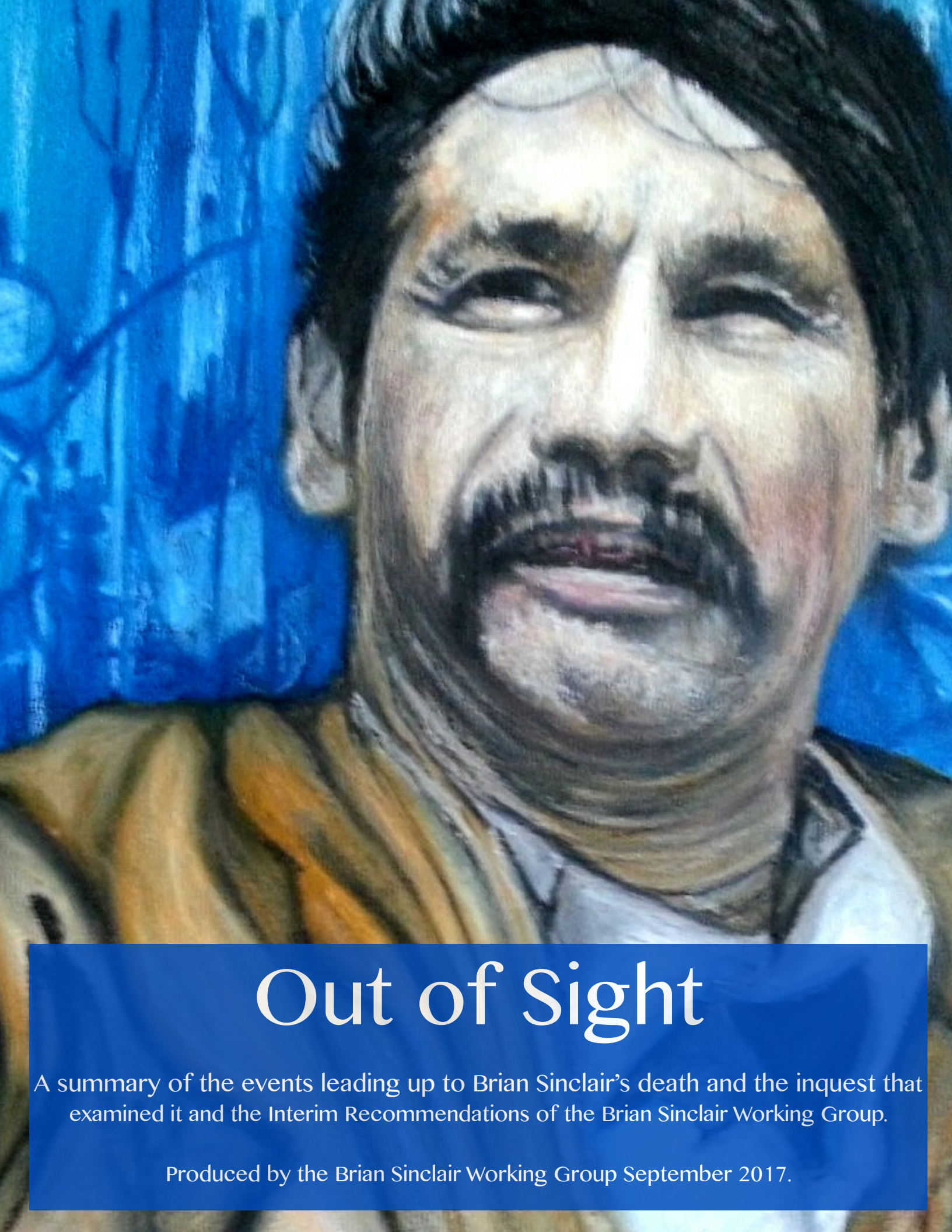

Out of Sight

A summary of the events leading up to Brian Sinclair's death and the inquest that examined it and the Interim Recommendations of the Brian Sinclair Working Group.

Produced by the Brian Sinclair Working Group September 2017.

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A summary of the events leading up to Brian Sinclair's death, the inquest that examined it and the Interim Recommendations of the Brian Sinclair Working Group

The Brian Sinclair Working Group

This summary is part of the ongoing work of the Brian Sinclair Working Group (the "Working Group"). It is being released with draft recommendations aimed at addressing racism within the healthcare system and improving the care of Indigenous patients.

The Working Group was formed to examine the role of racism in the death of Brian Sinclair and in the inquest that followed, in order to highlight ongoing structural and systemic anti-Indigenous racism in our contemporary health and legal systems. So far the activities of the Working Group have included establishing a cross-discipline collaborative approach for researching, analyzing and addressing systemic discrimination in the health care system. The Working Group wrote an op-ed for the Winnipeg Free Press (7 January, 2014) to describe the problems we are addressing and explain our work. In April 2014, the Working Group held a public forum in Winnipeg where health researchers discussed how discriminatory assumptions frequently have significant effects on the range of decisions made in healthcare, including diagnostic and treatment decisions. In September 2017, the Working Group will host a presentation by Dr. Sherene Razack about how Brian Sinclair's death and inquest reflect common themes of indifference towards the unnatural deaths of Indigenous people in Canada. The Working Group aims to release a final report in 2018.

