex-needs

patients. For example, the TED program links integrated case-management with supportive housing to try to address the social determinants of health. In fact, Dr. Turnbull applauded all current WRHA initiatives in this regard, such as a round-the-clock nurse practitioner at the Main Street Project.

[570] Dr. Turnbull was asked about the WRHA's latest transitional housing initiative, which is the Transitional Supported Care (TSC) program. It can support up to 20 clients at any one time, with an annual budget of 2.5 million and a potential annual client base in the hundreds. The transitional housing costs half as much as a hospital bed. The WRHA is partnered with the Provincial Department of Housing and Community Development. His response was transitional housing for the homeless is one solution. He strongly believes that hospitals have to build transitional housing, available to decompress access block.

[571] Dr. Turnbull applauded the new Riverpoint Centre in the North End of Winnipeg, which offers the services of three existing organizations (Main Street Project, the Addictions Foundation of Manitoba and the Behavioural Health Foundation) at one location. The goal at Riverpoint Centre is to provide a continuum of services, all housed under the same roof.

[572] Similarly, he approved of the current expansion of the Siloam Mission which will almost triple its ability to house the homeless. Currently there are 65 supported housing units and there are plans to add 160 more. The expansion includes an enlarged dining room and kitchen, a separate women-only shelter area and the addition of daybeds for those requiring bed rest and observation.

[573] Dr. Turnbull opined that these services also need to be integrated with **other** service providers, such as Child and Family Services and legal services. It is very important for the service providers to team up and work collaboratively.

[574] Although Winnipeg has a Downtown Biz initiative, the Community Homeless Assistance Team that seeks out and supports homeless people in the city core, Winnipeg does not yet have the type of integrated "engagement and diversion" program (the TED initiative in Ottawa). In other words, integrated structures where the marginalized have access to nurses, personal support workers, addictions counselors, social workers and professional health teams. Dr. Turnbull heartily endorsed integrated electronic communication between service providers. For instance, the Ottawa shelters are connected electronically to the ED.

*I therefore recommend:*

*51. That the WRHA review the feasibility of creating an integrated "engagement and diversion" program for the homeless.*

*52. That the RHAs review the feasibility of the installation of an electronic board to monitor the status of the patients in the ED, where deemed appropriate.*

## NURSING: THE UNION PERSPECTIVE

[575] Sandra Mowat provided the Court with the perspective of the Manitoba Nurses Union (MNU). She has been a Registered Nurse since 1983 and has worked in a surgical unit, an intensive care unit and 13 years at HSC ED. She was a CRN for four years. She was the Vice-President of the MNU since 2003. In 2008, she became the President. There are 12,000 union members: Licensed Practical Nurses, whose scope is less than a registered nurse but who still have an ability to cope with high-acuity patients; Registered Nurses, who are graduates of a four year Bachelor of Nursing program; Registered Psychiatric Nurses, graduates of a four-year program at the University of Brandon; Nurse Practitioners, who are registered nurses with a Masters degree; and Operating Room Technicians.

[576] All of these nurses require continuing education and renew their licenses annually. The College of Registered Nurses of Manitoba is governed by legislation and has the legislative authority to establish standards of practice in order to protect the public. Standards articulate the expectations the public can have of a nurse in any setting. Nurses' performance can be measured against levels of practice. The MNU bargains and enforces collective agreements and represents nurses on workplace and safety issues. The MNU also advocates for patient care and lobbies for funding. Nursing Advisory Committees are present at the majority of all worksites, dealing with issues of staffing, patient care issues and recommendations for physical planning.

[577] Ms Mowat described nursing as an exciting and rewarding career, framing ED nursing as the most exciting, catering to what she classified as "adrenaline junkies". 80% of people employed at EDs are nurses. From her perspective, HSC ED deals with the most acute, core-area community: nurses who work there choose to work there. After Brian Sinclair's death, the MNU met with all the nurses that worked that weekend, feeling strongly that they needed support.

[578] She too discussed the findings of the 2004 ED Task Force and agreed that the issues of concern were Canada-wide. Ultimately, there were 46 recommendations made regarding input, throughput and output. After the Task Force's final report in 2006, she was still hearing complaints from ED Nurses about the lack of throughput and overcrowding.

[579] The Nurse Practitioner position has been piloted at HSC, but is not system-wide. A dedicated Reassessment Nurse at each ED is still unattainable because of chronic understaffing. She pointed out that there are various strategies in place, but they are not in place in all EDs. For example, triage aides are not used by all EDs. There are dedicated triage nurses, psychiatric nurses and community service workers at some, but not all, EDs in the health region.

[580] She maintained that it is tough to free up a nurse for education purposes when the hospital is understaffed. Early in 2013, MNU facilitated a daylong session, bringing together Winnipeg-wide ED nursing representatives. The ongoing issues were themes echoed by other witnesses:

- admitted or "boarded" patients in EDs: in every hospital in Winnipeg, patients are admitted to the hospital from the ED. However, pending their admission to a specific hospital ward, these patients need to be cared for by ED nurses who are looking after all the other people coming through the ED doors. Ms Mowat pointed out that ED physicians are no longer assigned to a patient once that patient has been admitted, which is a patient safety issue;

- EDs are being used by physicians as a clinic or outpatient department. Non-emergent patients are being referred to the ED. Dr. Chochinov, the Director of Emergency Medicine, did not agree that this was now a huge concern;

- delayed response time from consulting: the perception from the ED nurse is that specialist physicians who have been asked by the ED to provide a consult on a patient in the ED tend not to prioritize emergency patients. From the ED nurse's perspective, the ED patient should be given top priority;

- diagnostic imaging and laboratory turnaround time: treatments are delayed as patients wait for diagnostic services. Patients often need to be transferred to another hospital for testing and must be accompanied by a nurse. A qualified radiologist needs to interpret a CT scan before a treatment plan can be initiated;

- nurses are forced to provide nursing care in non-assigned areas. This of course can include doubling-up in the observation area or the hallways. Appropriate equipment may not be in place in non-assigned areas; and

- impediments to "flow": from MNU's perspective, impediments include inadequate staffing, lack of sufficient specialized education for ED nurses who require specialized training, lack of appropriate working equipment, ambulance offloading, verbal and physical abuse of the nursing staff, inadequate public education about alternatives to EDs and lack of visible management presence.

[581] Ms Mowat explained that after their 2012 workshop, the MNU believed that ED services still fell short of recommended best practices. From the MNU perspective, an effective working group to deal with all these issues did not exist. The MNU came up with recommendations for positive changes for emergency patients and presented them to the Minister of Health in the fall of 2012. It was agreed that the parties would reconvene, after working groups had a chance to meet and report back. The working group consists of eight ED nurses, employer representatives from all sites, Ms Mowat and Ms Lamont.

[582] The MNU made the following practical recommendations to the Minister of Health:

1) Development of a regional overcapacity protocol;

2) Ensuring that each ED has the appropriate staff and physical layout to meet the needs of its patients: expanded use of nurse practitioners to reduce delay for less acute patients, a dedicated triage nurse, triage aide, resuscitation nurse, reassessment nurse, psychiatric emergency nurse (to assist with grief, aggression and self-harming patients), baseline or minimum staffing needs to be reassessed through meaningful discussions with the players and a reduction in overtime to minimize fatigue and risk to patients;

3) Ensuring that all facilities are safe and secure by employing regionally trained security staff to provide a deterrent to abusive behavior. Ms Mowat confirmed that about one-half of all nurses reported being physically assaulted;

4) Ensuring regular reassessment and reassignment of catchment areas for Winnipeg Ambulance Service, to reflect growth patterns and changing demographics. (A related challenge outlined by Ms Mowat was ambulance patients brought to EDs with minimal personal clothing or items, which militates against an efficient discharge);

5) Ensuring that sufficient diagnostic services are readily available where they are not present now and making the ED a priority. By having on-site x-ray, CT scan and laboratory services available, turnaround times will improve;

6) Enhancing home care service to reduce lengths of stay: discharge services should be in place around the clock. At two Winnipeg hospitals, there is a "hospital at home" project, where patients are discharged and returned home with a "home team" visiting or phoning;

7) Maximizing the use of urgent care clinics;

8) Ensuring that full-time nurse educators are present at all sites and mentorship is ongoing;

9) Educating community and on-site physicians to avoid using EDs for non-urgent referrals; and

10) Ensuring ongoing public education: the goal is to try to prevent people using ED services for primary health care needs.

