Photo: Maurice Bruneau

FACT SHEET: BRIAN SINCLAIR

1. The late Brian Sinclair, age 45, was a marginalized and very vulnerable Aboriginal man. He was poor; homeless; confined to a wheelchair after losing his legs (they were frozen on a Winnipeg street); cognitively impaired; formerly addicted to solvents; speech-impaired; afflicted by chronic illness including a seizure disorder, a kidney ailment, and a neurogenic bladder; and incapable of advocating for himself.

2. On September 19, 2008 at about 2:15 p.m., Brian Sinclair attended a community health clinic in Winnipeg (the Health Action Centre) complaining of abdominal pain, no urinary output in the previous 24 hours, and possible problems with his catheter.

3. A physician at the clinic gave Brian Sinclair a referral letter and directed him to immediately attend the Emergency Department of the Winnipeg Health Sciences Centre for further urgent assistance and treatment.

4. Mr. Sinclair arrived at the Health Sciences Centre at about 2:53 p.m. by taxi. He reported to the triage area of the hospital to be registered and attended to.

5. A hospital employee at the triage area spoke with Mr. Sinclair, made some notes, and then directed him to wait. Mr. Sinclair obediently wheeled himself into the waiting room.

6. Brian Sinclair remained there in his wheelchair in the waiting room for 34 hours, in considerable pain and discomfort, as sepsis set in uncontrolled. No medical staff had any contact with him during that 34 hour period.

7. For these thirty-four hours, Mr. Sinclair was neglected and ignored. No one gave Brian Sinclair the attention, emergency medical care, food, water, or other necessaries of life that he so urgently required.

8. On September 21, 2008, shortly after midnight, another patient alerted security staff that Mr. Sinclair appeared not to be breathing. Finally, at about 12:50 a.m. on Sunday, September 21, 2008, Brian Sinclair was wheeled into the treatment area, but he was already dead.

9. At this time, the referral letter from the physician at the Community Health Clinic was found in Mr. Sinclair's pocket.

10. The medical cause of Brian Sinclair's death was "acute peritonitis due to severe acute cystitis due to neurogenic bladder." This condition was treatable.

11. Brian Sinclair would have lived if he had been provided with prompt and appropriate emergency care, and the necessaries of life such as food and water, at the Winnipeg Health Sciences Centre.

12. The Chief Medical Examiner has appointed an official inquest into Mr. Sinclair's death. The purpose of the inquest is to determine the circumstances under which Mr. Sinclair died and what steps can be taken to prevent similar deaths in the future.

13. The Family of the victim are unable to participate at the inquest themselves and can't afford to pay for legal representation. Brian Sinclair's mother and sisters live in British Columbia and are physically and financially unable to travel. His surviving two brothers in Winnipeg are homeless, poor, and ill. His other nearest relatives are deceased.

14. For almost three months the Sinclair Family has been asking the Government of Manitoba for funding to participate in the inquest fully and equitably. Finally, in early June 2009, the government of Manitoba offered the Sinclairs funding that is grossly inferior with an absolute limit on the amount ($40,000 no matter how long the inquest lasts). This means they may not be able to see the inquest through to the end.

15. Governmental parties, such as the Winnipeg Regional Health Authority, will have legal counsel to represent them at the inquest. They will be paid with public funds on an open-ended basis and at very adequate rates.

16. In the 2000 Report of the Manitoba Pediatric Cardiac Surgery Inquest, Associate Chief Judge Murray Sinclair (no relation to the victim) stated that:

    > "The families [of the victims] are entitled to have all their legal costs associated with this Inquest paid. The role of all counsel for the families was of fundamental importance in these proceedings… Having counsel whose sole responsibility was that of advocating for the families was essential for a fair and proper proceeding."

17. Associate Chief Judge Sinclair recommended that victims' families' full legal costs of participation in inquests be covered (at the usual scale for government counsel) to ensure a "fair and proper proceeding". This important recommendation has been ignored in this case.

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