**Victoria Family Court and Youth Justice Committee**
**Notice of Meeting on Thursday, February 26, 2026 at 11:30 am**
**Boardroom, 6th Floor, 625 Fisgard Street, Victoria, BC**

Meeting to be conducted electronically and in-person.

Join Zoom Meeting | Meeting ID: 846 8038 0192 | Passcode: 190753

Toll-free number for Victoria area: +1-587-328-1099

https://www.victoriafamilycourt.ca

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1. **Territorial Acknowledgement**

2. **Approval of the Agenda**

   ***Recommendation: That the agenda for the Victoria Family Court and Youth Justice Committee meeting of February 26, 2026 be approved.***

3. **Adoption of Minutes**

   **3.1.** Minutes of the Victoria Family Court and Youth Justice Committee Meeting of January 22, 2026 (Attachment 1 – p.3)

   ***Recommendation: That the minutes of the Victoria Family Court and Youth Justice Committee meeting of January 22, 2026 be adopted.***

   **3.2.** Notes of the Victoria Family Court and Youth Justice Committee Steering Committee meeting of February 12, 2026 (Attachment 2 – p.6)

   ***Recommendation: That the notes of the Victoria Family Court and Youth Justice Steering Committee meeting of February 12, 2026 be received for information.***

4. **Chairperson's Remarks**

5. **Presentations/Delegations**

   **5.1.** Resource Agencies (if in attendance)
   **5.2.** Kathy Easton, Director of Implementation, Foundry BC, West Shore, Sooke & Port Renfrew
   **5.3.** Amy Schactman, Former Clinical Coordinator, Foundry BC, Victoria
   **5.4.** Foundry Youth Peer Counsellor - TBD

6. **Committee Business**

   **6.1.** 2025 Annual Report

   ***Recommendation: To amend and circulate when final financials are available.***

7. **Sub-Committee Business**

   **7.1.** Priorities and Grants (M. McLean)

   7.1.1. Victoria Youth Empowerment Society – Final Grant Report (K. Peterson) (Attachment 3 – p.7)

**7.2.** Capital Region Action Team for Sexually Exploited Youth
- 7.2.1. Formal Appointment of CRAT Chair
- 7.2.2. Presentation on the History and Purpose of CRAT
- 7.2.3. Mobile Youth Services Team Update

**7.3.** Youth and Family Matters (R. Stanton)

**7.4.** Court Watch (M. Little)
- 7.4.1. Revival of the Sub-Committee to Focus on Legislation and Service/System Gaps

**7.5.** Communications (J. Bateman)
- 7.5.1. Draft Calls to Action (M. McLean)
- 7.5.2. VFCYJC Website (R. LaBelle, Honeycomb Webworks) (Attachment 4 - p.12)
- 7.5.3. Future Guest Speakers
- 7.5.4. Open House 2026
- 7.5.5. Draft Report on the Panel Discussion of October 23, 2025 (Attachment 5- p.14)

## 8. Treasurer's Report

## 9. New Business
**9.1.** Succession Planning and the Qualification Matrix
**9.2.** Future Meeting in Central Saanich or Another Host Municipality
**9.3.** BC Coroner Service Report: Child Mortality in BC 2020-2024 (Attachment 6 – p.30)

## 10. Correspondence

## 11. Motion With Notice
**11.1.** Motion with Notice: VFCYJC Advocacy Letter to Central Saanich Police Board Re: Mobile Youth Services Team (S. Kim)
***Recommendation: That the Victoria Family Court and Youth Justice Committee write a letter to the Central Saanich Police Board advocating for the Mobile Youth Services Team.***

## 12. Adjournment

Roundtable to be held after adjournment, time permitting.

Next meeting of VFCYJC: April 23, 2026

Next meeting of Steering Committee: April 9, 2026

**Minutes of the Victoria Family Court and Youth Justice Committee meeting held Thursday January 22, 2026, CRD Boardroom, 6th floor, 625 Fisgard Street**

PRESENT:
Committee Members: M. Little (Chair), K. Guiry (Vice Chair), J. Bateman, D. Brown (EP), J. Crawford, C. Day, B. Gash, S. Kim, C. Lervold (EP), B. McElroy, M. McLean, T. O'Keefe (EP), E. Paterson, S. Riddell, R. Stanton, T. Vanwell (EP)

STAFF: S. Carey, Senior Manager, Legal & Risk Management; J. Ives, Committee Clerk; T. Pillipow, Senior Committee Clerk, Legislative Services; M. Essery, Recording Secretary (EP)

EP - Electronic Participation

Guests/Resource Members: K. Petersen, Youth Empowerment Society

Regrets: M. Olsen, M. Westhaver

The meeting was called to order at 1:06 pm.

## 1. TERRITORIAL ACKNOWLEDGEMENT

A Territorial Acknowledgement was provided in the preceding meeting.

## 2. APPROVAL OF THE AGENDA

**MOVED by S. Kim, SECONDED by K. Guiry,**
**That the agenda for the Victoria Family Court and Youth Justice Committee meeting of January 22, 2026, meeting be approved.**
**CARRIED**

## 3. ADOPTION OF MINUTES

### 3.1. Minutes of the Victoria Family Court and Youth Justice Committee Meeting of October 23, 2025

**MOVED by M. McLean, SECONDED by J. Bateman,**
**That the minutes of the Victoria Family Court and Youth Justice Committee meeting of October 23, 2025, be adopted.**
**CARRIED**

### 3.2. Receipt of the Steering Committee meeting notes of January 8, 2026

**MOVED by S. Kim SECONDED by K. Guiry,**
**That the notes of the Victoria Family Court and Youth Justice Steering Committee meeting of January 8, 2026, be received for information.**
**CARRIED**

## 4. CHAIRPERSONS REMARKS

The Chair had no remarks.

## 5. PRESENTATIONS/DELEGATIONS

### 5.1. Resource Agencies

K. Petersen shared an update on the Youth Empowerment Society.

## 6. COMMITTEE BUSINESS

### 6.1. Committee Orientation and Qualification Matrix Overview

Chair Little reviewed the Orientation PowerPoint for new and returning members.

Members are encouraged to complete the qualification matrix and email this information to vfamcourt@gmail.com.

## 7. SUB-COMMITTEE BUSINESS

### 7.1. Priorities and Grants (M. McLean)

There was no report.

### 7.2. Capital Region Action Team for Sexually Exploited Youth (CRAT) (B. McElroy)

After 19-plus years in the role, this will be B. McElroy's last VFCYJC meeting as CRAT Chair. R. Stanton has volunteered to assume Chair duties in his wake. A priority will be the completion and distribution of the now-completed graphic novel on sexual exploitation. B. McElroy will assist the new chair during the transition.

#### 7.2.1. Crat Meeting Notes of January 13, 2026

**MOVED by B. McElroy SECONDED by M. McLean,**
**That the notes of the Capital Region Action Team for Sexually Exploited Youth meeting of January 13, 2026, be received for information.**
**CARRIED**

#### 7.2.2. MYST Update

There was no report.

### 7.3. Family and Youth Matters (R. Stanton)

There was no report.

### 7.4. Court Watch (M. Little)

There was no report.

**7.5. Communications (J. Bateman)**

**7.5.1. Future Meeting Speakers**

Suggestions for future guest speakers are the Hon. Jodie Wickens, Minister of Children and Family Development; the Hon. Nikki Sharma, Attorney General and Deputy Premier; Minister of Attorney General; a representative from the province's Child & Youth Mental Health division; representatives from the Victoria Native Friendship Centre and Foundry BC; Patrick Jawes, Executive Director, The Rainbow Kitchen; and Colin Tessier, Executive Director, Threshold Housing Society.

M. Golden and Liz Nelson will be invited to provide a Mobile Youth Services Team update at the February 26, 2026, VFCYJC meeting.

## 8. TREASURER'S REPORT

There was no report. E. Paterson will help facilitate transition for J. Bateman, the new VFCYJC Treasurer, in collaboration with the CRD's M. Medland.

## 9. NEW BUSINESS

There was no new business.

## 10. CORRESPONDENCE

There was no correspondence.

## 11. NOTICE(S) OF MOTION

**11.1. Notice of Motion: VFCYJC Advocacy Letter to Central Saanich Police Board Re: Mobile Youth Services Team (S. Kim)**

S. Kim read the following notice of motion into the record for consideration at the next meeting of the Victoria Family Court & youth Justice Committee:
"That the Victoria Family Court & youth Justice Committee write a letter to the Central Saanich Police Board advocating for the Mobile Youth Services Team"

## 12. ROUNDTABLE

New Members B. Gash and J. Crawford introduced themselves.

## 13. ADJOURNMENT

**MOVED by M. Mclean, SECONDED by S. Kim,**
**That the Victoria Family Court & Youth Justice Committee meeting of January 22, 2026 be adjourned at 1:48 p.m.**
**CARRIED**

_____
Chair

_____
Committee Clerk

# Victoria Family Court and Youth Justice Steering Committee

## Meeting Notes – February 12, 2026 (11:30 am)

Attending: Chair Marie-Térèse Little; Vice Chair Kimberley Guiry; Committee Member Marcie McLean; Committee Member Jeff Bateman; Alternate Committee Member Rose Stanton; Committee Member John Crawford.

1. Regular Meeting Agenda

• Review of January meeting minutes and preparation process for the February meeting.

• Mobile Youth Service Team delegation anticipated for April.

• Delegation confirmed for February: Kathy Easton (Foundry West Shore, Sooke & Port Renfrew) and Amy Schactman (Foundry BC).

• Youth Empowerment Society final grant report added to Priorities and Grants.

• Decision to bring final Annual Report forward in April once CRD budget is finalized.

• Communications Subcommittee: confirmed call to action draft, website updates, future guest speakers, Open House 2026 planning, and draft report from Oct. 23, 2025 panel discussion.

• Treasurer's report not required—no significant updates since prior meeting.

• Subcommittee Business: Addition of formalizing CRAT Chair appointment and potential presentation on CRAT purpose and history.