[583] Ms Mowat maintained that ED patients are not given priority by the rest of the hospital because the hospital knows that the ED patients are being taken care of by ED nurses. She was quick to add that she was not suggesting that the rest of the hospital does not care about the issue of boarded ED patients. Ms Mowat agreed with WRHA Counsel Mr. Olson that there are no quick fixes. Resource allocation is always an issue. She agreed that there is a shortage of nurse practitioners, especially outside Winnipeg. She agreed that many areas have improved and there

is ongoing work, but she pointed out that there is inconsistency between ED sites. She agreed that Dr. Sokal is a caring Director who is alive to all of these issues. She agreed that continuing education opportunities do exist and there is an ongoing mentoring process. She agreed that doctors are now less likely to use the HSC ED as a default clinic and that regionally, there are ongoing efforts to avoid the phenomenon. She concurred with the paradox that HSC ED appears to be well-staffed, even though flow is always a problem. Obviously, it is of concern that there are 700 nursing vacancies in Winnipeg and about 500 outside Winnipeg.

[584] Ms Mowat told the Court that for the past year, ambulance charges in Winnipeg are being levied against a hospital if the ambulance workers are forced to wait at the ED for longer than half an hour to have their transported patient transferred to a bed in the ED. Creating a position of "offload nurse" to triage and care for the patient in the hallway of the ED is, in Ms Mowat's estimation, a band-aid solution. According to Ms Mowat, ED Nurses feel pressure to get the patient transferred to an ED bed, since it is costing the hospital money. She also contended that this process offends the principles of CTAS and triage, since higher-acuity patients may be left waiting to be admitted.

[585] She did concede that Winnipeg Ambulance Services are not within the control of the RHAs and so further meetings must occur for cooperative solutions to evolve. It was pointed out by WRHA counsel that if such an event occurred, it would be contrary to WRHA policy. Ms Mowat's overarching concern on this topic was related to the safety and flow of patients through the ED.

[586] Ms Mowat contended that community hospitals tend to rent out their Security services, unlike the WRHA, whose Security staff are their own employees. She claimed that private Security Officers are loath to intervene in instances of abuse of Nurses. Ms Mowat observed that HSC has a more visible Management presence in the ED. She opined that a Community Service Worker can diffuse a lot of these types of situations.

## NURSE FIRST?

[587] Numerous witnesses expressed an opinion on the registration, pre-triage and triage process. Indeed, Hay Group Health Care Consultants in their comprehensive 2009 review of Emergency Services at HSC and another Winnipeg hospital concluded that the current process of registration of an ED patient prior to triage contravenes a "national standard" of triage preceding registration. All of the Nurses who were asked about this said that ideally, patients ought to be seen by a

Nurse first and triaged immediately upon their arrival at an ED: triage ought to proceed before registration, to ensure optimal patient safety. Dr. Sokal, the Medical Director of the HSC ED agreed that ideally, a Nurse should be the first medical person to see a patient presenting. He agreed that triage is solely a nursing function. Dr. Chochinov, the Medical Director of the WRHA Emergency Program agreed that if a triage nurse "walks the line", literally eyeballing pre-triaged patients in a pre-triage area, that nurse is not triaging and is multi-tasking.

[588] Ms Sturtevant, Director of Patient Services, agreed that perhaps the "nurse first" would be the best system, but certainly not the best use of a Triage Nurse. She also wondered out loud how the ED could logistically "operationalize" or manage it. In fact, she confirmed that there have been numerous meetings between Management and Nursing representatives on this issue and the current system at HSC ED has been agreed to as the best workable option. Ms Sturtevant viewed it as being satisfactory for patients' safety.

[589] Ms Bergal analyzed the "nurse first" view and expressed her concern that a number of people are not, in fact, patients when they first arrive at an ED. There is always a security concern. Dr. Turnbull, Director of the Ottawa Hospital opined that in a perfect world, he would have a patient immediately triaged and registered at the same time. As for the "nurse first" recommendation, Dr. Turnbull said that in the Ottawa General Hospital, the first thing a new patient encounters is a Triage Nurse and a Registration Clerk. Dr. Innes from Alberta did not endorse a pre-triage area. He believed that the "nurse first" concept is the way the system should be designed.

[590] The Court accepts that in an ideal world, an incoming patient ought to immediately see a **doctor**. That is not contemplated anytime soon. The next best option is for the incoming patient to be triaged and registered simultaneously. Witnesses were divided on the practicalities of seeing a "nurse first" at the ED.

*I therefore recommend:*

*53. That the RHAs and MNU continue to review the feasibility of persons presenting at EDs seeing a nurse first.*

*54. That the RHAs review policies and procedures with a view to implementing uniform pre-triage systems at all EDs.*

## EMOTIONAL ERRORS AND PATIENT SAFETY

[591] The Court was referred to some of the academic medical literature around the issue of patient safety in the ED context. The Court heard a recurrent theme from ED nursing staff: stress and low morale. In the December 2010 issue of the Journal of Patient Safety, a group of doctors from the Departments of Emergency Medicine and Medical Education, Centre for Emotions and Health, and Department of Psychiatry from Dalhousie University, and Health Policy and Management School of Public Health, John Hopkins University, collectively authored an article, "Emotional Influences in Patient Safety". The article's thesis was that the emotional influences upon health care providers, both within themselves and toward their patients, may have an influence on their clinical performance and thus have an impact on patient safety. There are many ways that the emotional state of the health care provider can influence patient care, including the characteristics of the patient and the ambient conditions in the health care setting, resulting in errors or adverse events.

[592] The authors contended that error arises when trying to explain a person's behaviour in terms of the qualities or disposition of that person, rather than recognizing the situational circumstances in which the behaviour has occurred. A patient's appearance, demeanour or behaviour appears to represent a type of patient previously experienced by the provider that evokes a pre-determined and predictable response. To reduce these errors, the level of awareness of these factors should be raised. Emotional skills training should be incorporated into the education of health care professionals. Emotional competence is the recognition of emotions and the ability to limit influences of emotional states to diagnostic decisions. Specifically, clinical teaching should promote more openness and discussion about the provider's feelings towards patients. For safe patient care, service providers need competence with procedural, cognitive and emotional domains.

[593] In a 2007 article in the Society for Academic Emergency Medicine, "Profiles in Patient Safety: A "Perfect Storm" in the Emergency Department", it was recognized by the author, Dr. Pat Croskerry, a Professor at the Department of Emergency Medicine of Dalhousie University, that the ED of any hospital can give rise to error-producing conditions, because the decision-making process must be made quickly and often under pressure. However, such decisions follow a "dual process". The first process (the first impression) is intuitive, automatic, fast and effortless. The second process is analytical, deliberate, slower, costly and effortful. The second process is a check on the reflexive first process to critically analyze or

override the first impression. All decisions are made in context. A variety of factors can influence decision making; in this case, the simple visual presentation of the characteristic of Brian Sinclair (his gender, his race, his clothing, his hygiene, his frequent presence in the ED waiting room).

[594] Dr. Croskerry published an article in a special issue of the 2009 Healthcare Quarterly, "Context Is Everything or How Could I Have Been That Stupid?" He outlined that in a formal process of systematically reviewing medical decisions, it is very important to try to reconstruct the context as accurately as possible. Although it is impossible to reproduce the exact context in which a medical decision was made, context is a dominant influence.

[595] In the November 2000 edition of the Academic Emergency Medicine, Dr. Croskerry wrote "The Cognitive Imperative: Thinking About How We Think". In the article Dr. Croskerry examined the unique milieu of the Emergency Room in all its inconstancy, uncertainty, variety and complexity. He argued that although medical training for clinical skills is very important, of equal if not more importance is proficiency in the cognitive domain.

[596] It is important to remember that health care providers, as all of us, need to take care of their own emotional health.

*I therefore recommend:*

*55. That the RHAs review the feasibility of incorporating training in the area of emotional safety for health care professionals.*

## EMERGENCY MEDICINE AND ABORIGINAL HEALTH

[597] Brian Sinclair was an Aboriginal man and was a frequent user of the ED. He was physically and cognitively challenged. It was important for the Court to hear expert evidence in the area of Aboriginal health services in order to contextualize it for the terms of reference of this Inquest. Counsel for the Sinclair family, Counsel for the Aboriginal Legal Services of Toronto, Ms Spillett and Mr. Balfour all chose not to participate in the second phase of the Inquest because of the Court's decision not to expand the terms of reference of the Inquest. Their decision to not participate was unfortunate. The Court lost the benefit of their specific knowledge and focus and they in turn lost the opportunity to ask questions of any of the expert witnesses called about issues affecting Indigenous persons in the realm of Emergency Medicine.

[598] The Court heard valuable evidence from two expert witnesses in the field of Aboriginal health, namely Drs. Catherine Cook and Janet Smylie. Both Indigenous women brought with them a wealth of knowledge and experience. Both have devoted a significant portion of their careers to the development (Dr. Cook) and the analysis (Dr. Smylie) of Indigenous health programs. In Winnipeg, Indigenous people account for approximately 10% of the total Provincial population but over 40% of all hospital use. More than half of all persons accessing the HSC ED are Aboriginal. These statistics are difficult to track accurately, because patients do not always self-identify as Aboriginal.