The Working Group members are: Dr. Annette J. Browne, Emily Hill, Dr. Barry Lavallee, Dr. Josée Lavoie, and Dr. Mary Jane Logan McCallum

This work would not have been possible without the additional contributions of: Marcel Balfour, Christa Big Canoe, Linda Diffey, Brenda Gunn, Dr. Emma Larocque, Janice Linton, Murray Trachtenberg, Leslie Spillett, and Vilko Zbogar.

The Working Group also wishes to thank: Dr. Donna Martin, Amanda Penzick, Charlene Tehkummah, Jill McConkey and Gordon Hagman who graciously allowed his painting of Brian Sinclair to be part of this report.

Brian Sinclair's death: What happened at the HSC ED

Brian Sinclair is an Indigenous man who died in September 2008 of complications from a treatable bladder infection after being ignored for 34 hours in an emergency department of an urban Canadian hospital. The following is a summary of the events leading up to his death.

In the afternoon of September 19th, 2008 Brian Sinclair, a 45-year old resident of Winnipeg who used a wheelchair, went to the Health Action Centre, a community health care centre where he was often a patient. He went there because he was experiencing pain and needed assistance with the catheter bag he used. He was seen first by a nurse, and then a family physician. The physician determined that his catheter needed to be changed. The nurse and physician decided that this should not be done at the Health Action Centre because they were worried about ensuring that the catheter change was done in a sterile environment, they did not think they could lift him, and because it was important to get lab results quickly. As a result, the physician decided to send Mr. Sinclair to the Health Sciences Centre Emergency Department [HSC ED].

The physician told Mr. Sinclair that she was sending him to the HSC and that she would arrange a ride. He agreed. Because he was stable, the nurse and physician decided that he could take a taxi to the HSC. At first, Mr. Sinclair offered to wheel himself to the

HSC, but the medical staff said they would arrange the transportation. Before he left in the taxi, Mr. Sinclair was given a letter outlining his condition and was told to give the letter to the nurse.

Based on video footage of the HSC ED, when Mr. Sinclair arrived at the HSC at 2:53 p.m., he was alert and wheeled himself to the triage desk. He was greeted by a triage aid who is seen on the video interacting with Mr. Sinclair for about 30 seconds, and bending over to get closer to Mr. Sinclair with the triage list in his hand. The aid was supposed to record Mr. Sinclair's name, time of arrival and medical issue. However, either the aid did not do these things or, if the aid did record this information, for some unknown reason Mr. Sinclair was never called back to the triage desk and a chart was never started for him. As a result, Mr. Sinclair was not recorded as a patient who needed to be assessed by the triage nurse.

After this interaction, Mr. Sinclair wheeled himself into a corner behind the security desk. He took the letter out of his pocket and then put it away a short while later. It is clear he was told to wait to be called and so was wheeling himself out of the way to wait. For the whole time he was in the HSC ED, Mr. Sinclair was positioned in a way that he was visible to people walking around the ED.

At 3:15 p.m., Mr. 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., Mr. Sinclair can be seen returning from the washroom area of the waiting room. At about 3:40 p.m., Mr. Sinclair is asked by a security guard to move from the security desk area and Mr. Sinclair did so. At about 6:00 p.m., he wheeled himself to the security desk and spoke with a guard. The video shows that by 8:01 p.m. he is slumped in his wheelchair where he remains until the early morning of the next day.

A nurse checked on patients in the waiting room in the early morning hours of Saturday, September 20th. This nurse knew Mr. Sinclair by name and at some point between 3:00 a.m. to 5:00 a.m. she spoke to Mr. Sinclair. His response was garbled and she described him as lethargic, but the nurse did not ask Mr. Sinclair how he was feeling or determine if he had seen a doctor.
At 3:41 a.m. on September 20th, Mr. Sinclair wheeled himself back into the waiting room from the washroom area and the video shows him slumped in his chair again. At approximately 4:00 a.m., a triage nurse moved through the waiting room checking on the status of people in the waiting room who had been triaged and were waiting to see a physician. He said he checked Brian Sinclair's wrist to see if he was wearing a wristband, which would indicate he had been triaged. Because Mr. Sinclair was sleeping and was not wearing a wristband, he assumed that Mr. Sinclair had been discharged earlier and was waiting for a pickup, or he was homeless and seeking shelter or perhaps was detained as an intoxicated person. The triage nurse made no further inquiries. At 4:39 a.m., Mr. Sinclair can be seen on the video wheeling himself out of the washroom area. For the rest of Saturday morning he sat in his wheelchair with the video camera catching changes of his body's position and movement.

In the early afternoon of Saturday September 20th, Mr. Sinclair vomited. A man whose son was a patient in the emergency waiting room said he noticed Brian Sinclair right away because he looked obviously distressed. At 12:42 p.m. that day, the man approached the security guard and told the guard that a man was vomiting. The guard called housekeeping to clean up, but did not alert medical staff. He saw that Mr. Sinclair was motionless and had his eyes closed and assumed he was intoxicated and "sleeping it off". He said he made this assumption because Mr. Sinclair looked to him like someone who was intoxicated.