• Review of Court Watch Subcommittee added.

• New Business: Qualification matrix discussion for succession planning.

• New Business: Discussion to host a meeting in Central Saanich.

Next Meeting: April 9, 2026.

# Final Report
## VYES Youth Pathways Project

THE WORLD IS A BETTER PLACE
with you(th) in it!
VICTORIA YOUTH EMPOWERMENT SOCIETY

Prepared for The Victoria Family Court and Youth Justice Committee by Julie-Ann Hunter,
Executive Director, The Victoria Youth Empowerment Society

# Who We Are

For more than 30 years, The Victoria Youth Empowerment Society (VYES) has served youth ages 12–24 across three sites in Greater Victoria through a coordinated pathway of prevention, early intervention, and crisis care. Supporting over 1,000 youth and families annually, VYES provides welcoming, non-judgmental spaces of safety and belonging beyond home and school.

Youth accessing VYES often navigate complex, intersecting challenges including housing instability, family conflict, mental health and substance use concerns, school disengagement, and food insecurity. Through accessible, youth-centred programs, VYES fosters resilience, dignity, accountability, and long-term stability.

# What We Do

The Victoria Youth Empowerment Society (VYES) delivers a wide range of programs and services designed to support youth and their families through critical transitions, reduce barriers, and promote long-term well-being. Our work spans basic needs support, crisis intervention, life-skills development, emotional wellness, and housing stability, providing youth with the tools and connections they need to build safety, resilience, and independence.

Service Scope Includes:

- **Drop-in supports**: Safe space, meals, basic needs, and connection to services
- **Emergency shelter**: Short-term housing and crisis support for youth in unsafe situations
- **Detox and recovery supports**: Non-medical youth detox, counselling, and wellness groups
- **Youth outreach**: Mobile, community-based support, advocacy, and systems navigation
- **Youth & family services**: Counselling and family-focused supports to strengthen relationships
- **Supported independent living**: One-to-one help with housing, life skills, and transitioning to adulthood
- **Housing Support Fund**: Flexible financial assistance to help youth secure or maintain safe housing
- **Youth justice program**: Case management and advocacy for youth involved in the justice system
- **Life skills and groups**: Programs that build coping skills, healthy relationships, and resilience
- **Seasonal programming**: Summer opportunities, activities, and connections to supports
- **Food and basic needs support**: Pantry access and essential items to reduce barriers

# Executive Summary Youth Pathways Project

The Youth Pathways Project was developed as a six-month pilot project to provide short-term, flexible intervention and system-navigation supports to youth ages 12–19 who were waiting for long-term services through the Victoria Youth Empowerment Society (VYES). VYES had noted that due to increased wait times for long term services, many youth were waiting to access support during a crucial period where often short term support can be used to create solutions. The project focused on early engagement, prevention, and stabilization during periods of heightened vulnerability. Youth were assessed quickly, connected to appropriate community and VYES programs, and supported to develop coping strategies and safety plans while waiting for ongoing services.

All anticipated outcomes were achieved, with 71 youth being offered targeted interventions. Youth demonstrated increased awareness of supports, earlier risk identification, and smoother transitions into long-term programs. The success of this project has directly informed organizational development at VYES, and we are moving forward with the creation of an Intake Coordinator position to ensure sustained access to timely early intervention for youth. The project has meaningfully contributed to prevention services by reducing risk, and strengthening protective supports for vulnerable youth.

## Program Description

The Youth Pathways Project provided short-term, flexible interventions, advocacy, and system-navigation services to youth (ages 12–19) waiting for long-term support at VYES.

The project prioritized:

- Immediate assessment and prioritization of support needs.
- Addressing short-term support needs prior to escalation.
- Continuity of care during wait periods.
- Decreasing stress experienced by youth awaiting service delivery.

Referrals were received directly from youth and families, as well as through schools, probation, community service providers, and partner agencies. This cross-system collaboration strengthened diversion efforts and ensured youth were not left unsupported during critical transition periods.

### Program Objectives

The objectives of the Youth Pathways Project were to:

- Act as an access point for youth requiring support related to family conflict, homelessness, unemployment, mental health, and substance use.
- Serve as a bridge for youth on waitlists, ensuring stability during transition.
- Increase awareness of community supports and system navigation resources.
- Provide education related to risk factors, coping skills, and emotional regulation.
- Improve outcomes for marginalized youth and reduce risk of justice system involvement.

# Outcomes of Youth Pathways Project

**Over six months, the following outcomes were achieved:**

Number of youth offered targeted interventions: **71**

Number of youth connected to external community services: **38**

Number of youth transitioned to long-term services with VYES: **41**

Number of youth reporting improved emotional regulation: **28**

## Interpretation of Outcomes

71 youth accessed short-term stabilization during a high-risk period. 38 youth strengthened their support network through successful service connections. 41 youth transitioned into long-term services with improved readiness and stability. 28 youth reported improved emotional regulation, a key protective factor associated with reduced justice involvement. Together, these outcomes reflect strong engagement, early risk reduction, and effective bridging between immediate intervention and longer-term supports.

## Justice-Related Outcomes

The Youth Pathways Project directly supports the mandate of the Victoria Family Court and Youth Justice Committee by prioritizing prevention, diversion, and early engagement.

Rapid response allowed workers to identify risk related to justice involvement, including:

- family conflict
- school disengagement
- substance use
- unsafe peer involvement
- housing instability and homelessness

Through early identification and immediate intervention, youth were supported before situations escalated to police contact, court involvement, or deeper justice system engagement. This preventative model contributes directly to diversion efforts, promotes accountability and stability, and enhances community safety. By stabilizing youth sooner and strengthening protective factors, the project improves developmental outcomes for young people.

## Prevention and Early Intervention Impact

The Youth Pathways Project strengthened prevention capacity within VYES. By engaging youth immediately at referral, rather than waiting for long-term case assignment, workers were able to identify risk factors earlier and implement timely support strategies.

This proactive approach:

- stabilized youth before escalation to crisis.
- strengthened protective factors, including school engagement, family stability, prosocial peer relationships, and positive coping skills, all recognized as protective factors against justice system involvement.
- resolved many presenting concerns within short-term intervention.

Early intervention reduced the likelihood of youth progressing into deeper system involvement and reinforced a strengths-based, community-focused model of care.

## Organizational Development Resulting from the Project

Due to the demonstrated effectiveness of providing access to a youth worker at the point of referral, VYES is implementing an Intake Coordinator position.

This role will:

- provide short-term intervention at the initial point of contact
- offer consistent connection during wait periods
- reduce service gaps between programs
- strengthen coordination across youth justice and community systems

This structural enhancement ensures the sustainability of the prevention model piloted through the Youth Pathways Project.

## Conclusion

The Youth Pathways Project successfully met all objectives and demonstrated that early, short-term, flexible intervention significantly improves outcomes for youth awaiting services.

By bridging wait periods, reducing risk factors, and strengthening protective supports, the project contributed to measurable improvements in youth stability and reduced risk of escalation into court involvement or deeper justice system engagement.

With the implementation of a permanent Intake Coordinator position, VYES will continue advancing early intervention, diversion, and community-based prevention efforts in alignment with the priorities of the Victoria Family Court and Youth Justice Committee.

## Acknowledgement

We sincerely thank the Victoria Family Court and Youth Justice Committee for their generous support, which made this six-month pilot possible. Your investment has strengthened prevention capacity in our community and positively impacted the lives of vulnerable youth.

Contact Information
Victoria Youth Empowerment Society
533 Yates St, Victoria
250-383-3514
www.vyes.ca
https://www.instagram.com/vicyouthempowermentsociety/

**To:** Victoria Family Court & Youth Justice Committee
**From:** Ryan Labelle / Pixel Makers Creative
**Date:** April 24th, 2025
**Subject:** Proposal for Enhancing Digital Engagement and Website Infrastructure

Dear Committee Members,

I am writing to propose a series of improvements to the Victoria Family Court & Youth Justice Committee's digital tools and website infrastructure. These enhancements are designed to strengthen engagement, improve usability, and support the Committee's mission through modern, efficient technology.

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## Proposal Summary

### 1. Boost Member Engagement

- Introduce subscription options for blog and resource updates via email or text messages.
- Add members-only commenting and discussion areas to facilitate meaningful dialogue and collaboration.

*Benefit:* Increases active participation, strengthens connections among members, and ensures timely communication on key topics.

### 2. Enhance Library Tools and Resource Organization

- Upgrade the site's search functionality with keyword tagging and related content links.
- Reorganize resource content for improved clarity and accessibility.

*Benefit:* Enables users to find relevant information faster and more intuitively, supporting both internal use and public access.

### 3. Improve Advocacy Through Online Tools

- Allow users to compose and send advocacy letters or requests directly from the website.

*Benefit:* Simplifies the advocacy process and empowers the community to take meaningful action on issues that matter.

### 4. Encourage Application Submissions

- Replace downloadable PDF forms with user-friendly online applications.

*Benefit:* Streamlines the submission process, reduces administrative workload, and encourages more timely, complete applications.

**5. Improve Overall Usability and Content Organization**

- Conduct a usability review and restructure the site's content to prioritize user-friendly navigation and accessibility.

*Benefit:* Enhances the overall user experience, ensuring the site serves a wide audience including youth, families, and justice stakeholders.

**6. Upgrade Website Infrastructure**

- Implement a modern website theme and a live page builder for future flexibility.

*Benefit:* Provides a visually appealing, mobile-responsive platform that staff can easily update without relying on technical support.

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## Conclusion

These proposed enhancements offer practical, impactful solutions to modernize the Committee's digital presence, encourage greater engagement, and amplify the effectiveness of its advocacy work. I welcome the opportunity to discuss this proposal in more detail and look forward to supporting the Committee in bringing these improvements to life.

Sincerely,
Ryan Labelle
Pixel Makers Creative Inc.