[599] The Court heard evidence that over the past decade, the WRHA Aboriginal Health Services has established a wide range of services available for Indigenous persons. Dr Catherine Cook is currently Vice-President of Population and Aboriginal Health at the WRHA, and an Associate Professor at the Department of Community Health Sciences Section of First Nations, Métis and Inuit Health, Faculty of Medicine, University of Manitoba. Her medical experiences include delivery of primary health care medicine at an urban primary health care centre as well as years of work for the Northern Medical Unit in remote northern communities. She is a member of the Indigenous Physicians Association of Canada. She is a lecturer on topics ranging from the historical context for Aboriginal health care delivery, cultural safety and traditional health methods.

[600] As I stated, Dr. Cook is currently the Vice President of Population and Aboriginal Health. She explained that "population health" essentially looks at all aspects of health that can affect the population. It specifically includes things like public health, but also includes community development and support for seniors or people with mental health issues. She also has the responsibility for the development of the Aboriginal Health programs in the WRHA.

[601] Dr. Cook discussed the social determinants of health, such as education, social standing, income, job security, housing and access to health care, all of which have an impact on the health and well-being of the Indigenous peoples of Canada. As Dr. Cook put it:

> We know that the people who suffer the most inequality also tend to have disproportionate burden of illness. And so part of what we have attempted to do with our health equity strategy is (to be) mindful of all those factors that can impact an individual's ability to access an equitable level of care. You can't have equality without equity.

[602] In order to contextualize her analysis, Dr. Cook discussed how colonialism had an impact on both the structures and outcomes for Aboriginal health. She framed the concept of "Reserve" land as an "era of colonialism" that "continues to this day". She described how historically, racism and social exclusion resulted in First Nations being treated differently. She has concluded that the "inequitable" dual jurisdictions of health care of First Nation communities affect both the physical environment (challenges in housing, employment and education) and the health (physical and mental) of Indigenous people. She opined that First Nations' health care is cloaked in "jurisdictional ambiguity that continues to surround access to health care for First Nations, Métis and Inuit."

[603] Dr. Cook discussed stereotyping. "The kind of teaching that was done decades ago and is only now undergoing some change was quite significant in terms of instilling that concept of stereotypes. The media has reinforced that over the years." She added:

> So I think that the reason I was hired by the Regional Health Authority and by the University way back when was because those systems recognized that they needed to make change. They recognized that systemic racism existed. They recognized that there were inequities on many levels and they needed someone who could provide some guidance and gather others of like mind to work with us and begin to influence the system's development at many levels.

[604] Dr. Cook provided to the Court three articles that she wanted to be part of the public record. She explained that these articles provide theoretical and historical background for the concept of racism and its impact and also provide an opportunity for self-reflection and application to the workplace. The Court found these articles to be very helpful.

[605] Dr. Cook outlined some of her work with the WRHA. In 2001, a Review of Aboriginal Services was undertaken at both HSC and St. Boniface General Hospital. The 2001 Review was seen as both timely and valuable. The majority of Indigenous patients and family members quite clearly felt the effect of stereotyping.

[606] Not surprisingly, patients and their families identified the need to understand what was being told to them and have complete explanations given to them in understandable terms. They also identified their need to have their families close by when they expressed concerns or had questions. They wanted to feel welcome

and have someone to talk to who was like them. Barriers were identified by Aboriginal patients and family members: perceptions of racism and stereotyping; a limited sense of advocacy on their behalf; a lack of Aboriginal nurses, doctors or clerks; the fast pace of the hospital; the lack of physical space for families to stay; the lack of visible, round-the-clock Aboriginal services; and the perception that the hospital culture did not recognize, understand and accept the impact of Aboriginal cultural perspectives at critical times of birth, illness or death.

[607] On the other hand, a high level of satisfaction was noted where requests were granted for Elders, Healers, traditional medicines or ceremonies.

[608] As a direct result of the recommendations made by the 2001 Review, changes were made. All WRHA hospitals created a sacred space, a room in which to practice ceremonies. A part-time Elder position was put in place and a mobile team of Elders was formed at the HSC. A "Respectful Workplace" policy was created. Lastly, Aboriginal Health partnered with the Assembly of Manitoba Chiefs (AMC) to create a Patient Advocacy Unit, recognizing that Aboriginal patients did not always feel comfortable complaining to the institution where they were receiving care. Now they could seek the counsel of a patient advocate.

[609] After the 2001 review, Aboriginal Health felt they needed to centralize access to the resources, to make them available in the community hospitals as well, not only to provide access to an Elder but also a traditional Healer and to have people be able to have their own Elder or Healer attend while they were in hospital. In 2002, a Traditional Healers' Clinic was established at HSC at the Aboriginal Traditional Wellness Clinic. Presently, the Healer attends two days every month and the access is by self-referral.

[610] In 2003, a follow-up report was done, partly as a result of complaints about the way Indigenous persons felt they were being treated at the HSC ED. A review by a First Nation psychologist from Opaskwayak Cree Nation was undertaken at the HSC ED. The goal of the project was to identify health care needs and issues of concern facing the ED Aboriginal patient, to identify gaps in services delivered to Aboriginal patients and to produce evidence-based recommendations for the continuation of best practices and policies and for changing ineffective practices and policies.

[611] The Reviewing Psychologist outlined that the most significant finding of the 2003 analysis may have been that no overtly racist or culturally insensitive interactions or practices involving Aboriginal patients were either observed or

reported. However, several features of the ED that may have been problematic for Aboriginal patients were identified. Very few of the ED staff were identifiably Aboriginal and very few of the staff who were interviewed as part of the project had taken HSC's cultural competency training. Many ED staff members were not completely familiar with services available to Aboriginal patients both on site and off. The ED did not then track the health care experiences or outcomes of Aboriginal patients who used the ED.

[612] Recommendations in 2003 included: establishing effective programs to recruit and retain Aboriginal employees in the ED; ensuring that ED staff complete cultural competency training; developing a comprehensive description of services available through Aboriginal Health Services and ensuring that interpreters are available on a full-time basis to Aboriginal patients in the ED.

[613] Dr. Cook agreed with the author's following observation:

> To a researcher pointing out that in an environment where people are required to perform cognitively complex work under significant time pressures such as HSC ED, it is easy even for those who have received cultural competency training to fall back into old emotional and intellectual practices such as stereotyping. While cultural competency training can improve many aspects of service to Aboriginal patients, it is not a silver bullet.

[614] Early in the new millennium, the WRHA Aboriginal Human Resource Initiative was established, with a focus on recruitment and retention of Aboriginal staff throughout every level in the organization. This included communication with every level in the WRHA organization so that they understood the importance of the initiative. Aboriginal Health also joined the Inter-provincial Association on Native Employment, which was a Provincial body focused on recruitment and retention of Aboriginal employees. Data from 2005 showed approximately 10% of all hiring from all departments were Aboriginal. The percentage was approximately the same for hiring in long-term care. Dr. Cook confirmed that in 2006, the WRHA Chief Administrative Officer sent a memo to HSC site leadership outlining the need to enhance supports to developing a representative workforce. To that end, Dr. Cook was part of a session for the leadership of HSC presenting information about the initiative's service provisions and retention strategies.

[615] There is an ongoing set of initiatives undertaken by Aboriginal Health to not only successfully recruit and retain Aboriginal staff but to increase the ability to do

so. The initiatives focus more on areas of the City that have a higher proportion of Aboriginal people residing in those areas. The Court applauds these initiatives.

[616] When asked about difficulties between Aboriginal staff and non-Aboriginal staff, Dr. Cook said that it had been an ongoing issue for many years. For instance, when the Indigenous interpreters first became part of the staff complement, they were not formally trained, so they were not treated as part of the professional health care team. Dr. Cook confirmed that the situation is much improved, because the Aboriginal Discharge Planners are part of everyday Rounds and Committees, but it continues to be a challenge. Dr. Cook framed it as less a problem of cultural awareness and more a function of the culture of health care, where traditionally, only Doctors and Nurses have participated in Rounds.

[617] Dr. Cook confirmed that the Aboriginal patient community is a very diverse population, with varying cultural belief systems, ranging from traditional spirituality to Christianity. In 2006, Aboriginal Health Services and the Aboriginal Human Resources Initiative merged to form the Aboriginal Health Programs. One of the outcomes of the WRHA Aboriginal Health strategy was that the WRHA came to understand that Aboriginal patients are more comfortable receiving care from other Aboriginal people and it has increased efforts to have Aboriginal representation in the health care workforce. The office space of Aboriginal Health Services has moved to a central location in the hospital complex accessible to families and patients in need, close to the cafeteria and the sacred space. Dr. Cook outlined the present situation of her staff engaging in Rounds at Emergency and continually collaborating with the Social Worker in the ED. There is a mobile team of Interpreters and Discharge Coordinators.

