A JOURNEY THROUGH HEARTACHE

EXTERNAL REVIEW RESPECTING THE GOVERNMENT OF NUNAVUT'S ACTIONS REGARDING THE DEATH OF BABY MAKIBI, CAPE DORSET, 2012

Katherine Peterson | NOVEMBER 2015

A JOURNEY THROUGH HEARTACHE

FINAL REPORT

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EXECUTIVE SUMMARY

1. Background Facts

The Cape Dorset Health Centre was contacted by telephone by a parent of Baby Makibi at approximately 9:00 pm on the evening of April 4, 2012. Nurse McKeown took the phone call. Concern was expressed that Baby Makibi was not settling. Nurse McKeown advised that the baby be bathed and brought into the health Centre the following day. There are factual conflicts as to the extent inquiries were made as to the condition of Baby Makibi at the time of this phone call. Several hours later Baby Makibi was rushed to the Health Centre, unresponsive, and could not be revived.

The death was initially reported in April 2012 by the Chief Coroner as a SIDS death. The cause of death was amended by the Coroner in July 2012 to death as a result of widespread pulmonary infection. In October 2015 the cause of death was again revised to SIDS.

All critical incidents are to be reported immediately pursuant to the guidelines set out in the Community Health Administration Manual. Steps following the report of a critical incident include investigation, review, assessment, root cause analysis and development of remedial steps.

Prior to this fatality occurring, complaints had been made in writing by nurses to the Department of Health regarding the operation of the Cape Dorset Health Centre. Grievances were filed with the GN regarding the operation of the health centre and treatment of staff prior to the fatality. In addition, a complaint had

been filed by a nurse with RNANTNU regarding both the operation of the health centre and clinical concerns.

RNANTNU is not able, for privacy reasons, to communicate with any parties other than the complainant and the party complained about when acting on a complaint. RNANTNU placed conditions on the license of Nurse McKeown in June 2012 prohibiting her from providing care to children under the age of 10 years.

2. Responses by the Department of Health to the fatality

An investigation regarding a harassment complaint submitted by Gwen Slade (which complaint was submitted in January 2012) was undertaken by the Department of Health resulting in a preliminary finding that, *prima facie*, harassment had occurred and a full investigation should be undertaken. It is entirely unclear whether this investigation occurred. A written reprimand directed to Ms. McKeown was prepared and signed on behalf of the Department by the then Deputy Minister. Again, it is entirely unclear whether this reprimand was actually delivered to Ms. McKeown.

The fatality was not duly reported/investigated as a critical incident pursuant to the Community Health Administration Manual. Consequently, no investigation or assessment was undertaken immediately following the incident.

When conditions were placed on Ms. McKeon's license in June 2012 no details of the license restriction were recorded at Regional Office, nor, it appears, were there any steps taken to ensure adherence to the restrictions.

No investigation specific to the Timilak death was undertaken by the Department of Health at the time of the fatality, at the time of imposition of license restrictions on Ms. McKeown or at any time after the fatality. An investigation was undertaken by Regional Office in the summer of 2013, which was focussed on further harassment complaints that had been submitted by (then) recent employees of the Cape Dorset Health Centre. Accordingly, there has been no systematic review or investigation by the Department of Health into the circumstances surrounding the death of Baby Makibi.

The failure to conduct a timely and appropriate investigation regarding the death of Baby Makibi likely arises as a result of:

- The failure by responsible bureaucrats to properly report/investigate the death in accordance with the Community Health Administration Guidelines;
- The failure of communication between the District Supervisor, South Baffin and Regional Office;
- The failure to respond to known difficulties existing in the operation of the Cape Dorset Health Centre, which facts were known by Regional Office and District Supervisor, South Baffin in 2012 prior to the death of Baby Makibi.

The response of Regional Office and the Department of Health generally to the death of Baby Makibi appeared to be due more to external pressure than internal controls and steps.

The undertaking of regular performance appraisals, and record keeping regarding complaints and disciplinary steps respecting nurse employees is almost entirely absent, and when present, is disorganized and disjointed. As a result, limited avenues were available to Employee Relations regarding the ongoing employment of nurse Debbie McKeown.

Key Conclusions in the External Review

1. Two policies in the Community Health Administration Manual mandate an in person assessment of infants under the age of one (1) year. These policies were not followed by Nurse McKeown at the time the mother of Baby Makibi contacted the Health Centre on April, 4, 2012. This Report is not mandated to conclude, nor does the author have the expertise to conclude whether this would or would not have resulted in the survival of Baby Makibi.

2. There is a specified process for the reporting and investigation of critical incidents. A report was made by the attending nurse, D. McKeown to the District Supervisor, South Baffin (Heather Hackney) who in turn prepared a

Briefing Note regarding the incident which states it was copied to Regional Office. However, follow up investigations, root cause analysis, meetings with the family, collection of documents and witness statements did not occur.

3. There is a specified process for monitoring and evaluating the ongoing operation of a Health Centre, including annual visits, performance appraisals, assessment of connection with the community. This process either did not occur, or if it did occur, was sporadic and undocumented.

4. District and Regional offices have no specified process for the investigation and resolution of complaints regarding access to or competency of nursing care.

5. The investigation that was undertaken by Regional Office in Cape Dorset occurred in the late summer of 2013 and was in response to a further harassment complaint regarding D. McKeown. It was not in response to the death of Baby Makibi and that fatality received only a peripheral mention at the time this investigation occurred.

6. There was no investigation undertaken by the Department of Health specific to the death of Baby Makibi at the time of the fatality nor at any time thereafter. This was despite the fact that difficulties regarding the Cape Dorset Health Centre were known to Regional Office, the death was reported to Regional Office, Regional Office was aware of license restrictions (not to engage in pediatric care) on the license of D. McKeown. The only investigation specific to the death of Baby Makibi was a chart review conducted in the fall of 2012.

7. D. McKeown was promoted to Supervisor at the Cape Dorset Health Centre despite known restrictions on her license at the time of promotion and awareness of prior concerns having been raised regarding her conduct in the workplace.

8. There is an absence of documentation regarding employee appraisal, discipline, and fact finding investigations. There is an absence of communication and documentation regarding these matters as between Regional Office and Human Resources and Employee Relations. The failure to properly document resulted in reduced options regarding the ongoing employment of D. McKeown.

9. There are silos of information and action as between various arms of Health Care including communication with and between the Department of Health and RNANTNU, Human Resources, Employee Relations, the Office of the Chief Coroner, resulting in disjointed and poorly managed responses to critical situations.

10. The varying reports of the Chief Coroner as to the cause of death of Baby Makibi has left the community of Cape Dorset uncertain as to the facts, medical opinions, distrustful and angry. Various versions of events at the time have emerged leaving a situation of conflicting facts. These conflicting facts and medical opinions are best addressed by a formal Inquest in the community regarding the death of Baby Makibi.

11. The community of Cape Dorset continues to have a troubled relationship with the Health Centre. This is evidences by a lack of trust, anger and, at times, inappropriate conduct by patients at the Health Centre. Some, but not all, of this troubled relationship arises as a result of the death of Baby Makibi. Other factors contributing to it likely also include historical trauma, dysfunctional family dynamics, substance abuse, to name a few.

12. Both the actions and omissions of the Regional Office regarding issues respecting the Health Centre in Cape Dorset signify a lack of knowledge and engagement by that Office regarding issues of extreme significance to community members in Cape Dorset. These actions and omissions include a failure to investigate Baby Makibi's death as mandated in the Community Health Administration Manual.

Key Recommendations

1. Structural changes should be made in the Department of Health:
    - All HC employees report through the same chain of command;
    - Position of Chief Nursing Officer be entrenched and appropriately resourced for an expanded mandate;
    - Department of Health assume responsibility for discipline and termination of HC employees;
    - A two pronged reporting regime regarding critical incidents be instituted;
    - Defined policies for communication with affected Departments, for handling complaints and reporting outcomes be developed.

2. A complaints procedure be defined and instituted at Health Centres;
3. An Inquest be held into the death of Baby Makibi;
4. Personnel requirements at Health Centres and Regional Office be reassessed to alleviate overwhelming workloads, and match skills to community needs;
5. Nursing staff should receive timely and culturally appropriate orientation, respite time, peer to peer mentoring, and provide consents for release of information from RNANTNU regarding past history and current complaints/investigations and outcomes;
6. The External Review Report, and the GN response to same be publicly released, with Department officials being available to meet with community members to explain and discuss the Report and Recommendations.

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Part I INTRODUCTION

On April 5, 2012 Baby Makibi Timilak died in Cape Dorset, NU at the age of three months. The death was initially reported by the Chief Coroner, Nunavut as a "SIDS" death – Sudden Infant Death Syndrome in an otherwise healthy child.[1] It was thereafter reported as a death due to widespread pulmonary infection.[2] Most recently (October 2015) it was again reported as a SIDS death.[3] These (and other) circumstances gave rise to the request by the then Minister of Health, Monica Ell, for an External Review.

The Terms of Reference for this External Review, commissioned on February 23, 2015, are attached as Appendix 1 to this Report. While the Terms of Reference refer specifically to the events **following** the death of Baby Makibi, circumstances which occurred **prior** to his death form an important context in this matter and therefore cannot be excluded from the analysis in this Review. In addition, the contrasting reports from the Office of the Chief Coroner as to the cause of death are of considerable concern.

In conducting the Review, I interviewed persons who offered information regarding the events leading up to and occurring after this tragic fatality. The list of persons interviewed is attached to this Report as Appendix 2. Many of the interviews were conducted in person, and where interviews

[1] Report of Coroner April 11, 2012;
[2] Report of Coroner July 24, 2012, Supplementary Report of Coroner; Registration of Death September 13, 2012
[3] Opinion of Dr. S. Phillips, Department of Pathology, Health Sciences Centre, Winnipeg, MN July 27. 2015, Coroners Report October 20, 2015

were conducted by telephone, this is indicated in the Appendix. One person, namely Debbie McKeown, attending nurse at the Cape Dorset Health Centre at the time of this fatality, declined to be interviewed or participate in this Review. Reasons cited were the existence of litigation initiated by Ms. McKeown respecting professional disciplinary proceedings.

Volumes of documents were also reviewed in the preparation of this Report. These documents included those which were produced by Access to Information and Protection of Privacy (ATIPP) requests of various individuals, as well as source documents such as the Department of Health Policies and Procedures Manuals, Department of Health file materials, legislation, and other relevant materials. Without exception, Department of Health officials provided documents and information as requested and in a timely fashion.

The purpose of this Report is not to find fault with any individual or group of individuals, but rather to examine those circumstances and processes which existed which may have had an impact and to provide recommendations which could prevent such a tragedy from occurring again.

Many individuals gave freely of their time, offered advice and perspectives, which I hope have been appropriately analyzed and depicted in this Report. The Report could not have been prepared without this input, and I wish to thank those who contributed. Many did so despite painful personal circumstances, or difficult professional situations. I would particularly like to thank Neevee Akesuk and Luutaaq Qaumaqiaq, the parents of Baby Makibi, who agreed to meet with me in Cape Dorset in the presence of their legal counsel. Their comments and perspectives were extremely valuable in undertaking this matter.

PART II COMMUNITY HEALTH CARE

Health care in Nunavut is administered by the Department of Health, with involvement of the Department of Finance regarding Employee Relations matters. At the community level, health care is accessed through Community Health Centres, which vary in size depending on the population served. Community Health Centres provide ongoing care, emergency care, and community health programs such as immunizations. The staff of a Community Health Centre typically includes administrative staff, technical staff (for the operation of equipment such as imaging equipment), staff responsible for homecare, mental health, and nursing staff. The nursing staff is comprised of a Supervisor, Health Programs (sometimes known as the Nurse in Charge), and community health nurses. The Nurse in Charge of a Community Health Centre reports to the Director of Health Programs for the region, who in turn reports to the Regional Director of Health for the region.

Community Health Nurse (CHN)

↓

Supervisor Health Centre or Nurse in Charge (SHP)

↓

Director of Health Programs, South Baffin

↓

Regional Director of Health

Generally speaking, nursing care is provided by three categories of nurses: Indeterminate staff (full time permanent Government of Nunavut staff), Casual staff (GN employee) and Agency nurses. Agency nurses are those individuals hired from southern agencies for short term contractual periods.

Many agency nurses have practiced in various communities in Nunavut and the Northwest Territories over long periods of time.

There are contrasting schemes of remuneration as between the various categories of nurses. For example, agency nurses will be provided with transportation between their home community (usually in southern Canada) and their place of work, as well as accommodation in the community in which they provide nursing services. However, benefits such as pensions are not provided in their contracted services. Current GN practices make it more advantageous to nurses who do short term assignments in the communities rather than becoming a full time employee and a permanent member of the community. Some of these advantages include short term contracts with breaks in between, flights in and out of the community, subsidized rental accommodations, and cargo allowances. As a result, it is difficult for the Department of Health to attract and retain long term permanent nurses.

All nurses practicing in Nunavut (and in any other jurisdiction in Canada) are governed by the applicable Registered Nurses Association. In this case, nurses in Nunavut are governed by the Registered Nurses Association NT/NU (RNANTNU). A practicing nurse must be licensed by this organization and his or her professional practice is reviewable by it. Complaints made to RNANTNU regarding clinical or ethical practice are investigated by this organization and can result in discipline of the member nurse, including suspension of the license to practice.