**250-516-2921**

**October 23, 2025**

# Panel Discussion

# Greater Victoria Integrated Police Units

**Capital Regional District Boardroom, 625 Fisgard St., Victoria**

## Participants

### Integrated Mobile Crisis Response Team (IMCRT)

* Lorraine Bates, Manager, Mental Health and Substance, Island Health
* Debra Johnsen, Coordinator, Crisis Response & Outreach Services, Island Health

### Mobile Youth Services Team (MYST)

* Mia Golden, Crime Reduction & Exploitation Diversion (CRED), Pacific Centre Family Services
* Shauna Bainbridge, Constable, Saanich Police Department

### Regional Domestic Violence Unit (RDVU)

* Jon Cawsey, Detective Sergeant, Saanich Police Department

### Police Representatives

* Paul Douglas, Deputy Chief of Operations, Saanich Police Department
* Ian Lawson, Chief of Police, Central Saanich Police Service
* Stephen Rose, Acting Officer In Charge, West Shore RCMP

## Summary

This discussion focused on the three Greater Victoria Integrated Police Units impacted by strategic funding withdrawals by West Shore RCMP and Central Saanich Police Service starting in 2024.

Each participant provided context and details on their respective work and plotted the myriad connection points that link health-care professionals and police as they support vulnerable youth and adults. Among much else, we learned that the funding changes have led to new localized police initiatives along with regional innovation and contingencies by all parties to maintain critical services in the face of multiple and growing social crises in our region.

Service delivery challenges remain and have been exacerbated, however, in a region where young people freely cross municipal boundaries and enter jurisdictions where response teams are limited due to these funding decisions.

All agree that continuing and enhanced coordination, information sharing and collaboration is essential. An opportunity was identified for the VFCYJC to host a facilitated event or gathering that would involve police, government, health authorities and related non-profit agencies serving the region's youth and families.

# Introductions

Chair Little welcomed and introduced the participants before passing the mic to facilitator Jeff Bateman, Chair of the VFCYJC Communications Sub-Committee.

He noted that today's panel arose from a motion submitted by member Marcie McLean in June, 2025 and unanimously approved by the Committee. As did last year's panel discussion on youth issues in Greater Victoria, this discussion aligns with the VFCYJC mandate to explore matters involving youth and families who may become involved in the justice system.

The following materials were shared with Committee members in advance:

* Greater Victoria Integrated Police Units Annual Report 2024 (see pp. 41-54 of Saanich Police Board's Sept. 2025 agenda)

* West Shore RCMP Service Delivery Update (West Shore RCMP public notice, 2024)

* MYST Critical Status Report and Recommendations (Dr. Rebeccah Nelems, commissioned by the VFCYJC, 2024)

* *No Private Matter: Honouring Christian Lee* (Office of the Representative for Children & Youth, 2009)

It has been approximately a year since three Greater Victoria Integrated Police Units – IMCRT, RDVU and MYST – were in the news following decisions by the Central Saanich Police Service and West Shore RCMP to withdraw regional funding from these units and either begin or continue taking responsibility for each unit's respective services in their own jurisdictions.

We're keen today to learn how this process has unfolded over the last 12 months. To this end, we're joined by representatives from each unit as well senior officers from Central Saanich, West Shore and Saanich. In total, our speakers have well over 100 years of front-line experience between them. Sincere thanks to each for making time in their busy schedules. We'll proceed with presentations by the three units followed by the three police services, then close with a Q&A opportunity for our members.

***Please note that the following has been edited for length and clarity.***

# Integrated Mobile Crisis Response Team (IMCRT)

### Debra Johnsen, Coordinator, Crisis Response & Outreach Services, Island Health

- IMCRT was established in 2004. It includes mental health clinicians, psychiatric nurses, child and youth counsellors, and plain-clothed police officers. It services southern Vancouver Island, including Sooke, Port Renfrew, South Malahat and Sidney, and provides phone consultation to the Gulf Islands. Service runs from Noon to Midnight, 365/7.

- We're a multidisciplinary team with nurses and specialized child and youth counsellors. We serve people of all ages and their families across the CRD. 64% of our calls in 2024 were for children and youth aged 19 and under.

- The team responds in person or virtually to calls from the public, usually through the Vancouver Island Crisis Line (1-888-494-3888). We've received calls from medical professionals and other service providers, as well as through police requests for people experiencing a mental health, substance-use and/or behavioural crisis, children included.

- Police will refer to the team when they believe there is a mental health or substance use concern, and in cases where the person either doesn't have established heath care or may require further assessment.

- IMCRT provides episodic assessment, risk evaluation, stabilization, referrals, and follow-up as indicated to individuals and their families.

- Currently, our team has a fully integrated, embedded plain-clothes officer shared between Vic PD and Saanich PD. This officer can respond to the team during calls where there's an elevated safety concern requiring confinement under Section 28 (Emergency Procedures) of the Mental Health Act.

- The officer will also assist with action under Form 4.1 (First Medical Certificate – Involuntary Admission) if one of the families or individuals we've been working with is to be sectioned by a physician. This is seen as a less intrusive co-led health response.

- We are not restricted to timelines that would be normal with a police call, so there are times when we will spend several hours or we may be involved with the family for days or weeks while we work with them to stabilize their situation and get them connected to resources. And if we do apprehend somebody to hospital services, we follow up with the family to make sure care is bridged and they're feeling supported.

### Lorraine Bates, Manager, Mental Health and Substance, Island Health

- I will speak to shifting police priorities and future service delivery. There are definitely upsides in having a plain-clothed officer on the team. They jointly triage and prioritize calls with substance-use staff. And they can deal with a broader range of risk factors with support of a nurse or counsellor.

- That being said, we can still operate effectively without an embedded officer, and we certainly have over the years when the officer is on vacation or off-duty. Many Island Health mental health response services do not have an embedded officer, so we are experienced and comfortable with calling in our police colleagues during higher-risk situations the team may encounter.

- We prefer the plain-clothed officer approach; it is considered the least intrusive, most effective, less alarming approach when a team arrives on scene. But we certainly have worked effectively with officers in uniform.

- The team does have the opportunity with an embedded officer to do preventative work. Occasionally, the team becomes aware of a family that is attracting a high number of police calls, and this allows us to respond in a non-crisis but proactive engagement approach. A less urgent, non-threatening manner.

- As many know, in 2023 the west shore communities and then Victoria launched Co-Response Team (CRT) units (aka the CAR program, or Mobile Integrated Crisis Response Teams) with provincial funding and mandate. That's increased the access to a co-response model in the CRD, which is good and exciting news.

- In the future, we will continue to work closely with CRT and there will be continuing cross-pollination. Island Health has worked with police departments across Vancouver Island and the Gulf Islands to develop MOUs

and MOAs with municipal or RCMP departments so that we can have information sharing, partnership and shared response to families and adults in crisis.

- The IMCRT team will continue into the future. It will look a bit different but may not feel that different for those who have not had a police officer respond with the team. We will work in different ways to engage all our partners. We really value the partnership with police. Without them, we can't engage in high-risk scenarios under the terms of our Mental Health Act regulatory framework. So we look forward to evolving as decisions are made.

## Mobile Youth Services Team (MYST)

### Mia Golden, MYST Counsellor and Crime Reduction & Exploitation Diversion (CRED), Pacific Centre Family Services Association

- A little history to start. MYST began as a police initiative established 20 years ago. In 2013, several counselling organizations met with police to discuss gaps in the service. This included the Pacific Centre Family Services Association, the organization that covers my salary with the Crime Reduction and Exploitation Diversion Program. My focus was on gangs, the MYST officer was focused on exploitation. Given the crossover in these issues, we teamed up and MYST became a unit of two. Every three to four years, the police officer changes. Shauna started in January and she's amazing.

- Over the last decade, I've seen a very steady increase in community needs. Last year the numbers confirmed that our region has the highest youth gang recruits in the province.

- We get referrals from everywhere: Police, probations, hospitals, schools, parents, even youth themselves. And our focus is to respond as immediately as possible. We have an ongoing caseload. It's not a matter of meeting with a youth, completing a file and moving on. We constantly build relationships and rapport, and it's usually a long-game situation as we support youth, their parents or both.

- One of the barriers that has come up since the removal of (Central Saanich and West Shore funding) is how those referral sources are affected. We repeatedly have to say we're sorry, we're not funded for your part of the CRD. We find that we are still getting requests even from police officers (from Central Saanich and West Shore RCMP) who still refer and reach out to us in support of needs in their communities.

- Requests for consultations are still very much happening in the schools. Parents do not understand how a service like ours can say, 'No, I'm sorry, I can't help your child even though I know exactly what needs to happen.' So that has been an a very significant struggle for us because our whole purpose is to support youth. To know that we can help but are prevented from doing so when crossing a geographical boundary feels almost unethical from our perspective.

- For us, the best scenario is to continue with collaborative approaches. Youth needs are increasing, families are desperate, and there are no boundaries. No matter where youth reside they travel everywhere in the region. Our work may take us into downtown Victoria, but we're dealing with youth who live in the West Shore, Central Saanich and elsewhere. Shauna has prepared some recent statistics.

### Shauna Bainbridge, MYST Liaison, Constable, Saanich Police Department

– Initially Victoria was in charge of MYST and they kept statistics. I don't have access to them because the partnership moved to Saanich in January, but I can provide numbers for this year.

- Between April 1 and July 3, 2025, we engaged with the following jurisdictions:

* 57 calls within the West Shore
* 24 to Sidney
* 32 Oak Bay
* 68 Victoria
* 79 Saanich
* 21 Sooke
* 13 Central Saanich.

- Additionally, we have statistics from the beginning of July to the present as of yesterday that reveal where calls have taken us in recent months:

- 10 calls within Oak Bay
- 40 Saanich
- 14 Sidney
- 17 Sooke
- 40 Victoria
- 36 West Shore
- 1 Central Saanich

- So this gives you a clear sense of our numbers as they're developing this year. We continue to refine our stats templates and methods so that the data so it reflects the fact that we see some kids more frequently than others based on their needs. One kid could account for 10 calls.

