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For Immediate Release
2017PSSG0070-001911
Nov. 15, 2017

First Nations Health Authority
BC Coroners Service

Recommendations released from Death Review Panel on First Nations youth

COAST SALISH TERRITORY – VICTORIA – The First Nations Health Authority (FNHA) and BC Coroners Service (BCCS) have released a new report that shares key findings and recommendations to prevent unintended First Nations youth and young adult injury and deaths in British Columbia.

A ceremony in Victoria's Parliament Buildings today marked the release of the BCCS and FNHA Death Review Panel: A Review of First Nation Youth and Young Adult Injury Deaths: 2010-2015 report.

The panel reviewed the circumstances of unexpected deaths of 95 First Nations youth and young adults aged 15 to 24 years, who died between Jan. 1, 2010, and Dec. 31, 2015. These deaths are a loss deeply felt by family, friends and their community. The review of the circumstances that resulted in these deaths provided panel members with valuable information to help determine what could be done to prevent similar deaths.

The panel has made specific recommendations and actions to partners within four areas:

- Promote connectedness to peers, family, community and culture
- Reduce barriers and increase access to services
- Promote cultural safety, humility and trauma-informed care
- Elicit feedback through community engagement

The panel has stated that these First Nations unexpected deaths are preventable, and that prevention approaches must consider the unique cultural diversity, community strengths and protective factors, as well as factors that wear away at resilience. Many youth and young adults in the report had previous contact with supporting systems, such as schools, health care, community supports and services, but experienced barriers to accessing support. These represent missed opportunities to support these young First Nations people.

"We want to be clear these are not statistics. These are children, they are families and they are part of our communities. With these findings, we see again we need to give attention to our most vulnerable, our youth, and in particular, our young women," said Shannon McDonald, Deputy Chief Medical Officer with the First Nations Health Authority. "The findings that many of these youth had interaction with supporting systems of care shows that we as providers all have much more work to do to offer the care these youth need, when asked. We accept the recommendations aimed at the FNHA and look forward to implementation."

The mortality rate for First Nations youth and young adults found in this report is almost two times the rate of their non-First Nations peers. This review considered the historical legacy of colonization, the impact of the social determinants of health, and the First Nations perspective

on health and wellness when analyzing the facts and circumstances of deaths and to identify public-safety opportunities, including those specific to First Nations peoples, and to prevent similar deaths.

“We are grateful to have facilitated the important work of this death review panel which reviews and analyzes facts and circumstances of deaths, providing us with the opportunity to make recommendations to prevent future deaths in similar circumstances,” said Lisa Lapointe, chief coroner with the BC Coroners Service. “I extend my sincere thanks to the First Nations Health Authority and First Nations communities in B.C. for their guidance and wisdom in developing the report and recommendations, and for their commitment to bettering young people's lives.”

Recommendations are directed to the Ministry of Children and Family Development, First Nations Education Steering Committee, Ministry of Education, Ministry of Advanced Education, Skills and Training, and the FNHA. Each organization named in the report has been asked to respond with an action plan within 90 days.

Learn More:

BC Coroners Service and First Nations Health Authority Death Review Panel – A Review of First Nations Youth and Young Adults Injury Deaths: 2010-2015: http://ow.ly/hgl030gB8sM

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