Generally speaking, Nunavut is plagued by a chronic shortage of qualified nurses. Recruitment and retention of nursing staff is the single most challenging issue in the delivery of community health care. A large proportion, as high as 40% at times, of nursing care is provided by Agency nurses. Barriers exist for those trained in nursing in Nunavut, including the clinical placement of nurses. The low proportion of Nunavut trained and Inuit nurses also arises from low enrollment and /or low graduation from the Arctic College nursing program and the difficulties associated with engaging in a long term and demanding program in Iqaluit.

As with other community Health Centres, the Cape Dorset nursing staff has an extensive and broad scope of practice. There is no resident physician in the community, and assistance and advice is received by telephone,

electronic communications, and periodic visits by physicians. As such, nurses practicing in this environment are not only tasked with assisting in the general well being of the community population, but may also have to respond to extreme emergency situations. They are providing services to a largely Inuit population, with a distinctive culture and distinctive and varying communication skills. It is a stressful and demanding work environment which requires an extremely diverse range of skills. In addition, the nursing staff are working, and at times living together, in close quarters and isolated conditions. The combination of the scope of work and the working conditions require not only specific professional skills, but a personal dynamic that is both compassionate and professional. Workloads at the Community Health Centre can be overwhelming and contribute to burn out of professional and administrative staff.

The members of the community seeking health care at the Health Centre are also faced with language and cultural divides which can at times create obstacles to understanding and care. Trust in the competency and compassion of community nurses is an integral part of this relationship. For some members of the Community of Cape Dorset, this trust has been damaged or lost. Community members have at times felt unwelcome and disrespected. Similarly, trust and compassion on the part of practicing nurses in the community has at points been damaged or lost as a result of difficult, demanding or disrespectful conduct on the part of patients. The community of Cape Dorset continues to have an uneasy relationship with members working in the Health Centre. This contributes to high turnover in Health Centre staff, anger and frustration on the part of community members and Health Centre staff.

PART III BACKGROUND INFORMATION

1. Initial Circumstances

Baby Makibi was the first child of his young parents who resided in the Community of Cape Dorset, Nunavut. Cape Dorset is served by a busy Health Centre, with a complement of five nursing staff plus related administrative staff.

The mother of Baby Makibi contacted the Health Centre by telephone on the evening of April 4, 2012 at approximately 9:00 p.m.. The call was taken by the on duty nurse, Debbie McKeown. The details of this conversation are in conflict. It is clear that the mother contacted the Health Centre because she was concerned about her infant, and particularly that he was not settling. She was advised to bathe the infant and to come in for a check up the following day.[4] The infant was not seen by the on duty nurse despite clear Department of Health policies. The policies state:

> **Policy 07-006-00 Telephone Triage**
>
> "Every client shall be assessed on an individual basis. The following individuals shall have their presenting complaint fully assessed in the clinic:
>
> …
>
> 2. All infants up to one (1) year of age."[5]

> **Policy 07-008-00 Acutely Ill Infants**
>
> "All infants under one (1) year of age must be fully assessed in the clinic, whether it is during or after regularly scheduled clinic hours."[6]

The mother Neevee breast fed Makibi and he relaxed and was smiling through the night until they went to sleep.[7] Baby slept with his parents, on

[4] Statement of Luutaaq Qaumagiaq to RCMP officer Lawson
[5] Community Health Administration Manual, Telephone Triage, Policy 07-006-00
[6] Community Health Administration Manual, Nursing Practice, Policy 07-008-00

his stomach as this was the only position in which he would sleep well.[8] Nurse McKeown was advised that Makibi went to sleep around 2230/2300 hrs[9][10]

Several hours later, Baby Makibi was rushed to the Health Centre, unresponsive, and could not be revived.

The initial Coroner's report on April 10, 2012 regarding this fatality described it as a "SID"s death. However, in the Report of the Coroner dated July 24, 2012 it is stated that the cause of death was “widespread Pulmonary Cytomegalovirus Infection, Bilateral, SUDI”[11] The Supplementary Report states that microscopy sections from all lobes of both lungs showed moderate to marked congestion and that there was evidence of cytomegalovirus infection.[12]

The last opinion of the Coroner arising from a medical opinion dated July 27,2015 again reverts to the cause of death being SIDS.[13]

2. Government Personnel and Response

Key players at the time of this tragedy and in the months following included:

Deputy Minister Health	Peter Ma
Regional / Executive Director, Baffin	Roy Inglangasuk
Director of Population Health, Baffin	Markus Wilke
Director of Health Services (ending October 2012)	Virginia Turner
Director of Health Services, South Baffin (ending March 2013)	Heather Hackney

[7] Statement of Luutaaq Qaumagiaq to RCMP officer Lawson
[8] Statement of Luutaaq Qaumagiaq to RCMP officer Lawson
[9] Statement of Debbie McKeown to RCMP officer Lawson
[10] There are a number of conflicts in these facts as between the parents and Nurse McKeown, such as what were reported as symptoms, whether Baby slept in a crib.
[11] Report of Coroner dated July 24, 2012.
[12] Supplementary Report Additional Information of the Deceased
[13] Opinion of Dr. S. Phillips ,Coroners Report October 20, 2015 *supra*

Director of Health Services (April 2014)	Elise Van Schaik
Director of Professional Practice	Barbara Harvey
Supervisor Health Programs (Cape Dorset)	Susan Validen
Supervisor Health Programs (Cape Dorset)	Lennie Sapach
Community Health Nurse Cape Dorset	Debbie McKeown
Community Health Nurse Cape Dorset	Karen Rae
Community Health Nurse Cape Dorset	Gwen Slade
Chief Coroner	Padma Suramala
Clinical Supervisor	Mary Bender

Acting positions were assumed by a number of these individuals at various points. It was not uncommon for Regional Office personnel to assume multiple responsibilities at any given point in time and for District personnel to do the same respecting regional positions. Turn over in key positions, such as the Director of Health Services, has impacted both service delivery and processes to a very large degree.

At the time of Baby Makibi's death, Lennie Sapach occupied the position of Supervisor Health Centre ("Nurse in Charge"), Debbie McKeown was part of the nursing staff**,** and Gwen Slade had been previously employed in Cape Dorset as a casual nurse. Heather Hackney occupied the position of Director of Health Services, South Baffin. Regional Office staff was comprised of Roy Inglangasuk, Virginia Turner, and Markus Wilke. [14]

Earlier in the fall of 2011 Karen Rae, employed as a nurse at Cape Dorset, expressed concerns respecting the work environment in place at the Cape Dorset Health Centre. At the request of Heather Hackney, Director of Health Services, South Baffin, these concerns were provided in writing. These concerns were detailed in a nine page email, and included allegations of:

- bullying and harassment by the then Health Centre Supervisor, Susan Validen;
- poor judgment, lack of support and lack of managerial skills on the part of Susan Validen;

[14] This is not a full list of Regional Office staff, nor Health Centre staff, but only those most directly involved with events.

- Bizarre behaviour and lack of clinical skills on the part of Susan Validen;
- security and safety issues regarding nursing staff;
- the bringing of a premature infant receiving care at the Health Centre to a social party by one of the nursing staff;
- inappropriate guests at the Health Centre, drinking, and socializing on the part of Health Centre staff;
- favouritism respecting certain employees, particularly Debbie McKeown.[15]

This lengthy email contains a litany of disturbing allegations, many of which, if substantiated, would impact not only the functioning of the Health Centre, but the quality and competency of care provided to patients.

As a result of this email, a fact finding investigation was conducted by Heather Hackney, and Susan Validen was removed from the position of Supervisor or "Nurse in Charge" at the Centre, replaced by Lennie Sapach. However, Susan Validen remained part of the nursing staff at the Health Centre for some months thereafter.

While it is clear that these actions provided some immediate relief from what appeared to be a dysfunctional work environment, serious issues remained, and sadly, were to resurface within months. The continued allegations included bullying behaviour on the part of some nursing staff, including Debbie McKeown, credibility, work ethic and competency concerns, responsiveness to nursing staff concerns, and general quality of care.

In January and February 2012, concerns were again raised regarding conduct and functionality of the Cape Dorset Health Centre. It is likely that concerns were also communicated prior to this time, although documentation in this regard was not available. The unavailability could be as a result of concerns being raised orally, or due to documentation not being maintained. However, it is clear that concerns were communicated by Gwen Slade, who had returned to the Health Centre in January 2012. A total of four grievances (originally framed as complaints) were submitted by

[15] Email Karen Rae to Heather Hackney dated September 16, 2011

Gwen Slade, in addition to complaints filed with RNANTNU regarding Lennie Sapach and Debbie McKeown. These actions resulted in Ms. Slade being suspended pending investigation and leaving the community of Cape Dorset in February 2012. Apart from Ms. Slade no other suspensions pending investigation occurred.

It appears that the bureaucratic response to the concerns raised with the GN by Ms. Slade was defensive in nature. The focus at the time was that of refuting allegations made by Ms. Slade rather than the investigation or determination of the validity of these complaints. The credibility of Ms. Slade was treated as suspect from the outset. It is critical to note that no further investigations were conducted regarding the functionality of the Cape Dorset Health Centre nor the quality of care being offer by it, until the summer of **2013**, in excess of one year after the death of Baby Makibi.

Incredibly, the grievance process initiated by Ms. Slade has only recently been completed in October 2015.

As mentioned above, in February 2012 Ms. Slade filed a complaint with RNANTNU respecting Lennie Sapach and Debbie McKeown.

As a result of these complaints and investigations by RNANTNU, it learned of concerns regarding the circumstances of the death of Baby Makibi.

The complaint to RNANTNU regarding Ms. McKeown initially resulted in restrictions being placed on her practice in June 2012, namely:

> "The member will not provide nursing or other health care services to any patient who is younger than 10 years of age other than emergency situations".

This determination was achieved as a result of an Alternate Dispute Resolution process in which Ms. McKeown voluntarily participated. It included remedial steps to be taken by Ms. McKeown.

In March 2012 a complaint to RNANTNU was filed by Heather Hackney naming Gwen Slade. This complaint was investigated and ultimately dismissed. Given the timing of this complaint, and the circumstances preceding it, the complaint has a distinctly retaliatory or punitive flavour.

The death of Baby Makibi was not fully reported/ investigated as a critical or serious incident. A report of some description was provided by Debbie McKeown to Heather Hackney. Details of what was contained in this report were not discoverable by me apart from an email dated April 5, 2012 reporting the fact that a 3 month old infant had died. However, Heather Hackney advises that she contacted Debbie McKeown to ascertain details. Again, documents in this regard are either missing or were never prepared. A Briefing Note was prepared by Heather Hackney April 5, 2012, the very day of Baby Makibi's death. The Briefing Note bears the notation of a copy to Roy Inglangasuk, Regional Director. It appears that an assessment was made that because the infant was not "acutely ill" the protocol for in person assessments of all children under the age of 1 year did not apply.

Ms. Hackney advised that she "apprised and sent documentation to my supervisor (Roy Inglangasuk) of the situation concerning baby Macabie's (*sic*) death, interim settlement agreement and the decision to accommodate Debbie [McKeown] in the Acting Supervisor position". Regional Office (Roy Inglangasuk) advised that these documents were not provided. When asked whether, when he learned of the restrictions placed on Ms. McKeown's license in June 2012 he investigated or "dug into" the matter, his response was "not really". He stated that he was advised "at a superficial level" of the incident, and that "now" Ms. McKeown had to have restrictions on her license.

However, it is clear from the documents reviewed that Mr. Inglangasuk was substantially aware of the issues in Cape Dorset in early 2012. In **February 2012** Mr. Inglangasuk advised in an email directed to Heather Hackney and Virginia Turner that he would be "taking the lead on this file".[16]

[16] Email dated February 19, 2012 from Roy Inglangasuk to Heather Hackney, cc to Virginia Turner in reference to the harassment complaint of Gwen Slade and presumably matters generally arising in Cape Dorset

Although Mr. Inglangasuk "took the lead", there appears to have been:

- no substantive or pro active steps regarding complaints,
- no investigation into the death of Baby Makibi and the reasons for the license restrictions,
- no request to Ms. McKeown regarding the details of the license restrictions so that they could be recorded on file,
- No arrangement for the monitoring of adherence to the license restrictions imposed on Ms. McKeown and,
- after the fact, a disavowal of any detailed knowledge, indicating that his Directors had "let him down" by withholding information" from him.

As indicated above, it appears that the Briefing Note prepared April 5, 2012 regarding the death of Baby Makibi was copied to Mr. Inglangasuk.

In May 2013 Mr. Inglangasuk corresponded with RNANTNU stating:

> "We will be interviewing for the Nurse Manager position for our Cape Dorset Health Centre, however, Debbie advises that she is still waiting for your organization to determine if she has met the remedial requirements placed on her license. I agree with Debbie this is going at a snail's pace and not conducive to our staffing process. With the caveats placed on her license it may be impossible to interview her for the position.
> Debbie has proven to be a good manager for our health centre and enjoys the support of her staff and from my office because we have a well managed and operated health centre in a busy environment."[17]

This endorsement of Ms. McKeown was made at a time when Mr. Inglangasuk was aware of the harassment complaints, the death of Baby Makibi, and the restrictions on Ms. McKeown's license.

[17] Email dated May 7, 2013 from Roy Inglangasuk to RNANTNU, Subject Debbie McKeown, Acting Nurse Manager Cape Dorset

He was advised May 7, 2013 by RNANTNU that restrictions remained on the license of Ms. McKeown.