Later in the afternoon, the same man in the waiting room again saw Brian Sinclair vomit and again alerted the security guard because he thought Mr. Sinclair needed help. While housekeeping staff cleaned up, and a basin was provided, no healthcare staff responded to Mr. Sinclair's vomiting or the request for help from the member of the public. Nurses who testified at the inquest into Mr. Sinclair's death confirmed that vomiting can be a sign of medical distress.
Also that afternoon, a nurse practitioner saw Mr.

Sinclair and noticed the basin he had been given after he vomited. She thought someone else had attended to him and did not check if he needed care. Later in the day, she passed Brian Sinclair, whose head was slumped to the side. She assumed he was sleeping and that he was simply waiting for a bed in another area because someone had already taken care of him.

On Saturday evening, a couple waiting in the emergency room with their daughter intervened on behalf of Mr. Sinclair. They had first come to the HSC on the evening of Friday, September 19th and when they returned the following evening, the woman was alarmed because she noticed that Mr. Sinclair was still in the same position. She approached a student nurse and told her why she was concerned. The student nurse replied that people stay in the waiting room after they are released because they have nowhere else to go and that homeless people use the ED to sleep and stay warm. She also told a security supervisor that she thought someone should check on him, but no one did. The final video image of Mr. Sinclair, captured at 11:45 p.m. that night, shows him in the same location he was in at 4:37 p.m.

The HSC ED is the most comprehensive facility in Manitoba and north western Ontario. In the time that Mr. Sinclair was at the HSC ED, 150 other patients came to the ED. All 150 of them were triaged and all were treated or voluntarily left without being seen.

Just after midnight, the same woman again approached a security guard because she was concerned that Mr. Sinclair has not moved and she feared he was dead. At first, the guard replied that he was probably just intoxicated, but when she insisted that something was wrong, the guard went over to Mr. Sinclair. When he did not respond to being tapped and pinched, the guard realized Mr. Sinclair was dead and wheeled him to nursing staff. CPR was attempted, but it was too late. Brian Sinclair was pronounced dead at 12:51 a.m. on September 21st, 2008. The doctor`s letter that he was to give to a nurse was found in his jacket pocket

By the time Mr. Sinclair's death was discovered, rigor mortis had set in and a time of death could not be established. The cause of death was acute peritonitis that was a consequence of severe acute cystitis or inflammation of the bladder. The severe infection Mr. Sinclair experienced (called sepsis) caused an inflammation of his abdominal cavity and his blood pressure to drop. There was inadequate blood flow to the vital organs, including his brain, which led to a loss of consciousness and hypotensive shock. The autopsy confirmed he did not have drugs or alcohol in his system.

The HSC ED is the most comprehensive facility in Manitoba and north western Ontario. In the time that Mr. Sinclair was at the HSC ED, 150 other patients came to the ED. All 150 of them were triaged and all were treated or voluntarily left without being seen.

Conclusion

Brian Sinclair came to the HSC ED seeking urgent, but not critical care. Had he received the care he needed, he would not have died. His presence in the waiting room was visible to HSC staff, but he was not seen as a patient needing care. Instead he only appeared as someone to be ignored. Because staff assumed that he was homeless or intoxicated or just hanging around the ED, no inquiries were made into why he was still in the waiting room at any point during the 34 hours that passed after he wheeled himself in. Even as his medical situation worsened and he began vomiting and slumping further in his chair, no one saw him as a patient in distress. Even when members of the public intervened on his behalf, HSC ED staff members were quick to explain that he was not sick, but rather sleeping or intoxicated. This blindness to Mr. Sinclair's experiences allowed him to die in plain sight.

The Legal System's Response to Brian Sinclair's Death

The focus of the Working Group is to examine the ongoing systemic anti-Indigenous racism in our contemporary health and legal systems. Two legal processes failed Brian Sinclair. Neither the criminal justice system – which is supposed to ensure accountability for criminal wrongdoing – nor the inquest process – which is supposed to provide an accurate account of a death and consider how to prevent future similar deaths – met its prescribed goals.

The Criminal Justice System

In the case of Brian Sinclair's death, the Winnipeg Police Service did not investigate his death when it occurred in September 2008. Even after it was determined that his death was preventable and the full circumstances of what happened at the HSC ED was known, no police investigation was launched. Because of this, friends and family of Brian Sinclair had to pursue the issue on their own. In March 2010, the prominent Canadian criminal lawyer Clayton Ruby reviewed the circumstances of Mr. Sinclair's death and concluded that there were reasonable grounds to support the criminal charges of criminal negligence causing death and failure to provide the necessaries of life. Mr. Ruby said that the absence of a full and thorough police investigation in these circumstances was both inexplicable and shocking. This view was endorsed by two prominent human rights experts, the National Law Centre on Homelessness and Poverty, and 26 senior Canadian criminal law professors.

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Finally, in October 2010, the Winnipeg Police Service announced they would be launching an investigation. However, in July 2012, the Winnipeg Police Service announced that no criminal charges would be laid and when the Sinclair family requested that the reasons for the Crown Attorney's decision be publically disclosed, their request was refused.

