HEARTEAM

HEALTH EQUITY ACTION RESEARCH TEAM

INDIGENOUS HEALTH CARE ACTION SERIES

#01 Brian Sinclair Report (2015)

Who Was Brian Sinclair ... *Brian Sinclair was an Indigenous Canadian who, on September 21, 2008 died in the emergency department (ED) of the Health Sciences Centre (HSC) in Winnipeg, Manitoba. He died of a treatable bladder infection after waiting 34 hours without assessment or treatment.*

Prior to this, Mr. Sinclair had visited a primary health care facility for abdominal pain and catheter issues and received a referral letter for the HSC. Despite speaking to the Triage Aide upon arrival at the HSC ED, he received no medical attention during his extended wait in the ED.

Mr. Sinclair's death instigated an inquest into systemic racism in the health care system. This inquiry drew out a series of stereotypes and assumptions, and concluded that he was ignored to death, in a system that embodied structural racism.

KEY MESSAGES

Communication

Intervention

Information Gathering

What Actions Can I Take as a Healthcare Provider

Communication

1. Notify the ED staff by phone when sending a patient to the ED, and verify if there is a letter to present to the ED staff.
2. When possible, send letters regarding crucial patient health information to the ED electronically.
3. Communicate clearly with staff and other healthcare providers to attend to the needs of all patients' waiting room.

Intervention

4. Ensure that vulnerable persons, including persons with mobility issues, are assisted by staff with the triage process immediately upon their arrival at an ED.
5. Waken persons in ED waiting rooms at regular intervals.
6. Intervene when a person is experiencing visable signs of distress or concerning symptoms, including vomiting.

Information Gathering

7. Proactively seek information on patients waiting in the ED to be fully briefed on their health status.
8. Take initiative to continually engage in cultural safety and cultural competency training.