First Nations Health Authority
Health through wellness

BRITISH COLUMBIA | Coroners Service

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First Nations Health Authority and BC Coroners Service Partnership

The First Nations Health Authority (FNHA) and BC Coroners Service (BCCS) have nurtured an ongoing collaboration since the signing of a Memorandum of Understanding (MoU) in May 2014. The organizations are working collaboratively to ensure that the Coroners Service, in undertaking its statutory role, also undertakes to ensure cultural practices, customs and family perspectives are considered and respected, as well as how the two organizations can best work together in surveillance and prevention efforts.

Policy and Practice Environment for infant deaths

The provincial *Coroners Act* requires coroners to investigate all deaths of children under the age of 19 in the province. The Act also allows the coroner to authorize post mortem examinations if the coroner deems them necessary. The past policy required the retention of the brain of an infant (defined as a child under the age of one year), for a period of two weeks or more for detailed examination in all of these cases. BC First Nations raised this as a concern because of spiritual and cultural practices surrounding death.

As a result of the FNHA and BCCS collaboration, BCCS has changed the approach to the post mortem investigation of these deaths to ensure that the least invasive means possible is used based on each individual situation and discussions with the family. This means that BCCS no longer routinely requires the retention of the brain, and will only retain it in cases where other evidence and/or gross autopsy findings indicate a need for further neurological examination.

Ongoing partnership

The FNHA/BCCS MoU committed the partners to mutually and collaboratively support each other in a positive and constructive manner to improve the public safety and prevention of deaths for First Nations and Aboriginal peoples. It also outlines the goals of working towards cultural competency and culturally safe services, and strengthening relationships between coroners and First Nations communities, families, and individuals in a way that respects Community-Driven and Nation-Based decision-making. Commitments also included quarterly meetings on annual workplans, and annual meetings between senior executives of both organizations.

The 2014 Workplan included as common priorities:

- **Data Surveillance**
  - BCCS to collect First Nations and Aboriginal data in a standardized process and format.
  - BCCS and FNHA to work together to identify mutual data surveillance priorities.

- **Building of First Nations Relationships and Culturally Safe Services**
  - For the BCCS staff to engage and work more effectively with First Nations and Aboriginal families and communities through a greater understanding of First Nations and Aboriginal culture, traditions, protocols and context.
  - FNHA to support BCCS in the development culturally safe practices and environments.

At a July 2014 working meeting between senior and strategic staff, BCCS and FNHA discussed next steps in building on the MoU and joint partnership. A follow-up meeting between FNHA Regional Directors and Regional Coroners will occur in early December to start the discussion on how to improve communications, enhance relationships with First Nations, developing a common understanding of cultural safety and how it can happen at the regional and community level with the aim of improving family experiences and involvement in decision making in the event of a coroner investigation of a family death.

About the BC Coroners Service

The BCCS reports to the Ministry of Justice and has a legislated responsibility to honour all deaths and learn from them to support the living through independent death investigations and the analysis of patterns of death at a population health level. *The Coroners Act* specifies the deaths that must be reported and empowers coroners to gather the information needed in the investigation of each of these deaths. The service's investigations are independent from all law enforcement agencies, health authorities, and other branches of the provincial or federal government. BC Coroners investigate deaths to answer five core required questions: who, when, where, how and by what means did an individual pass away.

The BC Coroners Service is responsible for conducting reviews of all child deaths occurring within the province. This requires appropriate liaison with agencies such as the Ministry of Children and Family Development and the Representative for Children and Youth, among others. The BC Coroners Service also conducts special reviews on issues affecting the prevention of child deaths and on child safety more broadly.

More information on the BC Coroners: www.pssg.gov.bc.ca/coroners