

REMEMBERING KEEGAN



FRASER SALISH REGION
First Nations Health Authority

A BC FIRST NATIONS CASE STUDY REFLECTION



HONOURING KEEGAN

IN MEMORIAM

Keegan Combes, of Skwah First Nation, was a high school graduate, grade 10 pianist and chess champion who passed in September 2015.

While he is gone – he will be remembered

Keegan brought together Stó:lō and Coast Salish leaders to transform the health system from a sickness model to a wellness model of care. In Keegan's memory, the Fraser Salish Health Caucus leadership will work with the Board and Senior Executive Team of Fraser Health Authority to transform the care provided to all. In his memory, we will work together to ensure that all peoples from all places and all races will be provided the highest quality of care that is respectful of all cultures and beliefs.

Yeqwethet – Halq'eméylem

“to heal and straighten out”





KEEGAN COMBES

Sunrise: February 21, 1986 – Sunset: September 26, 2015




ACKNOWLEDGEMENTS

We hope that this case study reflection honours Keegan's journey and his legacy. Our team at the Office of the Chief Medical Officer at the First Nations Health Authority (FNHA) is grateful to Keegan's caregiver and his family – the people who knew him best and love him deeply. They have shared his story to prevent it happening to another person and their family.

Through the British Columbia (BC) First Nations Health Governance Structure, the FNHA is the health and wellness partner to BC First Nations and First Nations people, families and communities in BC. The FNHA's work takes place within the territories of many BC First Nations throughout the province. We are grateful to the ancestors of the lands where this work took place, and all the medicines within them. We also want to recognize the Fraser Health Authority and the Chilliwack General Hospital, where Keegan's death took place, for their decision to commit to their ongoing Cultural Safety and Humility journey through partnerships with BC First Nations of the territories where they operate.

Keegan's legacy has been to help shape the Cultural Safety and Humility transformation that is currently underway in the health system of BC. Addressing racism and discrimination in health care is critical to transforming the health system to be culturally safe for First Nations and Indigenous people. Transformation will require both behaviour change on the part of health providers, and system change, including structures, policies, practices and procedures.

Rhianna would like to thank Keegan's family for entrusting her to do this important work as the family advocate and to keep her promise to Keegan to share his story. She would also like to thank her incredible partner Paul, for his unwavering support, reassurance and encouragement through this difficult journey; Janene Erickson for walking alongside her throughout this long and emotional journey and continuing to honour Keegan by protecting the work and seeing it through; and Kate Jongbloed for sharing her skills to capture Keegan's story in a culturally safe way and developing the case study into an incredible learning tool for the health ecosystem and the leaders within it.






TRIGGER WARNING

The content in this case study reflection is distressing and may trigger unpleasant feelings and memories of negative experiences.

First Nations and Indigenous people may see it reflecting their own experiences of harm and cultural unsafety in the health care system. The content may also contribute to unpleasant feelings among non-Indigenous readers who are asked to witness and think differently about experiences of systemic racism that are often hidden from view.

This information is intended to acknowledge the culturally unsafe care that exists in the health system and help to address it. Those who require emotional support can contact the **24-Hour KUU-US Crisis Line at 1-800-588-8717**.





CULTURAL GROUNDINGS

As we reflect on Keegan's experience through this case study, we will see Cultural Groundings, such as the one given here. These groundings were shared from Knowledge Keepers in the Fraser region and have been placed throughout Keegan's story to help us honour and remember the teachings of our Elders and how they passed down stories and narratives to us.

We symbolically gather around our fires, lean in and listen with our hearts and minds.

We hear the teachings that are being shared with us. The stories are imbued with power, Stories are meant to teach us about wrongs and rights.


Inherently, they cause us to feel emotional, spiritual, mental and physical pain and joy.

We accept that in order to carry the burden of teachings. Physical demarcations on the landscape cause us to always remember the story. Keegan's sacrifice causes us to shift and say "never again".



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INTRODUCTION

Keegan Combes of Skwah First Nation was a high school graduate, a grade 10 pianist and a chess champion enrolled in a trades college at the time of his death. Keegan also lived with disabilities, and was non-verbal by choice. He is remembered, missed and loved.

Keegan died at the age of 29 following a delayed diagnosis and treatment after an accidental poisoning in September 2015. Telling Keegan's story is important as a way to bear witness, document "Culturally Unsafe Encounters" within the health care system and contribute to changing the system to prevent similar deaths or harm in the future. Keegan's legacy has been to help shape the Cultural Safety and Humility transformation that is currently underway in the health system of British Columbia (BC).

On the afternoon of September 15, 2015, Keegan's caregiver, Rhianna, who is also Indigenous, called 911 after finding him at home slumped, incoherent and covered with vomit. Keegan was admitted to an urban hospital in BC where he spent the night without receiving a diagnosis or treatment, despite lab results indicating the cause and severe health consequences of his condition being available within three hours of his arrival at hospital. By the time it was determined that Keegan had accidentally ingested windshield wiper fluid (methanol) – which is highly toxic but treatable if caught in time – his condition had deteriorated while in the care of the health system, to the point where he required intubation and was admitted to the Intensive Care Unit (ICU). This delay in diagnosis and treatment contributed to his preventable, tragic and unnecessary death on September 26, 2015.

Discussion with Keegan's caregiver identified a series of Culturally Unsafe Encounters with the health system surrounding his death. Lack of Cultural Safety and Humility was not benign; it actively contributed to delay in diagnosis and treatment that could have prevented Keegan's death. Layered on top of this was a failure to navigate Keegan's disabilities. Patients with complex needs, including those related to living with disabilities or other challenges that may lead to frequent engagement with the health system, deserve to receive timely and quality health care like anyone else. As a result, Keegan's caregiver has worked persistently to advocate for changes at the hospital to prevent discrimination and harm to other First Nations patients, including those with disabilities.




CULTURAL GROUNDING

**Letse'mot (Everyone working together) - Halq'eméylem
Piye? wí?x e? sc'úw (Everyone working together) -
Nlaka'pamux**

We open our hearts to the strength in humility.

We open our minds to suspend our reference, what we believe to be true.

Together, with one heart, one mind, we receive these teachings from the 7 Generations before us. We walk together in transformation to right our wrongs, to believe the 7 Generations after us have a healthcare system that is safe for us all.



Keegan's story is influencing how BC First Nations and mainstream health services are working together to transform the system. As a health and wellness partner to BC First Nations, the First Nations Health Authority (FNHA) works to improve how health and wellness services are delivered. In 2015, the BC Minister of Health and the chief executive officers (CEOs) from each of BC's six health authorities signed on to the Declaration of Commitment on Cultural Safety and Humility in Health Services. Since then, they have been joined by other health system partners, including all 19 regulatory bodies that govern health professionals working in BC, and the BC Coroners Service. In 2020, Keegan's story was shared in the *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* report documenting Indigenous-specific racism – and in particular systemic racism – in BC's health system, and helped to inform the report's 24 recommendations.

This momentum is translating into specific actions that respond to systemic racism and discrimination, to create cultural safety in health services for BC First Nations. There are many examples, including how the system is working to respond to Keegan's story, that show that the system is listening and engaging. The Cultural Safety and Humility journey is challenging and significant work remains to be done. As a result, this case study affirms several urgent recommendations to ensure that the injustices Keegan experienced do not continue to happen.

BACKGROUND

BC First Nations have a unique health governance partnership with the Province of BC and the Government of Canada. The parties have agreed to establish a new relationship based on mutual respect and recognition to improve the health outcomes of BC First Nations peoples and communities. The new relationship recognizes the role of BC First Nations to make decisions over the design and delivery of health and wellness services for First Nations people.^{1,2} Through consensus, BC First Nations leadership confirmed a shared vision, values and 7 Directives that continue to guide the work of the health governance partnership. This work included the formation of the First Nations Health Authority (FNHA) in 2013, which enabled the successful transfer of federal health services to BC First Nations control.

As a health and wellness partner to BC First Nations and First Nations in BC, the FNHA is responsible for planning, management, service delivery and funding of health and wellness programs, including First Nations Health Benefits. Working to transform the system from sickness to wellness, the FNHA's mandate is to plan, design, manage, deliver and fund the delivery of First Nations health programs in BC and to collaborate with the BC Ministry of Health and BC health authorities to coordinate and integrate their respective health programs and services to achieve better health outcomes for First Nations in BC. The FNHA champions the BC First Nations perspective of health and wellness, as well as Cultural Safety and Humility in health service delivery across the province and works to improve the way health and wellness services are delivered to First Nations in BC.



CULTURAL GROUNDING

While Keegan was rendered invisible, his caregivers unheard, his story one of systemic failure because of how a person presents it is imbedded with burden of teaching.

As imbedded as we are in our actions, inactions and choices, we serve ourselves and others to be better as we reflect.

To carry a burden of responsibility is an honour.

The burden of improvement for the 7 Generations after us is on all health professionals, now and for the next generation that will pass on our teachings.

WHY A CASE STUDY REFLECTION?

First Nations have a deeply rooted culture and tradition of storytelling as one of the ways of passing on knowledge. Storytelling is a traditional method used to teach about cultural beliefs, values, customs, rituals, history, practices, relationships and ways of life. First Nations storytelling is a foundation for wholistic learning, relationship building and experiential learning. This case study reflection is a learning tool for health professionals to learn from and reflect on personal and systemic conditioned biases that shape their practice, and engage in conversations to create safer health care environments and experiences for First Nations and Indigenous people – so that what happened to Keegan never happens to others.



