STOCKING OF NURSING STATION SUPPLIES IN WASAGAMACK FIRST NATION

I. Introduction

On September 17, 2009, you asked that I conduct an inquiry into the events surrounding the delivery of a large quantity of body bags to the Wasagamack First Nation in Northern Manitoba in September 2009. The results of this inquiry follow.

II. Key Findings and Recommendations

Health Canada nursing stations are located in many remote First Nation communities where access and transportation to provincial health facilities are limited. The isolated nature of these communities requires nurses to perform a broad range of activities, including emergency care (often on a 24/7 basis), primary health care, public health, and community liaison.

Throughout May and June of 2009, 21 remote and isolated communities in northern Manitoba were significantly affected by the H1N1 virus. This outbreak occurred as facilities across the country sought to augment their own supplies, given the mounting evidence of a true pandemic. As a result, some challenges were encountered in obtaining and transporting sufficient supplies. In preparation for a possible second wave of H1N1 pandemic, nursing stations were advised by senior management to order generously and fill supply rooms.

It was within this environment that the Nurse in Charge (NIC) for Wasagamack operated. Orders were placed by the NIC for generous amounts of various supplies. The order for 100 body bags by the Wasagamack nursing station (of which 38 were delivered), was disproportionately high in comparison to quantities in nursing stations across the country. Most nursing stations in First Nations communities stock less than 10 body bags or turn to other sources if and when body bags are needed (e.g., provincial and/or regional health authority, ambulance service or coroner).

While body bags are an important medical supply (e.g., to prevent transmission of infection from a deceased person to others), the amount ordered for Wasagamack was a clear overestimation. There was no evidence, however, of ill will or deliberate calculation on the NIC’s or anyone else’s part.

Following the incident in Wasagamack, Manitoba Region instituted a process by which regional medical and nursing officials review all orders for body bags. Manitoba NICs were also contacted to confirm whether their nursing stations had received shipments of body bags.

Concerns were raised in initial reports about whether body bags had also been shipped to other nursing stations. The following inquiries were made with respect to these reports. Firstly, it was confirmed that 5 orders for body bags were placed by other Manitoba region nursing stations.
between August and September 2009. However, Health Canada’s records confirmed that all of these orders were on back-order and none were shipped. It was also verified that nursing stations in each community reported that none of these orders were received. Finally, in respect of reports of shipments of body bags to God’s River, it has been confirmed that an order had not been placed and no shipment had been received.

The nursing station staff are the “on the ground” health providers and are best placed to assess the overall needs of patients in First Nation communities. Nevertheless, in recognition of the anxiety and alarm this incident caused First Nations, it is recommended that Health Canada institute stricter centralized controls within its procurement process for body bags – e.g., maximum quantity limits and a mechanism to flag unusual orders. It is further recommended that ordering patterns be reviewed by Regional staff when conducting quarterly audits.

III. Background

Provinces provide primary and acute care for all provincial residents, including First Nations people, at various health care facilities situated within the province, with the exception of those individuals located in First Nations communities. These communities receive their primary health care services from either Health Canada or the Band via nursing stations. There are approximately 200 nursing stations across the country, of which 22 are located in Northern Manitoba.

The remote and isolated nature of these communities requires that nurses perform a broad range of activities, including emergency care (often on a 24/7 basis), primary health care, public health, and community liaison. To support these activities and in light of transportation challenges, nursing stations stock a wide variety of medical and pharmaceutical supplies (e.g., prescribed, controlled and over-the-counter drugs, medical equipment, intravenous therapy supplies, wound care supplies, etc.).

The NIC of a nursing station is responsible for ensuring proper inventories of pharmaceutical and medical supplies. Supply decisions are influenced by such things as access to acute care facilities, medical conditions in the community, population and demographics, general medical and public health advice, and experience and professional judgement. Regional officials conduct quarterly audits of nursing stations to ensure narcotic control compliance and the presence of needed supplies. They also conduct patient chart audits and liaise with the community’s Health Director.

There are two central federal government distribution centres – the Drug Distribution Centre (DDC) in Alberta and the Centre de médicaments de Wendake (Wendake) in Quebec. Health Canada’s seven regions ² procure supplies from these two centres, in addition to purchases from

---

¹ The following orders were placed: Berens River (5); Red Sucker Lake (20); York Landing (2); Tadoule Lake (5); and South Indian Lake (5).

² The seven regions are: British Columbia, Alberta, Saskatchewan/Manitoba, Ontario, Quebec, Atlantic and Northern.
other commercial suppliers. Standard order forms (e.g., DDC catalogue) are used to place orders on an as-needed basis for routine products such as: oral and intravenous pharmaceuticals; lab and medical supplies; resuscitation equipment; suture trays; paper for electrocardiogram machines; x-ray film; and miscellaneous supplies such as blankets and body bags.

IV.   H1N1 in Manitoba First Nation Communities

Throughout May and June of 2009, 21 remote and isolated communities in northern Manitoba were significantly impacted by the H1N1 virus. To date, there have been 891 confirmed cases of H1N1 in Manitoba – 335 (38%) of these cases have been identified as First Nations or Métis persons living on or off-reserve. The rapid spread of the virus from one community to another resulted in large numbers of patients with illness, strains on the health system, and the rapid utilization of available supplies.

The outbreak of H1N1 influenza in Manitoba occurred only two months after the virus was first detected in Mexico and prior to the WHO’s formal declaration of a pandemic (Level 6) on June 11, 2009. At the time, information on the evolution, spread and impact of the virus was particularly scarce. The Manitoba outbreak was also the first concentrated outbreak of H1N1 influenza in Canada and occurred during the spring, when flu activity typically subsides.

