HIGHLIGHTS

For release 11 a.m.
April 7, 2006

BC Children and Youth Review
Hon. Ted Hughes, OC, QC, LL.D. (Hon.)

THE REPRESENTATIVE FOR CHILDREN AND YOUTH:

As an independent Officer of the Legislative Assembly, the Representative should be appointed for a five year term, report to a Legislative Standing Committee established to address issues of children and youth, and:

- provide individual advocacy support, with a regional focus, to support dispute resolution.
- monitor and undertake broader systemic reviews and make recommendations enhancing child welfare.
- have two Deputy Representatives, one for advocacy and one for monitoring the child welfare system. At least one of these three senior people should be Aboriginal.
- review injuries and deaths in the child welfare system, where warranted, with an enhanced focus on analysis of trends and patterns, to inform public health and prevention.

Introduction of legislation in the fall session to enable establishment of this office is recommended.

ADVOCACY:

Child and family advocacy in BC has suffered in recent years. There is strong support for the provision of advocacy services: for individuals, and more broadly for positive change in policies, practices and services.

This should include a regional presence, to help children, youth and their families find their way through the system, and to make sure their voices are heard and considered.

ABORIGINAL CHILDREN:

The ever-increasing numbers of Aboriginal children being taken into care highlights the pressing need for the child welfare system to pay attention to Aboriginal perspectives, and find better ways to respond to their needs.

Aboriginal people alone truly understand their communities and the needs of their children and families. It makes sense that their own wisdom and understanding should guide the way to any change in the governance structure of the child welfare system that serves them, in partnership with the support and experience of the Ministry.

Recommendations also include immediate measures to strengthen current Aboriginal delegated agencies, such as office management skills, computer equipment, Internet access to track cases and communicate quickly with other agencies, and access to basic and specialized training opportunities.

LEARNING FROM AND IMPROVING ON CHILD INJURY AND DEATH REVIEWS:

In the aftermath of the tragic death of a child, what is sometimes lost sight of is that the death rate among children in British Columbia is declining and has been for years.

Sadly, children will continue to die. Every child's death diminishes us all, and every child's unexpected death needs to be carefully examined.

The report recommends an enhanced public health perspective, with a greater emphasis on looking at trends and patterns of deaths and critical injuries, and less emphasis on individual reviews of deaths.

GOVERNMENT ACCOUNTABILITY:

Government has a responsibility to be accountable to the public for its performance in protecting and serving children and youth.

The Ministry needs a regular, coordinated program of public reporting on its activities and the results achieved for children in care and children at risk. This must include Ministry accomplishments and successes.

The Hughes review recommends that Ministry annual reports provide a statistical analysis of its death reviews and critical incidents, as well as resulting recommendations and progress on implementation.

DECENTRALIZATION:

Decentralizing child welfare programs means involving local communities in service delivery and resource allocation, to better address the needs of children and their families. The report supports the move to decentralization, but only if important guidelines are respected. The move to decentralize services and authorities to the regions, and eventually to Aboriginal governance authorities, poses many challenges.

It is recommended government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stabilization.

955 TRANSITION FILES:

Hughes said he is satisfied with the current status of the Coroners Service review of the transition files.

The review's examination confirmed that:

- 539 files were active at the time the Children's Commission office closed
- During the transition period of transferring responsibility for child death reviews to Coroner's Service, 416 child deaths were recorded in the database.

Coroner's investigations have now been completed on two-thirds of the files, and the Coroner intends to have all reviews completed by September 2006.

The report recommends having the new Representative for Children and Youth prepare a special report examining any patterns or trends relating to the files of those children in the 955 transition files who had been in care or receiving Ministry services.