In an email directed to RNANTNU on January 7,2014, details of the license restriction were requested by Mr. Inglangasuk. This further indicates that particulars of those restrictions, although known to be in place, were never previously sought or recorded.

Despite Mr. Inglangasuk's concerns communicated to RNANTNU that Ms. McKeown may not be interviewed for the Nurse in Charge position for Cape Dorset because of the restrictions on her license, this in fact occurred or at least, whether or not the interview occurred, Ms. McKeown was promoted to the full time permanent position of Supervisor or Nurse in Charge of the Cape Dorset Health Centre in June 2013. The license restrictions continued to be in place at this time. Ms. McKeown had previously been acting in this position.

The work of the Health Centre had a very high proportion of pediatric and obstetrical care. Such care occupies the majority of services provided by the Health Centre. There is also a well known custom of clinic nurses seeking the advice and assistance of the most senior member of the nursing team, who, as of June 2013, was Debbie McKeown. She was, at the time of receiving this promotion, precluded from practice in this area.

It appears that the enormity and seriousness of these events did not occur to those in Regional Office until the mid 2013. This coincides with mounting external pressure regarding events in Cape Dorset. Had an investigation occurred immediately following the fatality as is required pursuant to the Community Health Administration Manual[18], it would have disclosed a serious concern on the part of community members, including but not limited to the parents of Baby Makibi, regarding the quality of care being offered, and in particular, the care provided by Debbie McKeown. However, absent this, Ms. McKeown advanced in responsibility, was promoted and continued employment in an active fashion until a

Section Administration, Guidelines 05-004-01

suspension pending investigation in August 2013 regarding a further complaint of harassment.

PART IV ISSUES POSED IN TERMS OF REFERENCE

1. Does the Department of Health have a specific process for completing an internal review into the administrative processes of a case

It should be noted at the outset that there is a procedure in place for the reporting of and response to a serious or critical incident.[19] Interestingly, during my conversation with Regional Director, Roy Inglangasuk, he advised that there was no formal processes for internal review.

The process is contained in the Community Health Nursing Administration Manual. A critical incident is defined as:

1. An unplanned Adverse Event that caused serious harm to a client such as death, disability….;
2. Occurs during the provision of care;
3. Does not result from the client's underlying health condition;
4. Is not from a risk inherent in providing health services.

These steps include the immediate report (within one hour) by an attending nurse to his or her immediate supervisor. This in turn is to be promptly reported to the Director of Health Programs. The steps to be taken by the Director of Health Programs include:

- Keeping relevant clients, relatives, staff and others informed of developments;
- Immediately informing the Regional Director;
- In conjunction with the Regional Director, preparing and submitting a Briefing Note;

[19] Community Health Administration Manual, Section ADMINISTRATION, Risk Management

- Leading the preliminary investigation and leading the implementation of any remedial actions as a result of the preliminary investigation;
- Initiating with other appropriate staff and expertise a root cause analysis of the incident and directing, monitoring actions to be taken;
- Collating, all relevant records, documents, evidence and contemporaneous records and ensuring all external forms are completed.[20]

These steps, if followed, provide a comprehensive response to a serious incident, and, importantly, include the investigation, documentation and analysis of why the incident occurred, and what steps need to be taken as a result.

However, because the response to a serious incident involves reporting through only one chain of command, any break or failure within that chain of command can result in a serious incident not being reported or investigated. This risk can be corrected by a requirement that reports of serious or critical incidents are made both through the chain of command within the Department of Health and to an oversight position respecting risk management or quality of care. (See Recommendations 3,4,5,6).

In addition to the reporting of a serious incident, there are policies governing "continuous monitoring and evaluation of the quality of care delivered through the Community Health Nursing Program"[21] These include:

- At least an annual community visit by the Director of Health Programs of at least two to four days on site;
- The preparation of community summary reports;
- Administrative review of items such as staff moral (*sic)*,Supervisor or Nurse in Charge administrative duties, performance appraisals, rapport of Health Centre within the community.

Many other aspects of the operation of the Health Centre are to be included in the community visit. As with the policy on serious incident reporting, this

[20] Community Health Administration Manual, Guideline 05-004-01
[21] Community Health Administration Manual, Section: Standards

policy provides for a reasonable evaluation of the operation of a community Health Centre, its relationship with the community and the standards and competencies of health centre employees. The efficacy of this important Guideline is entirely dependent on tasked employees having the time, resources and inclination to undertake the requirements.

2. If so, were they followed in this case

(a) Critical Incident Reporting

The mandated steps respecting investigation of a serious incident were not followed in this case. While the matter was reported by attending Nurse McKeown to the Director of Health Services, South Baffin (Heather Hackney), the "investigation" of the incident appears to have been confined to a telephone conversation between Ms. Hackney and Ms. McKeown following notice of the fatality. As noted above, a Briefing Note was prepared by Ms. Hackney April 5, 2012, which appears to be copied to Mr. Inglangasuk. However, Mr. Inglangasuk states he was only "superficially advised" of events. The preparation of the Briefing Note tends to indicate that the matter was considered a serious or critical incident in April 2012. However, apart from this, I could locate no document that indicated that an investigation at the community level was undertaken. Nor was there evidence of fulfilment of the other requirements in the policy relative to critical incident reporting and investigation.

Apart from the telephone conversation mentioned above, there was no preliminary investigation to explore the facts of the fatality, compromising circumstances, root cause analysis or remedial action. Communication with the family was at best marginal, and was primarily comprised of some communication by the then nursing staff and a telephone conference between the Chief Coroner and family members during which the family was advised that the cause of death was SIDS. It should be noted that the parents of Baby Makibi spent many months thereafter with the impression that they were in some respect responsible for the death of their son even after the revision of the cause of death by the Chief Coroner in July 2012. The grief and guilt associated with this was enormous for them. Incredibly, the Chief Coroner did not directly communicate with them when she received a report that concluded that the death was due to pulmonary

infection. Instead, this information was passed on to a physician who was scheduled to visit Cape Dorset. It is obvious that this information was either not communicated at that time or it "fell between the cracks" resulting in the parents continuing to believe the SIDS conclusion. Interestingly, the final opinion of June 2015 reverting to the SIDS conclusion was transmitted by the Chief Coroner to the parents in a formal and expeditious fashion, as was the October 2015 Final Report.

There was no detailed follow up to the fatality and no exploration of the circumstances despite known difficulties with the functioning of the Cape Dorset Health Centre. There was no collection of critical documents, witness statements or charts.

A chart review was requested of Barbara Harvey in September 2012. This appears to be inspired by a complaint made to RNANTNU. Ms. Hackney states in an email to Mr. Inglangasuk:

> "I would like an independent review of the chart on the infant death that occurred in Cape Dorset last spring. One of the staff took the back door approach to reporting concerns around the management of this infant to RNANTNU and did not involved (*sic*) management. We as a department need to do our due diligence through a careful review of the files. …."[22]

This chart review was completed December 5, 2012. The review concludes that the telephone advice provided by Ms. McKeown was appropriate as the child was not reported to be acutely ill.

The Regional Director, Roy Inglangasuk, stated that he was not advised through critical incident reporting by the Director of Health, South Baffin Region, of the incident or the seriousness of it. He states that between the time of Baby Makibi's death (April 2012) and the date of restrictions being placed on Ms. McKeown's licence by RNANTNU (June 2012) he was not aware of the seriousness of the situation nor even that a fatality had

[22] Email dated September 21, 2012 from Heather Hackney to Roy Inglangasuk.

occurred. This is contrary to the Briefing Note indicating that he appears to have been copied with which contains the information concerning the fatality.

The Director of Health, South Baffin, communicated directly with RNANTNU that adjustments had been made to the practice of Ms. McKeown (not to see children).[23] While Ms. Hackney advised that this was communicated to Regional Office, there are no "c.c's" appearing on this correspondence. It appears that if these facts were communicated to Regional Office, it was done in a more informal fashion.

Mr. Inglangasuk further advised that upon learning of the license restrictions regarding Ms. McKeown, his responsibility was to ensure that the conditions on the license were met. Documents indicate that no record of the license restriction was on file at Regional Office and no particulars were requested by it. It is quite impossible to monitor conditions if the details of those conditions are unknown.

It should be noted that it is the responsibility of the employee (ie Ms. McKeown) to advise his or her employer of the results of any disciplinary proceedings undertaken by RNANTNU. This is due to protection of privacy considerations. Ms. McKeown made the required report to her supervisor.

Regional Office, including Mr. Inglangasuk and the then Deputy Minister, Peter Ma, were aware of the initiation of an investigation involving Debbie McKeown in February 2012. A formal demand for documents was issued by RNANTNU in correspondence dated February 27, 2012. Although this complaint to RNANTNU by Ms. Slade was focussed on harassing behaviour it also raised serious clinical concerns. The document production requested included clinical issues. The request for information from RNANTNU was detailed and included requests for the provision of certain patient files among other documentary information. The response from Mr. Inglangasuk at this time to the request for document production was that it imposed an undue burden on staff and the requirement for overtime hours. RNANTNU was invited to attend and conduct its

[23] Correspondence from Heather Hackney to RNANTNU dated June 8, 2012. There are no cc's on this correspondence.

investigation. Documents were ultimately supplied to RNANTNU, albeit after the deadline stipulated in the demand.

To further complicate matters during the time frame January 2012 to June 2012, a number of complaints and grievances centred on harassment by Ms. McKeown were submitted by Gwen Slade to the Government of Nunavut. The initial complaint to the GN by Ms. Slade was again with respect to harassing behaviour and not specifically with respect to clinical competencies. The first of a number of complaints was made approximately January 28, 2012.

In summary, in the early part of 2012, there was a flurry of complaints, grievances and investigations by RNANTNU. A brief and albeit incomplete synopsis of these steps is as follows:

- Early January 2012 Ms. Slade returns to the Cape Dorset Health Centre as an agency nurse;
- January 28, 2012 a complaint regarding harassment is submitted by Ms. Slade to the Department of Health (S. Burke, Human Resources and to the union representative);
- February 20, 2012 Ms. Slade is suspended pending investigation, and moves shortly thereafter from the community;
- February 27, 2012 the Department of Health receives demand correspondence from RNANTNU regarding an investigation into the conduct of Debbie McKeown;
- March 2012 Heather Hackney submits a complaint regarding Gwen Slade to RNANTNU (subsequently dismissed by RNANTNU);
- April 5, 2012 death of Baby Makibi and the Briefing Note is prepared by Heather Hackney;
- April 19,2012 Deputy Minister Peter Ma advises Debbie McKeown that a prima facie case for harassment has been established and a full investigation will be undertaken. Documents concerning this investigation are either nonexistent or could not be located;
- June 12, 2012 RNANTNU places restrictions on license of Debbie McKeown not to provide medical care to children under the age of 10;
- September 2012 a written reprimand from Deputy Minister Ma is signed regarding Debbie McKeown. It appears that this reprimand was never actually delivered to her;

- September 2012 Mr. Inglangasuk has copies of correspondence between Gwen Slade and Barb Harvey, which outline ongoing concerns;
- September 2012 Ms. Hackney and Mr. Inglangasuk agree that an independent chart review should be undertaken regarding Baby Makibi by Barbara Harvey;
- May 2013 Mr. Inglangasuk inquires of RNANTNU as to status of removal of the conditions on Ms. McKeown's license;
- June 2013 Debbie McKeown is promoted to Supervisor Health Care (nurse in charge) while license conditions remain outstanding. These restrictions were also in place while Ms. McKeown was acting in the position of Nurse in Charge;
- August 2013 further complaints are received regarding harassing conduct by Debbie McKeown and these complaints together with the performance of Debbie McKeown are investigated by Regional Office. Ms. McKeown is suspended pending investigation;
- November 13,2013 Ms. McKeown receives a letter of reprimand and is required to take an online course regarding respect in the workplace;
- November 2013 Ms. McKeown returns to work in Cape Dorset.[24]

It is very likely that the number of complaints, grievances, demands for documents, ongoing clinical management issues contributed to confusion and a lack of focus as to what was occurring in the Cape Dorset Health Centre. However, it would be impossible not to notice that there were serious issues at the Health Centre in advance of the death of Baby Makibi and following it.

Despite this, no steps were taken at this time to ascertain the nature and seriousness of the allegations made. There was no visit made to the Health Centre by the Director of Health Services, South Baffin, nor by any other responsible government employee, to investigate these concerns or to investigate the circumstances surrounding the death of Baby Makibi.

The "full investigation" regarding the complaint of harassment concerning Debbie MacKeown referred to in Mr. Ma's correspondence of April 2012 , if

[24] See Timeline of Events, Appendix 3

undertaken, was not accompanied by a site visit or witness statements. Grievances submitted by Ms. Slade to the GN in 2012 were not resolved until October 2015.

The more difficult question is not whether the established policies and protocols were followed but **why** were they **not** followed. Was the incident not considered sufficiently serious to engage these established steps? Were the steps unknown to the Nurse in Charge, or the Director of Health Services? Did overwhelming work loads lead to the omission of adequate reporting and response? Did Regional Management not take notice of the occurrence of an infant fatality in the Community of Cape Dorset?