The Inquest Proceedings

After his tragic death, Mr. Sinclair's family, along with a number of Indigenous organizations and community members, called for a public inquiry to address the broader issues that impact the experiences of Indigenous people in the healthcare system. The Manitoba government refused to call a public inquiry to address concerns about the experiences of Indigenous people in the healthcare system. Instead it ordered an inquest, which focuses on the specific circumstances of one death.

Inquests are legal proceedings governed by provincial statutes. Their form varies by province, but the purpose is the same: to determine the facts of deaths and to identify any changes that could be made to prevent similar deaths. Inquests are usually held into unexplained or unexpected deaths or deaths which occur in institutions like jails and mental health centres. Those presiding over inquests are prohibited from assigning blame for the death under investigation. In Manitoba, a provincial judge presides over an inquest.

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A number of individuals and organizations applied to participate in the inquest for Brian Sinclair. These applications were heard by the Honourable Chief Judge Raymond Wyant in the summer of 2009. Judge Wyant decided that in addition to the Winnipeg Regional Health Authority, [WHRA], the Manitoba Nurses Union, the physicians at the HSC, Mr. Sinclair's family, and three Indigenous organizations would be permitted to participate. These were: Aboriginal Legal Services of Toronto [ALST] (now Aboriginal Legal Services, or ALS); Ka Ni Kanichihk; and the Assembly of Manitoba Chiefs.

One important issue leading up to the inquest was legal funding for the Sinclair family. The lawyer for the Sinclair family sought funding so the family could participate at the same level as the other publically-funded parties, namely the crown attorneys who would present the case and the lawyers for the WRHA. At a hearing in June 2009, the presiding judge, Judge Wyant, urged the parties to negotiate a resolution and to consider the use of a third party arbitrator. On February 9th, 2010, the same judge issued another ruling which said that, while he did not have the jurisdiction to determine the amount of funding that the Sinclair family should receive, the amount being offered to the family was not fair. Ultimately, the family participated in the inquest. However, the inequities between the funding for the government lawyers and the WHRA and those of the family were never fully addressed or resolved.

An inquest always considers the circumstances of a specific death and how similar deaths can be prevented; however, the exact scope is set by the judge or coroner hearing the inquest. In the case of this inquest, the Chief Medical Examiner for Manitoba wrote to the Chief Judge of the Provincial Court of Manitoba on January 30th, 2009 and directed that an inquest be held for the following reasons:

- To determine the circumstances under which Mr. Sinclair's death occurred;
- 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 WRHA hospitals; and
  - (b) measures necessary to reduce the delays in treating patients in Emergency Departments.

The next commentary on the appropriate questions for the inquest was set out in Judge Wyant's August 31, 2009 ruling on standing in which he observed that racism, poverty, health and economic status were relevant in this case. He acknowledged that issues of

> racism, of poverty, of mental health, of health, of economic status, that all of those are issues that sort of transcend and, are weaved within the, the evidence and circumstances surrounding Mr. Sinclair's death, and I think it's very important from my perspective that those issues play a significant role as we look at preventing similar deaths in the future.

By the time the inquest began in August 2013, Judge Wyant was no longer hearing the case and the Honourable Judge Preston was presiding. Each party made an opening statement and counsel for the family and for all of the Indigenous organizations said that questions that arose from the case about Mr. Sinclair's background and situation were important and that they would ensure that the inquest focused on the real circumstances of his death and solutions for preventing future deaths.

Phase I of the Inquest focused on answering the questions about the circumstances of Brian Sinclair's death. It was conducted over 32 days and heard evidence from 74 witnesses. Much of the evidence heard over the course of the inquest confirmed what the Sinclair family and Indigenous organizations had suspected: that Mr. Sinclair had been visible in the waiting room but had been ignored because staff assumed he was intoxicated or homeless rather than in need of medical care.

During Phase I, the Sinclair family and the Indigenous

organizations brought an application for, among other things, an order that transcripts of the Inquest be provided to all parties at no cost. This was because the parties who did not have counsel – all Indigenous organizations – were being further left out of the process. In his ruling on October 10th, 2013, Judge Preston stated:

> [T]his court is alive to the issue of inequality and marginalization. The estrangement of Aboriginal peoples from the justice system and this process has been articulated on many occasions. I only have to mention, and I want to mention, our own Province of Manitoba Aboriginal Justice Inquiry, back in the last millennium, which articulated these real feelings and highlighted the over-representation of Aboriginal peoples in our justice system in various contexts. So the legacy of the Aboriginal Justice Inquiry looms large over all our justice proceedings, and more recent Supreme Court decisions have articulated the court's duty to address issues relating to the estrangement of Aboriginal people from our process.

[T]his court, this inquest, take the courageous step in shining a light on that darkness that is racism, discrimination, colonization, marginalization, and how it intersects to cause people to sit, within one of the busiest healthcare places in Winnipeg and go unnoticed.

Based on the rulings of the court on August 31st, 2009 and October 10th, 2013 and on the evidence heard in Phase I, the family and the Indigenous organizations believed that a significant portion of Phase II would focus on systemic issues related to Mr. Sinclair's experiences as an Indigenous person.