CULTURAL GROUNDING

We open our hearts to difficult truths

We hear the story

We value the experience

It is important for Keegan’s family and his caregiver to make public the events that resulted in the death of Keegan Combes. Truth telling is a critical part of the process of reconciliation. For so long, First Nations experiences of racism in BC’s health system have been unacknowledged, dismissed and silenced. As a health organization created by BC First Nations for BC First Nations and First Nations in BC, the FNHA has a role to honour First Nations truths and lived experiences in

the face of over 100 years of history where First Nations voices and experiences have been denied. Eliminating Indigenous-specific racism in health care and achieving health equity are shared goals of the First Nations Health Council (FNHC), the First Nations Health Directors Association (FNHDA) and the FNHA. These goals are critical in attaining our shared vision of healthy, self-determining and vibrant BC First Nations children, families and communities. The FNHC, FNHDA and FNHA recognize the importance of enhancing access to quality, culturally safe health care that affirms First Nations cultures, rights and identities in tandem with addressing systemic racism in the health care system.³⁵ Supported by the teachings in Cultural Safety and Humility, this case study reflection captures the truth and protects the family from having to retell a very difficult story. It supports the family’s ability to move forward, knowing the system will continue to learn and do better by learning from their experiences, which were captured in partnership and approved by the family to reduce any misleading interpretations of their experience and truth.



INDIGENOUS-SPECIFIC RACISM AND DISCRIMINATION IN THE HEALTH SYSTEM

Acknowledging the presence of racism and discrimination in the health system is difficult. It is a deeply held Canadian value to treat everyone equally, regardless of race, ability, gender, sexual orientation or other markers of identity.³ Yet the evidence of historic and ongoing racism towards Indigenous people in the health system, at the individual, institutional and structural level, is clear.⁴ Racism in health care results in reduced access to services and avoidance of care, mistreatment of patients as well as Indigenous staff, over or under prescribing of medications, delays in care that can have severe consequences and even denials of service.⁴⁻⁹ Racism and colonization in the health system continue to shape First Nations interactions and cause harm and death.

Painful memories of negative experiences of “health” services in residential schools, Indian hospitals and the mainstream system persist.¹⁰⁻¹² Survivors – including those who continue to access health services in BC and their descendants – have testified to the health traumas and abuses they experienced.¹² These included medical experimentation, coerced sterilization, electric shock therapy on genitals, mutilation, traumatic dental work, traumatic use of restraints (both chemical and physical), starvation and neglect.^{10, 11, 13, 14}

Today, many First Nations and Indigenous people continue to report having witnessed or experienced discrimination that prevented them or a loved one from getting the health care they are entitled to.^{4, 6, 15-19} Previous complaints have highlighted that racist stereotypes, particularly those related to substance use, contribute to substandard care and death among First Nations and Indigenous people seeking health services in Canada.^{4, 15-17, 19, 20} Yet in BC and across Canada, patient safety reviews continue to deny or downplay the role of racism and discrimination in the complaints brought before them.^{4, 6, 15}

Racism and discrimination are not always expressed in overt ways (e.g., slavery, genocide, racial slurs), but can take forms that present power inequalities as neutral and natural.²¹ When practice norms are shaped by discriminatory biases, they compromise standards of care.²² These negative experiences can include instances when concerns are discounted, assumptions are made about behaviour, someone is blamed or belittled, cultural health practices are diminished and/or rights and agency are undermined.^{6, 8, 15, 23, 24} Systemic racism also perpetuates the idea that Indigenous people are sicker than non-Indigenous people, which can contribute to biased and harmful normalization of illness and death.²⁵ Other diverse life experiences, such as those related to disability, substance use, poverty, gender identity and sexual identity, can be additional layers that contribute to experiences of discrimination.²⁶

Harmful experiences contribute to First Nations people’s mistrust of the system.⁴ Consequences of discrimination against First Nations people in health services are decreased access, reduced utilization, untreated concerns, negative health outcomes and untimely death.^{7, 23} In addition, First Nations and Indigenous people may be reluctant to come forward with complaints, for fear that their stories and experiences will not be believed or addressed, or for fear of retaliation in the form of withheld treatment or worsening racist experiences.^{4, 27}

Health care providers across Canada also continue to report witnessing racism and discrimination against Indigenous people in the health care system.^{4, 22, 28, 29} One example comes from the San'yas Indigenous Cultural Safety Training Program, which has trained over 70,000 professionals across Canada.^{28, 29} A recent study looked at over 300 real-life incidents described by health service providers participating in San'yas training to better understand stereotyping of Indigenous people in the health system.^{28, 29} The top 10 stereotypes included beliefs that Indigenous people are: (1) alcoholics; (2) addicted and drug seeking; (3) get or want free stuff; (4) promiscuous; (5) stupid/illiterate; (6) abuse the system; (7) uncooperative; (8) lazy; (9) unable to “get over it”; and (10) incompetent/neglectful parents.²⁸ The study showed that these stereotypes and biases contribute to harmful behaviours by health care providers that include lower effort, misdiagnosis, lack of adherence to protocol and procedures, minimization of condition, no medication or treatment, delay/denial of service and withholding of pain medication.²⁸ Emergency rooms (ER) have been identified as a “hot spot” where these experiences occur.^{28, 29} This is particularly concerning as province-wide data demonstrates that compared to non-Indigenous residents, First Nations in BC are more reliant on ER visits for primary care and other non-urgent care purposes due to well-documented and persistent structural and systemic barriers to accessing safe non-ER health care services.^{4, 30}

Admitting that we carry both visible and invisible biases that can harm others may be especially difficult for those who have chosen to work in the caring professions. While no person is immune, every person has the opportunity to recognize, understand and overcome the biases they carry.³¹ If we do not acknowledge and address our own personal biases and those embedded in the systems in which we work, harmful consequences will continue to occur. Addressing racism and discrimination in health care is critical to transforming the health system to be culturally safe for First Nations and Indigenous people. Transformation will require both behaviour change on the part of health providers and system change, including structures, policies, practices and procedures.



CULTURAL GROUNDING

Our transformer stories are inherently about correction and sacrifice.

In the stories, sometimes those who might have done wrong were transformed as a reminder to the rest of us of how to do things right.

At other times those who were generous were transformed and became a valuable resource for the rest of us.

In current climate, Keegan's experience was one of someone not able to speak for themselves.

We elevate his story, as he has been transformed into someone who speaks not only for the marginalized, invisible and unheard, but for all the rest of us.

He reminds us and exemplifies “one heart one mind”, “we have to take care of everything around us”.

Letse'mot – Everyone Working Together

CULTURAL SAFETY AND HUMILITY

First Nations and Indigenous people have the right to access a health system that is free from discrimination in their own lands and territories, as well as to feel safe and cared for when receiving health services. They deserve to be treated with respect and have their concerns taken seriously. Reconciliation requires resetting the relationship between Indigenous peoples and non-Indigenous Canadians to move forward together to address inequities in the determinants of health stemming from colonization.^{5, 32, 33} Establishing trust with First Nations individuals, families, communities and Nations requires Cultural Safety and Humility.³⁴




CULTURAL SAFETY AND HUMILITY

CULTURAL SAFETY is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving and making decisions about their health care. Cultural Humility is a lifelong process of self-reflection to understand personal and systemic biases and develop relationships based on mutual trust.

CULTURAL HUMILITY involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. Cultural Safety and Humility provides a set of protocols for health professionals, organizations and the FNHA to follow in their partnerships and relationships with First Nations individuals, families, communities and Nations on their health and wellness journeys.

The FNHA continues to work to “hard wire” Cultural Safety and Humility into the health system to reset and rebuild relationships with First Nations people and families. Health system partners throughout BC have signed, grounded in ceremony, the Declaration of Commitment on Cultural Safety and Humility in Health Services.³⁶ The initiative was led by a landmark commitment from the BC Ministry of Health and all six health authorities in July 2015.³⁶ Since then, many more partners in BC’s health ecosystem have signed on, including the regulatory bodies of all 19 health professions in BC, the BC College of Family Physicians, the BC Coroners Service, Providence Health Care, the Ministry of Mental Health and Addictions, Doctors of BC and the BC Patient Safety & Quality Council.^{37, 38} Federal partners Indigenous Services Canada and the Public Health Agency of Canada have also signed on. The release of the provincial report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, confirmed the widespread prevalence of Indigenous-specific racism across the province (with 84% of survey respondents stating they had experienced stereotyping or discrimination in the health care system) and the need for the health system to take action.⁴ With the release of the *In Plain Sight* report, these Declarations of Commitments are now also underpinned by 24 specific recommendations that health providers, organizations and the system as a whole must undertake to address Indigenous-specific racism.⁴



The FNHA's focus on transforming the health system in BC includes work to address Indigenous-specific racism. The FNHC, FNHDA and the FNHA have published an Anti-Racism, Cultural Safety & Humility Framework and Action Plan that outlines strategic objectives and priority action areas to support a vision of a health and wellness system in BC that is free of racism and discrimination against First Nations; one where First Nations people seeking health care feel safe from racism and have access to care that positively affirms their rights, identities and cultures.³⁵ The FNHA envisions a future where First Nations people have a new relationship with their health providers. From the FNHA's Policy Statement on Cultural Safety and Humility, "We will know that the health system is culturally safe when First Nations people tell us it is."³⁴



SUMMARY OF EVENTS SURROUNDING KEEGAN'S DEATH

The following summary of events surrounding Keegan's death was gathered through conversations with Keegan's caregiver, friend and advocate Rhianna Millman, who has consent from Keegan's family to share and advocate on his behalf. This role as spokesperson is consistent with First Nations protocols around death, and it also reflects a First Nations perspective of family and kinship ties. The summary also draws on the Coroner's Report into Keegan's death, Keegan's patient records and the letter the family received from the regional health authority's patient care quality office.