[618] Dr. Cook confirmed that all these initiatives demonstrate that Aboriginal Health Services has been involved in community outreach, support for seniors, mental health projects, home care projects, community health centres and urban community hospitals, including the Women's Health Program at the Women's Hospital, long-term care, palliative care and cancer care. Currently, there are two Aboriginal Discharge Coordinators covering all hospitals within the WRHA region. Dr. Cook explained:

> The intent is not necessarily to have to do all the discharge planning for Aboriginal patients, but really build capacity within the hospital, so that the understanding and awareness of some of the issues and challenges with discharge are known in every site. They (the Discharge Coordinators) have twelve interpreters for the region. They have three on a mobile team, three at

> St. Boniface (General Hospital) and six at the Health Sciences Centre. There are also three additional interpreters who do evening shifts, so that makes fifteen. There are three languages: Cree, Ojibway and Ojicree. They are all trained in not only the language, but also the medical terminology.

[619] Currently, two Aboriginal Elders serve the entire WRHA. They also can facilitate access to other Elders. The Elders currently maintain a visible presence in the HSC ED waiting room, walking around the waiting room at least two or three times daily or when otherwise summoned there. By all accounts, Indigenous patients in the ED waiting room feel very comforted by the presence of an Elder.

*I therefore recommend:*

*56. That the RHAs review the feasibility of recruiting and retaining an Indigenous Elder for EDs, where deemed appropriate.*

*57. That the WRHA Aboriginal Health Services continue to make efforts to recruit and retain the services of Indigenous Elders to be present in the HSC ED during peak hours, seven days a week.*

*58. That the RHAs review the feasibility of the hiring and retention of Aboriginal Discharge planners, where deemed appropriate.*

[620] Dr. Cook told the Court that information on the full range of services available to Aboriginal patients is visible and accessible to ED patients. Indigenous persons visiting the WRHA hospitals have access to a patient handbook for Aboriginal Health Services and its "frequently asked questions". Since 2005, at the hospital university campus, a centre for Aboriginal health education has developed as a resource centre for Aboriginal students in the disciplines of medicine, dentistry, nursing, pharmacy and medical rehabilitation. It is basically a resource centre and mentorship outlet. Not all pamphlets are printed in Indigenous languages.

*I therefore recommend:*

*59. That the WRHA Aboriginal Health Services review their informational pamphlets at each hospital site to ensure that the pamphlets are available in Manitoba's Indigenous and Inuit languages.*

[621] A two-day cultural competency workshop, which Dr. Cook described as active learning, is now mandatory for all WRHA staff. She outlined that it presents an opportunity for sharing circles and debriefing throughout the two days. "The real intent of all the work that we've done at the Winnipeg Regional Health Authority is to look at ways of addressing the social determinants of health." Therefore, they have multiple partners in all of these areas. For instance, Indigenous training is woven into Medical and Nursing Students' education. All new staff coming into an ED must complete an orientation that is specific to the individuals working in Emergency Medicine and part of that training includes cultural competency training.

[622] Dr. Cook concluded that as a result of the depth and breadth of services, programming and collaborations, the strategic objective of adapting current practice to better meet the needs of First Nations patients is ongoing and healthy. She verified that Aboriginal Health Services are continuing their direct engagement with the Health Directors of the Tribal Councils of First Nation communities. Dr. Cook's opinion is bolstered by the assessment of a 2011 independent accreditation, which observed:

> Many of the clients accessing services (at HSC) are Aboriginal. An outstanding Aboriginal health program has been developed to help serve this patient population. Through an extensive consultation process and partnership building, the key areas have been identified to best meet the needs of these clients. The service priorities include interpretation, counseling, advocacy, discharge planning, and promoting cultural proficiency among all staff. They work closely with Human Resource services on Aboriginal workforce development. They link closely with many community agencies to better meet the needs of Aboriginal patients during hospitalization and following discharge. They are very respectful and supportive of traditional customs and beliefs in meeting the needs of the clients they serve.

[623] Chief Nursing Officer Lori Lamont confirmed that there is a culturally-appropriate personal care home for Indigenous people, the Southeast Personal Care Home, an 80-bed personal care home opened in 2012 that is owned and operated by the Southeast Resource Developmental Council, a commercial arm of the Southeast Tribal Council. The application process for that facility is the same as any other facility in the WRHA, centrally managed by their long-term care Access Centre. Residents hail from both Winnipeg and other First Nation communities. The average age of residents is slightly younger than the rest of the personal care

home population. Ms Lamont contended that the greatest need for another Aboriginal personal care home is outside the city.

*I therefore recommend:*

*60. That the RHAs strategically plan with Manitoba First Nations to review the feasibility of the establishment of rural Indigenous personal care homes in the Province of Manitoba, where deemed appropriate.*

[624] Dr. Janet Smylie is a member of the Métis Nation of Ontario, a third-generation self-described "urban Métis with roots in the prairies". The Court asked to hear from Dr. Smylie as an independent expert, outside the WRHA ambit, to assist the Court in examining best practices for the health care of Indigenous people in the ED context.

[625] Dr. Smylie is currently the Director of the Well Living House: Action Research Centre for Indigenous Infant, Child and Family Health and Well-Being which is located at the Centre for Research on Inner-City Health at St. Michael's Hospital in Toronto. A Committee of Elders, (the Council of Grandparents), works in partnership with the hospital to improve the health of Indigenous families. Dr. Smylie also chairs the Aboriginal Health Working Group of the College of Family Physicians of Canada and is also an active Staff Physician at St. Michael's Hospital. She described some of her most significant contributions as the development and application of novel methods and research protocols to Indigenous Population and Public Health research, advocacy and action for better Indigenous health measurement systems and the promotion of enhanced health human resources for Aboriginal communities. Her studies currently focus on what she referred to as "Respondent-driven sampling" in order to understand and document the health needs of urban Aboriginal families.

[626] Dr. Smylie practiced and taught Family Medicine for 20 years. Her practical experience included coverage in EDs in both rural and urban settings. She confirmed that Aboriginal people use the ED 2 to 6 times more than the non-Aboriginal population. Her research tells her this arises from unmet health care needs.

[627] Dr. Smylie also discussed the historical role of racism on the well-being of Indigenous peoples in Canada and the social determinants of health. Dr. Smylie told the Court that historically, the medical system was not set up with Indigenous people in mind and functioned mostly by way of a bio-medical model. She

outlined that there has been limited, standardized research to measure discrimination in Canada. One of the problems with research in this area is the lack of self-identification of urban Aboriginal individuals in the health databases. Another stumbling block of the research in this area is that patients are not always asked about ethnicity.

[628] Matilda Patrick, the WRHA Aboriginal Resource Worker at HSC, told the Court that Indigenous patients are identified through intake, referrals or Consults. She too confirmed that it is not often possible to accurately track the actual number of Aboriginal patients, because persons are not asked their ethnic origin at the outset of their triage process. She is not always aware when an Aboriginal person is in the hospital. Aboriginal Discharge Planner Beverley Swan outlined that hospitalized, Aboriginal patients are often identified during Morning Rounds, in which the Aboriginal Discharge Planner participates. She has access to patient charting and is able to read diagnosis and progress. Sometimes on the written chart, she cannot read the handwriting. Sometimes, as she said, "what was spoken was not written".

[629] The Court heard evidence from Ms Patrick that she deals with First Nation people, Métis people and city-dwelling Inuit people. If the Inuit are not city-dwelling, she refers them to the federally-funded services. Ms Patrick receives patient lists from the Intake Coordinator, so that she can explain medical terminologies to Indigenous patients and liaise with medical services. Ms Patrick also confirmed that Aboriginal patients can be intimidated by the medical process and some of them are reluctant to speak up, but she told the Court that most of the time, Aboriginal patients can speak for themselves. She is always keenly alive to this issue. She routinely asks Indigenous patients if they are scared or whether they understand. She advises patients about the availability of spiritual care services and makes appropriate referrals. When Ms Patrick receives a complaint about discrimination, she liaises with the Hospital Site Coordinator and often refers the patient to the Aboriginal Health Program Patient Advocate.

[630] As she was to Brian Sinclair, she is a support when a patient does not have family support or visits.

[631] Ms Patrick is occasionally paged to the ED. She has worked fulltime since 2009 from Monday through Friday, 8:30 a.m. to 4:45 p.m. Recently those hours have been changed in her Department to include 1:00 p.m. to 9:00 p.m. shifts, Monday to Friday. She had no contact with Brian Sinclair during his 34 hours in HSC ED because it occurred on a weekend. Ms Swan also confirmed that there

was no contact by Aboriginal Health Services with Brian Sinclair on the weekend he died. They both recognized that from about 10:00 p.m. on Fridays through 9:00 a.m. on Mondays, there is a huge gap in service delivery.