As Phase I drew to a close, all parties were invited to make submissions about the scope of Phase II and witnesses they proposed. ALST, in consultation with Ka Ni Kanichihk and the Assembly of Manitoba Chiefs, submitted the names of ten additional witnesses, including seven Indigenous experts. These witnesses were experts about the discrimination experienced by Indigenous patients; understanding Indigenous approaches to health; and best practices, policies and training to provide culturally-safe care.

On January 10th, 2014 Judge Preston made a ruling about the scope of Phase II of the inquest. Judge Preston concluded that part of his mandate "is to make recommendations about best practices for ongoing training for frontline staff to ensure that they meet needs of all their diverse patients, including, of course, Indigenous patients" and ruled that one witness could provide such evidence, unless a second witness was required to speak to other issues of diversity. He also determined that social determinants of health, such as racism, poverty, disability and substance abuse were not within the scope of his mandate regardless of prior court rulings in the Brian Sinclair Inquest.

Judge Preston ruled that Phase II, including counsel's submissions, would be completed in thirteen days, less than half the length of Phase I. He ruled that there would be nine or ten witnesses in contrast to the 74 who had testified in Phase I. Seven of these witnesses were staff of the Winnipeg Regional Health Authority and, of the seven, six would be called to testify about triage and how patients moved through the HSC ED. Only one outside witness would be called to address systemic issues, such as racial discrimination in the healthcare experiences of Indigenous people.

After Judge Preston's decision about the scope

of Phase II, the Sinclair family and the Indigenous organizations discussed how to proceed. ALS and Ka Ni Kanichihk decided to withdraw from the process completely. ALS argued that failing to hear evidence about the discrimination experienced by Indigenous patients or Indigenous approaches to health would result in recommendations that do not address the lived experiences of Indigenous people. ALS explained that since the focus of the inquest had shifted to WRHA witnesses providing evidence about patient flow in the HSC ED, ALS could no longer justify using their limited resources to participate in the inquest. The Sinclair family and the Assembly of Manitoba Chiefs decided they would not present evidence or ask questions during Phase II, but would stay involved only so they could make final submissions at the end of the inquest.

When the Executive Director of Ka Ni Kanichihk, Leslie Spillett, addressed the court, she said that they had sought standing because it was important that:

[T]his court, this inquest, take the courageous step in shining a light on that darkness that is racism, discrimination, colonization, marginalization, and how it intersects to cause people to sit, within one of the busiest healthcare places in Winnipeg and go unnoticed.

She also said that when the inquest opened:

> [W]e asked our Elder to lift our pipes for us. This is really an important process and I want to share that this morning because it bound me, personally, and it bound us to do the right thing before all of creation. And this morning I ask, along with Aboriginal Legal Services, that we also be withdrawn from participation in this inquest. Brian's life is a life that's repeated frequently on the streets, on our streets. And we know, we can see it, we know as Aboriginal people that we, we are discriminated against by institutions.
>
> We are also in the process of what Canada calls a Truth and Reconciliation. And so truth, reconciliation will not happen without truth. We need to get to the truth of, of this particular incident and, of course, all of the truth that's part of all of Canada's relationship with Indigenous people. We also believed that this was a court of justice for Brian Sinclair. And we, I still pray that justice will prevail here. But I am concerned that with the very limited number of witnesses that are being called with respect to understanding the intersection of those systems of oppression that we experience every day, I am concerned that it will not.

The inquest ended on June 13th, 2014. Judge Preston issued his report six months later on December 12th, 2014. As a result of the ruling, almost all of the focus on Phase II was on sightlines within the ED, the triage process, delays in the ER and staffing levels, even though these issues posed no problems for the 150 people who received treatment at the HSC ED on the same weekend Mr. Sinclair died. The issues of stereotyping, assumptions, and racism within the healthcare setting were reduced to only two witnesses whose evidence took less than one day.

While the inquest heard from two Indigenous health experts, whose evidence gave rise to eight recommendations aimed at addressing the unique health needs of Indigenous patients, far more of the recommendations focussed on issues that, while important to the management at the HSC and nursing staff, are tangential to the reasons of Mr. Sinclair's death. For example recommendations that "WRHA continue pursuing the feasibility of the recruitment and retention of more Nurse Practitioner services in personal care homes" and that Regional Health Authorities "review the feasibility of providing on-site diagnostic equipment in EDs" and "review the feasibility of a seven-day work week for the office of the Home Care Coordinator" have little or nothing to do with the death of Mr. Sinclair.

Conclusion

There are many reasons why the inquest failed to address the issues that are central to understanding Mr. Sinclair's death. Some reasons relate to the ongoing systemic discrimination within the formal Canadian justice system; some relate to individual decisions that were made along the way; and some relate to the particular evidence and particular individuals involved in this case. A more fundamental problem also exists in the structure of inquests themselves. Inquests necessarily focus on one death rather than considering what one death may illuminate about larger patterns. Inquests focus on the "circumstances of death", defined narrowly as "when, where and by what means the deceased person died, the cause of the death and the name of the deceased person", even when these questions may not actually be the most important questions to consider to understand the true circumstances.