At the outset it should be stated that the workloads of those practicing nursing in Community Health Centres such as Cape Dorset are overwhelming. Despite the continuous and significant increase in population, there has been no corresponding increase in staffing levels over a number of years. Respite, job sharing, collegial meetings and support are all a necessary part of maintaining a full complement of quality care givers. These important aspects are either absent, or difficult to implement. As a result, there is large staff turnover. It is also difficult for community members to have confidence in their health care providers when there is constant change and a lack of continuity of care. (See Recommendations 9, 11, 18, 19, 26, 27, 28, 32, 33, 34)

As well, the complexity and work load associated with administering health centres in remote communities exceeds the capacity of Regional Office. This is due in part to the very nature of the work, and it is exacerbated by high turnover and vacancies in key management positions. In many cases I was advised by managers that it is not possible to undertake all duties at all times, and some aspects must be sacrificed to current more urgent situations.

Reporting requirements and lines of authority are difficult, inconsistent and lack efficiency. Not all employees of a Health Centre report through the same chain of command within the Department of Health. Accordingly, those being charged with the overall administration and effectiveness of a Health Centre lack a full and comprehensive picture. Most notably, while the Department of Health may recruit health care professionals, it lacks the bureaucratic authority to terminate employment. The authority respecting

termination of nursing staff rests with the Department of Finance, Employee Relations. (See Recommendations 1, 17)

With respect to discipline, suspension and termination of nurses, efficiencies in many government departments dictate that these functions exist within a section of expertise (in this case Department of Finance, Employee Relations). This works well with matters that require a consistent, often ongoing plan of progressive steps. However, it is ill suited to situations where the health and well being of community members may be placed at risk if a critical situation is not handled immediately and with authority. The Department of Health must have the authority to respond immediately, albeit with advice from Employee Relations and legal experts. Further, clinical issues are not within the expertise of Employee Relations officials and the seriousness or magnitude of issues may not be appreciated by those not trained or working in the health field. (See Recommendations 1, 17).

Aspects of recruitment and retention contribute to both turn over and a probability of hiring nursing staff ill suited to the very high demands of community health centres. There needs to be a better match between the skills needed by a community health centre and skills solicited in nursing staff. For example, while emergency care experience is no doubt valuable in a community health centre, the vast majority of work relates to obstetrical and pediatric care. (see Recommendation 9, 32, 33, 35).

In the recruitment process, an in depth review of past nursing history and in particular, past disciplinary history with Registered Nurses' Associations does not occur. While the RNANTNU cannot, for privacy reasons, release this on demand in the hiring process, it can do so if the applicant nurse has consented to the release of this information. A standard form consent for release of information should form part of the documents required in an application process. (see Recommendation 21)

Furthermore, the present situation regarding discipline of nurses by RNANTNU for current employees requires and is restricted to the employee nurse reporting to his or her employer the results of any such investigation. There is no direct communication of this between RNANTNU

and regional managers, due to privacy requirements. Again, this can be addressed by the consent and direction of the nurse employee. It must be a requirement of all nursing staff to provide such a direction and consent to facilitate communication on this important issue. Absent consent and direction, there is no guarantee that a disciplinary finding would even be reported to the employer by the nurse involved. (see Recommendation 22).

To return to the question of why the critical incident of Baby Makibi's death was not duly reported in the established protocol, the following are possible answers:

- The attending nurse McKeown and the Director of Health Services, South Baffin simply failed to report the death in the required written manner with the appropriate follow up investigations;
- The Regional Director failed to initiate and oversee the investigative steps mandated following a critical incident;
- The combination of work load and ongoing conflict at the Health Centre which had accumulated from January to April, 2012 diverted focus and attention to the degree that normal steps were not followed by the Director of Health Services, South Baffin and the Regional Director;
- The fatality was not considered to be a critical incident within the Guidelines set out in the Administration Manual;
- The Regional Director, Roy Inglangasuk, or the Director of Health Services, South Baffin, or both, were not fully apprised by Nurse McKeown or the Nurse in Charge in a timely fashion of the preceding telephone call to the Health Centre by Baby Makibi's mother, and the failure to undertake an in person assessment of the infant.

While these possibilities may explain why a critical incident report and follow up investigations were not **immediately** made, they do not address the fact that no such steps were taken in the months following the fatality when facts became clearer regarding at least the failure to do an in person assessment of the infant. I could find no evidence as to why an investigation regarding the fatality did not occur, at least at the time that license restrictions were imposed on Ms. McKeown by RNANTNU, if not prior to that point.

(b) Monitoring and Evaluation

There were no documents provided to me that evidenced that ongoing monitoring and evaluation occurred with respect to the Cape Dorset Health Centre. It may be that some assessment occurred when combined with a community visit that had other agenda items. It is clear that detailed performance plans and appraisals regarding key positions on the Cape Dorset nursing staff did not occur. Indeed, this is one of the reasons that resulted in extremely conservative advice from Employee Relations as to the suspension or termination of Ms. McKeown. The first serious effort at reviewing the conduct of Ms. McKeown occurred as a result of the further 2013 harassment complaint. Absent detailed and consistent documentation of performance evaluations, corrective actions, complaints, investigations and reprimands, options for correction of or termination of employment become extremely difficult. None of these issues was properly documented in the case of Ms. McKeown either by the Nurse in Charge at the Health Centre, or bureaucrats up the line of authority.

In speaking with residents of Cape Dorset, there appeared to be no effort on the part of the Department of Health to monitor, assess or address the rapport of the Health Centre within the community. This undoubtedly contributes to feelings of alienation on the part of community members.

3. WHAT WERE THE FINDINGS OF THE INTERNAL REVIEW COMPLETED BY THE DEPARTMENT OF HEALTH

As indicated above, it appears that the seriousness of the circumstances surrounding the death of Baby Makibi did not come to the attention of Department of Health Regional Office until at least1 ½ years after the event. It is difficult to understand in the circumstances why such an event could go unnoticed given the flurry of difficulties which had arisen at the Cape Dorset Health Centre in 2012 and 2013. Even if the fatality itself was not properly reported, there was awareness of difficulties at the Health Centre as a result of grievances being filed, investigations by RNANTNU and the imposition of restrictions on the license of Ms. McKeown. It is not sufficient for Regional Directors or other responsible bureaucrats to simply respond in the moment to grievance procedures and demands for documents from RNANTNU. Those persons with ultimate authority regarding the functioning of community health centres must ask "what is going on and why". This never happened in the case of Baby Makibi.

Action was taken in the summer of 2013 but it was **not** with respect to the Timilak matter. A further complaint of harassment had been received regarding the conduct of Debbie McKeown and interviews, community visits and documentary reviews were focussed on this. While none of these actions touched upon the death of Baby Makibi, it should be noted that a concentrated effort was made at this time by Health Regional Office to manage or, terminate the employment of Debbie McKeown. Advice from Department of Finance, Employee Relations precluded this from occurring. As indicated above, the absence of detailed and consistent documentation resulted in the disciplinary options being severely limited.

In an interview conducted with Mr. Inglangasuk in Pangnirtung April 29, 2015, he advised that there was no internal review regarding the death of Baby Makibi. He further advised that when Heather Hackney left the position of Director of Health Services, South Baffin in March 2013 he started to appreciate the seriousness of Ms. McKeon's conduct. This contradicts his position in his email of May 2013 to RNANTNU in which he inquires as to the status of the license restrictions and his wish to interview

Ms. McKeown regarding the position of Nurse in Charge of the Health Centre as well as his unequivocal endorsement of Ms. McKeown. In fact, there was no focus at this time regarding the fatality. Rather, the focus, more than one year later, was with respect to the further harassment complaint made by health workers at the Cape Dorset Health Centre in the summer of 2013.

There are no documents provided to me which indicate that there was any investigation at this time touching upon or specific to the death of Baby Makibi apart from the chart review undertaken by Ms. Harvey in September 2012. All interviews conducted by me indicate that at no point was an internal review undertaken by the Department of Health or Regional Office specifically regarding the Timilak fatality. In addition there was no fact finding process undertaken by the Director of Health Services, South Baffin regarding the fatality, nor following the imposition of the conditions on Ms. McKeown's license regarding pediatric care. There were no fact finding meetings regarding the performance, skills and management of Debbie McKeown or the Nurse in Charge relative to the Timilak matter.

The initial concerns respecting Cape Dorset submitted by Gwen Slade in January 2012 focussed on harassment in the work place. However, not long thereafter, clinical concerns were raised by Ms. Slade to RNANTNU. It was the investigation by RNANTNU and these complaints which linked the concern around the care or lack thereof respecting Baby Makibi. It was this investigation by RNANTNU that resulted in restrictions being placed on Ms. McKeown's license precluding her from providing nursing care to children under the age of 10, in June 2012. The then Director of Health Services, South Baffin, Heather Hackney, was aware of the death of Baby Makibi at the time its occurrence, and was aware in June 2012 of the restriction placed on Ms. McKeown's license. She was also aware of the grievances submitted by Gwen Slade regarding harassment and conduct on the part of Ms. McKeown. Despite this, no steps were taken by her to investigate these events in 2012 or indeed at any time thereafter. Incredibly, the license restriction appears not to have been formally reported in writing or in detail by her to Regional Office. Her advice to Regional Office regarding the complaints/grievances which had been submitted by Gwen Slade in early 2012 focussed on how they could be

refuted, rather than assessing whether there was legitimacy to the concerns.

It is possible that Ms. Hackney made a judgment call regarding the credibility of the complaints made by Ms. Slade. There had been prior issues in 2007 in which the suitability of Ms. Slade for northern remote practice surfaced. However, the responsibility of this position required a dispassionate and objective review of the early 2012 complaints, which was never in fact undertaken.

Commencing in the summer of 2013, when further complaints of harassment concerning the conduct of Debbie McKeown were received, steps were taken to seriously evaluate her performance. Visits to the community were made, evaluations were undertaken, chart reviews were requested. However, none of these steps were taken as a result of any focus respecting the Timilak matter. During the course of these investigations, Ms. McKeown was suspended from work at the Cape Dorset Health Centre.

In November 2013 significant deficiencies regarding the administration and operation of the Cape Dorset Health Centre were communicated in writing by the Regional Director, Roy Inglangasuk, to Debbie McKeown.[25] Some of the concerns included:

- The advice by health centre staff that a toxic work environment existed arising from the management style of Ms. McKeown;
- Poor communication with staff;
- Haphazard approaches to normal health centre programs, such as TB programs, treatment programs, emergency services, school health programs and so on;
- Lack of “connectedness” with the community;
- Possible poor patient charting;
- Refusal of nursing staff to return to Cape Dorset as long as Ms. McKeown remained manager.

[25] Correspondence dated November 13, 2013.

Ms. McKeown was advised that “the management of the Cape Dorset health centre is not meeting the standards of our other health centres on Baffin Island”. Mr. Inglangasuk further advised:

> “I deem the following factors to have contributed to the weak operations to one our (*sic*) larger health centres; lack of communication, micromanagement of our CHN’s, unclear expectations resulting in poor healthcare programming in Cape Dorset and not meeting the needs of the community, intimidation resulting in excellent nurse clinicians refusing to work at the Cape Dorset health centres and overall poor leadership skills resulting in conflicts in the workplace.”

While this correspondence clearly identifies significant concerns which had been identified as a result of the investigation undertaken by Regional Office, it sadly does not mention the death of Baby Makibi.

In December 2013 a lengthy history of concerns was communicated in writing by Gwen Slade to MLA David Joanasie. The initial position of the Government of Nunavut appears to have been one emphasizing damage control and characterizing the matter as employee conflict.

Regional Office started to connect the dots in January 2014.

On January 13, 2014 Elise VanSchaik expressed serious concerns regarding the events which had transpired in Cape Dorset:

- She states that the letter of June 8, 2012 authored by Heather Hackney to RNANTNU advising that Debbie McKeown would continue to provide nursing care with “suitable adjustments” to her tasks was not copied to anyone in the Department of Health and evidenced that this decision was made without any consultation with other Department authorities;

- The opinion of Ms. VanSchaik that this step was both negligent and incompetent in that Ms. Hackney, in the view of Ms. VanSchaik "not only had a responsibility to strictly enforce a work-place setting to closely monitor this employee, but failed in her responsibility to ensure that a thorough investigation of the facts were undertaken and that the safety of the public was given top priority.";

- There was no information on the file that indicated that Ms. Hackney had done any supervision of this employee nor which would indicate that any investigation was done regarding the bases of the restriction regarding pediatric care;

- Ms. VanSchaik advised that in her conversations with RNANTNU it was revealed that this governing body had been inundated with complaints about other, some former, employees over the past several years and the Department had no evidence of this. It appeared that fact finding meetings by the Director of Health Services had not been conducted regarding many of the complaints made to RNANTNU;[26]

- Ms. VanSchaik was of the view that a full and coordinated investigation needed to take place and that issues raised in the correspondence from Gwen Slade to MLA Joanasie needed to be addressed;

- She was also of the view that despite the return of Ms. McKeown to her duties in Cape Dorset in the fall of 2013 against the opinion of Regional Office staff, she should now be terminated from employment and investigations should continue regarding the prior performance of Ms. Hackney as Director of Health Services, South Baffin.

This email demonstrates just how much the Department, and specifically the Regional Office did **NOT** take steps regarding the Timilak event in Cape

[26] It should be noted that RNANTNU would not communicate the fact of or outcome of a complaint to the Department of Health unless the Department was itself the party complaining due to privacy issues.

Dorset as late as January 2014. It also speaks to the lack of proper documentation.