*I therefore recommend:*

*61. That the WRHA reviews the feasibility of expanding the Aboriginal Resource Worker position to include weekends.*

[632] The goal of one of Dr. Smylie's current projects is to work with Aboriginal, organizational stakeholders to develop a baseline population health database for urban Aboriginal people living in Ontario. As the doctor acknowledged, the majority of literature on this topic is still descriptive. She filed a number of documents with the Court, including a number of American studies.

[633] She referenced a 2011 Canadian study, "Access to primary care from the perspective of Aboriginal patients at an urban emergency department", wherein the authors collected data over 20 months of immersion in the ED of an unnamed Western Canadian city. 33 to 55% of all ED visits were classified as the non-urgent use of the ED. The authors noted that for vulnerable and socially disadvantaged populations, EDs can serve as an important safety net. The authors conceded that there remains a gap in knowledge concerning the social and contextual factors influencing access to primary care for Aboriginal people living in urban areas. What particularly struck the authors was the extent to which Aboriginal participants' lives and health issues were shaped by intersecting issues of trauma, violence and disconnection from their families and communities. Health issues were inextricably tied to social, economic and historical circumstances. 44 patients participated in the study. 34 self-identified as Aboriginal. 10 self-identified as Euro-Canadian. Almost 75% of them were unemployed. ED staff (Nurses, Doctors, Social Workers and Admitting Clerks) was interviewed and the authors were participant observers. An overriding theme was that Aboriginal patients anecdotally described their **anticipating** being identified as both Aboriginal and poor, and having this negatively influence their interactions. The health care providers who were interviewed decried the lack of resources in the ED, inadequate staffing and the lack of immediately available social services.

[634] Dr. Smylie outlined the concept of "cultural safety". In 2009, the Indigenous Physicians Association of Canada released a document, "First Nations, Inuit, Métis Health for Competencies" as a curriculum framework for undergraduate medical

education, under the auspices of the Association of Faculties of Medicine of Canada. Cultural safety was explained:

> Cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities including, but not limited to, visible minorities, gay, lesbian, transgendered communities and people living with challenges. Self-reflection in this case is underpinned by an understanding of power differentials. For First Nations, Inuit and Métis communities, this power imbalance is unequal and can be seen as a residual element of colonization and act as a barrier to facilitating the health and healing for First Nations, Inuit and Métis citizens of Canada. Providers should be able to understand their own biases and prejudices and how racism might play a role while providing care to these diverse communities.
>
> Cultural safety as a concept means something more than mere cultural awareness, which is the acknowledgment of difference, cultural sensitivity which is the recognition of the importance of respecting difference and cultural competence which focuses on the skill and knowledge base of practitioners. A central tenet of cultural safety is that it is the patient who defines what safe service means to them.
>
> Whereas cultural sensitivity and competence focused on learning about the culture, cultural safety direct healthcare providers to viewing everyone, including themselves, as bearers of culture. It requires health professionals to examine their own culture and lived experiences and beliefs and attitudes and an acknowledgment that they shape their approach to practice and impact how others respond to them.

[635] Dr. Smylie stressed that if health care providers focus solely on cultural **awareness**, they reduce it to a cultural **difference** as opposed to a different worldview. Aboriginal healthcare requires access to traditional Indigenous knowledge and non-Aboriginal connections. Competency in this area includes an understanding of the historical framework, the diversity amongst Indigenous communities, health care services available and healing and wellness practices available in the community. Addressing the power imbalance between medical provider and patient user requires that patient's way of knowing and being is valid, the patient is a partner in the health care decision-making process and the patient

determines whether or not the care they have received is culturally safe or not. Dr. Smylie outlined that the caregiver in the therapeutic relationship needs to recognize and redress the power imbalance, which requires the fostering of trust and respects the dignity and worth of the patient's culture.

[636] In 2014, cultural safety training was initiated throughout the Province of British Columbia. A website exists for the Indigenous cultural competency training program, which was designed for all professionals working in the healthcare field. Dr. Smylie recommended ongoing cultural safety training for all health care professionals. The Court also heard evidence from a number of security personnel who made a number of incorrect assumptions about Brian Sinclair.

[637] From Dr. Smylie's perspective, a lack of cultural competence may be the most directly remediable issue, if it is honestly recognized and if programs are designed to address it. She also recommended the creation of a dedicated, urban Aboriginal primary and urgent care centre.

*I therefore recommend:*

*62. That the WRHA review the training of all ED security personnel to ensure that they receive cultural safety training.*

*63. That the RHAs develop and initiate policies for the implementation of mandatory and ongoing cultural safety training for all health care workers and that the RHAs ensure that cultural safety training includes a component that has been designed and delivered with the assistance of Aboriginal persons.*

[638] In 2001, Dr. Smylie published in the Journal of the Society of Obstetricians and Gynaecologists of Canada a guide for health professionals working with Aboriginal peoples. She made a number of recommendations. She recommended that relationships between Indigenous people and care providers should be based on a foundation of mutual respect, recognizing that the current healthcare system presents gaps for Aboriginal individuals and communities seeking healthcare. She recommended that health professionals work proactively to address these gaps and barriers and provide culturally appropriate healthcare. Ideally, Indigenous people should receive treatment in their own language if possible, but service to Indigenous peoples in the healthcare realm should include cultural interpreters and Aboriginal health advocates on staff so that Aboriginal people can give informed consent. Health care providers must recognize the importance of family and community roles and responsibilities. Health professionals should respect

traditional medicines and work with Aboriginal Healers to seek ways to integrate traditional and western medicine. Healthcare professionals should take advantage of educational resources to become more sensitive to Indigenous communities and they should get to know these communities. Also, healthcare professionals working with Aboriginal communities should support the creation of community directed health programs and services for Aboriginal people, recognizing the need for preventative health programming.

[639] Dr. Smylie stressed that training strategies are crucial. One example of this would be to make sure that a patient can actually carry out the medical care by filling the prescription or obeying medical instructions. Dr. Smylie told the Court that communication is vital between the hospital and the community and the direct service staff. It is sometimes very difficult to get exact information about the Indigenous patient's home situation. Once that information is known, it needs to be documented so that consistent and appropriate home care can be provided to clients. The health care provider must be able to recognize, for instance, that a patient's return home might not be a recipe for a good rest, as it could tend to be in much of the population. A health care provider ought never to assume health literacy. They must be aware that many Aboriginal patients have suffered what she referred to as "cumulative wounding" or "multigenerational trauma". Basically, she recommended staff development programs that focus on crisis intervention, emphasize prevention and trauma-informed care through core, clinical competencies, inter-professional collaboration, routine checks with patients and safety plans for patients. She recommended the hiring of patient navigators to support frequent Indigenous ED users.

[640] She recommended various strategies to foster progress in the area of Aboriginal health: education and training; community engagement; psychological support for patients and their families; feedback for patients and providers; restructuring the healthcare team; improved language and literacy skills.

[641] Best practices suggested by Dr. Smylie included:

- assessing organizational capacity;
- fostering a culture of equity;
- appointing indigenous staff and securing "buy-in";

- incorporating disparities interventions into existing systems and anticipating ripple effects;

- involving members of the target population including family and community during program planning; and

- utilization of multidisciplinary teams of care providers.

[642] By these standards, the WRHA has a vibrant Aboriginal Health strategy and program. Indeed, Dr. Smylie readily agreed that Dr. Cook has been operating, administering and leading the way with decades of experience in the Aboriginal health field. Dr. Smylie commended the WRHA for its recruitment and retention programs and supported their "substantial efforts". Dr. Smylie heralded the creation of specialized roles such as those created by the WRHA. She commended the hiring of the Aboriginal Support Workers and Discharge Planners in the WRHA. She agreed it was crucial for Aboriginal Patient Liaisons to serve as a bridge between Indigenous patients and the health care system, thereby providing support and advocacy for Indigenous patients. She described as "cutting-edge" the University of Manitoba First Nations Health programs. Her only suggestion for Aboriginal Health Services was for them to follow the patient in the community.

[643] On that point, the Court had the benefit of hearing the evidence of Beverly Swan, the WRHA Aboriginal Discharge Planner. As I stated, the WRHA employs two Aboriginal Discharge Planners. The two divide up work at the various WRHA hospital sites. They receive referrals from their unit, the hospital multiple disciplinary team or from families. A patient is identified as an Aboriginal patient most often during rounds every morning. The discharge planners participate in rounds in order to identify complex-discharge Aboriginal patients. For homeless Aboriginal patients in the ED, a social worker usually contacts the discharge coordinator by pager or phone. If the discharge planners are both off-site, one of them will contact the multi-disciplinary team to liaise with the team. Ms Swan outlined clearly in her evidence that discovering and understanding patients' historical and cultural issues gives her a better understanding of the supports they need. Ms Swan strongly felt that her team does a thorough assessment. Aboriginal Health Services is an important link in the chain of effective patient care. Her definition of a "complex discharge" includes medical needs, community resources, housing, health services' programs, family supports (or lack of family supports) or palliative care. She advised the Court that there are no palliative care programs, as yet, in First Nation communities.