Keegan lived with a community caregiver, Rhianna Millman, who is also Indigenous, and Rhianna's partner, Paul.³⁹ In the afternoon of September 15, 2015, the caregiver came home at around 16:00 to find Keegan extremely ill.³⁹ He was slumped over and covered in vomit. When she asked what was wrong, although Keegan was mostly non-verbal, he replied, "I don't know."³⁹

The caregiver called 911. Upon arrival, the emergency responders shared that they knew Keegan.³⁹ The caregiver got the impression that the emergency responders held a negative view of Keegan as a result of his previous interactions with the health system, as well as preconceived ideas related to his race and disabilities.⁴⁰ Despite what the caregiver saw as clear evidence of health distress – vomiting without a clear cause, slumping and incoherence – the emergency responders seemed reluctant to take Keegan to the hospital and she recalls having to advocate on his behalf.⁴⁰

Keegan was taken to hospital by ambulance.^{39,41} He arrived at the Emergency Room at 17:21 with a complaint of a dry cough, vomiting and an altered level of consciousness.^{41,42} He was triaged by the nursing team and seen by a resident physician at 18:05. A Most Responsible Physician (first MRP)¹ was listed, but did not see Keegan in person.^{42,43}

Lab tests were ordered and the first set of results became available at 19:10.⁴² The results showed a wide anion gap and wide osmolality gap that would indicate severe metabolic acidosis.⁴² In addition, the toxicology and drug screening drawn at the same time indicated that Keegan had ingested toxic levels of methanol.⁴² However, these results were missed by the resident and the first MRP (ER). Later, they were also missed by the second MRP (ER) who took over that night. The Coroner's Report states that, "admission urinalysis confirmed he had ingested methanol" and that Keegan was, "subsequently diagnosed with severe metabolic acidosis secondary to toxic alcohol ingestion."⁴¹ Yet it is unclear when this diagnosis occurred as it is not present in patient charts from September 15, nor was it communicated to Keegan's caregivers at any point that day or night. Put simply, the information that would have allowed a quick diagnosis and time-sensitive treatment with Fomepizole to prevent Keegan's death was available two-and-a-half hours after he arrived at hospital but was missed by the physicians responsible for Keegan's care.

¹The term most responsible physician or most responsible practitioner generally refers to the physician, or other regulated health care professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time. (Source: [Who is the most responsible physician? Check your knowledge](#))

Following the initial assessment at time of admission, Keegan was next seen by the resident at 23:30.⁴² During this interaction, the caregiver recalls asking again what was wrong with Keegan and the resident responding that his “liver enzymes were elevated,” but receiving no diagnosis.³⁹ She remembers that the resident wanted to discharge Keegan, but that she pushed back as Keegan continued to exhibit concerning behaviour including being unsteady on his feet, having difficulty using the bathroom on his own, holding his stomach, becoming more agitated, keeping his eyes closed and wincing in pain.^{40,43} To the caregiver, Keegan was showing obvious signs of pain and discomfort.

At this point Keegan had been in the hospital for more than six hours without improvements in his condition. The lab results that indicated methanol poisoning had been missed by the physicians involved in his case. The absence of any additional efforts to reach a diagnosis (for example, no additional lab tests were ordered, the lack of a diagnosis does not appear to have been escalated to the MRP and no internal medicine consult was requested) suggest that Keegan’s condition was not perceived as severe, urgent or acute despite a lack of improvement since his arrival at the hospital, as well as the caregiver’s ongoing concern.

During the 23:30 reassessment, the resident initiated a conversation with Rhianna about placing a do-not-resuscitate (DNR) order in Keegan’s file.³⁹ This suggestion shocked the caregiver, given the recent assessment by the resident that Keegan was well enough to be discharged. The caregiver recalls the resident saying “based on his quality of life, if it was a member of my family, I would have a DNR.” The caregiver felt this statement reflected that the resident did not feel Keegan’s life was worth saving, and only saw him for his disabilities – not his many abilities.³⁹ In the discussion with the resident, the caregiver recalls asking “what would you usually do for a 29-year-old man who you didn’t know who had been in a bad accident?” and that the resident replied “we would try to save them.” The caregiver responded, “then do that”.


Keegan’s medical records indicate that at 23:45 he was transferred to the care of a second MRP, a family physician working in the ER. Both medical records and discussion with the caregiver indicate that Keegan was not seen in person by the second MRP (ER) at this time, and it is unclear if the 2 MRPs communicated about Keegan at the time of their handover. Around midnight, the caregiver went home to rest and Keegan remained overnight in the emergency department.³⁹



CULTURAL GROUNDING

Collectively we open our hearts to difficult truths; we honour each truth; each story; we value the experience.

We create the space to suspend our beliefs beyond the constraints of defined procedure or policy where we can transform the institutions that often fail the individual experience.



According to orders and directives documented in Keegan's medical charts following the 23:30 resident visit, it appears that Keegan's neurovital signs were to be monitored every two hours overnight, with any change being reported to the MRP.⁴² Following these orders, recording of neurovital signs would have been expected at approximately 01:30, 03:30, 05:30 and 07:30. In reality, they were recorded at 21:30 (September 15) with a Glasgow Coma Scale (GCS) of 15/15 and then at 01:30 (September 16) with a GCS of 12/15. Then there is a gap of 6.5 hours before the next set of neurovitals are charted at 08:00 the following day, which show a dramatic decline to a GCS rating of 6/15.^{41, 42} Other vital signs recorded at 02:40 show an increase in blood pressure from the previous two recordings.^{41, 42} Lack of charting suggests that the physician's directives were not followed and that Keegan was not adequately monitored through the night.

The Coroner's Report reveals that Keegan was also restrained to his bed for several hours during the night.⁴¹ He was found on the floor beside his bed at approximately 02:40.⁴¹ At 03:30 he was noted as very restless and trying to get out of bed and a waist restraint system was applied.⁴¹ Notably, this situation was not reflected in Keegan's medical records. In their internal review, the regional health authority determined that the application of restraints was appropriate; however, documentation standards were not met, suggesting he was not monitored with the frequency required by policy.⁴¹ This information indicates that the nursing team was in contact with Keegan as his condition was worsening and they did not comply with guidelines or the orders and directives provided by the physician related to neurovitals monitoring. They did not alert the MRP.

The caregiver called the hospital for an update on Keegan's condition shortly after 07:00 the following morning (September 16) and was told she would receive a call back after morning rounds were complete.³⁹ She quickly received a call back saying that Keegan was being intubated and that she should come immediately.³⁹ Medical records indicate that at 08:15 the second MRP working in the ER was urgently called to see Keegan, who had significantly declined during the night to a GCS score of 6/15 and needed intubation.⁴² The third MRP (ER) was also called at this point. The first medical record in which the third MRP (ER)'s own stamp, writing and signature appear is at 09:09. In this record, the doctor states that, "I unfortunately had not done rounds yet and was not aware of this patient."⁴² It appears that the third MRP was not present and had not rounded, and it is unclear if the second MRP was aware that Keegan had been admitted to their service the previous evening at 23:45. Care was then transferred to a fourth MRP (Internal Medicine (IM)-ICU) at 09:09.⁴² Keegan was transferred to the Intensive Care Unit (ICU) at 10:50.

When the caregiver arrived at the hospital, she was met by a team of hospital staff, including a social worker.³⁹ She was taken into the family room and told that when Keegan was checked on in the morning he was not breathing.³⁹ Over the course of the conversation it became clear that Keegan had been restrained to his bed in the ER and left alone for several hours.³⁹

The first time the subject of methanol poisoning came up in discussion with the caregiver was in the ICU. Following the fourth MRP (IM)'s call to "poison control" (British Columbia Drug and Poison Information Centre), the caregiver recalls that the fourth MRP (IM) asked her if there was any way that Keegan could have ingested methanol. This prompted the caregiver's partner to attempt to retrace Keegan's steps from the previous day. The clerk at the convenience store where Keegan often bought snacks recalled that Keegan purchased chips and a drink. On his way out, Keegan saw another customer select and buy a bottle of windshield wiper fluid, after which Keegan bought a bottle himself. Over a year later as they were packing to move, the caregiver found what may have been the bottle Keegan bought. It was hidden from sight and approximately one cup was missing from the bottle. To the caregiver, the bright yellow liquid looked very similar to an energy drink and she suspected Keegan had bought and consumed it after mistaking it for an energy drink similar to those available in the household.



CULTURAL GROUNDING

First Nations stories are where the invisible becomes visible. Introspection causes humility. Revelation brings appreciation. Balance is restored to our relationships with ourselves and the way we treat one another. The "other" becomes "us."

The caregiver recalls that when she went to visit Keegan that morning in the ER, and again in the ICU, the fourth MRP (IM) shared his distress that he was not called to consult the previous evening as he could have responded to the concerns highlighted in the 19:10 lab work.³⁹ Later, the regional health authority acknowledged that had the more experienced emergency physician

on duty reviewed the initial lab results instead of only the resident, it may have altered the final outcome for Keegan.⁴¹ It is not clear whether they were referring to the first, second or third MRP by this statement, and whether or not this constitutes a breach of supervision.

On September 16, Keegan was transferred to another urban hospital in BC where he died on September 26, 2015.³⁹ The BC Coroners Service was called to investigate. The investigation into Keegan's death affirmed that despite lab results with critical diagnostic information being available soon after his arrival at hospital, his accidental poisoning resulting from ingesting windshield wiper fluid (methanol) was not diagnosed or treated for over 12 hours.⁴² Following Keegan's accidental poisoning, the delay in diagnosing the cause of his illness (methanol poisoning) resulted in delayed fomepizole treatment and, ultimately, his death.⁴²

PHYSICIANS INVOLVED IN KEEGAN'S CARE

PHYSICIAN	DATE AND TIME KEEGAN WAS UNDER THE CARE OF PHYSICIAN
Resident physician (in training)	September 15, 2015 *18:05 - end time not noted *Time of first contact with Keegan
First MRP ² in ER (family physician)	September 15, 2015 *18:05 - 23:45 *This was the time Keegan was seen at the hospital and not the start time of MRP
Second MRP in ER (family physician)	September 15-16, 2015 (overnight) 23:45 - 08:20 The physician was urgently called at 08:15 to intubate Keegan
Third MRP in ER (family physician)	September 16, 2015 (the morning Keegan needed intubation) The physician noted at 09:09 that rounds were not done yet
Fourth MRP Internal medicine specialist in ICU (Internal Medicine)	September 16, 2015 10:50 Keegan was transferred from the ER to the ICU and under Fourth MRP physician

²MRP (most responsible physician or most responsible practitioner) generally refers to the physician, or other regulated health care professional who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.
(Source: [Who is the most responsible physician? Check your knowledge](#))




CULTURALLY UNSAFE ENCOUNTERS SURROUNDING KEEGAN'S DEATH

The story of Keegan's death describes a series of encounters with the health system that were culturally unsafe for Keegan and his caregiver, Rhianna. The caregiver describes these as "warning signs" and that even had Keegan lived, she would have brought forward significant concerns with the way he was treated. The lack of cultural safety actively contributed to the delay in diagnosis and treatment of Keegan's accidental poisoning that may have prevented his death. The lack of Cultural Safety and Humility in Keegan's care affirms that racism and discrimination exist in our health care system and they can be fatal.