It appears from my review that these concerns, coming late as they did in the history of events, arose as a result of **external** pressure and information, including the ongoing communication by Gwen Slade, and the inquiries initiated by David Joanasie, MLA for Cape Dorset. The efforts and questions arising in Regional Office at this time did not arise as a result of its own internal processes or adherence to established guidelines and protocols.

Matters from this point forward did not focus on the conduct of a full and substantial review of circumstances that had transpired in Cape Dorset. Instead, protracted discussions and disagreements occurred both within Regional Office and between Regional Office and Employee Relations (the latter with respect to what steps could or should be taken regarding the ongoing employment of Ms. McKeown). Mr. Inglangasuk advised that he was directed by Employee Relations to cease any further investigatory steps regarding Ms. McKeown. Employee Relations states that, while concerns were raised regarding further steps, there was no such direction. As a result, focus was lost on those matters which actually gave rise to this, including the death of Baby Makibi. It became easy for the focus to be Nurse McKeown rather than the internal failings of the Department.

As indicated above, there was no internal review specific to the Timilak case, nor was there an internal review in which the Timilak case was even a peripheral consideration. There was a file review regarding the fatality requested of Barb Harvey regarding the fatality, but this in no sense constituted an internal review. At the latest, once a detailed investigation was undertaken between August 2013 and November 2013, it is hard to understand how the connection could not have been made between the poor practice and management at the Cape Dorset Health Centre and the infant death. This is particularly the case, as in July 2012 the cause of death was amended by the Chief Coroner from SIDS to widespread pulmonary infection. This amendment appears not to have been communicated by the Coroner to Regional Office, or, if it was communicated, it went unnoticed.

4. WERE ALL GOVERNMENT OF NUNAVUT POLICIES, PROCEDURES, TRAINING AND GUIDELINES RESPECTING NURSING CARE, STANDARDS OF NURSING CARE AND COMPLAINTS PROCESSES FOLLOWED IN THE TIMILAK CASE

(a) Nursing Care and Standards of Nursing Care

Not all applicable guidelines and policies were followed with respect to the Timilak case respecting nursing care and standards of nursing care.

The orientation for Ms. McKeown did not occur until the fall of 2013, long after her initial hire date of August 2011. There are additional questions concerning the adequacy and cultural components of the orientation program.[27] (See Recommendation 32, 34, 35).

Although Ms. McKeown indicated at one point that she was not aware of the policies regarding assessment of infants under the age of one (1) year, these policies are clearly stated in the Community Health Administration Manual. This document is a fixture in all Health Centres.

As indicated above, there are a number of areas of failure to adhere to or meet then existing policies and protocols:

- Baby Makibi was not seen in person at the time of the initial phone contact with the Health Centre, which is contrary to the policies regarding assessment of infants and telephone triage. Approximately six months after the fatality, there appeared to be the conclusion that this policy did not apply respecting Baby Makibi as it falls under the policy heading "Accutely Ill Infants". However it should be noted that Policy 2 under this heading states "All infants less than one (1) year of age must be weighed naked at each visit including public health clinics. All weights shall be documented on the gender/age appropriate growth chart". Although under the same policy heading,

[27] Nunavut Nurse Recruitment and Retention Survey, RNANTNU, 2005 indicates that "A large number of the respondents were concerned that the **length of the orientation process was insufficient,** that orientation was not always provided in **a timely manner**, or was not provided for all nurses." At page 18.

this clearly does not relate only to acutely ill infants. In addition, this conclusion ignores the policy on Telephone Triage regarding the in person assessment of children under the age of 1 year.

- The death of Baby Makibi was not reported/investigated as a serious incident in the manner mandated by the Administration Manual;

- Accordingly, there was no coordinated effort to communicate with and update family members, no preliminary investigation, no remedial actions identified, no initiation of a root cause analysis, no organization of a disclosure team and no in person follow up meeting with members of the family by any person in the Department of Health;

- No investigation occurred immediately following the death of Baby Makibi as to remedial steps required, collection of witness statements, charts and other critical documents. There was no significant communication with family members;

- During the critical time in question there was no substantive ongoing monitoring and evaluation of the Cape Dorset Health Centre. Performance appraisals remained undone or incomplete and were not filed with or maintained by Regional Office, community summary reports appear not to have been prepared, and evaluation of rapport between the Health Centre and the community did not occur;

- There appears to have been no monitoring or documentation on monitoring regarding the license restriction of Ms. McKeown and whether in fact it was being honoured, and no fact finding regarding the original basis for the restriction.

(b) Complaints

The capacity to make a complaint and the processes available to make a complaint regarding the quality of a nurse's care, or the ethical practice of a nurse are not well known or understood by members of the public. At

present, there are two “formal” avenues through which a complaint can be made.

(a) A complaint can be made by any person to RNANTNU regarding the conduct of a nurse.[28] The complaint must be in writing and must be directed to RNANTNU which is obliged to review and investigate all complaints received.

In addition to this, all nurses (who must be registered with RNANTNU) are **obliged** to report alleged incompetence or unethical practice of another nurse. Failure to make such a report is itself unprofessional conduct.[29] This means that if a nurse is aware of possible unprofessional conduct on the part of another nurse, the failure to report this can result in discipline for the nurse not reporting it.

(b) A concern or complaint can be made by a member of the public to the Office of Patient Relations, Government of Nunavut.

With respect to members of the public, many are not aware of either of these avenues. More often, concerns are made known to the MLA for the community, which he or she may then raise either in a public fashion or when the Legislature is sitting, or by communicating it to the Minister Responsible for Health. This way of making a complaint has no process, defined procedure or outcome and accordingly, lacks both immediacy and effectiveness. Ironically, despite this, it is likely these type of steps that were central to the commissioning of this Review.

(i) Complaints to RNANTNU

With respect to complaints made to RNANTNU, while this avenue is the most appropriate regarding serious concerns with respect to the quality of health care and standards of nursing care, it is virtually unknown to members of the public. In addition, the understandable requirement that

[28] Nursing Profession Act, SNWT 2003 c. 15, s. 34
[29] RNANTNU By-Laws Section 5

complaints be made in writing is a barrier to those whose literacy in English is limited. Complaints made to RNANTNU were investigated resulting in firstly the conditions on the license of D. McKeown, and ultimately the suspension of that license. However, these complaints were not made by members of the public, but rather by nurse(s).

(ii) Complaints to the Office of Patient Relations

With respect to issues that are brought forward to the Office of Patient Relations which was established in July 2013, it was reported to me that no complaints had been received on issues such as misdiagnosis or negligence. The majority of complaints are with respect to access issues, issues of resource allocation, such as home care, medical travel and capacity to escort.

When complaints are received by this Office, the first inquiry is whether the complainant has raised the issue with the nurse in charge so that correction can occur at the point of care. If that has been unsuccessful, the Office of Patient Relations will look into the issue and, in doing so, may contact the responsible Regional Director. At this point, the matter is out of the hands of the Office of Patient Relations, and decisions are made at the regional level as to whether investigative steps such as a chart review should occur.

At times, mediative steps are taken to facilitate communication between the complainant and those within the health care system responsible for the decision or process which is causing the concern. This can at times involve the Territorial Chief of Staff, or other appropriate health care teams. The Office of Patient Relations can make recommendations in particular matters and can suggest improvements to policy or processes. However, this Office has no ultimate authority to direct specific actions. No complaint was specifically directed to the Office of Patient Relations regarding the Timilak matter.

In addition this Office has limited resources to conduct outreach and awareness campaigns and has no present capacity to have community personnel in places such as Cape Dorset. I was advised that there are three positions associated with this office, one of which has remained unfilled.

This Office has the potential to be extremely valuable **if appropriately resourced**, in assisting in solving process and administrative issues, facilitating communication and providing an avenue for the respectful interaction with patients and users of the health care system. It is not suited, by structure and authority, to solving serious patient care/ nursing standards concerns.

(iii) Complaints – General

In a more informal way, problems which arise regarding the competency and standards of nursing care can be addressed through an "as needed" process within Regional Office. This allows for a more immediate and responsive reaction when a problem has been identified. It can include a review of the employee's work, interaction with colleagues, chart audits, investigative steps through fact finding meetings and what are known as 360 Reviews. The 360 Review contemplates the involvement of multiple sources of information to assess the performance of an employee. The difficulty with this avenue is that it depends for initiation on a regional office employee. There are no defined triggers for engaging this process and no policies as to when and what type of investigation should occur. (See Recommendation 8).

In this matter, complaints were also made directly to the Government of Nunavut. Notably, complaints were made commencing in January 2012 by Gwen Slade to Human Resources and to union representatives. In speaking with Shawn Burke, Manager, Human Resources, he advised that complaints which were sent to him, authored by Gwen Slade, were sent on to Heather Hackney, as the Director responsible for the Cape Dorset Health Centre, and Roy Inglangasuk, the Regional Director. Mr. Burke further advised that no response was received from either party. He further advised that Regional Office is better positioned to evaluate clinical concerns. Finally, he advised that Employee Relations was involved in the matter at an early date, and he (Mr. Burke) had no further involvement in the matter after January 2012.

Mr. Burke's evidence conflicts with advice received from Mr. Inglagasuk that he was not aware in January 2012 of the concerns being raised regarding the Cape Dorset Health Centre.

While the avenue exists to submit a complaint directly to the Department, efforts in this regard on the part of Ms. Slade resulted in no immediate action being taken or even pursued, apart from Ms. Slade's suspension pending investigation. The complaint process eventually evolved into a grievance procedure which took more than three years to complete.

Investigative, evaluative and monitoring processes arising from complaints made directly to the Department of Health did not occur.

5. WERE THE EXISTING HUMAN RESOURCE POLICIES, PROCEDURES, TRAINING AND GUIDELINES RESPECTING EMPLOYEE RELATIONS AND PERFORMANCE MANAGEMENT FOLLOWED AND ADEQUATE.

There are several avenues through which employee relations are handled within the Government of Nunavut[30]. The formal process are contained in several documents – the Human Resource Manual, and specifically regarding practicing nurses, the Community Health Administration Manual. Both documents speak at length to procedures associated with ongoing monitoring of employee performance and competence, mentoring and guiding performance, and disciplinary steps in appropriate circumstances. Both documents require systematic performance appraisals, with appropriate guidance and directions arising from regularly conducted appraisals. In addition to this, valuable steps associated with setting performance expectations, monitoring achievement and coaching are set out in the Government of Nunavut Performance Management, Guidelines for Supervisors.

As well as these documents, legislation in the form of the *Public Service Act,* sets out a number of aspects of employer/employee relations, including the capacity to report unacceptable conduct.

The steps and processes for properly monitoring, correcting or disciplining an employee are in place in Government of Nunavut Human Relations procedures and mandates. In the matter of Baby Makibi, and the circumstances of Nurse McKeown, these steps were not followed. There was no systematic review of performance and if any appraisals were conducted, they were not documented in any detail. In August 2013 when Employee Relations was significantly involved in addressing the most (then) recent harassment complaint, there was no prior documented history of an investigation in 2012 (referred to by the then Deputy Minister Ma) and no record of a reprimand arising from that. There was no record in the Human Relations Department of action taken regarding the complaints that had been made by Gwen Slade. There was no record of corrective action relative to Ms. McKeown at all despite the fact that RNANTNU had

[30] This discussion excludes any reference to processes defined and governed by the Collective Agreement

imposed license conditions, and numerous complaints and inquiries as to status of same, were made by Gwen Slade.

Mr. Burke advised me that he did not see himself as having a role in the matter and if not requested to undertake an investigation, his function is limited to ensuring a flow of information. He appears to see no pro active or follow up responsibility.

There must be performance appraisals regularly conducted and documentation maintained with respect to hiring, training, appraisal and discipline of an employee. My inquiries indicated that there was no systematic file system in this regard. The most logical location for this file material is the Human Relations Division within the Department. Human Relations cannot hope to provide sound advice to the Department if proper records are not maintained. (See Recommendations 15, 16).

In situations of serious complaints, responsibility for action and direction must come from more than one position. Offloading responsibility to the Department completely, absent any other review process, creates risk. If the Department is not responsive, if proper records are not maintained, if the Regional Director is not available, if competing emergencies exist, the matter will languish unnoticed, which is what happened in this matter. Every link in the chain must perform to high standards for risk to be avoided. In the Timilak matter, not only did performance to high standards not occur, the links in the chain were broken entirely. (See Recommendations 3, 4, 5, 6, 7)

Accordingly, while there were appropriate policies and procedures available, the failure to follow guidelines, and document steps resulted in inadequate and disjointed responses. As well, the absence of a two pronged approach to the receipt of and response to serious complaints results in an inadequate safety net thereby leaving gaps which should not be present with respect to serious matters. For example, if a fatality occurs at a Health Centre that may have implications regarding the quality or competency of nursing care, this should be duly reported as a critical incident to Regional Office and the Chief Nursing Officer as well as the mandated report to the Coroner. Complaints received regarding the provision of competent nursing care should be reported by the recipient of the complaint both to Regional Office and the Chief Nursing Officer. The

implementation of a bifurcated or two pronged reporting system regarding both risk and complaints creates a safety net for risk management which is otherwise absent in a single line reporting system. The current risk management regime is focussed on issues such as workplace safety and is ill suited to the assessment of clinical concerns.
(See Recommendations 3, 4, 6, 7,13).