**Mia Golden** - There isn't a day that goes by that we don't receive at least one referral. We are constantly playing catch up. Do we believe that there should be MYST teams in every community? Absolutely. But we think that they should be collaborative and working together with multiple agencies as one unit. The community needs it. And my fear is the future health of our youth is going to continue to decrease significantly if this collaboration doesn't happen.

## Regional Domestic Violence Unit (RDVU)

### Jon Cawsey, Detective Sergeant, Saanich Police Department

- I'm currently the sergeant in charge of the Regional Domestic Violence Unit. I'm a Saanich police officer and have been for 21 years.

- The RDVU came about after a coroners inquest study into the death of Sunny Park, her child Christian and her parents in Oak Bay in 2007. The recommendation at the time was that more collaboration and information-sharing was required when it came to high-risk intimate partner violence so as to ensure safe practices and effective response.

- Since 2010, the unit has been operating very efficiently throughout the CRD. We are a multi-disciplinary team that currently involves two investigators -- one from West Shore RCMP, one from Victoria PD – and me as the NCO in charge.

- We have two in-house victim support workers supplied by the Victoria Women's Transition House Society who work extremely diligently on our files. We have an embedded Ministry of Children and Family Development social worker responsible for child safety. And we have a probation officer from Community Corrections who works with the unit and supports clients.

- The day-to-day activity is that every file is referred to and discussed by this unit. Laws were designed to direct on how we share information and we collaborate on the highest-risk domestic cases. Due to its sensitivity, this work requires in-room-discussion-only where we can talk about legal processes and how to proceed. Ultimately, we come up with the best safety plan to protect women and children.

- One of our bread-and-butter pieces is the relationships we build with our community partners, and that includes Crown Counsel, Defence Counsel, Community Corrections, Island Health, counsellors and psychiatrists. When we're involved, people understand the level of risk immediately and they buy into our process.

- The secondary mandate of the RDVU is to educate and support community resources in making best-practice decisions and being trauma-informed in how they deal with intimate partner violence.

- The referrals from police agencies and others recognize that our support is needed by victims, survivors and their families. Typically, we'll get an email or a phone call – very brief, 'we see some risk here, could you have a look, discuss it as a team and see if you can take it on?' We'll then secure as much data as we can from police records, corrections and the ministry … and discuss the safest plan moving forward. Can we support directly or can we make a recommendations back to the home agency?

- We call this process 'consulting and accepting.' If we accept a file, it's assigned to an investigator, a victim service worker and a social worker if there are children involved. Their primary responsibility is a safety plan. This is checked on a daily basis. No action is also a decision, but we collaboratively make that decision while understanding the full risks.

- We may hold a file for a month or three years. It can be a lifetime with offenders who present a strong demonstrated risk of violence. There is an average of 11 calls per day in the region related to intimate partner violence.

- Offender management is a rare but much needed piece to the RDVU's case load as we work to end the cycle of violence. Many offenders are coming from broken homes themselves. They have their own trauma. In understanding where they come from and their risk to women, we can mitigate the risk. We can work to find them a job, drive them to appointments when they can't drive themselves, work with their defence counsel to establish a safety plan to get them into treatment and move them forward successfully.

- Offender management is both a supportive and an enforcement piece. Unfortunately, some offenders don't want to sit with a police officer and have a coffee and talk about how we can support them. And that's okay, but we're also there for the safety and enforcement. We have strategies in place to keep them away from victims or survivors.

- I have case examples, but I think I've eaten up enough time. I've close by saying the RDVU is a valued resource recognized as the gold standard across Canada. This is how we need to be doing business when it comes to intimate partner violence: Sharing information and working collaboratively in multi-disciplinary, co-located units.

## Police Representatives

### Ian Lawson, Chief of Police, Central Saanich Police

- I certainly feel like I'm a little bit on the hot seat, but hopefully I can articulate and rationalize our decisions. Central Saanich has been part of the integrated units for many years now. We embarked on a review of all the units several years ago. One of the identified concerns was the lack of service that Central Saanich was getting from several of the units and this had created gaps that we had to address.

- Part of it was the structure of the units themselves. For instance, I don't believe there is an existing MOU between MYST and Central Saanich Police. Certainly there were no joint management team meetings, which I think is always very important for the structure. That goes with the RDVU as well. There was no regular Joint Management Team meeting or protocols to make sure gaps were being addressed. Additionally with IMCRT, its MOU is with Vic PD but not necessarily with other CRD participants.

- Our review was conducted internally with staff as we looked at the value of the services and the statistics. We also looked at whether we were getting responses to our referrals. What we found was, in the case of RDVU for instance, we had 10 files over four years and we weren't necessarily getting the service back.

- So we restructured our own detective units internally to have our own RDVU. It is important for us to do a very comprehensive interview of the victim to be able to get a history, to support bail and ensure that they feel safe locally on an ongoing basis.

- Our funding participation had been primarily for a police officer. We were not seeing that value or we were having some frustration. This was not the case at the clinician level. When we look through our stats for IMCRT, for instance, we're getting really good value. We have also partnered with the Saanich Peninsula Outreach Team for that expertise in clinician work. A significant number of our files are related to mental health and our officers are engaged in those files, often in plain clothes.

- There didn't seem to be a lot of value in paying for an officer who was primarily operating in the City of Victoria or Saanich. So we restructured our community engagement officer to work directly with youth while still offering assistance to MYST and IMCRT through information sharing.

- In 2024, we paid $25,000 towards RDVU for one year but we didn't see the value and felt this money could be used elsewhere. We really want to provide service to our community.

- Our child and youth online safety team in Central Saanich started the pilot project (that led to the 2024 restart of the Greater Victoria Integrated Child Exploitation Team). We found funding and now have three full-time police officers in an Integrated Child Exploitation Unit. We have seconded a Sargeant to lead that ICE unit and our hope is that it will become a permanent unit on behalf of the CRD.

### Stephen Rose, Acting Officer In Charge, West Shore RCMP

- Madam Chair, councillors and community members. It's my pleasure today to meet with you and discuss West Shore RCMP's decision to exit two integrated units (MYST and IMCRT).

- First and foremost, I think the foundation for such a decision is that we at West Shore RCMP are closely looking to innovate and provide value for dollars. As you are well aware, policing is becoming more expensive and municipalities must balance policing costs with other priorities. Any time we are using taxpayer dollars to fund the service, we need to ensure that there is a substantive and clear return on that investment. When possible, we need to innovate, share resources, and ensure that service delivery meets overall community needs and expectations.

- In this instance, we undertook a review of those integrated units. We are a bit unique in that, some time ago, we recognized a need for enhanced service given population growth on the West Shore. That led to substantial advocation with elected officials to enhance the service delivery around mental health calls. It resulted in our municipalities supporting and funding three positions for a crisis response team. At the time about 30% of our calls for service had some mental health component and the numbers continued to increase.

- We had been a contributor to IMCRT and were helping pay for the plain-clothed officer within that unit. So instead of relying upon that one officer and team, we enhanced the service on the West Shore by adding three officers to a west shore-based crisis response team. They were joined by two nurses funded and provided by Island Health.

- We asked whether or not it made sense to continue to fund what we perceived as a duplication of service with IMCRT and we decided it didn't. Our exit allowed IMCRT to focus on a smaller portion of the CRD. IMCRT's non-police staff continue to have contact with West Shore clients. And we've established communication lines where referrals can be made with our crisis response team and the newly opened mental health hub in Colwood.

- Similarly, MYST has an incredibly important mandate in working with at-risk youth and preventing gang recruitment. It was well recognized that the trends were going in the wrong direction. Problems were arising and the demand for MYST services continued to increase. So, in 2021, the officer-in-charge at the time told our municipalities, 'We need to do better, and we need to do more in supporting youth and youth at risk on the West Shore.'

- As a result of that effort, a councillor position at Pacific Family Services was funded by the West Shore municipalities to work with our youth officers to target the needs of youth specifically on the West Shore.

- From that point forward, they continued to work and share information with, in a referral sense, the primary or original MYST team. If a youth from the West Shore went downtown, that was conveyed to MYST and vice versa, keeping in mind that civilian support of both units were employed by the same agency. So there was an ample opportunity there to share information and ensure that any cross-boundary challenges could be overcome.

- After I arrived at West Shore in December 2021, one of the considerations that I had was the demand for youth services. And as we advocated each year for additional resourcing from our municipal funding partners, one of those members was earmarked for an expansion of our school liaison and community policing program. So we grew that team from four to five.

- By having a dedicated service on the west shore, we were allowing the very limited resources within MYST to serve a smaller population within the CRD. As with IMCRT, we have replaced our participation in MYST with specific dedicated resources on the west shore for residents of the west shore. The information sharing continues and it's facilitated if and when required between those entities.

- I'll close by saying I can't understate the importance of the work of the units being discussed today. Our withdrawal was in no way a reflection of the work or the dedication of the men and women in those units. It was simply that the West Shore has continued to grow and the limited shared resources were no longer meeting the mandate. We needed to advocate to expand the service delivery, and that's what we did by creating our own two personalized units and then withdrawing funding from the larger CRD units.

*Asked about the proposed creation of a West Shore Intimate Partner Violence Unit and withdrawal from the RDVU, Rose noted ...*

- As part of the original notice to our partner agencies in 2024, we did mention a potential exit from the RDVU at the end of December 2026. That's still a ways away. As we've embarked upon the creation of an intimate partner violence unit specific to the West Shore, we've learned, in working with some of the partners Sergeant Cawsey alluded to, that there are limits on how some partner agencies can contribute to a West Shore team. That has caused us to pause and to reflect on whether we can continue with that intention.

- As you know, I'm here today as Acting Officer In Charge. Once we have determined who will be leading the detachment going forward and that decision is finalized, then West Shore RCMP will continue a robust conversation about the feasibility of a West Shore Partner Violence Unit.

*West Shore RCMP videos:*
- **West Shore Youth Outreach Team** (2025)
- **West Shore Mental Health Unit** (2025)

## Paul Douglas, Deputy Chief of Operations, Saanich Police Department

- I'd like to thank our subject experts here who've done a wonderful job in presenting and advocating for their units. I will echo that the pressures that are currently on policing right now for cost-cutting measures is making everyone look internally to find more efficient ways to deliver services.