[644] When asked if the WRHA tracks Aboriginal patients after discharge, Ms Swan explained that approximately two years ago, Aboriginal Health Services entered into a partnership with the Assembly of Manitoba Chiefs to jointly oversee a Patient Advocate Unit and a Patient Navigation Unit. This partnership provides additional, external support after discharge from the hospital and connects the patient to the appropriate community agency. Appropriate patients will be referred to this program. This occurs only after Ms Swan has attempted to have the hospital team diffuse or resolve a situation. She attempts to hear the patient's voice and helps to ease communication between the family and the health service providers. She felt that patients will ordinarily tend to agree with the discharge plan if it is effectively communicated to them and if the patients' concerns are effectively communicated to the team. She has definitely seen Aboriginal patients feeling intimidated by the medical staff. When this occurs, she helps with that issue: the outcome as far as she is concerned is better patient care. Care plans may include referrals to a Nursing Station on the First Nation or another First Nation health care facility. She did add, however, that Aboriginal Health Services is not well-known to all of the hospitals in the regions outside of WRHA.

[645] Dr. Cook explained that that when an Indigenous person is treated in Winnipeg at a hospital and transported to a First Nation community in Manitoba or North-Western Ontario, the level of service thereafter available for that individual will vary, depending on the community they reside in, so it is absolutely critical that the Aboriginal Discharge Coordinator in the hospital has direct contact with the community. Access to various services differs greatly. Often it involves staying in Winnipeg for a brief period of time to receive the services that would otherwise not be available at the First Nation.

[646] Indeed, Ms Swan told the Court that housing is a complex issue and takes up a lot of her time. One of the biggest problems from her perspective is the jurisdictional barrier existing in the system: the Federal, Provincial and Regional jurisdictions are constantly challenging to her. Her definition of "housing" included remote community placement and program supports in the community. Parenthetically, Ms Swan commented that there were really no other housing options for Brian Sinclair. The Quest Inn best satisfied both his care needs and his complex medical issues.

[647] HSC Case Coordinator Ms Davidson confirmed that her office works in consultation with the Aboriginal discharge planners and Aboriginal Health representatives. She has a direct line to the Aboriginal discharge planner. For out-of-town Aboriginal patients, the HSC Case Coordinator liaises directly to the

relevant First Nation. For urban Aboriginals, if home care coordination is in effect, she does not necessarily liaise with Aboriginal agencies.

[648] Dr. Smylie was not impressed with the idea of the security guard at HSC ED as the first contact or "greeter" for vulnerable populations. However, she agreed that security concerns at HSC are valid and that a visible, security presence is reassuring, for there are unpredictable behaviors. Dr. Smylie correctly pointed out that the presence of a security guard as some sort of greeter remains a difficult concept and hard to reconcile for anyone who has a history of conflict with people in authority. She maintained that there needs to be a security presence, but the Security Guard should not be the Greeter.

[649] Dr. Smylie concluded that the WRHA has sent a clear message at the highest level of Management that WRHA supports cultural diversity in the workplace. She endorsed the WRHA's refinement of the outreach and support worker concept that she described. She also commended the ED community support worker position to monitor and advocate for patients in HSC ED. She commended the presence of an Elder and commended the attempt to try to increase the presence of an Elder. Dr. Smylie also found commendable that the design of the new HSC ED was assisted by Aboriginal agencies and that the new premises were blessed by an Aboriginal ceremony. She commended the fact that there is a substantial Aboriginal presence, both in an advisory capacity to the WRHA Board and in the three Aboriginal positions that exist on the WRHA Board. She thought that an Aboriginal Advisory Council should exist for each hospital.

[650] Indeed, the Court heard evidence from Ms Kubas, the WRHA Home Care Case Coordinator that her office deals with many Aboriginal clients, many of whom have physical and cognitive disabilities. These are her clients and this is part of her jurisdiction. She always looks to the Aboriginal agencies for resources in the community. Those agencies were not involved in Brian Sinclair's care plan. She confirmed that there are not many Aboriginal housing resources available. Home Care tries to match up Aboriginal clients with Aboriginal care providers such as Darwin Ironstand. She confirmed that her Office of Home Care deals with diverse cultural issues. The care plans she coordinated for Brian Sinclair all factored in his Aboriginal heritage. Ms Kubas wanted him to reside in an accommodation and an area where he was comfortable. She stressed that she was very respectful and aware of Brian Sinclair's cultural heritage.

[651] Dr. Smylie agreed that many positive actions and changes are occurring in Winnipeg, but she viewed Brian Sinclair as "the tip of the iceberg" and decried the dearth of scholarly examination of outcomes. She mused that a Postdoctoral Fellow should follow Dr. Cook around for research purposes. She was pleased to hear that Dr. Cook seeks to import the British Columbia cultural safety model to Manitoba.

## Other perspectives on Aboriginal health

[652] Brian Sinclair's support worker Mr. Ironstand explained that his training focused on providing culturally competent care to his clients. He agreed that social determinants of health such as poverty, racism, exposure to violence or a lack of education create hurdles for vulnerable and marginalized persons. He readily agreed that there are particular hurdles for Aboriginal people negotiating the health system because of stereotyping and profiling of Aboriginals. He agreed that training for health care professionals needs to focus on the root causes and the predisposition of a community to the legacies of colonization, residential schools and inter-generational trauma. Addictions may be a symptom; the cause has to be treated. It is important to have the front line workers educated on institutional legacies in order for those workers to provide care and community assistance and to understand why individuals fall through the cracks. Mr. Ironstand strongly believed that it is crucial for vulnerable people to receive specialized services. In his time with Brian Sinclair, he believed that Brian Sinclair's needs were met. Brian Sinclair was not referred to Aboriginal agencies. Mr. Sinclair specifically preferred to attend the Siloam Mission to be with his brothers and friends and his social network.

[653] HSC Social Worker Mr. Koberstein testified that Aboriginal cultural training for his team is organized by Aboriginal Health Services and the Social Work Department, usually by in-house staff, three times a year. He agreed that it is important to involve all patients in their own discharge planning if at all possible. He also agreed that historical inequalities can be a barrier and that Indigenous patients can sometimes be alienated by hospital service providers. He agreed that it is important to have culturally appropriate training for **all** hospital staff.

[654] Dr. Sokal, Medical Director of the Adult Emergency Department at Health Sciences Centre told the Court that Aboriginal Health Services were a vital part of every working group for the HSC ED Front End Operations Development, including the Mental Health team, the Reassessment Zone team, the Triage team and the Minor Treatment Area team.

[655] Ms Sturtevant, Director of Patient Services at HSC ED told the Court that their ED would benefit greatly by having an Aboriginal Elder's constant and reassuring presence in the Emergency Room. The Court agrees and has made an earlier recommendation in that regard.

[656] In a very recent accreditation, October 2013, the WRHA Aboriginal Health program was described as "outstanding" in its service to the Aboriginal patient population.

> "Through an extensive consultation process and partnership-building, the key areas have been identified to best meet the needs of these clients. The service priorities include interpretation, counselling, advocacy, discharge planning and promoting cultural proficiency among all staff. They work closely with the Human Resource Services on Aboriginal workforce development. They link closely with many community agencies to better meet the needs of the Aboriginal patients during hospitalization and following discharge. They are very respectful and supportive of traditional customs and beliefs and meeting the needs of the clients they serve."

## AFTERWORDS

[657] Dr. John Sokal, Medical Director of the HSC ED, summed up the issue of delay from his perspective:

> I hope that the main point that I make all day is that the main constraint for the whole system is movement out of acute care facilities.

[658] Susan Alcock, veteran ED Nurse, spoke for her fellow nurses at HSC ED:

> As a health care system we failed Brian and for that I am deeply sorry. Unfortunately, change occurs very slowly in the health care system. Sometimes it takes a tragedy like this to get listened to…. I believe we all have a purpose on this earth…. I believe Brian was a martyr for us. It is because of him that we have seen many positive changes in the emergency room. I thank you, Brian.

[659] Dr. Chochinov invoked the vision of Pierre Elliott Trudeau and his concept of a "just society", which Dr. Chochinov viewed as integral to the Canadian health care system:

> A just medical system was one which would be best judged as just by how it served those most vulnerable and unable to advocate for themselves and so without taking any more time, if we sort of zoom into the hospital and into the ED flow continuum, the most vulnerable, the ones about whom we will be judged, are the ones in the waiting room.
>
> And you know we spend so much time talking about the patients here in the hospital and in the hallways and in the back room at personal care homes and trying to decide who owns them and that we really sort of missed the point here.
>
> The point is it's not about them or us, it's about the patients who are in the waiting room who are potentially very sick and are vulnerable and unable to advocate for themselves and I think that if we look at this issue through that lens it would be helpful.....
>
> Timely access to quality care will be the yardstick upon which our health care system is measured. Timely access to care in Emergency Departments predicts outcomes and crowding in Emergency Departments can be directly correlated to morbidity/mortality. Emergency medicine has improved in terms of training and expertise but unless Emergency physicians can access the patients in the waiting room in a timely manner the outcomes will be threatened.

