

**Brian Sinclair’s death: What happened at the Health Sciences Centre Emergency Department (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 [HSCED]. 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 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.

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 northwestern 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.

Excerpt from “Out of Sight: Interim Report from Brian Sinclair Working Group”

<https://www.dropbox.com/s/wxf3v5uh2pun0pf/Out%20of%20Sight%20Final.pdf?dl=0>