With respect to processes outlined in the *Public Service Act*, the legislation allows for the disclosure of "wrongdoing" which can include harassment, an act of reprisal and "an act or omission that creates a substantial and specific danger to the life, health or safety of persons.."[31] If such a report is made and not satisfactorily resolved by the supervisor or others in the chain of command, the report can be investigated by the Ethics Officer to determine whether wrongdoing has occurred. This is a relatively new provision in the legislation and was not available in 2012. However, there are presently concerns as to the extent to which these remedies are known and accessed by Government of Nunavut employees. It should also be noted that these provisions apply to complaints or reports made by Government of Nunavut employees about Government of Nunavut employees, and accordingly would exclude the capacity for a report by or about a person who is not a GN employee, such as an agency nurse.
(See Recommendations 29, 30, 31).

[31] Public Service Act, section 38

6. WHAT INTERACTION AND MECHANISMS EXIST BETWEEN THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF FINANCE (EMPLOYEE RELATIONS), THE DEPARTMENT OF JUSTICE, THE CHIEF CORONER, AND THE REGISTERED NURSES ASSOCIATION OF NORTHWEST TERRITORIES AND NUNAVUT REGARDING COMPLAINTS RELATING TO REGISTERED NURSES

At present mechanisms and communication channels between these various arms is by practice or ill defined protocol and is *ad hoc* in nature. In some instances, communication channels are non-existent resulting in "silos" of information and action, with steps being taken without the knowledge or involvement of other related arms of the health care system.

As indicated, complaints can occur through the Registered Nurses' Association, through the Office of Patient Relations, or by direct communication to health care providers or responsible bureaucrats within the Department of Health. While complaints often occur via elected MLA's, this practice it has no defined process and can be subject to the vagaries that a political environment can encourage.

(a) Department of Health and RNANTNU

Privacy considerations and legislation create barriers between the RNANTNU and other affected bodies, in particular the Department of Health. The past disciplinary history of a nurse, the occurrence of a complaint regarding a nurse and the outcome of any investigation regarding a nurse undertaken by RNANTNU is communicated only to the affected nurse complained about and the person or body making the complaint. Information regarding disciplinary hearings is recorded on the RNANTNU web site, but only by registration number of the affected nurse. However, requests for documentary evidence regarding a complaint are frequently made to the Department of Health thus providing an indirect communication regarding the existence of a complaint. It is unlikely, or indeed likely not possible, for RNANTNU to change its practice regarding these matters due to legislative requirements.

However, information regarding the existence of past disciplinary history, a current complaint and the outcome of a complaint is critical information for the Department of Health. It cannot hope to manage and maintain competencies in its nursing staff without it.

The absence of this critical information can be addressed in a fashion that recognizes the need for this information as well as the privacy interests of those affected.

There needs to be a more established communication link between the Department of Health and RNANTNU, the organization charged with the responsibility of addressing, among other things, the ongoing competency of nursing staff in Nunavut. At least annual meetings should occur between officials of these bodies, and in addition, Regional Directors should be encouraged and resourced to attend the annual general meetings of RNANTNU.

A protocol needs to be established between the Department of Health and RNANTNU regarding investigative processes so that overburdened Department employees are not tasked with investigative responsibilities. (See Recommendation 13)

Properly worded consents for release of information from RNANTNU relative to disciplinary history, complaints and outcomes of investigations should be put in place together with established written protocols that allow both for the release of this information and the protection of it within the Department of Health. This information is both sensitive and potentially significant to the career of a registered nurse and safeguards must be in place to ensure that it is treated accordingly. All steps in this matter should be undertaken with the advice of the ATTIP Commissioner. (See Recommendations 21, 22).

(b) Department of Health and the Office of the Coroner

Communication between the Department of Health and the office of Chief Coroner similarly appears to be governed by informal protocols and practices. The office of the Coroner falls within the Department of Justice. It is also an office which requires a high degree of independence as its

mandate must be free of both government political influence and influence from the public.

However, the aspect of independence does not preclude the existence of established communication channels which would facilitate responsive action by the Department of Health regarding serious incidents. In situations where a death has occurred at a Health Centre or otherwise, where the practice, competency or involvement of a health care professional may be in issue, the Coroner should be obliged to report the details of this to the affected Regional Office and the Chief Nursing Officer, should the conduct in question involve a member of the nursing staff. (See Recommendation 13).

With respect to the Office of the Chief Coroner, it appears that there are no established communication links with the Department of Health in the event of possible concerns regarding nursing care competency. There has been communication between the Chief Coroner and RNANTNU and a recognition by the Coroner of the investigative mandate of RNANTNU. However, it is important that issues in this regard also be communicated to the Department of Health. In addition, had there been thorough communication from the Chief Coroner to the Department of Health regarding the revision of the cause of death to pulmonary infection, this may have inspired further investigation of the matter on the part of the Department. Two of the consistent issues throughout this matter have been the inconsistent documenting of concerns, discipline and remedial steps and a lack of defined or functioning communication links. In instances where a fatality may have implications about the care delivered, or available, communication should automatically occur between these offices. (See Recommendation 13).

(c) Department of Health and Department of Finance (Employee Relations)

The exchange of communication, maintenance of documents and exercise of authority as between the Department of Finance (Employee Relations) and the Department of Health requires better definition, policy and structure. Employee Relations holds ultimate authority with respect to termination of nursing staff. It must rely on documented histories in order

to assess the availability of options for the Department (or indeed all client Departments). Poor record keeping and lack of communication by, to and within the Department of Health all seriously contributed to the tragic events in this matter. Examples of this include:

- the failure to document the investigative steps and outcome of the initial harassment complaint regarding Ms. McKeown,
- the failure to fully report and document the death of Baby Makibi as between the Director of Health South Baffin and Regional Office,
- the failure of Regional Office to apprise HR and Employee Relations of the outcome of the RNANTNU investigation into the conduct of nurse McKeown,
- the failure of the nurse in charge of the Health Centre to conduct, maintain records of, and communicate to Regional Office ongoing employee evaluations regarding nursing staff,
- the failure of Regional Office to conduct timely orientations regarding nursing staff, and maintain records of performance and completion of orientation,
- the failure to document and monitor adherence to the conditions placed on the license of Ms. McKeown,

to name but a few.

Accordingly, when the advice of Employee Relations in this matter was sought, it had limited options available. Progressive discipline and the opportunity to correct behaviour and practices are two of the hallmarks of sound human relations practice. Absent documentation in this regard, the HR process becomes extremely delayed, protracted and ultimately, inappropriate to the actual ongoing circumstances. (See Recommendations 15, 16).

However, the entire question of whether employee discipline and termination ought to be maintained in the Department of Finance with respect to nurses requires a careful reassessment. As indicated previously, the position, and possible implications regarding nurses is distinct from the vast majority of positions within the public service. The health and well being of community members can be at risk, and may be compromised if actions are not timely and decisive. Furthermore, the assessment of clinical errors is much better made by those with clinical

knowledge and experience. From the perspective of safety of the public, it makes much more sense for this authority to rest within the Department of Health, with input and advice from Employee Relations and a position such as the Chief Nursing Officer, representing best practices and risk management. However, with this authority comes the responsibility to maintain complete, accurate and up to date employee records, and to conduct employee management pursuant to best practices. (See Recommendations 15, 16, 17).

(d) Department of Health and the Department of Justice

At present, legal advice is sought regarding issues on an as needed basis from the Department of Justice. Not all situations require the input of legal analysis. However, defined parameters of when legal advice should be sought would be helpful to the Department so that the involvement of Justice is not left to the initiation of a particular individual. Some of these parameters could include:

- Review and advice in all situations of critical incident reporting;
- Review and advice in situations where progressive discipline is ongoing;
- Review and advice in all situations regarding prospective termination of a health care professional.

(See Recommendation 13)

7. HOW CAN THE GOVERNMENT OF NUNAVUT IMPROVE ITS PROCEDURES IN ORDER TO PROVIDE FOR A MORE RESPONSIVE SYSTEM FOR RECEIVING AND ADDRESSING COMPLAINTS RELATED TO NURSING CARE IN NUNAVUT

(a) Complaints Processes

It is likely that in many situations, the first point of complaint or concern will either be at the Health Centre, or to managerial members of the Department of Health. There is at present no structured protocol for the handling of complaints made to either of these. Accordingly, procedures must be established that facilitate the making of a complaint and the assessment of it in terms of appropriate follow up steps. At the Health Centre, a written policy regarding the receipt of, handling of and follow up for complaints must be established. This policy should include:

- The direction that a patient communicating a concern about the provision of health care at the Health Centre be asked whether they wish to submit a formal complaint at the Health Centre, or submit their concern through contact with the Office of Patient Relations;

For complaints taken by the Health Centre and not referred to the Office of Patient Relations:

- That a specific (and contemporaneous) time be set to interview the party wishing to make the complaint;

- That details of the complaint be recorded in a standardized format in writing and reviewed orally with the complainant. The complainant should be asked to sign the written document;

- That steps to be taken to assess and investigate the complaint be discussed with the complainant at the time the complaint is signed;

- The nurse in charge of the Health Centre assess the complaint with a view to determining:

- Whether the complaint can be addressed satisfactorily at the Health Centre, and why;
- Whether the complaint requires further investigation and upon that being completed, the complaint may be resolved at the Health Centre and why;
- Whether the complaint requires further investigation by a third person not employed at the Health Centre.

- The Supervisor advises the complainant of the outcome of the assessment, why that particular assessment has been made, and what further steps if any, will be taken;

- The assessment of and follow steps be recorded in the complaint file;

- For all complaints naming the Supervisor, the complaint be received and recorded by another staff member of the Health Centre, and be forwarded to the Director, Health Care for the region for appropriate assessment, and action if required;

- All steps taken to investigate and resolve a complaint be committed to writing;

- All steps taken to assess and investigate, assess and report the outcome of a complaint be undertaken in a timely manner;

- A summary of all complaints received and steps taken be reported on a monthly basis to the Director, Health Care for the region and to Regional Office. Information regarding complaints of a serious nature involving competency of care should also be reported to the Chief Nursing Officer and RNANTNU, where appropriate. Copies of complaints and resolutions should be provided to the Office of Patient Relations.
  (See Recommendation 7)

(b) Health Employee Management

One of the difficulties which was encountered in the present situation was the absence of ongoing performance appraisals. Regular performance

appraisals of all professional health care staff must be made a priority and occur at a stipulated time during the calendar year. At present, employee appraisals seems to be one of those items that gets done if there is time, and there is seldom, if ever, spare time available to nurses in charge at Health Care centres, and district and Regional Directors.

In addition, records of performance appraisals must be maintained together with information concerning complaints made and disciplinary steps taken. These records must be maintained at both the Regional Office and the Department Human Relations office. Clear communication protocols must be developed between the Health Centre, the Regional Office and Human Relations that result in all offices being aware of and recording in a consistent fashion all matters relative to professional staff performance and discipline.

All critical incidents must be reported in the format established in the Community Health Administration Manual and policy should be amended that mandates that reporting also be made to the Chief Nursing Officer. Follow up must occur in a timely fashion as contemplated by the guidelines for reporting of critical or serious incidents. (See Recommendations 3, 4, 5, 6, 7).

At present, Risk Management is housed in the Department of Finance. However, risk management in the provision of health care services requires specialized expertise and immediacy. Regional Directors and District Supervisors in the Department of Health currently do not have the time or resources to properly undertake appropriate risk management. A position which has the defined mandate of investigating complaints, critical incidents and the development of appropriate risk management protocols for health centres should be developed, and report to the Regional Director as well as the Chief Nursing Officer. In this fashion, critical incidents are more likely to receive the attention and investigation required and contemplated by the Community Health Administration Manual. When this mandate is mixed in with a broad spectrum of responsibilities including recruitment and retention, it is easily lost.(See Recommendations 3,4,20).

(c) Role of the Office of Patient Relations

The Office of Patient Relations has a close connection to those matters causing concern to community members and those interacting with the health care system. However, any information gathered appears not to be communicated to affected arms of the health care system except on a case by case basis. As well, maintenance of overall statistics regarding the nature of complaints made are not maintained.

The information available to this Office should be gathered in appropriate statistical formats indicating not only the number of complaints received and the resolution, if any, of the complaint, but the nature of the complaint. In this regard, categories of complaints can easily be developed (such as medical travel and escorts, access to health care, quality of health care, etc) which ease the collection of this data.

All complaints concerning the care by or competency of health care professionals must be reported to the affected Regional Office and the Chief Nursing Officer for appropriate action. (See Recommendations 13, 24).

(d) Chief Nursing Officer

The position of Chief Nursing Officer has been filled on, at best, a sporadic and short term basis. This Office and position holds the most promising potential regarding oversight of the quality of care provided by nurses in Nunavut. Through the mandate of this Office, many important aspects of nursing care can be addressed in a cohesive and coherent manner. It can:

- Oversee the qualifications required for nursing care at a community level;
- Participate in the better matching of expertise and qualifications at a community level. Not all communities require the same profile of nursing staff, and valuable dollars may be expended hiring expertise that may not be required when matched closely with community needs;

- Participate in the oversight of nurse employee appraisals and discipline;
- Be a reporting point of all competency complaints, risk management concerns, near misses and other critical incidents;
- Participate in oversight of all investigations touching upon nursing care competencies and adherence to standards and guidelines;
- Oversee the criteria and timing of proper orientation for nurses;
- Receive reports from the Chief Coroner of all fatalities occurring at nursing centres or which may be related to nursing care;
- Amend and update policies and protocols regarding the provision of nursing care at the community level;
- Facilitate the communication of complaints and investigations regarding the quality of nursing care.

