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News Release

For Immediate Release

External review report released in Iqaluit

IQALUIT, Nunavut (November 30, 2015) – A report titled “A Journey through Heartache” was publicly released in Iqaluit today by Minister of Health Paul Okalik, following a meeting with the parents of baby Makibi Timilak, during which he offered an apology to the family.

“On behalf of the Government of Nunavut and the Department of Health, I apologize to baby Makibi Timilak’s family. In particular, I apologize to Makibi’s parents, Neevee Akesuk and Luutaaq Qaumaqiaq, for the heartache and suffering they experienced following their son’s untimely death in 2012,” said Minister Okalik. “I also extend apologies to the people of Cape Dorset for any uncertainties they have experienced about the quality of health-care service delivery in their community, and assure them of our commitment to a higher standard.”

In the fall of 2014, the Minister of Health called for an independent investigation into the circumstances surrounding the death of three-month old baby Makibi Timilak. Katherine Peterson, a retired lawyer from the Northwest Territories, was retained in early 2015 and was directed to provide a final report by November 30, 2015.

Ms. Peterson’s final report contains 47 recommendations, including encouraging the Chief Coroner for Nunavut to call an inquest into the death of baby Makibi Timilak, addressing issues relating to human resources, procedures, patient relations and critical incident reporting protocols. All 47 recommendations will be adopted by the Department of Health.

“I wanted to ensure that we fully co-operated in this process in an open and honest way, and I thank Ms. Peterson for her evaluation and dedication to the review process,” said Minister Okalik. “I have advised Department of Health senior staff to begin implementing all the recommendations, and I will provide a follow-up during the next sitting of the legislative assembly.”

The report is scheduled to be tabled during the February 2016 sitting of the legislature. The copy of the external report, “A Journey through Heartache”, is available on the Department of Health website: http://www.gov.nu.ca/health/information/reports-and-documents.

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Backgrounder

Key recommendations summary from "A Journey through Heartache"

Background Facts

A parent of baby Makibi Timilak contacted the Cape Dorset Health Centre by telephone at approximately 9 p.m. on April 4, 2012. Nurse Debbie McKeown took the phone call expressing concern that baby Makibi Timilak was not settling. Nurse McKeown advised that the baby be bathed and brought into the health centre the following day. There are factual conflicts about the inquiries made about baby Makibi Timilak's condition at the time of this phone call. Several hours later baby Makibi Timilak 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 sudden infant death syndrome (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.

Key Recommendations

1. Structural changes should be made in the Department of Health:
   - All health centre 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; and
   - 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 fromRegistered Nurses Association of Northwest Territories / Nunavut (RNANT/NU) 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.