[660] Brian Sinclair did not have to die, but he did not die in vain. His death prompted a complete overhaul of the "Front End" of HSC ED and a systematic streamlining of the registration and triage process in that facility. Hopefully, the recommendations in this report, a report that was also precipitated by his death, will assist Emergency Departments to provide timely and appropriate health care to all persons in need of care and in the process, improve the flow of patients through the health care system.

Dated at the City of Winnipeg, in Manitoba, this 9th day of December, 2014.

*"original signed by:"*
Judge Timothy J. Preston

## LIST OF RECOMMENDATIONS

1. That the Office of Public Trustee and the RHAs review their policies and procedures to ensure the primary care giver and service providers of any Committee of the Public Trustee are made aware of the Committeeship.

2. That WRHA Home Care review its policies and procedures to ensure that Home Care updates service providers concerning any hospitalization of their clients.

3. That WRHA Home Care review its policies and procedures to ensure that each service provider is made aware of the specific care plan for each Committee.

4. That WRHA review its policies and procedures to ensure that when a medical service is put on hold, suspended or withdrawn from any client for any reason, that there is an alternate plan in place or that the hold be reviewed on a regular basis.

5. That WRHA Home Care reviews its policies and procedures to ensure the provision to service providers of relevant background information of their vulnerable clients.

6. That the RHAs and the Office of the Public Trustee continue to review the feasibility of compatible electronic charting of all relevant medical information for clients of the Public Trustee.

7. That the Office of the Public Trustee and the RHAs review their policies and procedures to ensure that when a patient is a Committee of the Public Trustee, the patient's Committeeship status is clearly flagged on that patient's medical chart.

8. That the RHAs review the feasibility of electronic charting for all their facilities.

9. That the protocol that requires primary care physicians sending patients to an ED to notify the ED in advance by phone be maintained, including verification of whether a letter has been given to a client to present to the ED staff.

10. That the RHAs continue to review their policies and procedures to examine the feasibility of letters from primary care physicians to EDs being sent electronically.

11. That WRHA review its policies and procedures to ensure that primary care facilities develop a uniform protocol for the transportation of clients with mobility or cognitive challenges to other health care facilities.

12. That all RHAs review their policies and procedures to ensure that vulnerable persons, including persons with mobility issues, are assisted by staff with the triage process immediately upon their arrival at an ED.

13. That paper triage lists at any ED be eliminated and that each presenting person's information be entered electronically into a hospital registration system upon first point of contact by ED staff.

14. That RHAs review the floor plan of all EDs to ensure that no persons in the ED waiting room requiring medical care face away from the triage desk.

15. That RHAs review their policies and procedures to ensure that persons in ED waiting rooms are awakened at regular intervals.

16. That the RHAs review the feasibility of secondary traumatic stress training for all ED staff.

17. That the RHAs review their policies and procedures to ensure that staff intervenes when a person is vomiting in an ED.

18. That the RHAs review their policies and procedures with respect to interview notes taken on behalf of hospital Administration after the occurrence of critical incidents, with a view to having the notes dated and initialed or otherwise authenticated by the interviewee.

19. That the RHAs review handover policies in the ED to ensure that the oncoming triage and reassessment nurses are fully briefed on the status of persons present in the waiting room.

20. That all RHAs review the feasibility of a security presence at the entrance to an ED.

21. That ED Security staff receive training in the areas of substance abuse and dealing with persons with physical or mental challenges.

22. That all RHAs review the feasibility of implementing the recommendations of the Brian Sinclair Critical Incident Review Committee.

23. That all RHAs review the feasibility of the presence of a Community Support Worker for EDs, where deemed appropriate.

24. That all RHAs review the feasibility of creating a distinct pre-triage area for EDs, where deemed appropriate.

25. That all RHAs review the feasibility of replicating the HSC ED front-end procedures throughout the system, where deemed appropriate.

26. That the RHAs continue to review, create and implement long-term strategies for the recruitment and retention of nurses.

27. That the RHAs continue to review a rotation of roles and hours of work for ED Nurses in an effort to reduce fatigue.

28. That RHAs, health care site Directors, Nurse Directors and MNU representatives continue to convene ongoing meetings focused on an interdisciplinary, integrated health care model for Emergency Medicine.

29. That the WRHA review the feasibility of establishing Transition Centres for vulnerable patients discharged from urban EDs, where deemed appropriate.

30. That the RHAs identify staffing demands in all EDs and strategically plan to supply adequate staffing for all EDs.

31. That an ongoing review of staffing ratios for all EDs be undertaken by all RHAs to match supply to demand.

32. That the RHA Directors, Site Directors, ED Directors and the Ministry of Health review the feasibility of strategic planning to implement accountability structures, including measurement and reporting systems.

33. That the RHAs review the feasibility of creating a region-wide Overcapacity Protocol, such as the Alberta Overcapacity Plan, where deemed appropriate.

34. That the RHAs review the feasibility of providing on-site diagnostic equipment in EDs, where deemed appropriate.

35. That the RHAs review the feasibility of a seven-day work week for the office of the Home Care Coordinator.

36. That the relevant Utilization representative(s) meet with the Ministry of Health, Housing and Healthy Living representatives to continue to review bed registry and guidelines for transfers and discharge of patients from hospital, including the feasibility of a seven-day work week.

37. That RHAs review the feasibility of the implementation of the delivery of primary care, after-hours, urgent services, where deemed appropriate.

38. That the WRHA review the feasibility of community health care facilities with integrated models of care.

39. That RHAs continue to review the feasibility of incorporating more Nurse Practitioner positions in EDs, where deemed appropriate.

40. That RHAs review the feasibility of recruiting and retaining Hospitalists, where deemed appropriate.

41. That RHAs review the feasibility of the implementation of "one way consults" from the ED to the hospital ward, where deemed appropriate.

42. That the RHAs review the feasibility of hiring and retaining Physician Assistants to work in EDs, where deemed appropriate.

43. That the RHAs review the feasibility of creating a process to establish a deadline for admitting a "boarded" ED patient to a hospital bed, where deemed appropriate.

44. That the RHAs create a Hospital Length-Of-Stay Reduction Committee to monitor and optimize patient flow in RHA hospitals.

45. That the WRHA engage in strategic planning with the Ministry of Health and Manitoba Housing for the funding and construction of more long term care facilities.

46. That WRHA continue pursuing the feasibility of the recruitment and retention of more Nurse Practitioner services in personal care homes.

47. That the RHAs review the feasibility of the creation of a single electronic health record accessible to all health care facilities.

48. That the Ministry of Health and the RHAs review the feasibility of the expansion of Primary Care Networks.

49. That the WRHA review the feasibility of the expansion of Nurse Practitioner-operated Quick Care Clinics to help ease wait times at EDs and Primary Care Physicians' offices.

50. That the WRHA and the Ministry of Health continue to create strategies to educate the public about the existence, function and location of community health care centres.

51. That the WRHA review the feasibility of creating an integrated "engagement and diversion" program for the homeless.

52. That the RHAs review the feasibility of the installation of an electronic board to monitor the status of the patients in the ED, where deemed appropriate.

53. That the RHAs and MNU continue to review the feasibility of persons presenting at EDs seeing a nurse first.

54. That the RHAs review policies and procedures with a view to implementing uniform pre-triage systems at all EDs.

55. That the RHAs review the feasibility of incorporating training in the area of emotional safety for health care professionals.

56. That the RHAs review the feasibility of recruiting and retaining an Indigenous Elder for EDs, where deemed appropriate.

57. That the WRHA Aboriginal Health Services continue to make efforts to recruit and retain the services of Indigenous Elders to be present in the HSC ED during peak hours, seven days a week.

58. That the RHAs review the feasibility of the hiring and retention of Aboriginal Discharge planners, where deemed appropriate.

59. That the WRHA Aboriginal Health Services review their informational pamphlets at each hospital site to ensure that the pamphlets are available in Manitoba's Indigenous and Inuit languages.

60. That the RHAs strategically plan with Manitoba First Nations to review the feasibility of the establishment of rural Indigenous personal care homes in the Province of Manitoba, where deemed appropriate.

61. That the WRHA reviews the feasibility of expanding the Aboriginal Resource Worker position to include weekends.

62. That the WRHA review the training of all ED security personnel to ensure that they receive cultural safety training.

63. That the RHAs develop and initiate policies for the implementation of mandatory and ongoing cultural safety training for all health care workers and that the RHAs ensure that cultural safety training includes a component that has been designed and delivered with the assistance of Aboriginal persons.

