Today, judicial inquest judge Tim Preston released his report into the tragic death of Brian Sinclair in the Emergency Department (ED) of Health Sciences Centre (HSC).

The inquest started on August 6, 2013, heard from many different witnesses and experts, and concluded on June 13, 2014 following a total 40 hearing days in which 82 witnesses provided testimony.

As I have said previously, Mr. Sinclair's death was preventable. He came to us seeking care, and we failed him. His death identified a gap in the way HSC's ED functioned at that time, a gap that missed an individual seeking care, leaving him untriaged and ultimately resulting in his death. We certainly recognize that processes should have been in place to make certain that a person in need of care was triaged and thereafter received the care he needed.

On the first day of the inquest, we apologized to his family as part of our opening statement. I was in the court room that day, and I also personally apologized to members of Mr. Sinclair's family on behalf of the Winnipeg Regional Health Authority and the Health Sciences Centre.

This will again be a difficult time for Mr. Sinclair's family who have waited over five years for the Inquest process to conclude. It is also a challenging time for many of our staff who knew and provided care to Mr. Sinclair throughout the years he received services from us, as well as those who participated in the inquest.

In his report, the judge made 63 recommendations to address various issues he identified as contributing to Mr. Sinclair's death. Judge Preston has provided keen insights and direction on how we can strengthen continuity of care, dismantle silos, and build a more integrated and seamless health system.

We accept his report and recommendations. We will continue the work we are currently doing as directed by judge Preston, and will immediately begin assessing the best approach to implement his other recommendations. I also want to thank inquest judge Timothy Preston for his thorough assessment of the challenges facing our health system.

Ensuring we provide safe and high quality services to our patients, clients, and residents is critical.

Continuous improvement in health care is rooted in learning from what goes wrong when the system breaks down. But it is also about learning from what we get right. Across our region, we get a lot of things right, every day.

We also need to learn from watching others. We need to develop and follow best practices. We need to research and innovate. We need to change the system based on our growing base of collective knowledge of what works well and what doesn't, and we need to continue sharing, collaborating, and learning from all the times we get it right, and wrong.

This is why I encourage all of you to take time to read and review the inquest report. It is available for download at this link.

Each of us play an important role in providing safe, high quality health services. Combined, all our efforts help build a culture of safety across the region, and this is how we ensure the services we provide are safe and high quality.

As always, if you have any questions or concerns please talk to your manager or send me an email.

-Arlene Wilgosh