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February 13, 2018

VIA EMAIL (ChiefCoronerCorrespondence@gov.bc.ca)

Ms. Lisa Lapointe Chief Coroner Office of the Chief Coroner Ministry of Public Safety and Solicitor-General PO Box 9259 Stn Prov Govt Victoria, BC V8W 9J4

Dear Ms. Lapointe:

On November 15, 2017, the British Columbia Coroners Service and the First Nations Health Authority released a joint review of First Nations Youth and Young Adult Injury Deaths (2010-2015). The review panel reviewed the circumstances of unexpected deaths of 95 First Nations youth and young adults aged 15 to 24, who died between January 1, 2010, and December 31, 2015. The report contained specific recommendations to prevent future similar injury related deaths and support wellness and well-being:

- Promote Connectedness to Peers, Family, Community and Culture;
- Reduce Barriers and Increase Access to Services;
- Promote Cultural Safety and Humility and Trauma-Informed Care; and
- Elicit Feedback through Community Engagement

On behalf of the First Nations Health Authority, and as Co-chair of the joint *Review of First Nations Youth and Young Adult Injury Deaths (2010-2015)*, it is my pleasure to share with you our Action Plan (Appendix: Action Plan – FNHA Youth DRP Response – 2018 Feb 13), developed in response to the report's recommendations.

I would like to thank the British Columbia Coroners Service and the panel members for their work on the report and recommendations, and for the opportunity to jointly examine the issue.

Sincerely,

Dr. Shannon McDonald Acting Chief Medical Officer First Nations Health Authority

cc: Joe Gallagher, CEO, First Nations Health Authority Grand Chief Doug Kelly, Chair, First Nations Health Council Michael Egilson, Chair, Child Death Review Unit