## WITNESS LIST

1. Esther Joyce Grant
2. Ken McGhie
3. Dr. Thambirajah Balachandra
4. Dr. John Kherallah Younes
5. Dr. Marc Ronald Del Bigio
6. Dr. Maria Cariolna Araneda
7. Leonard James Koberstein
8. Keri Ranson
9. Jodi Bachmier
10. Sylvia Chidlow
11. Darwin Ironstand
12. Kathryn Harrison
13. Lisa Lynn Blanchette
14. Linda Davidson
15. Shireen Loat
16. Danielle Harling
17. Alexandra Diane Komenda
18. Dana Gwyneth Connolly
19. Diane Carol Kubas
20. John Joseph O'Donovan
21. Norman Wolfgang Schatz
22. Roberto Garcia
23. Robert McKendry
24. Edward Charles Latour
25. Gary Francis
26. Howard Nepinak
27. Ron Galbraith
28. Alain Daniel Remillard
29. David James Trump
30. Peter Vandenoever
31. Kathleen Joy Christianson
32. Susan Alcock
33. Kathlynn Mary Collis
34. Nicholas John Wedel
35. Elizabeth Franklin
36. Valerie Unice Penner
37. Wendy Krongold

38. Tasia Mennell
39. Todd Torfason
40. Laura Johnson
41. Lori Stevens
42. Jordan Loechner
43. Helen Principe
44. Keith Donald Thomas
45. Travis Morgan Minish
46. Dennis Sheldon Grant
47. Evelyn Grant
48. Marni Waters
49. Janelle McRae
50. Cathy Janke
51. Matilda Patrick
52. Kathy Boddy
53. Beverly Swan
54. Sylvia Lone
55. Robert Terrance Hartley Cox
56. Debbie MacPhail-Abraham
57. Glen James Abraham
58. Shawn Morgan Lanceley
59. Elaine Hawkins
60. Allison Peterson
61. Cynthia McKillop
62. Clarissa Immaculata
63. Esther Oyas
64. Michelle Anne Smagalski
65. Lethwinder Pannu
66. Diane Bell
67. Adrienne Martin
68. Nadir Kharma
69. James Brian Campbell
70. Robert Malo
71. Michael Head
72. Janet Kozubal
73. John Sokal
74. Alecs Chochinov
75. Laverne Frances Sturtevant
76. Patricia Kathrin Bergal

77. Lori Margaret Lamont
78. Catherine Louise Cook
79. Sandra Mowat
80. Grant Douglas Innes
81. Janet Kathleen Smylie
82. Jeffrey Michael Turnbull

## EXHIBIT LIST

1. Letter from Chief Medical Examiner calling the Inquest dated January 30, 2009

2. Application Record of Aboriginal Legal Services of Toronto dated June 12, 2009

3. Written submissions of the Sinclair Estate and Family

4. Order releasing the Winnipeg Police Service Criminal Investigative Report into the death of Brian Sinclair dated October 29, 2012

5. Order for disclosure by the Winnipeg Regional Health Authority of medical records and information to the Inquest into the death of Brian Sinclair dated January 18, 2013

6. 11 file folders of documents received by the Inquest Office marked Sections I – VI: A – S with four disks of the documents, a disk (A27) of the Tape Review time line and three DVDs (M1) marked HSC Security Services DVR Footage

7. Curriculum Vitae of Dr. Thambirajah Balachandra, Chief Medical Examiner

8. Curriculum Vitae of Dr. John Kherallah Younes, Forensic Pathologist

9. Curriculum Vitae of Dr. Marc Ronald Del Bigio, Neuropathologist

10. CBC news article entitled “New info contradicts health authority on Winnipeg homeless man’s death”

11. Foley Catheter

12. Curriculum Vitae of Dr. Araneda

13. Standards of Practice for Registered Nurses

14. Code of Ethics for Registered Nurses

15. Diagram of HSC ED Floor Plan, as at September 19, 2008 (G1)

16. Winnipeg Police Service Document for Disclosure - Document: Task 0008

17. Winnipeg Police Service Document for Disclosure - Document: Task 007

18. Winnipeg Police Service Document for Disclosure - Document: Task 018

19. Winnipeg Police Service Document for Disclosure - Document: Task 004

20. Winnipeg Police Service Document for Disclosure - Document: Task 058

21. Winnipeg Police Service Document For Disclosure - Document: Task 003

22. Painting of Brian Sinclair

23. Diagram marked G1, marked up by Edward Charles Latour

24. Diagram marked G1, marked up by Gary W. Francis

25. Security Department Daily Shift Report

26. Diagram marked G1, marked up by Peter Vandenoever

27. Three file folders of documents received by the Inquest Office marked Sec IV: L55 and N24-N104

28. Curriculum Vitae of Susan Alcock

29. Clinical Resource Nurse Job Description, Health Science Centre

30. Nursing Work Load/Staffing Report Guidelines

31. Memos: ER Observation Unit

32. Poster entitled: “ER Walt Times: Why So Long?”

33. Adult Emergency Documentation form and still photo

34. Adult Emergency Documentation form and still photo

35. CTAS Listing – September 19 - September 21, 2008

36. Video Edits-clips and video (disc) by Beth Franklin

37. Copies of a letter from Ms. Spillett and Ms. Demas

38. Letter dated June 10, 2009 from NARCC, Notice of Application, Affidavit

39. Letter from Ms. D. Clemons dated August 18, 2009

40. Fax from Assembly of Manitoba Chiefs

41. Letter from Ms. S. Ewanchuk

42. E-mail chain between Craig Doerksen and Catherine Tolton dated October 9, 2013

43. Dr. Marnie Waters' letter dated September 19, 2008

44. Report of service for Clarissa Immaculata, Sylvia Lone and Esther Oyas

45. 5 page document showing Home Care visits

46. Waiting room floor plan with indications marked by Mr. Lanceley

47. Map of Emergency Department layout at Health Sciences Centre

48. G1 diagram marked by Adrienne Martin

49. G1 diagram marked by Mr. Nadir Kharma

50. G1 diagram marked by James Brian Campbell

51. Brian Sinclair Inquest - Section VII: U (accordion folder)

52. Diagram showing Michael Head location

53. "Winnipeg Emergency Care" (Manitoba Nurses Union) dated October 2012

54. Diagram of HSC ED

55. Overview of the WRHA

56. HSC Adult Emergency Flow Chart

57. Article "How to Compare Six Sigma, Lean and Theory of Constraints"

58. HSC Adult Emergency Actual Total Vists by CTAS

59. HSC ED Statistical Control Charts

60. # of Main Unit Beds per day Continuously occupied with Admitted Patients waiting for Inpatient Beds

61. Manitoba First Nations Communities and Health Facilities

62. HSC ED Photos

63. Control Room/Monitors Photos

64. Location of Cameras within Emergency Dept

65. WRHA Emergency Program-Site Summary Report-HSC Adult

66. Health Sciences Centre Adult Emergency Patient Volumes 2013

67. Health Sciences Centre-Triage Process Improvement Initiative Meeting notes of March 11/08

68. EDIS Triage and Process Improvement Update-March 19/08

69. Health Sciences Centre-Triage Process Improvement Initiative Meeting notes of April 8/08

70. Draft WRHA Emergency Program Triage Improvement Initiative

71. Draft HSC Adult Emergency EDIS Triage Process Improvement and Implementation Project – 17 April 2008

72. Draft HSC Adult Emergency EDIS Triage Deployment Strategy – 22 May 2008

73. EDIS Triage Implementation Checklist 14 August 2008

74. Adult Emergency Intoxicated Persons Detention Act-IPDA

75. Disc Showing HSC Emergency Dept

76. "The Disintegration of Silos" article dated June 8, 2010

77. UMS Successes and Challenges in the WRHA:Our Amazing Race – October 2013

78. “Preparing for Manitoba’s Boomers” article

79. Projecting Personal Care Home Bed Equivalent Needs in Manitoba through 2036 article dated October 2012

80. “Culturally Competent Healthcare Systems - A Systematic Review” article

81. “Racial Microaggressions in Everyday Life” article

82. “Going Public-Levels of Racism: A Theoretic Framework and a Gardener’s Tale” article

83. Collective Agreement between Concordia Hospital and Concordia Nurses Local 27 of the Manitoba Nurses’ Union - October 1/2009 to March 31, 2013

84. Documents provided by Dr. Grant Innes – Section VIII: V1-V21

85. Documents provided by Dr. Janet Smylie W1-20

86. Documents provided by Dr. Jeffrey Turnbull X

87. Excerpt from Dr. Innes’ curriculum vitae

88. Recommendations to solve access block by Dr. Innes

89. Framework for Action – Cultural Proficiency and Diversity

90. Building Winnipeg’s Health Equity Action Plan

91. “Walk the Talk: Be Accountable” PowerPoint

92. Winnipeg Free Press articles