- I'll throw a ruthless plug out as an E-Comm board member for the CRD and municipalities to pursue a 911 levy and get it established ASAP. That cost is being borne by our residents and the user groups are largely unaffected by that.

- Saanich Police just announced this week that we also will be withdrawing from IMCRT and going to a new model like the ones we've heard today. This was done in consultation with Oak Bay and the District of North Saanich as well. We have worked diligently with Island Health and we are working internally right now to restructure with dedicated resources. We won't have a clinician riding with our officers, but we're looking at having a team of subject matter experts internally that would be at the beck and call of clinicians when they are doing assessments and may face risks.

- Jon has given you a good overview of the RDVU. I do want to throw Mia and Shauna some props. They recently brought forward a proposal to embed a Ministry of Children and Family Development worker with their team to increase capacity and leverage legislation that will greatly enhance the safety of our youth. We

took that back to the area chiefs last month and it was unanimously supported. We are working now on a MOU with the Ministry to embed this individual. We did get a modest bump in funding for the team, so we are working the corners and doing what we can.

- With Saanich Police, we too have had to cut programs due to financial realities. For instance, we are having to cut our dive team, which featured a boat and six members, effective Jan. 1. And we must deal with costs outside our control. E-Comm levies are closing in on an 80% increase over the last five years. Our towing bills have gone from about $20k to $110k a year practically overnight. Costs at a shooting range have risen per person from $19 to almost $90. All these costs are realities for us.

- I will also make another shameless plug for all the police staff in the CRD who I work closely with. They are all doing way more with less out of a sense of pride and commitment, but these things do have an impact on them. So I will leave it at that and say thank you for a very informative, engaging session today.

## Committee Member Questions

**Cllr. Susan Kim, City of Victoria:** Thank you each of you for taking the time to be here. I recently met with Restorative Justice Victoria and started to learn more about their work. It highlighted how little I know. Could you tell me about more non-traditional forms of response and how you have diversified what your work looks like.

**Stephen Rose:** Restorative justice has an important role in diverting persons involved in a first offence or minor offence or a property related offence away from the substantive workload of the provincial court system. There's no disputing the fact that the person must be held accountable, and the RJ program is an available option to police agencies. An individual can take responsibility and bring closure to the victim, the business or whoever has been impacted. For 2024, West Shore Restorative Justice had 38 formal restorative justice formal outcomes, and I believe we have had 29 such forums so far this year. We're dealing with youth and adults who've made bad choices and need to be responsible. We have an RJ coordinator, Randi Johal, who performs an outstanding role in working with all the parties.

**Jon Cawsey:** For the RDVU, we typically deal with the highest-risk files, so for the majority of those files restorative justice wouldn't be applicable. We're in public safety, we're not in the charging unit, and it's kind of a mantra for us that we don't need to charge everyone. We work with Crown and defence all the time on conditions and orders that might keep offenders out of jail and out of the courts long term so they can get into treatment facilities and away from their victim.

**Mia Golden:** Prior to MYST, I worked in (the Pacific Family Services) Family Violence Program, so following up on Jon's comments, I can say that RJ is often not the appropriate response for victims of domestic or family violence because of the trauma experienced by the victim. From a youth perspective, we often have youth who will receive EJS (Extrajudicial Sanctions) but this doesn't necessary include restorative justice since it may not land where they're at developmentally as it does with older individuals. But we have seen it effective in young adults when it's appropriate.

**Cllr. Terri O'Keefe, Town of Sidney**: Thank you for these excellent presentations. I have several questions. First, I should know the answer to this, but does Sidney and North Saanich RCMP participate in these regional units?

**Jon Cawsey:** I can answer for the RDVU. Our mandate is from Sooke to Sydney, and we cover out as far as Port Renfrew when we can. We also consult nationally. So definitely yes, your detachment is involved.

*Affirmative answers also from MYST and IMCRT.*

**Terri O'Keefe:** I'm curious as to how the Saanich Peninsula Outreach Team (SPOT) works alongside and integrates with your regional units.

**Mia Golden:** This is the first time we at MYST are hearing about that team, so we will definitely be adding them to our list and reaching out to explore collaboration.

**Debra Johnson:** IMCRT has some working relationships with the peninsula crisis and outreach teams, largely through out encampment and indigenous outreach teams mostly.

**Terri O'Keefe:** A question for Chief Lawson. I understand SPOT may be losing its funding. What impacts will this have?

**Ian Lawson:** I hadn't heard about that until now. SPOT is one of the various clinical teams we have engaged with depending on the call or services required. We certainly will continue to work with an IMCRT clinician, either offering support or requesting it from them.

**Terri O'Keefe:** My last question is whether there is any danger of these three important, valued and proven units folding now that they have lost or will lose significant parts of their regional funding?

**Debra Johnsen:** Our funding is through Island Health and the Ministry. So the nursing, child/youth clinicians, and counselling staff are not in jeopardy. As you've heard, we likely will be operating without the benefit of an embedded officer, but we will have other ways to partner with police as needed. The service will continue to operate with a health-led response, for lack of a better term.

**Jon Cawsey:** The short answer is I think it's always at risk when you take away funding. RDVU will require a bit of a restructure. The difficulty lies with our counterparts in our unit, because they also are responding to the entire CRD and if we isolate just the police resource that becomes a logistical problem. Crime doesn't stop at the border. So how do we provide a victim-service worker or a ministry worker when we don't have a dedicated police officer? It'll be a learning curve.

**Shauna Bainbridge:** From MYST's perspective, I will echo that. The issue now is municipal borders limiting our reach. The good news is that we are adding people to our team from the Ministry and that Victoria, Saanich and other communities remain committed.

**Mia Golden:** I'll add a note that we must take into consideration the overall costs, not only financial but social costs. My concern is that if we continue to go down this road of creating more similar but siloed teams, then we lose the advantage of larger, integrated teams with better communications and increased benefits to all of the communities.

**VFCYJC Chair Marie-Terese Little**: Thank you all for your presence today and the reaffirmation that all of the integrated units are functioning at maximum capacity in terms of response while also dealing with underfunding. We certainly empathize with you as councillors and mayors of municipalities thar are also experiencing extreme challenges as well.

We at the VFCYJC advocate for youth and families who are coming into contact with the criminal justice system. The big red flag from what I've heard today is that youth who are moving between different municipalities are falling into the gaps. I'm wondering how the committee, in its advocacy role, can help prevent that and mitigate the risks.

**Mia Golden**: Thank you for that question. We actually just came from a regional safety meeting this morning where we discussed this exact thing. Youth are so fluid in terms of their movements, and so we were again talking about how we must work collaboratively to ensure fewer children fall through the cracks. I know I keep harping on this silo versus collaboration issue, but it's been a challenge for me to watch these frail, vulnerable children suffer. The increased opportunities for predators and exploiters to access children is really scary for me at this time when we are pulling back. There's just the two of us at MYST. I've been in this position for 11 years and I'm getting a bit long in the tooth, so I'm now thinking in terms of succession at a time when these crises are escalating. These victimized children will grow up to become adults who either fall into the mental health or criminal justice systems. Now is always the best time to intervene as best we can.

**Lorraine Bates**: To add to what Mia is saying, we at IMCRT do see youth on the streets who are younger and younger experiencing grooming, the social media pressures and getting into very dangerous situations. We do sincerely appreciate MYST and want to see it sustained into the future.

**Jon Cawsey**: We typically deal with adults and the Ministry of Children and Families are responsible for the child aspect. Yet integrated teams like our own are dedicated to supporting healthy and safe homes that will hopefully provide the conditions where children are supported. We stay involved with the Ministry for months and sometimes years to ensure families are safe.

**Marie-Terese Little**: My second question involves collaboration and joint planning that would address the siloing issue Mia has highlighted. I hear that there are regional safety meetings, but who is responsible for getting you together for an annual workshop or gathering of some kind so that units can gather to plan, brainstorm and collaborate. We in Metchosin could definitely host and feed you for day, so I put that invitation out there. But my question is how do you come together and share information in a timely fashion?

**Stephen Rose**: Generally, it is within the mandate of the unit to ensure they're working with their counterparts. The Monday before last, West Shore hosted a lot of our mental health peers from the CRD and up-island to do some joint training at the detachment. That was an opportunity for information sharing, learning and networking.

In the case of the counsellor within Pacific Family Services that works with our officer, they share a mandate with Mia and her team within the same organization. If there's a need to talk about a client for a family that's transitioning from one part of the CRD to another, then it's a given there would be some communication among these peers.

As far as a structured annual get-together, there is always an opportunity there and I support that. But practically and operationally, the communication must be way more fluid than that. Our police agencies and partner stakeholders need to be sharing that information in real time. So our crisis response team, if they

know that the client they're now dealing with is also a client of IMCRT, then they'll be reaching out that same day, often within the hour. And vice-versa. We do have an Island Health clinician on our team, and they're sharing info with other mental health nurses. The service must be nimble and sharing information on the fly.

There is oversight with the joint management teams. Most of the integrated units, if not all, here in the CRD regularly consult, meet and get updates. The bi-monthly meeting of the area chiefs of police has recognized that there needs to be improvements around the MOUs and clear rules of engagement for all the partner agencies.

**Jon Cawsey:** I do report to a Joint Management Team every few months on the daily activities and direction of the units. The RDVU underwent an external review some six or seven years ago to formalize where we've come since inception and where we should go in the future. It recognized we need to expand and develop the program as we're seeing it today.

**Ian Lawson:** Accountability, coverage and sharing of information are all critical. The area chiefs have engaged a contractor to review the current integrated units to determine their needs. This is long overdue. These are all great units, but they grow and need a formalized structure so as to review their services and determine their needs – funding, staffing -- as they evolve.

**Cllr. Marcie McLean, District of Highlands:** Thank you all for joining us today. My first question is to Chief Lawson. Do you have an idea approximately of how much Central Saanich has saved in 2025 by withdrawing from the three integrated units?