Keegan's story also demonstrates that his death was not a result of one mistake by "a bad apple," but rather the result of a series of culturally unsafe and harmful encounters with a team of registered Canadian health professionals working in an urban setting that impacted their ability to provide high quality care and save his life. When responsibility cannot be put on a single person, it indicates that there is something wrong with the culture of the system. Systemic racism can therefore be understood, "not as a set of individually held beliefs or actions...but as a structure of indifference" affecting the likelihood of a good outcome.⁴⁴ The important thing is not just how to keep bad health providers from harming patients, but also how to keep good providers from harming patients.

ENCOUNTERS THAT WERE CULTURALLY UNSAFE FOR KEEGAN AND HIS CAREGIVER:

- **HEALTH PROVIDERS' DECLARATION THAT "WE KNOW KEEGAN"**
- **CAREGIVER CONCERNS DISMISSED**
- **DELAY IN DIAGNOSIS – LACK OF URGENCY**
- **"DO NOT RESUSCITATE" SUGGESTION**
- **DEVIATION FROM PROTOCOLS AND DIRECTIVES**
- **RESTRAINT AND NEGLECT**
- **LACK OF COMMUNICATION WITH THE CAREGIVER AND FAMILY**
- **CONCERNS WITH CORONER'S INVESTIGATION AND REPORT**
- **DENIAL BY THE PATIENT SAFETY REVIEW THAT RACISM AND DISCRIMINATION PLAYED A ROLE IN KEEGAN'S DEATH**



Systemic bias leads to culturally unsafe and harmful behaviours, as Keegan’s story reflects. In the section that follows, each Culturally Unsafe Encounter is identified and described in detail. It is important to note that these experiences are interconnected in complex ways. Each encounter also clearly mirrors growing evidence of what Indigenous-specific racism and discrimination look like in the health system, as reported by both Indigenous people and Canadian health providers.^{4, 28}

Discussion of each Culturally Unsafe Encounter also includes a brief discussion of what Cultural Safety and Humility could look like in this context. The Cultural Safety and Humility learnings presented are not prescriptive as cultural safety is not “one size fits all” and can look differently to different people, in different settings and circumstances.

It is also critical to recognize that Cultural Safety and Humility is not “optional” or exceptional to existing standards of care, codes of conduct and provider compensation. Declarations of Commitment to Cultural Safety and Humility have been signed by each of the regulatory bodies that govern health professionals in BC, leaders of each of the regional and provincial health authorities, and finally by the Ministry of Health and Ministry of Mental Health and Addictions. The commitment to change and transformation has been made at every level – from individual to employer to system.

HEALTH PROVIDERS' DECLARATION THAT "WE KNOW KEEGAN"

Biased judgments that prevented health providers from responding with care to Keegan's accidental poisoning seemed to have begun with Keegan's very first point of engagement with the health system and continued throughout his experience in the ER. The emergency responders who answered the caregiver's 911 call told her that they "knew Keegan." The hospital team also indicated they were familiar with Keegan, as affirmed through comments made during the regional health authority review process. This indicated that the health providers already held negative perspectives of Keegan, perhaps because of his previous interactions with the system and/or judgments related to Indigenous people (especially around substance use) or people with disabilities. This sense that the health providers held preconceived ideas about Keegan and his "quality of life" came up for the caregiver again when the resident suggested putting a DNR on Keegan's file.

Keegan's experience echoes the story of Brian Sinclair, an Indigenous man who died of a bladder infection having never received care following a 34-hour wait in the Winnipeg Health Sciences Centre Emergency Department waiting room in 2008.¹⁵ His experience reflects how bias and judgments can lead to a stereotyped person being simultaneously "invisible" and "overly visible."⁴⁵ Declaring that they "knew Keegan" suggested the health providers believed they already knew what was wrong with him. It contributed to his caregiver's impression that the health providers felt that having to interact with Keegan again was a waste of time or a nuisance. This experience seems to reflect two of the top 10 most prevalent stereotypes of Indigenous people identified in recent San'yas research, including that they are "alcoholics" and "drug addicts."²⁸ This prior "knowledge" appeared to affect the emergency responders' behaviour as they seemed reluctant to bring Keegan to the hospital, despite evidence that something was very wrong. The caregiver needed to advocate strongly for Keegan to be taken to hospital.



CULTURAL SAFETY & HUMILITY LEARNING

Cultural Safety and Humility means meeting people where they are at, regardless of the complexity of their case or the challenges they face. As a result, knowing a patient can be a positive thing. From the caregiver's perspective, if the health providers really had "known" Keegan, they would have found other ways to communicate with him, despite him being non-verbal. They would have taken care to monitor him, knowing that showing signs of distress or worsening condition may look different for a person with different abilities and with Keegan's life experiences. They would have listened and responded to the caregiver's concerns that something was really wrong with Keegan without pushing back. They would have assessed the current facts and situation instead of relying solely on their biased previous experience with the patient.

CAREGIVER'S CONCERNS DISMISSED

Throughout Keegan's time in the ER, the caregiver – an Indigenous woman – felt that her worries about the severity of Keegan's condition were not taken seriously or acted upon. She felt she had to advocate for Keegan to be taken to hospital by the emergency responders in the afternoon, and for him not to be discharged from the hospital by the resident that night. While the signs that something was wrong with Keegan were clear to her, they did not seem visible to the health professionals involved in his case. Her expertise and knowledge could have helped the health providers navigate Keegan's disabilities and nonverbal communication. Instead, the caregiver felt that she was perceived as a nuisance by the health providers as she tried to advocate for Keegan. Her experience is consistent with prevalent stereotypes identified in recent San'yas research from BC, including that Indigenous people "abuse the system" and "don't cooperate."²⁸



CULTURAL SAFETY & HUMILITY LEARNING

Families and caregivers have an important role to play in a patient's support system and circle of care. Keegan's caregiver brought with her knowledge and expertise about Keegan, including what was normal for him and how to communicate with him. Cultural Safety and Humility includes respecting and calling on a person's or family's knowledge to support the patient on their health and wellness journey. Listening, believing and addressing the concerns of those closest to the patient is essential.

DELAY IN DIAGNOSIS – LACK OF URGENCY

Within 2.5 hours of arriving at hospital, lab results were available that indicated that Keegan had ingested toxic levels of methanol and was experiencing a medical emergency (metabolic acidosis).⁴² However, it took more than 12 hours from the time the lab results showing the severity and cause of Keegan's condition came in to when he was diagnosed. Missing these results prevented Keegan from getting timely access to treatment and constitutes a major clinical error on the part of the physicians responsible for Keegan's care. This is a significant concern that has been discussed in the regional health authority's review of Keegan's case. As acknowledged by the regional health authority, had the emergency physician reviewed the initial lab results, it may have altered the final outcome.⁴¹

However, this is not the only concerning issue around diagnosis of Keegan's condition. It is alarming that the physicians involved in Keegan's case did not appear to be making an effort to reach a diagnosis at all. In the eight hours between being admitted to the ER (at 17:21) and care being transferred to the second MRP (at 23:45) by the resident physician, Keegan's condition did not improve. Yet no additional efforts appear to have been taken to come to a diagnosis following the first physician's visit, such as further lab testing, discussion with a more senior physician or a referral. It does not appear that Keegan's case was seen by or discussed with an attending physician at any point prior to 08:00 the next day. Lack of effort suggests that the team of physicians and nurses did not believe that there was something seriously wrong with him and that he was being left alone to "sleep off" his symptoms. Again, this culturally unsafe experience recalls the San'yas research that identified persistent stereotypes related to substance use and abuse of the system by Indigenous people held by health providers in BC.^{4,28} Further, it reflects the discriminatory behaviours by health providers that result from these stereotypes and biases: less effort, lack of diagnosis, minimization of the condition, delays and not providing treatment.^{4,28} As a result of a diagnosis not being pursued with urgency, a time-sensitive yet treatable condition went untreated. Keegan died as a result.



CULTURAL SAFETY & HUMILITY LEARNING

Cultural Safety and Humility would have involved the team of health professionals demonstrating urgency, commitment and effort to come to a diagnosis of Keegan's condition and responding with appropriate timely treatment. "Consider first the well-being of the patient" is the premier fundamental responsibility outlined by the Canadian Medical Association's Code of Ethics and Professionalism.⁴⁶ It applies to all patients, regardless of their ethnicity, abilities, experiences with substance use current or past, the complexity of their case or their previous engagement with the health system.

