

NEWS RELEASE

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Ministry of Public Safety and Solicitor General BC Coroners Service

Death review panel recommends prevention opportunities to help youth in care

VICTORIA – Following a review of 200 deaths of young people who died transitioning to independence from government care between 2011 and 2016, a death review panel has issued a series of recommendations to several provincial ministries.

The report, titled BC Coroners Service Death Review Panel: Review of MCFD-Involved Youth Transitioning to Independence: January 1, 2011 – December 31, 2016, identifies four areas of focus to reduce deaths of youth in transition from government care in B.C.:

- 1. Extending service supports based on the young person's needs;
- 2. Improved communication between service providers with the goal to increase engagement of youth;
- 3. Engagement with youth on service planning and policy development; and
- 4. Monitoring outcomes and use findings to support service planning and policy changes.

These findings are the basis for the following three recommendations put forward to the chief coroner by the panel. Details and timelines for each recommendation can be found within the report:

- 1. Expand agreements with young adults (AYAs) to address self-identified transition needs;
- 2. Ensure collaboration to support effective planning and service provision; and
- 3. Monitor support-service effectiveness for youth leaving care.

The death review panel, chaired by Michael Egilson, included 19 panel experts from social services, child welfare, health care, policing, First Nations, education and mental health and addictions.

"The transition from adolescence to adulthood can be challenging for most young people, and most continue to receive financial and other supports from their families well into young adulthood," Egilson said. "However, young people leaving government care often face additional life challenges during their transition to adulthood. They lose financial and other means of support, leaving them to face the transition to adulthood on their own."

"The issue of successful transition to adulthood for these young people is broader than just the scope of the Ministry for Children and Family Development," Egilson added. "The roles of Indigenous partners and education, advanced education, health and mental health ministries are also critical."

Generally, the review found:

• A lack of documented transition planning for youth leaving care or on youth agreements;

- A disproportionate number of Indigenous young people died;
- High rates of suicide and drug overdose deaths;
- · High rates of health and mental health issues;
- · Lower completion of educational attainment; and
- Barriers (system and personal) to successful transition to independence.

"Ultimately the goal of the panel is to identify issues to inform recommendations aimed at prevention deaths in similar circumstances," said Egilson. "It is our hope that these recommendations and findings can lead to positive change."

The full report is available online: https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/child-death-review-unit/reports-publications/youth_in_transition_-_death_review_panel_report_-_28-05-2018.pdf

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