**Ian Lawson:** I think it's just short of $50,000.

**Marcie McLean:** Thank you. Sergeant Jon Cawsey, do you have any ideas how the lack of trust by survivors in the criminal justice system might be addressed?

**Jon Cawsey:** That's a big question. It's being addressed in many ways. First, it's about breaking down barriers in how we present initially. Dressing in plain clothes is a first step to building trust. Then, by collaborating and working with our community partners, we're creating a one-stop shop for survivors and offenders. They don't need to go to seven different service providers to figure out how to navigate their lives. This creates better conditions for a trusting relationship.

**Marcie McLean:** Thank you. What does the growing need for education on impacts and support for survivors broadly in respect to domestic violence?

**Jon Cawsey:** I spoke in the media the other day about the need to be having these conversations with our youth and our families. We need to talk about what a healthy relationship actually looks like, and that needs to also happen with school-age kids. I have three kids myself, and we've reached out my seven-year-old to have this conversation just as we do with my older children. Second, the integrated units need to be vocal and public. At RDVU, we host training sessions quite often where we bring in all our community partners and sometimes the public is invited as well. We're sharing this information and doing the education so everyone's aware.

**Marie-Terese Little**: Thank you everyone for your participation today. This has been a wonderful educational opportunity for us all and now it's up to our members to take what they've learned back to their own councils, boards and communities. Even by simply mentioning that our residents are being served by these integrated units, you're spreading the word and recognizing the value and need for these teams. That's our educational mandate, and I urge you to do your part in acknowledging the remarkable work of all our guests today.

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# Further Reference

## Greater Victoria Integrated Police Units

* 2024 Annual Report
* Overview of the 12 units

## Greater Victoria Police Victim Services

- About Us
- Support Agencies Directory
- Fact Sheets and Brochures
- 2025 Annual Report

## Police Services - Capital Regional District

### BC RCMP Police Services

* Programs and Services
* Children and Youth Safety Tips
* Online Safety

### - Sidney North Saanich RCMP

* About

### - Sooke RCMP

* Contact

### - West Shore RCMP

* About
* Community Policing Services
* West Shore Restorative Justice
* **Community Policing Advisory Committee**

### - Central Saanich Police Department

* Strategic Plan
* Child & Youth Online Safety
* Resources for Youth and Parents

**- Esquimalt**
* Policing in Esquimalt
* Policing Service Delivery Project
* Community Policing Fact Sheet

**- Oak Bay Police Department**
* Strategic Plan
* Integrated Policing

**- Saanich Police Department**
* Strategic Plan, Annual Reports, Statistics
* Community Programs

**- Victoria Police Department**
* Strategic Plan
* Community Engagement
* Community Data Dashboard

## Integrated Teams

- Assertive Community Treatment (ACT) (British Columbia Advanced Practice)

- Supports expanding for people in mental-health, substance-use crisis - Mobile Integrated Crisis Response (MICR) Teams (BC Ministry of Mental Health and Addictions announcement, 2023)

*Research Studies*

- Mobile Youth Services Team Critical Status Report and Recommendations (Dr. Rebeccah Nelems, commissioned by the VFCYJC, 2024)

- Integrating Municipal Police Officers onto Assertive Community Treatment teams (IMPACT): Findings from the Victoria Police Department Database (Erica Woodin, Ph.D. & Catherine Costigan, Ph.D., Department of Psychology, University of Victoria, Sept. 2024) + UVic press release

- Integrating Municipal Police Officers onto Assertive Community Treatment teams (IMPACT): Social Service, Criminal Justice, and Emergency Health Care Perspectives (Erica Woodin, Ph.D. & Catherine Costigan, Ph.D., Department of Psychology, University of Victoria, May, 2019) + release

- Interfaces Between Mental Health and Substance Use Services and Police (toolkit produced by the Canadian Mental Health Association BC Division on behalf of the Ministry of Health's Mental Health and Substance Use Branch and the Ministry of Public Safety and Solicitor's General's Policing and Security Branch, 2019)

- Study In Blue and Grey – Police Interventions with People With Mental Illness: A Review of Challenges and Responses (Canadian Mental Health Association BC Division, 2003)

## Domestic Violence

### Province of British Columbia

– Domestic Violence website home page
- Gender-based violence, sexual assault and domestic violence

- Final Report: The British Columbia Legal System's Treatment of Intimate Partner Violence and Sexual Violence – Dr. Kim Stanton, June 2025 + About the Review + Stanton Report Fall Update 2025

– Taking Action on Domestic Violence in British Columbia (Ministry of Children & Family Development, 2012 report)

### Justice Education Society of BC

– Abuse and Family Violence

### Public Health Agency of Canada

– Evaluation of Preventing and Addressing Family Violence: The Health Perspective Program (2019-2024)

### Government of Canada

- Saanich Police RDVU Spotlight (Public Safety Canada, 2013)
- Find family violence resources and services in your area

### Victoria Police Department

- We Believe You (updated article originally posted on Vic PD's Stories From The Street blog in 2014

### News Articles

- *Strangulation a common thread in Greater Victoria domestic violence* (Saanich News, Feb. 13, 2025)
- *Domestic violence can include anything from verbal disputes to violent incidents* (Times Colonist, Feb. 23, 2025)

## Miscellaneous

### Public Safety & Solicitor General

* Launching Mental-Health Screening Tool to Support People In Crisis (Jan. 26, 2026)
*HealthIM has launched in Central Saanich, Saanich, Victoria/Esquimalt and Oak Bay municipal police departments. Partnered with the BC Association of Chiefs of Police.*

### Ministry of Children & Family Development

- Help for youth and their families
- Reporting child abuse in BC

- A Case For A Civilian-Led Community Crisis Response (Manitoba Police Accountability Coalition, 2024)

# Child Mortality in British Columbia
## January 1, 2020 – December 31, 2024

## Introduction

### About the Child Death Review Unit

By law, every child's death in British Columbia must be reported to the BC Coroners Service (BCCS), an agency within the Ministry of Public Safety and Solicitor General. As part of its mandate under the *Coroners Act* (2007), the BCCS must review, on an individual or aggregate basis, the facts and circumstances of child deaths in British Columbia for the purposes of discovering and monitoring trends in child deaths and determining whether further evaluation is necessary or desirable, or in the public interest. In fulfilling its mandate, the BCCS reviews child deaths considering the impact on public health and safety and how to prevent similar child deaths in the future.

### About This Report

This report presents findings related to the 1,536 child deaths that occurred in British Columbia during the five-year period between January 1, 2020 and December 31, 2024. It primarily consists of descriptive data that is intended to characterize child mortality in B.C. through the demographics, causes and circumstances surrounding the deaths.

#### *Key Terms*

The Coroners Act defines a child as a person under the age of 19 years. Children have been grouped by their age at the time of death as follows:

- Neonate (0-28 days);
- Infant (29 to 365 days);
- 1-4 years;
- 5-9 years;
- 10-14 years; and
- 15-18 years.

### *Data Source*

Multiple data sources were used for this review. Sources are described as follows:

- **All Cases** – Includes all child deaths in BC that occurred between January 1, 2020 and December 31, 2024, inclusive.
- **Protocol Questions (2020-2024)** – For all child deaths, coroners complete an additional set of questions, called protocols, that provide more insight into the circumstances surrounding the death.
- **Linked Data Cohort** – BC Vital Statistics provided linked data for all child deaths between January 1, 2020 and December 31, 2024, inclusive.

### *Data Limitations and Confidentiality*

The BC Coroners Service operates in a live database environment. Data contained within this review includes open and closed Coroners Service case files as of July 2, 2025. It also includes analysis of investigative notes, toxicology results, medical records and other documents collected, and completed protocols questions and coroner investigations. Some investigations remain open and are therefore subject to reclassification. Provisions under the Coroners Act and the *Freedom of Information and Protection of Privacy Act* (*FOIPPA*)* allow the BCCS to disclose information to meet its legislative mandate and support the findings and recommendations generated through the review process. For the purposes of this report, information is presented in aggregate. Details that could identify decedents have been omitted to respect the privacy of both the children and youth who died and their families.

Small discrepancies in mortality counts between BCCS mortality data and BC Vital Statistics data may exist. These discrepancies are attributable to coding differences between the two agencies and the time delay involved in reconciling any changes between preliminary and final certifications of death. Small discrepancies could also arise with future reports, as 393 cases are still under investigation at the time of data extraction.

## Considerations for Future Review

### *Indigenous Children and Youth*

Indigenous (First Nations, Métis and Inuit) ethnicity data is not currently uniformly collected for all child deaths. The collection of Indigenous health and mortality data is essential to addressing existing health inequities experienced by Indigenous people, which reflects continuing structural and systemic disadvantages created through the history of colonization. Indigenous peoples have the right to own, control, access, and steward data about their communities, lands, and culture. Information management and data collection strategies must align with the practices and culture

* *Freedom of Information and Protection of Privacy Act (FOIPPA)* provides access to records and information created and compiled by the public bodies of B.C.

of the Indigenous Nation, community or Peoples who are represented in the data. For these reasons, Indigenous and non-Indigenous mortality data is not differentiated in this report.

The commitment to creating necessary systemic change is situated in the context of reconciliation between Indigenous and non-Indigenous peoples in B.C. and Canada, which was affirmed when the provincial government passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in November 2019.

BCCS convened a death review panel in March 2025 to review deaths by suicide of youth and young adults and make recommendations regarding policy and practice in an effort to prevent future deaths. One of the recommendations was directed to BCCS to collaborate with the Ministry of Health, Métis Nation British Columbia, and provincial Inuit leadership to implement information sharing strategies as the only Memorandum of Understanding that is currently in place is between BCCS and the First Nations Health Authority. The BC Coroners Service is committed to working alongside and supporting Indigenous partners to identify ways to improve outcomes for all youth in B.C., which includes ensuring that a distinctions-based approach to collecting and sharing information is utilized.