“DO NOT RESUSCITATE” SUGGESTION

Patients have the legal right to a DNR order, which has roots in compassion and patients’ rights. In the context of Keegan’s experience, however, the way the discussion of the DNR took place felt like the opposite – a lack of recognition of Keegan’s rights and capabilities, and a lack of hope or commitment to helping him get well. The resident initiated a DNR conversation with Keegan’s caregiver, seeming to reflect an assumption that Keegan was not capable of making this important decision for himself. Further, the caregiver got the strong impression that the resident went beyond a standard discussion and set of questions, and instead was suggesting a DNR be placed on his file. This further indicated to the caregiver that the resident did not feel Keegan’s life was worth saving and only saw Keegan for his disabilities – not his many abilities. Unfortunately, this suggestion also echoes a racist stereotype that has been a part of Canadian society for hundreds of years. Since first contact, one of the ways that settler Canadians have justified colonization is a faulty belief that Indigenous people were physically inferior and destined to “die out.”^{25, 47} Today, the tendency of media and scientific research in Canada to focus only on health disparities perpetuates and normalizes this idea that Indigenous people are sick and dying. Deep-rooted societal biases as old as Canada itself may play out in health care as health providers subconsciously determine who is worthy of intense effort, expensive treatment or therapies. This notion is so deeply rooted in Canadian society that it can impact everyday interactions, such as when a resident physician suggests a DNR for a 29-year-old college student with undiagnosed symptoms.



CULTURAL SAFETY & HUMILITY LEARNING

First and foremost, a DNR order should be the decision of the patient. Cultural Safety and Humility would have involved asking Keegan about his own wishes. As well, the caregiver asked the resident what her code of ethics would say about a DNR for another 29-year-old man who came into her care (a stranger about whom the provider held no preconceived judgments), and recalls the resident saying, “We would try to save him.” This interaction shows that for the caregiver, Cultural Safety and Humility meant that Keegan would be seen and treated like any other man of his age coming into the ER.

DEVIATION FROM PROTOCOLS AND DIRECTIVES

It appears from the medical charts that the resident ordered Keegan's neurovital signs to be checked every two hours and that any change should be reported to the MRP. These directives were not followed. No neurovitals were recorded between 01:30 and 08:00. Despite a decrease in Keegan's Glasgow Coma Scale from 15 (at 21:30) to 12 (at 01:30), the MRP was not contacted as directed. When Keegan's caregiver left the hospital for a rest, she put trust in the health providers that they would monitor and respond to any issues that arose. However, in her absence, he was neglected and his condition worsened to the point of critical without anyone responding. Similarly, San'yas research identified that stereotypes and biases against Indigenous people can result in health providers not following procedure.²⁸ In this case, failure to follow procedure further contributed to Keegan's death. It is important to recognize that the health providers were in contact with Keegan during the night in the process of restraining him to his bed. Yet, despite their contact with him, they did not take the prescribed steps to monitor his condition nor did they take action in response to any other signals that may have alerted them to his worsening condition. The layers of Keegan's identity as a First Nations person with disabilities who previously had a lot of contact with the health system created a solid wall through which his symptoms and physical distress were rendered invisible.



CULTURAL SAFETY & HUMILITY LEARNING

Cultural humility is an ongoing process of reflection by individuals and organizations to recognize and address embedded biases that can cause harm. Cultural safety would have the health professionals involved in Keegan's care following the physician's directives, appropriate procedures and upholding their codes of conduct, with no exceptions. Just like all BC residents, First Nations and Indigenous people deserve to receive the highest standard of care and trust that the system will adhere to guidelines, protocols and codes.



RESTRAINT AND NEGLECT

As the Coroner's Report highlights, Keegan was put into waist belt restraints during the night.⁴¹ The reasons given for restraining Keegan documented in the Coroner's Report (but not in the medical records) were that he "was found on the floor beside his bed at approximately 02:40 on September 16."⁴¹ At 03:30 he was noted as very restless and trying to get out of bed.⁴¹ The caregiver explains that it was hard to understand the use of restraints, rather than some alternative measure, as a response to Keegan's behaviour. It was not clear to the caregiver that the principle of "last resort" was applied in this case. Instead, restraining Keegan gave his caregiver the impression that he was perceived of as a "problem patient" by hospital staff, rather than seeing his fall and restlessness as signals that something was seriously wrong. "Barbaric" and "chained up like an animal" are the phrases that the caregiver uses to describe her outrage that Keegan was restrained and left alone instead of being treated with compassion, care and kindness with real efforts to get to the root cause of his symptoms through a diagnosis.

Conventional standards around the use of restraints are that they should be used as a last resort in situations where all other efforts have failed. These considerations are especially critical in the context of traumas that took place in Canada's residential schools and Indian hospitals, as well as their legacy among intergenerational survivors that may include child apprehension and incarceration experiences. Under the Indian Act, Canadian law makers claimed authority to make residential school and Indian hospital attendance compulsory for First Nations people.^{12, 25} Survivors have testified to abuses – including use of restraints – in these schools and hospitals.^{13, 48, 49} This is not abstract in the context of health services that are delivered in BC in close proximity to the 21 former residential schools and three former Indian hospitals (Coqualeetza Indian Hospital in Chilliwack, Miller Bay Indian Hospital in Prince Rupert and Nanaimo Indian Hospital in Nanaimo). Survivors of these schools and hospitals, as well as their descendants, continue to access mainstream health services provided by the hospital and regional health authority. Present day use of restraints can trigger traumatic memories of systemic abuse and lack of agency experienced in imposed colonial institutions such as schools, hospitals and prisons.^{10-12, 20, 49} Urgent need for First Nations input into laws related to both chemical and physical restraints are underscored by recent figures from BC's Office of the Ombudsperson highlighting substantial increases in people experiencing involuntary detainment in psychiatric care in the last decade.⁵⁰ Building trust between the health system with BC First Nations means holding First Nations rights, agency and decision-making paramount in health care settings.

There is no indication in Keegan's medical records that alternative strategies to restraint were pursued; in fact, there is no charting related to him being restrained at all. Again, the health providers entrusted with Keegan's care failed to adhere to protocols. Restraint standards were not followed as there was no documentation about his condition in the time between being restrained (around 03:30) and 08:00 when his condition was found to have declined significantly.

For Keegan's caregiver and family, thinking about their loved one left in restraints and unmonitored, counter to restraint protocols and physician's orders, is profoundly distressing. Knowing that Keegan was dying from severe poisoning during this time intensifies the shock at the use of restraints and the feeling that it was cruel and contributed to additional suffering. It gives the impression that Keegan's health and well-being mattered so little to the health providers that securing him to his bed was preferable to navigating the complexity of his non-verbal communication to address the issues that contributed to his restlessness and fall.



CULTURAL SAFETY & HUMILITY LEARNING

Current restraint policies have been developed through a mainstream ethical lens. First Nations perspectives, values and decision-making have not informed these protocols. Part of Cultural Safety and Humility is ensuring that First Nations beliefs, laws and cultural practices are acknowledged and respected in mainstream health settings. The caregiver shared that she was surprised that she was not called in to assist when Keegan was having difficulties during the night, which illustrates an alternative approach of an Indigenous-informed restraints policy where the family or caregivers would be called upon as part of efforts to ensure that restraints are used as a last resort.



LACK OF COMMUNICATION WITH THE CAREGIVER AND FAMILY

Throughout Keegan's stay in the emergency department, he and his caregiver experienced long periods of time between contact with physicians. Five hours elapsed before he was seen following his initial triage visit. During this time, the caregiver made several requests of nursing staff about what was going on with him and his care. She got the impression from their response that she was perceived as a nuisance. When the resident visited that evening, the caregiver recalls having to ask, "What is wrong with him?" because information on his condition was not offered. It is not clear if this met or did not meet expected standards within this emergency room setting. Despite the caregiver's persistent advocacy, her efforts did not prompt the health care providers to investigate further into the cause of Keegan's condition. In fact, she was told to take him home and, later, to go home herself. In this context, the missed diagnosis created additional harm to the caregiver, as she is left with a profoundly distressing worry that if she had only advocated harder for Keegan, the outcome might have been different.

Several powerfully embedded dynamics are evidenced in these experiences. One is enduring power differentials between health providers and patients (and their families). Another is an underdocumented but often articulated understanding that "Seeking Care While Indigenous" requires going to great lengths to improve the chances of being taken seriously and treated with respect. Examples include changing clothes before going to the hospital and carefully controlling language or behaviour to avoid being perceived of as difficult, for fear of retaliation.⁴ Finally, it reflects that Indigenous people may feel like they need to remain constantly vigilant for their loved ones and not leave them unattended, stemming from knowledge that the health system has often been an unsafe place for Indigenous and/or people with disabilities.



CULTURAL SAFETY & HUMILITY LEARNING

Establishing trust with First Nations and Indigenous patients and their families is essential to Cultural Safety and Humility. It is especially important in the context of historical and present-day traumas experienced within the health system. Patients and their families have the right to be informed about their care. Reciprocal engagement with caregivers and family contributes to a culturally safe health services environment. When a patient enters the doors of the hospital, by definition they have lost some control and agency in their health and wellness journey. Now, their health depends on the involvement of health providers who may be strangers without shared life and cultural experiences. Rather than "taking over," cultural safety may mean that health providers join the circle of care that exists around the patient and work together with other members of that team. Clear, respectful and regular communication with the patient and their caregivers is essential to Cultural Safety and Humility.



CONCERNS WITH THE CORONER'S INVESTIGATION AND REPORT

After his death, the caregiver was in contact with the BC Coroners Service as part of ensuring that Keegan could be buried within four days in accordance with Coast Salish death protocols. The caregiver was asked some questions that helped the Coroner determine that Keegan's death was not a suicide. Although the Coroner's Report was issued on April 23, 2017 (nearly two years after Keegan's death), the caregiver was not contacted again during the investigation to share information about the circumstances of Keegan's death or his experience at the hospital. She was not informed of its conclusion or provided with the report when it was released.