In order to undertake a mandate of this breadth, the position needs to be solidified as a permanent position, with appropriate remuneration and support staff.
(See Recommendations 2, 3, 5, 6).

It also must have the benefit of established communication links with other offices, including Regional Offices, the Office of Patient Relations, the Chief Coroner's Office, Department of Health Headquarters, and community Health Centres. These communication links must be mandated in written form to allow for the reporting by affected providers within the system. As indicated above, all critical incidents and complaints of a serious nature should be reported in this two pronged fashion.

8. HOW CAN THE GOVERNMENT OF NUNAVUT INCREASE TRANSPARENCY IN ITS COMMUNICATIONS WITH THE PUBLIC AND AFFECTED PARTIES FOLLOWING INCIDENTS, WHILE RESPECTING ITS OBLIGATIONS UNDER THE *ACCESS TO INFORMATION AND PROTECTION OF PRIVACY ACT*

The effectiveness of a complaints and reporting process is only as strong as the awareness of these processes. Quite apart from the transparency issues following upon a significant incident, there must firstly be a broad public awareness of what complaint processes exist, how they are accessed, and how critical incidents are managed by the Department of Health. Communication after the fact of a significant incident, while appropriate to those directly affected, provides only piecemeal and ad hoc information. Materials in the form of poster information and public service announcements should be developed on these items and distributed throughout Nunavut. The materials must also be available at all Health Centres. All MLA's should be briefed on the availability of the complaints avenues, as well as the processes involved in investigation of complaints and serious incidents. Elected representatives should be advised to make this information available to constituents and to encourage constituents to use these avenues in favour of complaints made to elected Members of the Legislature.

When an individual or family is affected by a significant incident, or critical incident, they must be canvassed at an appropriate time as to the extent to which any information arising from this situation can be shared with other parties or the public at large. This responsibility would normally rest with the health care providers most closely involved with the family and the incident. Should an individual or family so affected choose to consent to release of information or, themselves, to divulge in a public fashion the nature of the incident or concern, the affected part of the Department must in turn when requested, provide to the public domain those facts and circumstances which are relevant to the matter. It is no longer appropriate in this circumstance to obfuscate departmental responses (or lack thereof) behind the language of privacy or employee relations issues. Conversely, when an affected individual or family chooses to keep matters out of the

public domain, this must be respected by not only the Department, but other interested parties such as media or members of the general public.

PART V GENERAL CONCLUDING COMMENTARY

I wish to offer some broad observations regarding the detailed information set out above.

It is clear that the Cape Dorset Health Centre was a troubled work environment long before the death of Baby Makibi in April 2012. Complaints had been made orally, in writing, by formal grievance, to supervisors and union officials well before the fatality occurred.

These concerns were not fully investigated and in some cases, the credibility of the complainants was entirely marginalized without investigation. The grievance procedure was slow to engage and the responsiveness of senior supervisors was both limited and marginal.

Clear and obligatory policies and processes were not followed.

Government responses were more focussed on risk reduction and defending positions than remedial or investigative steps.

The opinion of the Chief Coroner has been revised a number of times since April 2012. It is difficult to understand why a further opinion was sought by this Office three years after the fatality. These differing opinions require explanation. The parents of Baby Makibi deserve to know why these differing opinions exist and what prompted medical professionals to have different views of the cause of death. In addition, there are conflicting facts as to what occurred the evening of April 4, 2012 when Neevee Akesuk contacted the Health Centre. These are important facts and issues. It is not possible for this writer to determine either the cause of death or definitively speak to one version of events over another. However, those questions can be posed at an Inquest into the death of Baby Makibi. Given the remaining unanswered issues, the degree of concern, and the existence of factual discrepancies and the presence at times of misinformation, a formal inquest will assist the parents, the community of Cape Dorset and Nunavut residents generally in better understanding these tragic events.
(See Recommendation 43).

It should also be noted that a culture of fear has developed within the Government of Nunavut, from the very base of employees and work environments through the hierarchical ladder of authority which now represents government function and process. There were a number of instances where health care practitioners did not want to be identified when speaking with me, for fear of repercussions to their employment. This fearfulness was amplified by the facts surrounding the treatment of Gwen Slade, which was seen as punitive in nature. This fearfulness thrives in organizations that resort to authority over collaboration, and retribution over communication. This culture is not only contrary to the first principles which were the guiding philosophy in the creation of Nunavut, but it erodes the capacity to maintain a fully transparent and accountable public government. The development of a fear based culture within government can only be addressed by reverting to and entrenching government actions in accordance with the first principles as originally articulated in the formation of Nunavut.

It is likely that the experience of both nurses and patients of the Cape Dorset Health Centre are not exclusive to that community. The nature and circumstances of nursing practice outlined above occur throughout Nunavut. Accordingly, the development of dysfunctional work environments can occur in any community, leaving the burden of monitoring, investigating and remediation on Regional Directors and supervisors, whose work load is consistently overwhelming. It is critical that staffing levels be reassessed so that the responsibility of delivery of competent, consistent heath care is not beyond the capacity of those bearing this responsibility. (See Recommendation 9, 19).

Restorative action is required to reinstitute both trust and functionality at the Cape Dorset Health Centre, and likely in other Health Centres across Nunavut. It is possible that such practices have been commenced by nursing staff engaged at Health Centres, but this needs to occur in a comprehensive fashion which is not dependent on the insight and effectiveness of particular staff. In addition, staff working in these environments require both recognition of the significant stresses of their positions, but also respite and professional "inspiration" in the form of opportunities for collaboration and mutual support.

Restorative action is also required with respect to the members of the community who at present feel a sense of disenfranchisement relative to the health care system. As indicated, they frequently feel unwelcome, misunderstood and marginalized. A greater understanding of Inuit culture and history on the part of nursing staff as a central part of orientation would be one step towards a greater connection with community members. However, the responsibility for healthy engagement between a community and its health centre does not rest solely with health centre employees or indeed the Department of Health. Historical trauma, substance abuse, lack of understanding of health care delivery all contribute to what are often angry responses by community members, at times accompanied by attitudes of entitlement. These responses actively contribute to the divide between health care professionals and their patients. These root causes do not only affect health care providers but other service providers at a community level. The situation tends to spiral such that providers become unwilling to work in particular communities, thus leaving only the brave or the marginally competent workers to forge forward. This atmosphere is not only current in Cape Dorset, but has existed over many years. Action which hopes to address this dynamic must be more broadly based than this current Review. It must focus on those factors, such as historical trauma, and current individual and family dysfunction. It is a long and arduous road, not easily undertaken or achieved. However, if the cycle of division between community members and service providers is to be addressed, this effort must occur.

Finally, as a first step in restoring community confidence, the Minister of Health should publicly release this Report in its entirety, together with the detailed and concrete steps to be taken in response to it.

(See Recommendations 44, 45, 46).

This review is restricted to the operations of the Department of Health and related Departments, and will not consider the cause of the infant Makibi Timilak or any conclusions of the Chief Coroner for Nunavut regarding the case.

Expected outcomes:

The report of investigation will make recommendations related to those human resource policies, procedures and support mechanisms to ensure the safety and well-being of all patients, and will attempt to answer the following questions:

1. Does the Department of Health have a specific process for completing an internal review into the administrative processes of a case? If so, was it followed?
2. What were the findings of the internal review competed by the Department of Health? Were there any changes implemented as a result of the internal review?
3. Were all Government of Nunavut policies, procedures, training and guidelines respecting employee relations and performance management followed and adequate?
4. What interaction and mechanisms exist between the Department of Health, the Department of Finance (Employee Relations), the Department of Justice, the Chief Coroner for Nunavut, and the Registered Nurses Association of Northwest Territories and Nunavut regarding concerns and complaints related to Registered Nurses?
5. How can the Government of Nunavut improve its procedures in order to provide for a more responsive system for receiving and addressing complaints related to nursing care in Nunavut?
6. How can the Government of Nunavut increase transparency in its communications with the public and affected parties following incidents, while respecting its obligations under the Access to Information and Protection of Privacy Act?

Upon completion of the review, the Minister of Health may accept or reject the recommendations made by the independent reviewer, and may take any steps that the Minister deems necessary or desirable to address the issues raised in the review.

Process:

Reporting:

APPENDIX 2 LIST OF PERSONS INTERVIEWED

Date	Community	Persons
February 2015	Contact made: Trenton, Ontario	Gwen Slade, Nurse
	Contact Made: Cape Dorset	Neevee Akesuk, Mother deceased
	Contact made: legal counsel for Debbie MacKeown	
March 2015	Contact Made: Iqaluit	MLA David Joanasie
	Trenton, Ontario	Gwen Slade
	Iqaluit, Nunavut	Colleen Stockley, DM Gogi Greeley, A/ADM Operations Karen Kabloona, EA Minister Okalik MLA David Joanasie Peter Ma, Past DM Health T. Rohner, Nunatsiaq News Hilary Burns, Employee Relations Sandy Macdonald Dr. Madeleine Cole
	Cape Dorset, Nunavut	MLA David Joanasie Residents Cape Dorset Eileen Patterson, nurse in charge, Cape Dorset Health Centre Parents of Baby Makibi
	Contact by telephone	Agency nurse
April 2015	Pangnirtung, Nunavut	Roy Inglangasuk, Executive Director Qikiqtaaluk Region, Marcus Wilke Director Population Health, Feloreh Saremi, A/Director Health Programs
	Iqaluit	Office of Patient Relations
	Contact by phone	Elaine Keenan Bengts Privacy Commissioner
	Ottawa	Elise Van Schaik, past Director Health Programs

APPENDIX 2 LIST OF PERSONS INTERVIEWED

	Contact by telephone	Heather Chang, Yellowkife – retired nurse and active in RNA
	Contact and document provision RNANTNU	
	Teleconference	Heather Hackney, Community Health Nurse [was Director Health Programs, Qikiqtaaluk] and legal counsel
May 2015	Conference by Telephone	Barb Harvey, Director of Professional Standards
June 2015	Receipt of further information and comments	RNANTNU, H. Hackney, G. Slade
	Electronic communication	Marshall, legal counsel for D. Mckeown
	Receipt of reports and communications	Chief Coroner, Nunavut
	Ottawa Iqaluit	Meeting with Chief Coroner Meeting with Employee Relations and Human Resources, meeting with Health HQ members, Interview with Nunatsiaq News
July 2015	Contact with media	CBC
	Contact with former GN employees, contractors	
August 2015	Receipt of further documents	Regional Office, Pangnirtung, B. Harvey, Professional Standards
September 2015	Telephone Interview	Mary Bender, Department of Health, Clinical Supervisor
		Jennifer Berry, Chief Nursing Officer
	Telephone Interview	

APPENDIX 3 TIMELINE OF EVENTS							
Sept 2011	Jan 2012	Feb 2012	Mar 2012	April 2012	June 2012	July 2012	Sept 2012
K. Rae communicates list of issues at Cape Dorset Health Centre to Heather Hackney. Fact Finding investigation and removal of S. Validen from nurse in charge position	Gwen Slade returns to Cape Dorset Health Centre G. Slade submits harassment complaints to GN Complaints forwarded to H. Hackney, R. Inglangasuk by S. Burke	G. Slade submits further complaints to GN G.Slade files complaint with RNANTNU re D. McKeown, L. Sapach Gwen Slade leaves community of Cape Dorset RNANTNU issues demand for documents for information re G. Slade complaint to Feb 2012	D. McKeown remains in Cape Dorset Documents due to RNANTNU Mar 15 not provided, but are provided at a later date Continued correspondence by G. Slade as to status of complaints/ grievances	Baby Makibi dies April 5 H. Hackney prepared Briefing Note regarding the fatality Coroner concludes death is SIDS death RNANTNU learns of death and failure of nurse McKeown to personally attend with infant contrary to GN policy	License restrictions placed on D. McKeown license not to provide care to children under the age of 10 Heather Hackney advises RNANTNU that restriction on license will be accommodated for Ms. McKeown Possible “superficial advice” from H. Hackney to R. Inglangasuk regarding infant death and license restriction	Revised cause of death from Chief Coroner stating death due to widespread pulmonary infection	Letter of reprimand to D. McKeown from Deputy Minister P. Ma written Chart Review regarding Baby Makibi authorized by Department of Health

APPENDIX 3 TIMELINE OF EVENTS							
		R. Inglangasuk responds that documents will not be provided R. on Inglangasuk advises by email that he will be "taking the lead on this file" Director of Workplace Safety recommends to DM that a full investigation be done re G. Slade harassment complaint					

APPENDIX 3 TIMELINE OF EVENTS						
May 2013	June 2013	Aug 2013	Sept 2013	Nov 2013	Dec 2103	Jan 2014
R. Inglangasuk responds in writing to K. Rae re her concerns about CD Health Centre R. Inglangasuk inquires of RNANTNU of status of license restrictions re D. McKeown as he would like to interview her for SHP position in Cape Dorset RNANTNU responds that license restrictions still in place	D. McKeown offered and accepts full time permanent position as nurse in charge for Cape Dorset	Further complaints from other staff at Cape Dorset regarding alleged harassment by D. McKeown Dept. of Health Regional Office investigates harassment complaints D. McKeown suspended pending investigation. During investigation further complaints are revealed.	Suspension of D. McKeown extended, investigation continues Health Regional office trying to make case for termination of D. McKeown with Employee Relations Regional Office wishes to schedule further fact finding meetings regarding the additional concerns	Letter of Reprimand issued to D. McKeown by R. Inglangasuk. Ms. McKeown is directed to take on line Respect in the Workplace course D. McKeown returns to work D.McKeown takes Orientation in Pang Regional Office advised it was directed to cease further investigations regarding Ms. McKeown by Employee Relations. Employee Relations Nov 2013 states it had concerns regarding any further investigations but does not recall any direction to cease.	G. Slade writes lengthy letter to D. Joanasie re concerns about Cape Dorset Health Centre. D. Joanasie communicates concerns to Health Minister Ell.	D. McKeown requests leave of absence from work Issues continue between Dept of Health and Employee Relations as to proper handling of McKeown matter. Regional Office Health wants termination, ER disagrees. Regional Office states it made requests to DM and ADM Health re full investigation of matters that transpired in Cape Dorset Health Centre Jan 2014 since 2012 and there was no response. Unclear whether this was actually communicated by Regional Office to DM or ADM Health.