### *Race-Based Data Collection*

As of the writing of this report, there is no provincial data standard for collection and reporting of race-based information. Accordingly, with the exception of Indigeneity, the BCCS does not collect data or report on information related to race.

The Anti-Racism Data Act, which introduced on May 2, 2022, and passed unanimously through the legislative assembly and received royal assent on June 2, 2022, has allowed the Province to begin the work to collect intersectional demographic data, such as age, gender identity and ethnic origin. This will align B.C. with all jurisdictions in Canada, helping break down barriers and better identify interconnected issues, such as economic status, employment and outcomes in health care.

BCCS recognizes the importance of aligning its work with provincial data standards in a manner that recognizes and addresses systemic racism and other prejudice. The death review panel on deaths by suicide of youth and young adults also includes a recommendation to BCCS to collaborate with the Ministry of Health and the Ministry of Attorney General to document information including but not limited to the race and ethnicity of decedents; the BCCS intends to include this important information in all death review activities as soon as practicable.

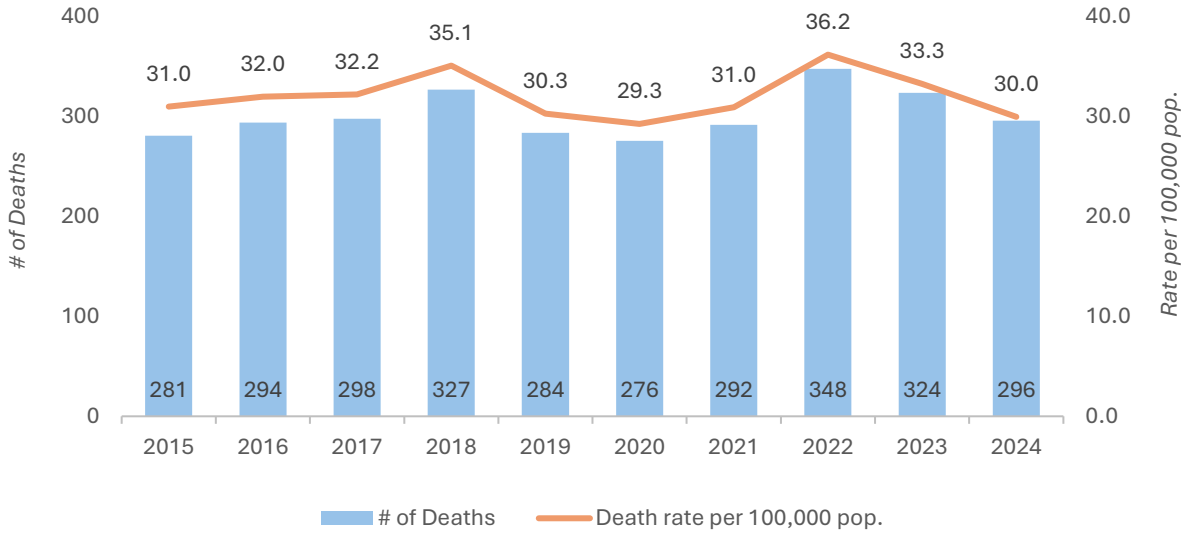
### *Rurality*

While the total number of child and youth deaths in rural and remote areas of the province remains low, the rates of child deaths (expressed in deaths per 100,000 residents under 19 years of age) is significantly higher in the Northern Health Authority than in other health authorities. While this

review does not contemplate the impacts of rurality on health care services available to residents of more remote communities, there are opportunities to develop collaborative relationships and identify further learning and understanding in the future.

# Part One: Overview of Child Mortality in British Columbia

**Figure 1: Child Deaths in British Columbia, 2015-2024** [1]




From 2020-2024, there were a total of 1,536 child deaths reported to the BC Coroners Service.

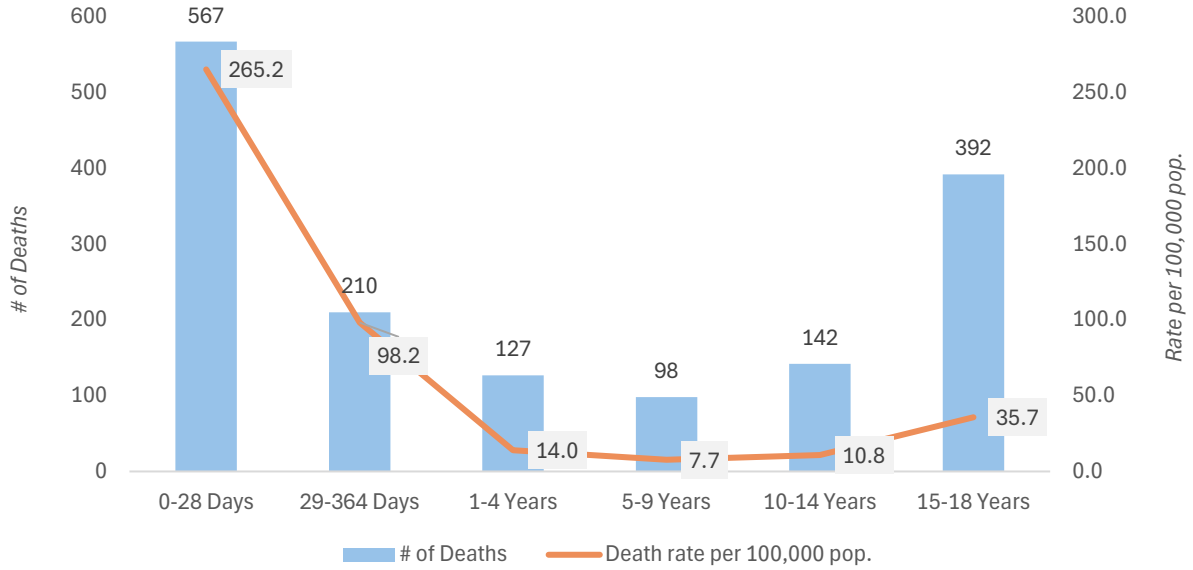
- Within this 5-year period, the average annual number of child deaths was 307 (increased from the average annual of 297 deaths in the previous 5-year period, between 2015 and 2019).
- The average annual death rate remained unchanged at 32 deaths per 100,000 child population between the reporting 5-year period (2020-2024) and the previous 5-year period (2015-2019).

## Age Group

**Table 1: Child Deaths By Age Group, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 | **Total** |
|---|---|---|---|---|---|---|
| 0-28 Days | 110 | 111 | 123 | 120 | 103 | 567 |
| 29-364 Days | 42 | 39 | 46 | 40 | 43 | 210 |
| 1-4 Years | 22 | 20 | 30 | 30 | 25 | 127 |
| 5-9 Years | 19 | 15 | 16 | 21 | 27 | 98 |
| 10-14 Years | 14 | 27 | 46 | 30 | 25 | 142 |
| 15-18 Years | 69 | 80 | 87 | 83 | 73 | 392 |
| **Total** | 276 | 292 | 348 | 324 | 296 | **1,536** |

**Figure 2: Child Deaths & Death Rate By Age Group, 2020-2024** [1, 2]

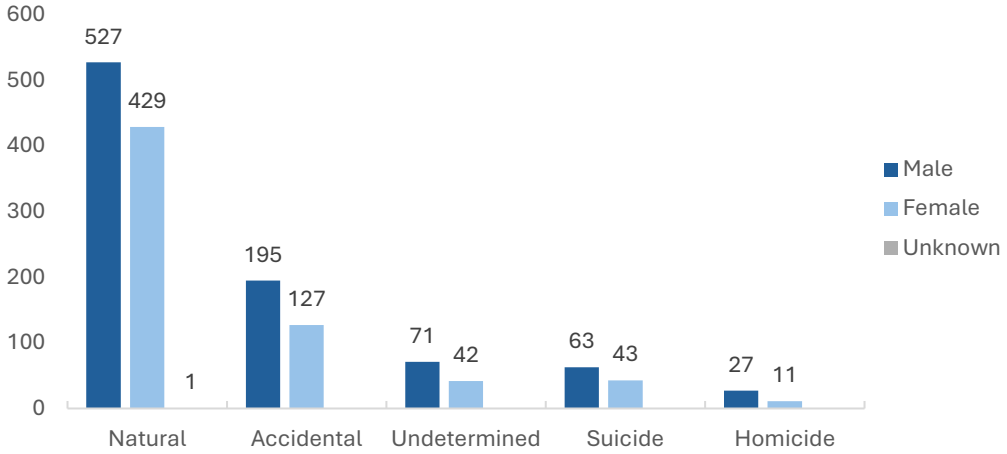



*Note: Rate of death is calculated per 100,000 population of children within the corresponding age group for children aged 1-18 years. For children under 1 year old, death rate is calculated per 100,000 live births.*

- Neonatal (0-28 days) deaths accounted for the majority of all child deaths (567) and the highest rate of deaths among all age groups (265.2 per 100,000 live births).
- The second largest number of child deaths were in the age group of 15-18 years (392 deaths).
- The age group with the second highest rate of death were infants over one-month and under one-year (29-364 days; 98.2 per 100,000 live births).
- Children aged 5-9 years accounted for both the smallest number of deaths (98 deaths) and the lowest death rate (7.7 per 100,000 child population).