The Coroner's Report was made available to the caregiver for the first time in November 2017 at a meeting described below, which was a surprise, as the caregiver had expected to be notified when the investigation was concluded. The initial report also raised several concerns. The initial report did not reflect the complexity of the case, the lack of cultural safety or the delays by health professionals in diagnosing and treating Keegan. Instead, it framed the situation as an "accident" solely related to his ingestion of methanol. This is especially surprising given that his death was sufficiently of concern to warrant a patient safety review by the regional health authority. Although the Coroner has authority to make recommendations to help prevent similar deaths under Section 16 of the BC Coroners Act, no recommendations were made.⁵¹ There were also concerns about inaccurate statements made in the initial report that added to the sense that the investigation was not thorough. The way the Coroner's Report was written put the onus of the "accident" on Keegan for ingesting the windshield wiper fluid, with no discussion of the health providers' delay in diagnosing and treating Keegan while in their care. In this way, it omitted the role of the health providers in Keegan's death, thereby helping to maintain harmful stereotypes about Indigenous people and normalize the death of a 29-year-old BC First Nations man. Finally, it also represents an example of the failure of a "Nothing About Us Without Us" approach to inclusivity, as the caregiver and Keegan's family were not involved or even notified within the Coroner's process.



CULTURAL SAFETY & HUMILITY LEARNING

Cultural Safety and Humility in the context of the Coroner's investigation would have included open communication with the caregiver and family about how the investigation was progressing and when it came to an end. It would have reflected greater concern about the circumstances of Keegan's death, including investigating the health professionals' delay in diagnosing and treating him, as well as the other disturbing aspects of his stay in the emergency room. Part of this investigation would have included calling on the caregiver's knowledge of Keegan and the events surrounding his death. Finally, the caregiver and Keegan's family would have been notified about the conclusion of the investigation and provided the final report related to the death of their loved one.



DENIAL BY THE PATIENT SAFETY REVIEW THAT RACISM AND DISCRIMINATION PLAYED A ROLE IN KEEGAN'S DEATH

The FNHA's Policy Statement on Cultural Safety and Humility makes it clear that we will know that the health system is culturally safe when First Nations and Indigenous people in BC tell us that it is.³⁴ That is why it is important to listen when people like Keegan's caregiver work hard to tell us when it is not.

The caregiver has shared that she believes Keegan was treated differently because of his First Nations identity and disabilities.³⁹⁻⁴¹ This included when the emergency responders and health providers did not seem concerned when she tried to tell them that his behaviour was not normal.^{40, 41} It was indicated by the apparent lack of effort to arrive at a diagnosis and suggestion that a DNR be placed on Keegan's file, as well as the use of restraints. It was also reflected in the health providers' neglect of Keegan during the night, deviating from both doctor's orders and documentation guidelines.⁴⁰ The caregiver is able to point to six different and specific experiences of cultural unsafety that contributed to Keegan being treated differently than how another young man (able and non-First Nations) would have been treated in his place.

Following Keegan's death, a patient safety review took place at the regional health authority. The facts at the time of this report note that the review panel did not include any First Nations or Indigenous representation. The panel focused on the technical errors made by the health providers, rather than the culture of care that made it possible for Keegan and his caregiver to have so many culturally unsafe experiences. It is common for complaints processes to take the position that considerations beyond technical aspects are outside of their scope.^{15, 20, 44, 45}

However, this constitutes a form of cultural unsafety in and of itself. Not including considerations of cultural unsafety, racism and discrimination within a complaints process echoes documented anti-Indigenous stereotypes that portray Indigenous peoples as not being able to "get over it" (harms of the past).²⁸ Discounting the caregiver's concern that Keegan was treated differently or that discrimination and cultural unsafety played a role in the technical errors made by the health providers meant that the harms she and Keegan experienced were not fully considered or addressed. Left unaddressed, it became possible for the harm to continue to happen to others. The caregiver's worst fears were realized when two years later another instance of cultural unsafety prevented a member of Keegan's Nation from getting prompt and adequate care at the same hospital emergency room.

In addition to denying that Indigenous-specific racism or discrimination played a part in Keegan's experience while at the hospital or in his death, no health care providers involved appeared to face consequences or disciplinary action for breaches of standards and protocols (such as monitoring neurovitals or documenting the use of restraints). The question of why these protocols and standards were not upheld does not appear to have been explored in the course of the patient safety review. The patient safety response was to order training to review practice expectations, although it is unclear whether this was for the specific nurses involved or more broadly across the ER or the regional health services.

While this is certainly an important action, for Keegan's family and others who have heard his story, it raises the question, what is the consequence for neglect or harm? What is the incentive to provide high quality care and service to every member of the public if there is no consequence for not doing it? If not a breach in protocols designed to raise the alarm about the worsening condition and resulting in the later death of a young patient, then when? From this perspective, the lack of repercussions appears to be another example of the ways in which the health system demonstrates a tolerance of racism.



CULTURAL SAFETY & HUMILITY LEARNING

There is strong evidence that Indigenous-specific racism and discrimination, which underpins settler colonialism and create harms within health contexts, persists in the BC health system and its services.^{4, 24, 28, 29, 52-54} **BC health leaders have begun to acknowledge this fact, including it as part of the healing ceremonies that took place with Keegan's family and the regional health authority (see Keegan's Legacy, September 2019).**

Embedding Cultural Safety and Humility into complaints processes involves building a framework in which issues of Indigenous-specific racism and discrimination can be examined and addressed. Transforming complaints processes must be undertaken in partnership with BC First Nations to ensure that First Nations are represented and that First Nations decision-making and perspectives of health and wellness are respected. This means reviewing the independence, composition, processes, transparency and accountability of complaints committees. It also means reviewing the quality, fairness and consistency of their decisions around complaints, and reviewing their access to effective educational tools.

SUMMARY

Keegan and his loved ones experienced a series of culturally unsafe and harmful encounters that contributed to him not receiving the care he needed to survive an accidental and treatable poisoning. Actions (or lack of action) taken by health professionals resulted in not one but multiple occurrences when health professionals did not take steps that would have contributed to a timely diagnosis and treatment of his condition. Although the lab request taken at admission indicated both the cause and the severity of Keegan's condition, there was a 12-hour delay once the lab results were available during which he was not diagnosed or treated for methanol poisoning. The lack of urgency and neglect that Keegan experienced at the hospital suggested that he was being left to "sleep it off" and echoes common experiences of stereotypes about Indigenous people (racist beliefs) shown to lead to discriminatory behaviour in emergency health care settings.^{28, 29} Layered on top of this was a failure to navigate Keegan's disabilities effectively. Patients with complex needs, including those related to living with disabilities, substance use or other challenges that may lead to frequent engagement with the health system, deserve to receive quality health care like anyone else.

In the years since Keegan's death, his caregiver has worked persistently to advocate for changes at the hospital that would prevent discrimination and harm to other First Nations patients, including those with disabilities.³⁹ The Truth and Reconciliation Commission of Canada developed a definition of reconciliation and a guiding set of principles for truth and reconciliation. One of the principles states, "Reconciliation is a process of healing of relationships that requires

public truth sharing, apology, and commemoration that acknowledge and redress past harms."¹² There must be the opportunity for truth before reconciliation can take place. The caregiver's goal is to "Make an example of this situation to ensure these injustices don't continue to happen. Continued discrimination needs to stop. We need to change the way all Indigenous people, including those living with disabilities are treated while in the care of those who should be providing fair and equitable treatment to every patient, with no exceptions."³⁹



CULTURAL GROUNDING

We walk together in partnership and in care

Receiving a teaching with an open heart and a strong mind empowers the voice the creator has given us all to speak when we hear, when we see and when we feel action that does not align with the teachings our Elders, our knowledge keepers charge us to uphold



KEEGAN'S LEGACY: HELPING TO SHAPE THE HEALTH SYSTEM'S CULTURAL SAFETY AND HUMILITY JOURNEY

First Nations and Indigenous people deserve to receive culturally safe health care in their own lands and territories. This includes the best of both traditional and mainstream medicine. Transforming mainstream health services to ensure that they are culturally safe and provide the highest quality health care for First Nations people in BC requires resetting the relationship between First Nations people and the whole health system in ways that are inclusive and respectful of First Nations rights, perspectives of health and wellness, and that recognize the impacts of colonial history including Indigenous-specific racism and its contribution to less access, poor health services and harmful experiences. It's important that every person working in the health care system knows that they can positively contribute to a new narrative moving forward. First Nations people in BC are beginning to come forward with complaints that reflect the harms they have experienced within the health system.⁴ It is important that they are heard. There needs to be more clear, transparent and effective processes for people to raise their concerns, and for the adjudication and resolutions of these issues to translate into policy and practice changes that create a safer health care system for Indigenous people.

Keegan's ongoing legacy has been to help shape the Cultural Safety and Humility journey that is currently underway in BC's health system. Setbacks and missteps have been part of the journey. Yet BC First Nations leadership through the First Nations Health Governance Structure, advocacy by the caregiver and commitments to Cultural Safety and Humility have led the system to pay attention, engage and take steps to make change. The next section highlights some of the events and milestones that have taken place so far. The journey is still unfolding.

EVENTS AND MILESTONES IN THE CULTURAL SAFETY AND HUMILITY JOURNEY OF BC HEALTH CARE

JULY 2015

BC Health Authority CEOs sign the Declaration of Commitment on Cultural Safety and Humility with the FNHA. Around the time of Keegan's death, the FNHA came together with the BC Ministry of Health and the CEOs of each of the health authorities in the province to sign the very first Declaration of Commitment on Cultural Safety and Humility, grounded in ceremony. Since then, many other provincial and federal health system partners have signed on as well, including the regulatory bodies that govern all health professionals in BC. The Declaration has created a foundational framework to enable a climate of change and a new accountability to First Nations and Indigenous people in BC.

OCTOBER 2015

Regional health authority conducts patient safety review into Keegan's death. On October 27, 2015, the caregiver met the regional health authority's review panel.³⁹ The review resulted in a number of recommendations and immediate outcomes.



