Death Review Panel: DC et al
Report to the Chief Coroner of B.C.

July 2009

Preamble

On April 18, 2008 and July 4, 2008, a Child Death Review Panel was convened in Burnaby, B.C. to examine the circumstances related to the deaths of six Aboriginal youths. These youths died between 2004-2005 in the Northern, Interior and Vancouver Island regions. There were three females and three males between the ages of 13 and 18 years old. Circumstances of death included a motor vehicle crash, suicide, exposure, and poisoning; alcohol was a factor in all six deaths.

Sixteen individuals were appointed as panel members under section 49 of the Coroners Act. A Chair was appointed under section 49(2).

The purpose of a death review panel is to review the facts and circumstances of deaths in order to provide advice to the Chief Coroner with respect to medical, legal, social welfare and other matters that may impact public health and safety and the prevention of deaths.

Following the review by the panel, the Chair is required to report to the Chief Coroner, any findings respecting the circumstances surrounding the deaths that were the subject of the review and any recommendations respecting the prevention of similar deaths.

Members of the death review panel must not make any findings of legal responsibility or express any conclusion of law.

Terms of Reference

The Terms of Reference for the panel were established under section 49(2) (c) of the Coroners Act and were as follows:

- To review the findings of the Child Death Review Unit, namely the circumstances, risk factors, protective factors and levels of preventability with respect to the six youths;
- To confirm trends, patterns or themes arising from the six deaths;
- To discuss and confirm what services currently exist in B.C. for Aboriginal children and youth who are challenged with issues related to alcohol and substance use, in particular, those in more rural communities;
- To identify any gaps in service; and
- To provide the Chief Coroner with advice on how to prevent similar deaths in the future.

Findings Arising from the Circumstances

While the deliberations of the panel are subject to the privacy provisions under the Act, the Chief Coroner may prepare, publish and distribute materials for the purpose of informing the public respecting the prevention of deaths.

After examining the specific circumstances related to the six deaths, the panel determined that each youth, in an acute state of intoxication, was either placed or left in a high risk situation that subsequently resulted in their death. Further, that the youths' peers, family and community members were aware of the high risk situations and failed to intervene in a manner that would have likely resulted in a different outcome.

The panel found that communities need to ensure youth are not left alone and in harms way, in particular, if alcohol and other substance use has contributed to a high risk situation. Youth and other vulnerable members of a community need to be able to expect a level of care from within their communities.

Jurisdictions responsible for serving vulnerable Aboriginal children and youth need to consult with youth in order to ensure intervention strategies are youth-centered and meaningful. Further, these jurisdictions need to share information intended to support vulnerable Aboriginal children and youth before a critical event occurs.

Coroners need to be supported in responding to Aboriginal child deaths in a culturally appropriate manner. Coroners need to have strong relationships with Aboriginal leadership in communities prior to a child death. This will ensure the Coroner's response is culturally sensitive and that death investigations will be informed by family, friends and communities in a timely manner.

Recommendations

The Coroners Act directs that any recommendations made by the panel respecting the prevention of similar deaths or the protection of the health, safety and well-being of children generally, be submitted to the Chief Coroner of British Columbia for his distribution to the appropriate jurisdictions for their response.

1. To the Ministry of Health Services; Ministry of Healthy Living and Sport

That the Ministries consider sponsoring a project that will include the following elements:

- To engage and consult with Aboriginal youth across B.C. to seek their advice on how to increase care in community whereby no one is left on their own in a circumstance of high risk (e.g., alcohol intoxication);
- To use this information to develop a risk reduction strategy that is community designed, driven and implemented in community by community;
- To advance a pilot of this risk reduction strategy;
- To complete an evaluation of this work.

Response from the Ministry of Health Services; Ministry of Healthy Living and Sport:
We support your recommendation and believe it has excellent potential to help close the health disparity gap between First Nations people and the general population. We have initiated follow-up discussions with the Tripartite First Nations Health Plan management team and believe this recommendation will work well with several initiatives already underway. These include the development of an Aboriginal Mental Health and Addictions framework; youth suicide prevention forums and Aboriginal ActNow initiatives.