Since Mr. Sinclair's death, not a single staff member or service provider received any disciplinary action in the workplace or from a professional governing body. Complaints made to the College of Registered Nurses of Manitoba were forwarded to the Investigation Committee. They decided that in some cases no further action was required and in some cases they issued a letter of guidance to the member. None of the complaints were forwarded to by the Investigation Committee to the Discipline Committee. Brian Sinclair's family appealed six of the decisions of the Investigation Committee to the Board of Directors. All six appeals were dismissed. The inability of the criminal justice system, the inquest process, and the rules that govern professional workplaces to account for Mr. Sinclair's death sends a clear message to Indigenous public in Manitoba, that failing to do one's job and meet one's professional obligations will not have any consequence if the victim is someone like Mr. Sinclair.

Next Steps

The Working Group is working on a comprehensive report that will examine the circumstances of Mr. Sinclair's death from both health and legal perspectives. The report will consider the historical background of how healthcare is provided to Indigenous people and communities; the negative health consequences of racism and of discriminatory health care services; and best practices for health care providers. The aim of this work is to improve the care Indigenous patients receive and the examination of the experiences of Indigenous people in the legal system. This work is aimed at honouring Mr. Sinclair's legacy and preventing a similar tragedy from occurring again.

In the meantime, we have developed the following Interim Recommendations aimed at making the change necessary to prevent another tragic death like Brian Sinclair's

This work is aimed at honouring Mr. Sinclair's legacy and preventing a similar tragedy from occurring again.

The Brian Sinclair Working Group Interim Recommendations

In this summary, we have outlined how individuals, institutions, and whole systems failed Brian Sinclair. We have outlined how people tasked with his care failed to see that he needed healthcare assistance and made incorrect assumptions about his needs, his personal circumstances, and his legitimacy as a patient based on stereotypes. However, it can be argued that within the context of the 'multiple system failure' that Brian Sinclair experienced, one thing did not fail. Two members of the public who were themselves seeking care in the HSC ED saw Brian Sinclair for who he was – a person who had become very ill in the waiting room and needed help. Whereas to staff and healthcare providers he had been invisible, other individuals chose to advocate for him.

A man whose son was a patient in the emergency waiting room said he noticed Brian Sinclair right away because he looked "obviously distressed". During the four hours he was in the waiting room, this man saw Brian Sinclair vomit twice. On each occasion, the man went to the security guard and told him that Mr. Sinclair needed help. At the inquest, the man was asked if he knew Brian Sinclair and he replied, "No, I just, I was just being his advocate because he didn't have anybody with him so I was his buddy for the moment."

Another couple waiting in the emergency room with their daughter also intervened on behalf of Brian Sinclair. They first came to the HSC on the evening of Friday, September 19th, 2008. The woman noticed Brian Sinclair when they arrived, and when they returned the following evening the woman was alarmed because she noticed that Mr. Sinclair was still in the same position. She approached a student nurse and told her why she was concerned. She also told a security supervisor that she thought someone should check on him. More than an hour later, when she observed Brian Sinclair in the same position, she again approached the same nurse, and then the same security supervisor and told him she thought the person was deceased. Shortly after this interaction, Brian Sinclair was finally assessed, first by a security guard who thought he was "just sleeping", when in fact it was determined that he had died. While these well-intentioned interventions tragically did not result in a different outcome for Brian Sinclair, they provide a clue as to how we can work to prevent such tragedies in the future. Change mechanisms are needed to ensure that Indigenous patients are cared for and attended to when seeking access to health institutions, that their concerns are treated as legitimate healthcare needs, and that they are given respect and compassion regardless of their personal circumstances. Strategies are needed for supporting people who have the courage to speak up even when staff members in charge are ignoring a situation. Also, it is imperative to hold those staff members in charge accountable. These are ways forward to address the ongoing systemic discrimination and racism that continues to contribute to poor health outcomes and in extreme circumstances, even death, as in the case of Brian Sinclair.

The members of the Sinclair Working Group understand that no one in the healthcare system and beyond wanted what happened to Brian Sinclair. We have developed reasonable recommendations for various groups and authorities in the hopes that this never happens again. What follows are the interim recommendations of the Working Group to achieve that goal.

Overall Recommendations

We recommend that all stakeholders in the healthcare system (including the federal government, the provincial government, Regional Health Authorities, unions, professional organizations, and post-secondary institutions involved in the delivery of professional programs) adopt anti-racist policies and implementation strategies that include committing resources to providing anti-racist training and supporting independent investigations when complaints are filed.

Resources are also needed to generate annual report

cards based on ongoing experiences of Indigenous people seeking care at healthcare institutions in Manitoba. The analysis reflected in these report cards should be undertaken by third party systems distant from the Regional Health Authorities and governments. Additionally, this process will be guided by Indigenous patients' representatives who will be provided resources to engage in this process in an equitable way.