OCTOBER 2015

These included follow-up with the resident physician regarding having clinically appropriate conversations, and changes to laboratory testing and procedures.⁴¹ Now, 100% of CP7 labs that have an abnormal bicarbonate and anion gap will have an auto-run serum osmolality, and more extensive toxicology screening will be undertaken for all patients presenting to the Emergency Department with an altered level of consciousness.⁴¹ Further, when ER physicians conduct reviews with their residents, clinical information such as charts, diagnostics and lab reports are now to be included for reference. However, the scope of these changes is not clear as to whether they're applied at the hospital or across the health authority. The review panel also fell short of acknowledging the dynamics of racism and discrimination that contributed to lack of cultural safety in Keegan's care and the impact this may have played in his death. The caregiver's understanding of Keegan's ordeal as being rooted in racism and discrimination was not believed or recognized by those reviewing the case.

DECEMBER 2015

Cultural safety training encouraged by the regional health authority. In response to recommendations from the patient safety review, the regional health authority encouraged all nurses and staff to participate in an Indigenous Cultural Safety Training Program.⁴¹ It is important to note that the FNHA continues to advocate for cultural safety training to be mandatory for all people working in BC's health system.

JANUARY 2016

Regional health authority initiates nurse training. In response to recommendations from the patient safety review, the regional health authority initiated training sessions in partnership with the BC College of Nursing Professionals (now the BC College of Nurses and Midwives) to review practice expectations; although it is not clear what practice expectations were reviewed (e.g., restraints, documentation, assessments).⁴¹

FALL 2016

The FNHA establishes a Quality Agenda. In the fall of 2016, the FNHA established a Quality Agenda with six strategic priorities to be implemented over a number of years. Strategic Priority 3 is to "establish an FNHA complaints process which supports the quality of all health services accessed by First Nations in BC." As a signatory to the Declaration of Commitment on Cultural Safety and Humility, the FNHA has a responsibility to help make the health system safer for First Nations people in BC through health system partnerships. Keegan's story is one of the first complaints the FNHA engaged with, and it has been key to beginning to develop a culturally safe complaints process that brings together BC First Nations and health system partners to address harms and create a safe environment of care.



AUGUST 2017

Regional health authority hires Elder-in-Residence. The hospital introduced an Elder-in-residence who works one-on-one with the Emergency Department team and attends staff meetings to support understanding of First Nations culture.⁴¹

FALL 2017

Regional health authority reports on Cultural Safety and Humility initiatives to the Tripartite Committee on First Nations Health. As part of the regional health authority's accountabilities outlined in the Tripartite Framework Agreement on First Nation Health Governance, the health authority reported on Cultural Safety and Humility initiatives undertaken in 2016/17.⁵⁵ During this time, they developed and enhanced a culturally safe process for the intake and reporting of Indigenous-specific complaints; established a multi-year Elder-in-Residence initiative to provide cultural services to staff and patients in two hospitals; implemented a video and poster campaign articulating the shared vision of a Cultural Safety Framework that was developed to help staff understand their role in improving services for the Indigenous population; and worked in partnership with the FNHA and Métis Nation BC to develop an 'Introduction to Aboriginal Health' eLearning module.

SEPTEMBER 2017

Another incident at the same hospital resurfaces the caregiver's concerns. Another incident in 2017 involving a member of Keegan's Nation at the same hospital affirmed that racism and discrimination against First Nations people within the ER persisted. Hearing about this person's experience resurfaced the caregiver's concerns that more people could die as a result of the lack of Cultural Safety and Humility at the hospital.

OCTOBER 2017

Case brought forward to the FNHA and partners. In October 2017, with the issue still unresolved, the caregiver brought the issue forward to the chair of the FNHC. Concerned about Keegan's case, as well as two others related to the Hospital, the Chair met with the caregiver and then brought the issue forward to be addressed by the regional health authority, the FNHA and the BC Coroners Service.

NOVEMBER 2017

Caregiver meets with First Nations and health system leaders. A meeting took place with Keegan's caregiver and representatives from Keegan's Nation, the FNHA, the regional health authority, the FNHC and the BC Coroners Service. The caregiver shared Keegan's story. There was discussion about the role of racism and discrimination in what had happened to Keegan. The regional health authority initially stated that the gaps in care for Keegan were not attributable to racism.⁴¹ The FNHC chair emphasized that the point was not to single out individual providers for racist beliefs or behaviour, but rather acknowledge that racism is embedded in the system and that it must be addressed. Acknowledgement from the regional health authority leadership that systemic racism exists in the health system was powerful, and has been reflected in shifting narratives by regional health authority leadership during subsequent engagements. During the meeting, each organization made commitments to take steps to address the caregiver's concerns and plans were made to reconvene.

MAY 2018

Revised Coroner's Report is issued. At the November 2017 meeting, the caregiver had brought forward her concerns about the BC Coroners Service's investigative process which she felt was inaccurate and insufficient. Involvement of the BC Chief Coroner and Regional Coroner at that meeting provided an opportunity for the caregiver and the BC Coroners Service to revise and develop a more fulsome Coroners Report that was issued on May 13, 2018.⁴¹ It included the following recommendations submitted to leaders of specific agencies in the BC health system:

- **To Dr. Ian Rongve, Assistant Deputy Minister, Ministry of Health:** That a copy of the Coroner's Report be reviewed for information purposes and consideration given to sharing the changes that have been made by the regional health authority with other health authorities. Other emergency departments may benefit from the lessons learned from Keegan's death, especially where resident physicians may commonly practice.
- **To Dr. Roger Wong, Executive Associate Dean, Education, Faculty of Medicine at UBC:** That a copy of the Coroner's Report be reviewed for information purposes with a view to improving practice by resident physicians working in acute care hospital settings.
- **To Dr. Heidi Oetter, Registrar and CEO, College of Physicians and Surgeons of BC:** That the College of Physicians and Surgeons of BC considers reviewing the care provided to Keegan with a view to improving practices around supervising physicians and their review of clinical decisions made by learners (students and residents). That consideration is given to sharing the circumstances of Keegan's death with practicing Emergency Department physicians in BC.

NOVEMBER 2018

Regional health authority board of directors to take cultural safety training. In November 2018, all members of the regional health authority's board of directors committed to take Cultural Safety and Humility training.

FALL 2018

Regional health authority commissions region-wide external review of cultural safety. The regional health authority's board of directors commissioned a region-wide external review of cultural safety within their health services including policies, strategies and practices. The review was undertaken by an independent team, led by a First Nations physician with significant experience in addressing racism and discrimination through cultural safety in health systems across Canada. The caregiver was invited to give specific input into this review.



SEPTEMBER 2019

Honouring ceremony at the hospital. A plaque and an artwork in Keegan's honour were unveiled at the hospital during a ceremony on the fourth anniversary of his passing (September 26, 2019). It was followed by a longhouse healing ceremony that included Keegan's family and caregivers, as well as representatives from his Nation, the regional health authority, the FNHC, the FNHA, the BC Coroners Service and others involved in Keegan's story. These actions are in keeping with the Truth and Reconciliation Commission's third principles of reconciliation: "Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms".¹² During the ceremony, Keegan's mother offered forgiveness to the health providers involved in Keegan's experience at the hospital.

FALL 2019

Creation of a scholarship and bursary in Keegan's name. The Keegan Combes Memorial Award was established to honour Keegan's memory. Keegan was at the start of a new chapter of his life when he died. He had attended his first day of classes to become a construction craft worker, but was never able to go to his second day. To honour Keegan's story and the path he was on, the FNHA has worked in partnership with Keegan's caregiver and family advocate to name one scholarship and two bursaries dedicated to supporting other First Nations students as they embark on their learning journeys.

JANUARY 2020

Renewal of the Fraser Partnership Accord. Building on the 2011 Fraser Partnership Accord, the Fraser Salish Regional Caucus, Fraser Health Authority and the FNHA renewed their relationship in January 2020. The Partnership Accord centres on the shared principle of Letse'mot (everyone working together) and includes six priority areas, one that focuses on Cultural Safety and Humility. A joint working group on Cultural Safety and Humility was created to carry out initiatives and objectives related to this priority, in accordance with the Fraser Health Aboriginal Work Plan: The Way Forward 2019-2024.

2020

Commitment to transforming complaints and strengthening quality through partnership. The renewed Partnership Accord included specific commitments to improve complaints, concerns and feedback processes and conduct joint reviews of critical injuries and deaths of First Nations persons. Acknowledgement that current complaints systems do not work for First Nations was also highlighted in the findings and recommendations of the *In Plain Sight* report. Three areas of work have been initiated by the FNHA Fraser Salish regional team: (1) mapping current complaints processes to identify a starting point for transformation; (2) hiring a full-time wellness systems quality care coordinator whose role is to take an early intervention approach to addressing Indigenous-specific racism and cultural unsafety when it occurs in any area of the regional health and wellness systems; and (3) building relationships across the region throughout the journey to refine processes that support the possibility of trust.



NOVEMBER 2020

Inclusion of Keegan's story in the *In Plain Sight* report. The *In Plain Sight* report was released following an investigation of Indigenous-specific racism in BC's health system. Keegan's story is shared as an emblematic story in both the executive summary and the full report. The report puts forward 24 recommendations to address Indigenous-specific racism in the health system that must be carried out by government, health organizations and all individuals working within the health system.

DECEMBER 2020

Statement of acknowledgement and apology. In partnership with local First Nations leadership, the President/CEO and the board chair of the regional health authority issued a statement fully accepting of the *In Plain Sight* report findings. The acknowledgement stated that "systemic racism has been a feature of our health care system from the beginning." It also included an apology to all those who had suffered in the regional health authority system. Signatories agreed that the Aboriginal Health Steering Committee will be the main table for anti-racism work, and that the United Nations Declaration on the Rights of Indigenous Peoples will serve as the framework for action.