RECOMMENDATIONS ARISING FROM THE EXTERNAL REVIEW

In submitting recommendations, I have tried to categorize them into broad categories that may assist in the analysis of them, and implementation. In addition, I have tried to avoid sweeping broad recommendations that ultimately, while they may sound satisfactory, are of little practical value.

GOVERNMENT PROCESS, REPORTING AND AUTHORITY

1. All staff employed in the operation of a community health centre should report through a single chain through the nurse in charge, Director of Health Services for the region, to the Regional Director.

2. The position of Chief Nursing Officer should be solidified into a permanent full time position, with a mandate that includes a significant role in risk management regarding health care personnel, education, orientation and remedial training of health care personnel and collaboratively, the discipline of health care personnel in warranted circumstances. In addition, this Office would be responsible for assessing and amending health care policies and guidelines to ensure that they remain current and appropriate. Resources, including additional personnel, should be dedicated to this Office to allow for the proper undertaking of this mandate.

3. All critical incidents should be reported to the Chief Nursing Officer in addition to the reports required within the chain of command of the Department of Health.

4. All critical incidents should be the subject of investigation that extends beyond the review of nursing charts, and includes interviews with family members of the affected patient in strict accordance with the policies set out in the Community Health Administration Manual.

5. Policies respecting the reporting of critical incidents should be amended to establish structured communication links between the Department of Health and the Office of the Chief Coroner, the RCMP, RNANTNU, Employee Relations, and between the Regional Office and Headquarters of the Departments, as may be appropriate to the circumstances of the incident.

6. The Department of Health, Regional Office should collaborate with the Chief Nursing Officer respecting appropriate responses and investigations concerning critical incidents.

7. Procedures must be established that facilitate the filing of a complaint and the assessment of it in terms of appropriate follow up steps. At the Health Centre, a written policy regarding the receipt of, handling and follow up of complaints must be established. This policy should include:

- The direction that a patient communicating a concern about the provision of health care at the Health Centre be asked whether they wish to contact the Office of Patient Relations or submit a formal complaint at the Health Centre. For those wishing to submit a complaint at the Health Centre:

- That a specific (and contemporaneous) time be set to interview the party wishing to make a complaint;

- That details of the complaint be recorded in a standardized format in writing and reviewed orally with the complainant. The complainant should sign the written document;

- That steps to be taken to assess and investigate the complaint be discussed with the complainant at the time the complaint is signed;

- The Nurse in Charge of the Health Centre assess the complaint with a view to determining:

    - Whether the complaint can be addressed satisfactorily at the Health Centre and why;
    - Whether the complaint requires further investigation and upon that being completed, can be resolved at the Health Centre and why;
    - Whether the complaint requires further investigation by a third person not employed at the Health Centre and why;

- The Nurse in Charge advises the complainant of the outcome of his or her assessment of the complaint and why that particular assessment has been made and what further steps, if any, will be taken;
- The assessment of and follow up steps be recorded in the complaint file;
- For all complaints naming the Nurse in Charge, that the complaint be recorded in writing by another staff member of the Health Centre and forwarded to the Director of Health Programs for the region, for appropriate assessment and action, if required;
- The results of any steps taken within the Health Centre to resolve the complaint, or any steps taken as a result of investigation of the complaint be reported in person to the complaint;
- All steps taken to resolved the complaint and all investigations undertaken regarding the complaint be committed to writing;
- All steps taken to assess, investigate and report the outcome of a complaint be undertaken in a timely manner;

- A summary of all complaints received, and steps taken respecting same be reported on a monthly basis to the Director of Health Programs for the region and to the appropriate Regional Director.

For complaints that are made directly to the Department of Health, other than staff at the Health Centre, a policy be instituted regarding the handling of the complaint:

- A written record of the complaint in a standardized format be completed;

- An assessment be undertaken as to whether the complaint should be referred to the Nurse in Charge of the Health Centre for investigation and resolution, which assessment is committed to writing in the complaint file;

- If the matter is deemed to require further investigation by a third party, the points to be investigated be articulated and provided in writing to the third party;

- Information regarding the assessment, investigation or follow up steps be reported to the complainant;

8. Regional Office must have articulated policies which define when fact finding or other investigative steps are triggered or when it is appropriate to have a complaint referred to the Ethics Officer or Chief Nursing Officer.

9. An assessment should be undertaken regarding personnel requirements of community health centres that allows for the closer matching of the skills of health care professionals to the needs of the community served.

10. Regional Directors should have or exercise the authority to amend the hours of operation of a community health centre to more appropriately meet the needs of a community.

11. Regional Directors or their delegate should make at least annual visits to community health centres within their region to observe and assess the workload, personnel requirements, competency of care provided and

connection to the community. Community input should be sought in all such visits both to engage community members in the operation of the health centre and to hear concerns that may exist.

12. Regional Directors must develop a closer working relationship with RNANTNU with the capacity to attend the Annual Meeting of that organization.

13. Defined communication links and protocols must be established between the Department of Health and:

- RNANTNU for the release of information regarding past disciplinary history of an applicant nurse, and information concerning complaints received and outcomes of investigations regarding nurses practicing in Nunavut, the facilitation of provision of information by the Department of Health to RNANTNU regarding the conduct of any investigations;
- The Office of the Chief Coroner for the reporting by the Coroner to the Department of Health of any fatality where the practice, competency or involvement of a nursing professional may be in issue;
- The Chief Nursing Officer for the review, and if necessary, revision of requirements for qualifications for nurses hired to practice at community health centres, the assessment of community health care professional needs, collaboration in the oversight of all investigations, reviews and discipline respecting nurses at community health centres, assessment and revision of the orientation procedures for community health nurses, the review and adherence to policy guidelines regarding all critical incidents occurring a community health centres, the oversight and amendment of all policies regarding the provision of nursing care at the community level.
- The Department of Finance (Employee Relations Division) for the establishment of defined frameworks in which advice is sought and required regarding employment, discipline and suspension of nursing staff at community health centres, or related to the quality/ competency of nursing care;

- The Department of Justice for legal advice respecting implications arising from critical incidents occurring at community health centres related to the quality/ competency of nursing care;
- The Office of Patient Relations regarding the provision of information touching upon the quality/ competency of nursing care at community health centres, and the provision of statistics regarding the nature and resolution of complaints;

14. The Office of Patient Relations should maintain both numerical and category statistics which are reported to the Chief Nursing Officer and Regional Directors.

HUMAN RESOURCE MANAGEMENT

15. Files must be maintained at Regional Office and in the Human Resource section of the Department of Health regarding the recruitment, employment, training, orientation, appraisal, and discipline of all nurses employed at community health centres.

16. All health care professionals employed at community health centres must receive annual appraisals, articulation and amendment of employment expectations. This task should be undertaken during a specified month each year, irrespective of the date of hire of an employee.

17. The capacity to investigate, discipline, suspend or terminate the employment of a nurse should rest within the Department of Health, with required collaboration with the Chief Nursing Officer, Employee Relations, Department of Finance and the Department of Justice.

18. Assessment of the relative values of remuneration as between GN employed indeterminate and casual nurses should be undertaken. While parity between these two categories may seem advisable, encouragement towards indeterminate employee can be emphasized through higher levels of compensation to that category.

19. Assessment of the personnel requirements at community health care centres should be undertaken in order to match the staffing levels relative to increases in population and health centre traffic. Similar assessments should be undertaken with respect to personnel requirements in managerial positions. For example, it may not be sensible to have a Regional Director undertaking

community investigations when this can be accomplished by a delegated position. This is better accomplished by the establishment of a position or amending existing job descriptions to allow for a specific mandate to investigate and oversee complaints.

20. A position within Regional Office Department of Health should be instituted or designated to undertake, in collaboration with Human Resources, Employee relations and the Chief Nursing Officer, all investigations regarding complaints as between personnel, and with respect to serious incidents occurring at Health Centres within the responsibility of that Office.

21. All applicants for nursing positions should be required to execute a consent for release of past Registered Nurses' Association Records relative to discipline and educational achievement.

22. All employed nurses should be obliged to authorize the RNANTNU to release particulars of any complaints filed regarding that employee and the outcome of any investigation to the Regional Director, Department of Health and the Chief Nursing Officer.

23. All complaints relative to competency of nursing care received directly by the community health centre, the Director, Health Care for the region or the Regional Office should be provided to the Chief Nursing Officer for collaborative decision making and appropriate, timely investigation.

24. All complaints received by the Office of Patient Relations and MLA's respecting the quality or competency of care by a health care professional should be directed to the Regional Office and Chief Nursing Officer for collaborative decision making and appropriate, timely investigation.

25. Family members of a patient who is the subject of questionable quality of care must receive disclosure of steps undertaken in reviewing and investigating the incident in question. (see Recommendation 7 above) Those undertaking any investigative steps arising from questionable quality of care must be responsive to questions and concerns of family members.

26. Nursing staff must be provided with appropriate respite time.

27. The Department must explore avenues for mentoring of nurses in practice, case review and continuing education.

28. A protocol of peer to peer mentoring be established for nurses practicing in Nunavut, with designated mentors. Mentors must have workloads adjusted to take into account the additional responsibilities as mentor. Information as to the role of the mentor, and contact information be provided in all Health Centres and to all nurses practicing in Nunavut.

29. A strategy should be developed by Employee Relations to publicize provisions of the *Public Service Act* regarding processes available for the reporting of wrongdoing by Government of Nunavut employees.

30. Information and resources must be delivered to Government of Nunavut employees which assist them in the recognition of bullying and harassing conduct, and assist in distinguishing inappropriate conduct from conduct which is requiring due performance of employment responsibilities.

31. Processes and policies for complaints or reports of wrongdoing must be developed which allow for the making of reports by and about persons employed by the Government of Nunavut who are not “employees” within the meaning of the *Public Service Act.*

TRAINING AND EDUCATION

32. Newly hired health care professionals with no prior experience of northern community health centres should undergo orientation in a timely fashion and in any event, not later than six (6) months from the date of hire.

33. Rural and remote experience should receive formal preferential treatment in the recruitment process.

34. Reassessment of the orientation program should be undertaken by the Chief Nursing Officer to determine whether it is undertaken in a timely fashion and whether it sufficiently integrates cultural awareness. Any expansion or redesign of cultural awareness components should be undertaken with the advice of identified Inuit experts in the area.

35. Agency nurses lacking rural or remote experience must be required to undergo orientation.

36. Discussions should be undertaken to secure the availability of Rural and Remote Practice certification for nurses practicing in Nunavut or the development of a curriculum in this regard at Arctic College.

37. Peer to peer mentoring should be established with identified mentors who have the availability and credentials to offer mentoring to community health care providers.

38. Annual meetings of Nurses in Charge of Health Care Centres should be undertaken to allow for the exchange of experience and practice issues, and to encourage the development of networks between Supervisors of various Health Care Centres.

39. Exchange of positions as between community health care providers for short term rotations should be available to allow for differing clinical experiences and varied management perspectives.

COMMUNITY AND THE HEALTH CARE CENTRE

40. An assessment should be undertaken regarding the efficacy of the Cape Dorset Community Health and Wellness committee. Consideration should be given to the appointment of a community liason person who facilitates connection between the Health Centre and the community, assists in problem solving at the point of care, provides information regarding health care policies.

41. Public Information materials should be prepared in collaboration with the Office of Patient Relations respecting complaint processes that are available to users of health care services and those working within the health care system. All elected Members of the Legislative Assembly should be briefed on these matters by the Department of Health.

42. Community and school outreach should be encouraged by the attendance of health care professionals at important community events, the development of school outreach materials to be delivered by a health care professional on areas such as Nursing as a Profession, What are vaccinations and why are they important, Being Responsible for your own health and wellness, etc.

43. A formal Inquest into the Death of Baby Makibi should be convened to review the facts associated with the provision of care and the medical opinions as to the cause of death.

44. A copy of this Report should be released to the public at the earliest opportunity, followed by a public release of the Government of Nunavut response to the Report (with appropriate translation).

45. Department Officials or representatives should be available to meet with community members to explain and discuss the commentary and recommendations of this Report.

46. Mental health specialists should be engaged to work closely with the residents of Cape Dorset to explore and assist in resolving trauma experienced arising from the death of Baby Makibi, historical trauma associated with experiences with the provision of health care, TB treatment, and related issues, cultural identity in the face of government service delivery.

47. Public Information materials should be developed and distributed, which have as the key message that the provision of quality health care is a **shared** responsibility between community members and health care providers.