We applaud efforts in British Columbia and Manitoba to provide cultural safety training to employees in the health care system. We also applaud the University of Manitoba's Faculty of Medicine's adoption of a revised anti-racist and anti-colonial medical education curriculum. These are important steps toward fostering health equity for Indigenous peoples, and this movement will be strengthened with the adoption and implementation of policies and practices aimed to eliminate anti-Indigenous racism in healthcare and healthcare delivery. Such innovative structural and behavioral changes to eliminate racism serve, additionally, to improve the wellbeing of providers and will improve health outcomes for other communities targeted by oppressive behaviours and practices in health systems.

Cultural safety training and anti-racist, anti-colonial education are important steps toward fostering health equity for Indigenous people. We also argue that anti-racist and cultural safety training cannot stand on their own but need to be reinforced with the adoption and implementation of policies and practices aimed to change structures in order to eliminate (anti-Indigenous) racism in healthcare and healthcare delivery.

Recommendation #1: We urge the federal government to implement a national, overarching, explicit anti-racist policy to be adopted at all levels of all healthcare systems operating in Canada, including provincial and territorial systems and those under federal purview (the First Nations and Inuit Health Branch of Health Canada and Veterans Affairs). Accountabilities for the implementation of anti-racist strategies will rest with the federal, provincial and territorial Ministers of Health, and will include yearly reporting on progress with national Indigenous groups adequately supported with resources.

Recommendation #2: Manitoba Health, and other provincial/territorial Health Departments across Canada adopt an explicit anti-racism policy in which the Health Department and Regional Health Authorities (RHAs, where they exist), develop anti-racism implementation plans and report on progress in their annual reports. These policies shall include specific actions, remediation and supports to assist systems and healthcare workers and administrators. Further, the authorities will advance these requirements to all contract service provider systems, consultants, contractors and others involved in the capital development of health services in Canada.

The SWG notes that Recommendation 63 from the Recommendations of the Brian Sinclair Inquest Report states: "That the RHAs develop and initiate policies for the implementation of mandatory and ongoing cultural safety training for all healthcare 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." One of the defining features of cultural safety is that it requires healthcare institutions, administrators, policy makers and staff members to examine the ways in which power relations, racism, and stereotyping influence the care provided to Indigenous patients. Cultural safety is founded on the assumption that issues of racism and other forms of discrimination are features of our social world, and therefore also operate (regardless of intention) in healthcare contexts. Responsibility for examining how systemic and other forms of racism operate in healthcare settings can therefore be understood as a routine aspect of quality assurance processes. The Working Group also notes the growing body of evidence documenting how conventional approaches to "cultural sensitivity" training do not provide an adequate framework for addressing issues of racism and other forms of discrimination in healthcare. The limitations of cultural sensitivity training stem from the risks inherent in further entrenching negative, culturalist stereotypes about Indigenous

peoples. Explicit anti-racist frameworks are therefore needed to achieve this recommendation.

In addition, the Manitoba Regional Health Authorities Act should be revised to ensure representation by First Nations, Metis and/or Inuit on every RHA Board in proportion to their healthcare utilization pattern. This will bring Manitoba in line with other provinces. For example, the province of Ontario has defined the membership of health authorities to ensure Indigenous representation, and Nova Scotia and British Columbia require the boards of health authorities to represent the cultural and geographical makeup of the population. In contrast, the Manitoba Regional Health Authorities Act is silent on the need for First Nation and Métis representation (http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php).

Recommendations for Unions and Professional Organizations

The Working Group commends the Manitoba Nurses Union (MNU), the Manitoba Government Employees Union (MGEU), and the Canadian Union for Public Employees (CUPE) for advocating for their members to ensure that workplace standards are met. We commend the unions for identifying a system breakdown in Mr. Sinclair's death.

Recommendation #3: The Working Group recommends that Unions and nursing and medical professional organizations issue clear and unequivocal position statements of zero tolerance for racism in the workplace. Further, mechanisms to receive complaints and concerns by Indigenous patients need to be adequately developed to eliminate and reduce the harms of racism in at multiple levels, including in organizational policies and practices, and at the point of care. The nursing and medical colleges in Manitoba must develop processes to support positive behavior changes by healthcare providers to foster equitable healthcare for Indigenous people. Professional accountability and performance management strategies are needed to ensure that repeat actions of racism warrant severe disciplinary actions accordingly.

Recommendations for all Health Professional Schools

Recommendation #4: All health professional schools must adopt anti-racism curriculum, and share best practices in relation to curriculum development with an emphasis on cultural safety for First Nations, Metis and Inuit communities. Further, schools must increase the number of visible First Nations, Metis and Inuit healthcare students, faculty and administrators and commit to anti-racist policies to improve the experience of all learners. Learners, administrative staff and faculty members who are members of communities historically affected by oppressions (including Two Spirit and LGBTQ people, peoples of color, recent immigrants and refugees and those with differing abilities) will all benefit by adoption and implementation of the recommendations. Collaboration with continuing health education offices in the institutions offer excellent ways to address the ongoing behaviour and attitudinal changes that foster excellent in care for Indigenous patients in healthcare practices.