APRIL 2021

The FNHC, the FNHDA and the FNHA publish the Anti-Racism, Cultural Safety and Humility Framework and Action Plan. The Anti-Racism, Cultural Safety and Humility Action Plan focuses on two overarching objectives: 1) to work with partners in BC to support a racism-free health system with embedded Cultural Safety and Humility practices; and, 2) the FNHC, FNHDA and FNHA are champions of Cultural Safety and Humility in BC. Priority action areas under the objectives are: 1) First Nations-led responses; 2) regional innovation and focus; and 3) service excellence.



RECOMMENDATIONS

BC First Nations and Indigenous peoples have already provided clear instructions for reconciliation within the:

- United Nations Declaration on the Rights of Indigenous Peoples⁵⁶
- 94 Calls to Action of the Truth and Reconciliation Commission of Canada¹²
- 231 Calls for Justice of the National Inquiry into Missing and Murdered Indigenous Women and Girls⁵⁷
- BC Declaration on the Rights of Indigenous Peoples Act⁵⁸
- 24 recommendations in the *In Plain Sight* report.⁴

We add our voices to call for the full implementation of these foundational frameworks as the way forward to address systemic harms and injustices outlined in this case study reflection. Keegan's case also brings to light a number of specific and urgent actions that must be taken by organizations and individuals throughout BC's health system. It is important that these organizations have First Nations/ Indigenous leadership in implementing their responsibilities.

It is also recognized that the environment is evolving to address Indigenous-specific racism and embed Cultural Safety and Humility throughout BC's health care system. Given that mechanisms are being set up to implement the recommendations of the *In Plain Sight* report and ensure accountability to First Nations and Indigenous peoples, the implementation and accountability process for this case study reflection should leverage these mechanisms rather than creating separate processes if possible.


SEE THE NEXT PAGES FOR OUR SPECIFIC RECOMMENDATIONS:

1. **CULTURAL SAFETY AND HUMILITY IN HEALTH SERVICES** (see page 35)
2. **CULTURAL SAFETY AND HUMILITY IN COMPLAINTS PROCESSES** (see page 37)
3. **CULTURAL SAFETY AND HUMILITY IN CORONER INVESTIGATIONS** (see page 38)



1. RECOMMENDATIONS: CULTURAL SAFETY AND HUMILITY IN HEALTH SERVICES

- 1.1** Share Keegan's story in a meaningful way with the health system for learning and action – including signatories to the Declaration of Commitment on Cultural Safety (Ministry of Health, Ministry of Mental Health and Addictions, Provincial Health Services Authority, all five regional health authorities, the BC Coroners Service, all 19 regulators of health professions in BC, the Ministry of Social Development and Poverty Reduction, Community Living BC, the Community Social Services Employers' Association, Health Employers Association of BC, disability and inclusion networks, the Ministry of Advanced Education and educational institutions).
- 1.2** Incorporate Keegan's story into Cultural Safety and Humility education in BC for the purposes of learning to recognize and understand culturally unsafe experiences in the health system, as well as how individual practitioners and systems can change to become more culturally safe for BC First Nations and Indigenous people in BC.
- 1.3** Provide mandatory Indigenous support personnel to First Nations and Indigenous peoples who are non-verbal, have communication support needs or a complex disability, and who are accessing health services without family or advocates, and support training for this if needed. This position would coordinate with patient support systems and the family community to ensure proper information and responsive health services.
- 1.4** In partnership with First Nations and Indigenous peoples, work with all bodies involved in complaints in the health care system (patient care quality offices, regulatory bodies, the Health Profession Review Board, etc.) to review their processes collectively through a lens of patient safety and Cultural Safety and Humility (relationship-based care). This means reviewing the independence, composition, processes, transparency and accountability of complaints committees. It also means reviewing the quality, fairness and consistency of their decisions around complaints, and reviewing their access to effective educational tools. This group would also be asked to work towards a set of recommendations for legislative changes to support identified gaps through this collaborative process.
- 1.5** Make Cultural Safety and Humility education and disability awareness training mandatory, meaningful and experiential for all current and trainee health professionals in BC, recognizing this as a starting point in a lifelong journey.
- 1.6** Require explicit and ongoing acknowledgement by all levels of the health system that racism and systemic violence persist in the health system. Establish policies and safe pathways to support health professionals who witness racism and discrimination taking place at any level to disrupt or flag the situation and prevent it from causing greater harm. The system, teams and individual health professionals must learn to recognize discrimination, name it when it occurs, and address it with care and vigilance.

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- 1.7** Establish First Nations led co-created accountabilities related to racism and disability discrimination for health care organizations and professionals into quality, policies and practices. This must be hardwired into related human resource policies to ensure both patient and workplace safety.
 - 1.8** Increase and strategically promote opportunities for First Nation and Indigenous people to recruit, train and retain health professionals and paraprofessionals. Demonstrate priority and report on progress.
 - 1.9** Ensure patient rights and standards of care by creating a mechanism for a “rapid reality check” that allows First Nations and Indigenous people with concerns about the care they are currently receiving or have recently received to touch base about whether their experience is/is not meeting standards. Develop a feedback mechanism for follow-up.
 - 1.10** Undertake a review, in partnership with BC First Nations, of current physical and chemical restraint policies to ensure Indigenous-specific anti-racism, Cultural Safety and Humility, and trauma- and violence informed practices are embedded within these policies.



2. RECOMMENDATIONS: CULTURAL SAFETY AND HUMILITY IN COMPLAINTS PROCESSES

- 2.1** Provide public-facing clarity on the complaints and investigation processes, including standards, scope, workflows, public safety risk assessment tool, timelines and accountabilities. It is not clear who or when a report or complaint goes to the regulatory bodies and whether this knowledge is shared with the complainant through the process.
- 2.2** Confirm the independence and appropriate composition of any review panel. The review panel fell short of recognizing or acknowledging the dynamics of racism and discrimination that contributed to lack of cultural safety in Keegan's care and the impact this may have played in his death.
- 2.3** Require mandatory training to support individuals to recognize and understand systemic and structural racism and discrimination through the lens of colonization. This training should include Cultural Safety and Humility, Indigenous-specific anti-racism, trauma- and violence-informed practice and disability awareness for all staff who work as part of or support complaints and investigation processes.
- 2.4** In partnership with First Nations and Indigenous peoples, work with all bodies involved in complaints in the health care system (patient care quality offices, regulatory bodies, the Health Profession Review Board, etc.) to develop a patient risk assessment tool with which to help recognize or determine racism and/or discrimination and its related harm and risk to the public.
- 2.5** Require the regional health authority to establish a distinct, integrated and accessible entry point for First Nations complaints and feedback that is culturally safe and provide meaningful responses. The health authority will also be an active participant in the provincial work of enhancing complaint management for Indigenous populations and pursuing opportunities to coordinate with professional regulatory bodies, the Ministry of Health and the FNHA.
- 2.6** Develop and implement a communications strategy and campaign to ensure that BC First Nations and Indigenous people in BC know how to initiate a complaint.
- 2.7** Ensure that responses to complaints are done in partnership with and according to the protocols of the family, territorial leadership and territorial Elders or Knowledge Keepers to honour the principle of "Nothing For Us Without Us."
- 2.8** Implement the recommendations coming out of complaints processes more broadly to increase patient safety for all. For example, the change in practice regarding laboratory testing resulting from the regional health authority patient safety review should be implemented not just in the hospital where Keegan's experience occurred but in all hospitals across the province.



3. RECOMMENDATIONS: CULTURAL SAFETY AND HUMILITY IN CORONER INVESTIGATIONS

- 3.1** Make changes to the policies and practices of the BC Coroners Service in order to enable First Nations traditional laws, protocols and practices around death to be upheld. Identify if changes to the legislation are required to align the BC Coroners Act with the BC Declaration on the Rights of Indigenous Peoples Act (DRIPA), and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).
- 3.2** Improve standards with timeline requirements to ensure that family members and caregivers are kept informed during and following an investigation into the death of a loved one.
- 3.3** Systematically take into account the expertise of family members and others in the deceased's circle of care to determine the circumstances of death and develop recommendations to guide change. This should be undertaken only if the family and caregivers want to be involved, at their discretion and pace, with adequate supports in place.
- 3.4** Recognize the role that Indigenous-specific racism and discrimination can play in the deaths of First Nations and Indigenous people in BC, and make sure this is reflected in all coroner's reports. One example may be to take an approach similar to how a Gladue report is used in the criminal justice system to provide context.
- 3.5** Require mandatory training to recognize and understand systemic and structural racism and discrimination through the lens of colonization. This training should continue to include Cultural Safety and Humility and trauma-informed practice for all staff in the BC Coroners Service.



HOW TO MAKE A COMPLAINT IN BC

First Nations and Indigenous people have the right to access a health care system that is free of racism and discrimination and to feel safe when accessing health care. This means individuals, families and communities are able to voice their perspectives, ask questions and be respected by health care professionals about their beliefs, behaviours, lived experiences and values.

First Nations people who are unsatisfied with any aspect of their health care experience in BC, including racism or discrimination are encouraged to report the incident to the facility or hospital where the incident occurred, as well as to the regional health authority in which the incident took place. Indigenous Patient Navigators are available in every region and can offer in-hospital assistance to improve the quality of health care delivery to Indigenous patients through support or advocacy when dealing with healthcare providers. Among other services provided, Indigenous Patient Navigators may be able to attend medical appointments or meetings on site with you, or provide assistance with making a complaint.

If the incident was a result of racism, discrimination or negligence by a health professional, patients are encouraged to also report the incident to the regulatory body which the health professional belongs to.

First Nations people and their families have the right to raise concerns, and receive a timely response to their concerns, without fear of retribution or an impact on their health services and care. The FNHA can be your partner as you go through any of these processes. The FNHA will do their best to support your cultural and psychological safety throughout the process. *Note that you can choose to remain anonymous when working with the FNHA.* If incidents are unreported, they cannot be resolved or captured and used to support our collective work to transform the system to be a safe environment for our people.

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