2. **To the Ministry of Health Services**
That the Ministry of Health Services target specific funds to provide a spectrum of alcohol prevention and treatment services for Aboriginal youth in B.C. and further, that this be done in collaboration with Aboriginal leadership at the community level.

Response from the Ministry of Health Services and Healthy Living and Sport:
We support your recommendation that the Ministry of Health Services target specific funds to support a spectrum of alcohol prevention and treatment services for Aboriginal youth in British Columbia. In response, we will contact our tripartite partners within the Tripartite First Nations Health Plan to discuss how to implement your recommendation in the best and most timely fashion.

3. **To the Ministry of Housing and Social Development, Ministry of Children and Family Development, Ministry of Health Services and Health Canada**
That a working group be formed from across these provincial and federal jurisdictions to explore the feasibility for supportive housing options developed specifically for Aboriginal youth in B.C. living with addictions.

Response from the Ministry of Housing and Social Development:
This ministry recognizes the importance of improving outcomes for all clients in need. To that end, the ministry is committed to exploring opportunities, both federally and provincially, to improve services and housing options to support Aboriginal youth living with addictions.

Response from the Ministry of Children and Family Development:
We have initiated follow-up discussion with the Ministry of Housing and Social Development and will plan an initial meeting of the proposed collaborative partners to explore the opportunities, both provincially and federally, to improve outcomes for Aboriginal youth living with addictions through supportive housing options.

Response from Health Canada:
We are prepared to work with the provincial ministries referred to in an attempt to find meaningful and timely solutions to meet the needs of these severely at-risk youth. The First Nations Health Council, of course, has a pivotal role in this process and we will work with the Council to ensure that one of the agencies involved takes a lead role in bringing those responsible together to formulate a response to the crisis.

4. **To the Provincial Advisory Committee on First Nations Health (PACFNH)**
That this body in collaboration with MCFD, oversee the development of a community designed and delivered protocol intended to guide communities in cross-jurisdictional responses when critical issues related to child wellness arise (suicide; multiple child deaths in motor vehicle crash).

Response from Ministry of Children and Family Development:
…Further, we would be pleased to work with the provincial Advisory Committee on First Nations Health in a collaborative partnership to support community engagement in developing resources that support cross-jurisdictional responses to critical issues related to child wellness.

5. **To the Chief Coroner**
That the BC Coroners Service ensure that its policies reflect an expectation of culturally sensitive practice. This should include:

- human resources and investigative policies;
- basic training that addresses cultural awareness and sensitivity (either through direct instruction, self-study or on-line learning);
- support for Coroners to strengthen working relationships and liaisons with Aboriginal leadership within their communities.

Response from the Chief Coroner:
The BC Coroners Service fully supports the recommendation directed by the panel. Our policies are currently under review and will be revised to reflect an expectation of culturally sensitive practice. Our training plan will be enhanced to include a module specific to cultural awareness. We remain committed to our collaborative relationship with the First Nations Health Council and look to them to provide advice on the overall health and well-being of B.C.'s First Nations children and youth.

Concluding Advice to the Chief Coroner

We the panel, recognize the unique circumstances within every Aboriginal child's life and death. We recognize that the BC Coroners Service and other child serving jurisdictions strive to provide those services to the best of their ability. Our overarching advice is this:

Every child-serving agency in the province of British Columbia must sincerely commit to carrying out their responsibilities in a culturally respectful, sensitive, appropriate, competent and culturally safe manner. It must be the only manner in which to conduct business. Jurisdictions must seek out advice, guidance and wisdom from Aboriginal Peoples to ensure Aboriginal children and their families are best served in life and honoured in death.

Further, that any initiatives intended to serve children and youth must be informed by youth.

Kellie Kilpatrick
Chair, DC et al Child Death Review Panel
Executive Director, Child Death Review Unit