For more information please visit: http://libguides.lib.umanitoba.ca/indigenoushealth/ForBrian

TIMELINE OF IMPORTANT EVENTS IN THE DEATH AND INQUEST OF BRIAN SINCLAIR

Sept. 19, 2008

Sinclair went to the Health Action Centre because he was experiencing pain and needed assistance with the catheter bag he used. After being seen by a nurse and a physician, it was decided that Sinclair should go to the HSC ED to have his catheter changed. Before he left in a taxi to the HSC, he was given a letter outlining his condition and was told to give the letter to the nurse.

Sinclair arrived at HSC ED at 2:53 PM and interacted with a triage aid, however he was not recorded as a patient who needed to be assessed by the triage nurse. He later took the letter out of his pocket and then put it away a short while later. He was told to wait to be called. He was positioned in a way that he was visible to people walking around the ED.

Sept. 20, 2008

Sinclair was spoken to by a nurse in the early morning. He fell asleep. At approximately 4:00 AM a triage nurse checked his wrist to see if he was wearing a wristband, which would indicate he had been triaged. Because he was sleeping and not wearing a wristband, the triage nurse assumed that Sinclair had been discharged earlier and was waiting for a pickup, or he was homeless and seeking shelter or perhaps was detained as an intoxicated person. The triage nurse made no further inquiries.

Sinclair vomited in the early afternoon. A man approached a security guard and told the guard Sinclair was vomiting. Housekeeping was called, but not medical staff. The guard assumed Sinclair was intoxicated and "sleeping it off". Later in the afternoon, the same man alerted the security guard because he thought Sinclair needed help. No healthcare staff responded to Sinclair's vomiting or the request for help from the member of the public. That evening, a woman approached a nurse and told her that she was concerned that Sinclair was in the same place as he was the night before. The student nurse replied that people stay in the waiting room after they are released because they have nowhere else to go and that homeless people use the ED to sleep and stay warm.

Sept. 21, 2008

Just after midnight the same woman again approached a security guard because she feared that Mr. Sinclair was dead. At first the guard replied that he was probably just intoxicated, but she insisted that something was wrong. When the guard realized he was dead, he was wheeled to nursing staff. CPR was attempted but it was too late.

Sinclair was pronounced dead at 12:51 a.m. on September 21, 2008, 34 hours after he entered the HSC ER having never been treated. Over 150 other people received treatment at the HSC ED on the same weekend that Sinclair died.

Sept.- Nov. 2008

The WRHA launched an Critical Incident Review and later an Administrative Review. Manitoba's Chief Medical Examiner reported that an autopsy found that Sinclair had a bladder infection because of a blocked catheter and that his death was preventable.

Nov. 08- Feb. '09

The Winnipeg Police Service did not investigate the death of Sinclair and the friends, and family of Sinclair pursued the issue on their own. A number of Indigenous organizations and community members called for a public inquiry. The Manitoba

	government refused and instead it called an inquest in early 2009 and heard applications for participants over the summer, with WRHA, MNU, HSC physicians and Mr. Sinclair's family, as well as Aboriginal Legal Services Toronto, Ka Ni Kanichihk and the Assembly of Manitoba Chiefs permitted to participate. The Sinclair family lawyer sought funding equal to the publically-funded parties, namely the crown attorneys who would present the case and the lawyers for the WRHA. Inequities were not resolved.
Aug. 09–Mar. '10	In August 2009 Judge Wyant decided that the scope of the inquest was to include racism, poverty, health and economic status as relevant to the case. In March 2010, Criminal Lawyer Clayton Ruby reviewed the circumstances of Sinclair's death and concluded that there were reasonable grounds to support the criminal charges of criminal negligence causing death and failure to provide the necessaries of life. Ruby also said that the absence of a police investigation was shocking.
September 2010	The family of Brian Sinclair launched a civil suit in the Manitoba in the Court of Queen's Bench against 18 defendants, including the Manitoba government, the Winnipeg Regional Health Authority and its director of clinical care.
October 2010	The Winnipeg Police Service launched an investigation and concluded in July 2012, that no criminal charges would be laid. When the Sinclair family requested that the reasons for the decision be publically disclosed, their request was refused.
Aug. – Oct. 2013	Phase I of the inquest began, presided over by Judge Preston, an focusing on the circumstances of Brian Sinclair's death. It was conducted over 32 days and heard evidence from 74 witnesses. Much of the evidence confirmed that Sinclair was visible in the waiting room but had been ignored because of erroneous staff assumptions about him. As Phase 1 drew to a close, participants assumed the scope of Phase 2 would include a discussion of racism and submitted names of 10 expert witnesses.
January 2014	On January 10, 2014, Judge Preston ruled that the scope of Phase II of the Inquest would focus on best practices for ongoing training for frontline staff and that social determinants of health, such as racism, poverty, disability and substance abuse were not within the scope of his mandate. Phase II was completed in 13 days; seven witnesses were staff of the Winnipeg Regional Health Authority and of the seven, six would be called to testify about triage and how patients moved through the HSC ED. Only two witnesses addressed issues of stereotyping and racism within the health care setting, and their evidence took less than one day.
Jun –Dec. 2014	The Inquest ended June 13, 2014 and the Report of the Inquest was released Dec. 12, 2014.
February 2016	After a series of motions, a re-re amended Statement of Claim in the civil suit was filed. Statements of Defence were filed shortly after and the case is currently in case management.