This outbreak also occurred as health facilities across the country sought to augment their own supplies, given the mounting evidence of a true pandemic. As a result, some difficulties were encountered in obtaining and transporting sufficient supplies in a timely manner. Some items were on backorder or difficult to access, and various avenues had to be pursued to ensure the provision of sufficient supplies.

The pandemic’s consequences were felt significantly by First Nation persons who contracted the disease, their families and their communities. It also had a powerful impact on those responsible for ensuring health services to First Nation communities and heavily influenced planning for a second wave of viral activity.

Officials were concerned about recurrent H1N1 activity in remote and isolated communities, based on surveillance reports of influenza-like-illness throughout the summer. Another concern pertained to the potential secondary effects of pandemic activity in other parts of Canada on remote and isolated communities (e.g., disruptions in supply and transportation systems caused by pandemic outbreak in city centres, exacerbated by the fact that northern Manitoba communities rely on varied transportation routes and means to supply their communities).

Ensuring nursing stations were well-stocked for a second wave of H1N1 influenza became a preoccupation of the Region’s planning and preparedness strategy. The repeated message given to nurses from senior levels down was to “order big”. NICs were directed to review their current stock and procure sufficient pharmaceutical and medical supplies for a 3 to 4 month utilization period - a departure from the typical 6 week utilization period. NICs were also told to use the

---

3 Source: [http://www.gov.mb.ca/health/publichealth/sri/cases.html](http://www.gov.mb.ca/health/publichealth/sri/cases.html)
DDC order form as a guide and to indicate on the forms that the order was related to H1N1. This would allow the pharmacy technician in the Regional Office to follow up with DDC and ensure quick delivery.

In respect of certain crucial supplies (such as antivirals and intravenous fluid), the Director of Care and Treatment and the Director of Health Protection for the Manitoba Region, gave more precise guidance to NICs on the types and quantities of products required to meet and maintain community preparedness capacity. In respect of the remaining products required for pandemic or normal usage, the direction given was to fill supply rooms and err on the side of overstock. Regional officials reasoned that if worst-case pandemic scenarios did not materialize, overstock of non-perishable items could in any event be used over time.

V. Wasagamack First Nation

Wasagamack is a remote and isolated First Nation community of approximately 1,750 people, located in northern Manitoba. A nursing station is located on-site with two nurses and a NIC. A physician typically visits the community once per week. Responsibility for the nursing station administration – i.e., nursing station support staff including clerks, security and housekeeping personnel – is transferred to the Band, while the nurses are Health Canada employees.

The Wasagamack NIC has worked in the community since September 2008. She appears to be well integrated into the community and indicated that recent events have not negatively impacted her interactions with patients. In fact, as indicated in the chronology below, the Chief of Wasagamack recently went on the local television station to thank the NIC and her staff for the health services they provide to the community.

As to what influenced the order of body bags, the NIC indicated the following:

- responding to directions from Regional Office to ensure nursing stations were abundantly supplied;
- the challenges faced during the spring pandemic in obtaining adequate supplies for the nursing station;
- the transportation challenges routinely faced in getting supplies to Wasagamack, exacerbated in the fall when the next wave of pandemic may occur. One must take a plane and boat (in summer) and a plane and ATV (in winter) to reach Wasagamack. During ice break-up in the spring or ice formation in the fall, people and supplies are transported by a small helicopter. A typical supply shipment may require 3 or 4 helicopter flights. In addition, cargo shipments are routinely deferred if the helicopter is transporting passengers. Bad weather can further delay deliveries to Wasagamack;
- sixty percent of the Wasagamack community is under 25 years old. Therefore, in addition to high risk factors present in many Aboriginal communities, there are significant numbers of children, youth and pregnant women – groups at risk for complications of influenza.
Following is a chronology regarding the ordering of body bags for Wasagamack First Nation:

- **August 12, 2009** - NIC faxes to Regional Office an order for various medical supplies, including wrist splints, single use scalpels, surgical gloves, surgical masks, sterile water, and benzalkonium chloride towelettes. This order also includes a request for 100 body bags. The order is placed by Regional Office with DDC on the same day. DDC ships 18 body bags on August 17 and 20 body bags on September 9, 2009.

- **September 14, 2009** - Winnipeg regional office is contacted by the Executive Director of Neewin Health regarding body bags.

- **September 15, 2009** - The Nurse Manager calls the NIC for details and asks that 20 body bags be returned to the DDC. This is done by the NIC. The Nurse Manager contacts the community’s Health Director by phone and e-mail to advise of the corrective action. The order for the remaining body bags (which are on backorder) is cancelled the next day.

- **September 16, 2009** - Chief Knott, accompanied by the Band Constable, informs the NIC that he needs to confiscate the body bags from the nursing station. The NIC gives him the remaining 18 body bags. There are currently no body bags at Wasagamack.

- **September 16, 2009** - Chief Knott returns the 18 body bags to the Regional Office in Winnipeg.

- **September 16, 2009** - In recognition of sensitivities around the distribution of body bags, regional medical and nursing staff review all orders for body bags. The Regional Director’s approval is required before an order can be placed for body bags.

- **September 17, 2009** – Regional nursing officials contacts NICs in all nursing stations to confirm that no other body bags had been received.

- **September 17, 2009** - The Regional Director holds a press conference to apologize for any unintended alarm that the order of body bags may have caused.

- **September 18, 2009** - Chief Knott asks the NIC to appear with him on the community television station and thanks the Nursing Station staff for their ongoing work for the community.

- **September 21, 2009** - A letter of apology is sent from the Regional Director to all Chiefs and Band Councils in Manitoba apologizing for the unintended alarm that the order of body bags may have caused. (Attached as Annex A).