## Biological Sex

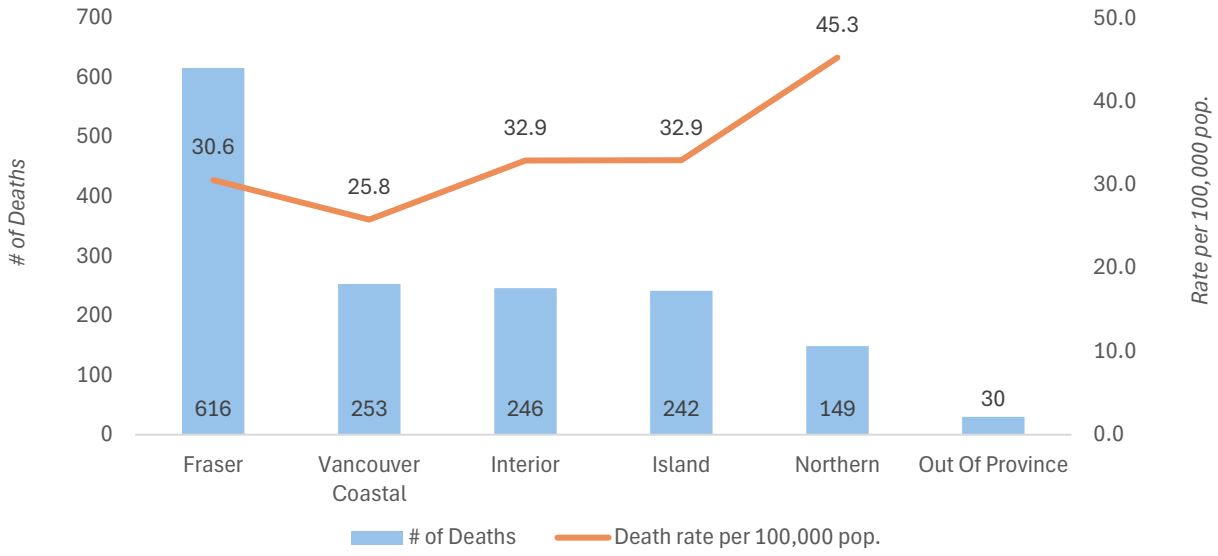
**Figure 3: Classification of Death By Biological Sex, 2020-2024**




- More child deaths occurred among males (57%) than females (42%) across all classifications.

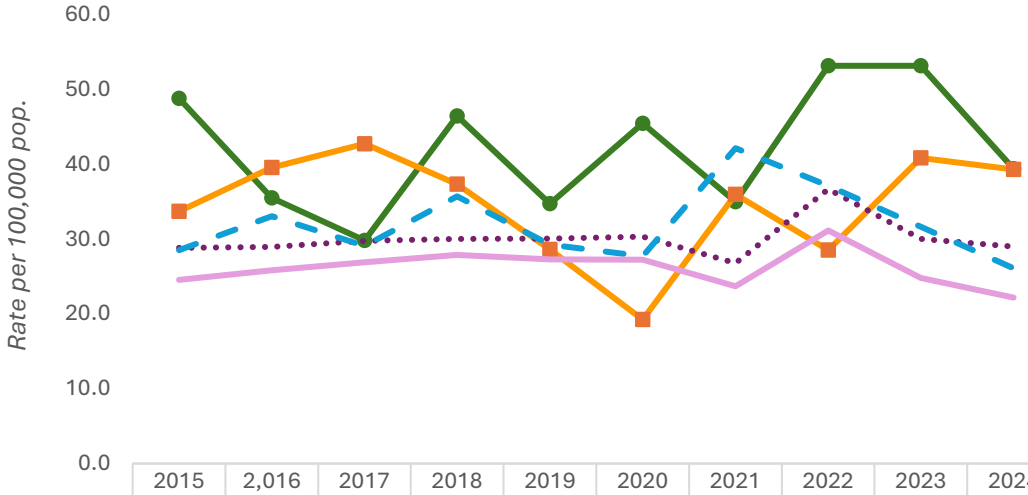
## Health Authority of Residence

**Figure 4: Child Deaths and Death Rate By Health Authority of Residence, 2020-2024 [1]**




- The largest number of deaths were of children residing in Fraser Health Authority (616), followed by Vancouver Coastal Health (253). Northern Health recorded the smallest number of child deaths (149).
- However, Northern Health recorded the highest child death rate (45.3 per 100,000 child population), followed by Interior Health and Island Health, each at 32.9 per 100,000 child population.

**Figure 5: Child Death Rates per 100,000 by Health Authority of Usual Residence, 2015-2024** [1]




| | 2015 | 2,016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|
| Northern | 48.8 | 35.5 | 29.8 | 46.5 | 34.8 | 45.5 | 35.0 | 53.2 | 53.2 | 39.4 |
| Interior | 33.7 | 39.6 | 42.8 | 37.3 | 28.6 | 19.2 | 36.0 | 28.5 | 40.8 | 39.3 |
| Fraser | 28.9 | 29.0 | 29.8 | 30.0 | 30.1 | 30.3 | 26.8 | 36.7 | 30.0 | 29.0 |
| Island | 28.6 | 33.1 | 29.1 | 35.7 | 29.3 | 27.7 | 42.2 | 37.1 | 31.7 | 26.1 |
| Vancouver Coastal | 24.5 | 25.9 | 26.9 | 27.9 | 27.3 | 27.2 | 23.7 | 31.2 | 24.8 | 22.2 |

- Northern Health had the highest child death rate in comparison with other health authorities in most years during the reporting period from 2020 to 2024.

## Categorization of Deaths

The BC Coroners Service (2025) investigates all child deaths and determines the classification of death as below:

- **Natural**: Death primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.
- **Accidental**: Death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.
- **Suicide**: Death resulting from self-inflicted injury, with intent to cause death.
- **Homicide**: Death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
- **Undetermined**: Death which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

The BC Coroners Service uses these classifications to categorize child deaths into three main groups:

### *Group One: Natural Causes*

Natural deaths are fatalities caused by an internal disease process, such as an underlying medical condition or acquired illness, or from complications of the condition or treatment. With natural deaths, the child is generally under the care of a physician and the cause of death may be expected or, occasionally, sudden and unexpected due to a previously undiagnosed medical condition or an unanticipated deterioration.

### *Group Two: Injury Causes*

Injury deaths include fatalities caused by damage to the body from external causes. Injury deaths are generally classified as either accidental or non-accidental.

- **Accidental deaths** are deaths in which injuries are not purposely inflicted.
- **Non-accidental deaths** result from injuries purposely inflicted by self or others where the manner of death is classified as Suicide or Homicide.

### *Group Three: Undetermined Causes*

Undetermined deaths include those that due to insufficient evidence or inability to otherwise determine cannot be reasonably categorized as natural or injury related. This includes some infant sleeping deaths in which the cause of death cannot be confirmed. This may also include deaths in the preliminary stages of investigation at the time of this report where classification has yet to be determined. Table 2 identifies total deaths by cause of death categorization type.

| Table 2: Child Deaths By Categorizations of Death and Age Group, 2020-2024 | | | | |
|---|---|---|---|---|
| Age Group | Natural | Injury-Related Death | Undetermined | **Total** |
| 0-28 Days | 542 | 5 | 20 | 567 |
| 29-364 Days | 128 | 35 | 47 | 210 |
| 1-4 Years | 69 | 41 | 17 | 127 |
| 5-9 Years | 72 | 24 | 2 | 98 |
| 10-14 Years | 62 | 69 | 11 | 142 |
| 15-18 Years | 84 | 292 | 16 | 392 |
| **Total** | 957 | 466 | 113 | **1,536** |

# Part Two: Child Deaths By Cause

The three most common causes of deaths for each age group are displayed in Table 3.

**Table 3: Leading Causes of Child Death By Age Group, 0-18 Years, BC, 2020-2024**

| Rank | Under 1 Year | 1-4 Years | 5-9 Years | 10-14 Years | 15-18 Years |
|---|---|---|---|---|---|
| 1 | Certain conditions originating in the perinatal period[1] | Other Accidental Injury[2] | Neoplasm[3] | Suicide | Unregulated Drug Toxicity[4] |
| 2 | Congenital malformations, deformations and chromosomal abnormalities[5] | Undetermined[6] | Motor Vehicle Incident[7**] | Neoplasm[3] | Suicide |
| 3 | Undetermined[6] | Neoplasm[3] | Other Accidental Injury[2**] | Unregulated Drug Toxicity[4] | Motor Vehicle Incident[7] |

[1] Includes prematurity, complications of pregnancy, labour and delivery, diseases and disorders specific to, and originating in the perinatal period (P00-P96; ICD-10).
[2] Includes unintentional injuries excluding motor vehicle incident and unregulated drug toxicity.
[3] Includes malignant neoplasms, in situ neoplasms, benign neoplasms, and neoplasms of uncertain or unknown behaviour (C00-C97, D00-D48; ICD-10).
[4] Includes deaths from unregulated drug toxicity which are classified as "Accidental".
[5] Includes congenital disorders and chromosomal abnormalities, excluding inborn errors of metabolism (Q00-Q99; ICD-10).
[6] Includes cases which the death is classified as "Undetermined" and the death investigation is completed or still in progress and subject to change.
[7] Includes accidents involving motor vehicles, passenger vehicles, and off-road vehicles happening on public or non-public roadways. Excludes ATV, dirt bike, and snowmobile accidents on off-road or non-public roadways. Excludes pedestrian conveyance incidents not involving a motor vehicle or passenger vehicle.
** Motor Vehicle Incident and Other Accidental Injury are ranked equally in this age group; however, "Motor Vehicle Incident" represents a broader category and are therefore listed ahead. In contrast, "Other Accidental Injury" includes a wider range of incident types such as accidental drowning, falls, and fire-related deaths.

## Natural Deaths

Total number of natural deaths: **957.**

62% of all child deaths that occurred during the reviewed period were due to natural causes.

**Figure 6: Percentage of Classification of Death in Child Mortality, 2020-2024**

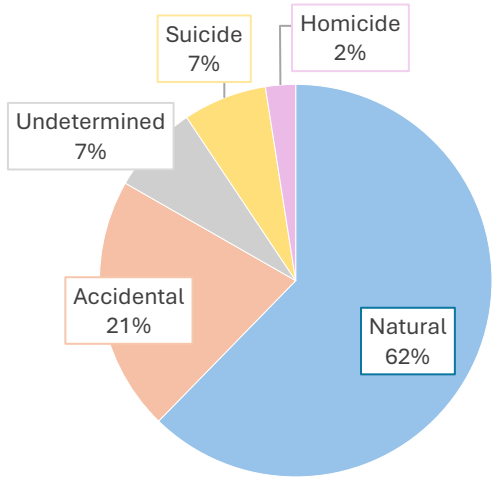
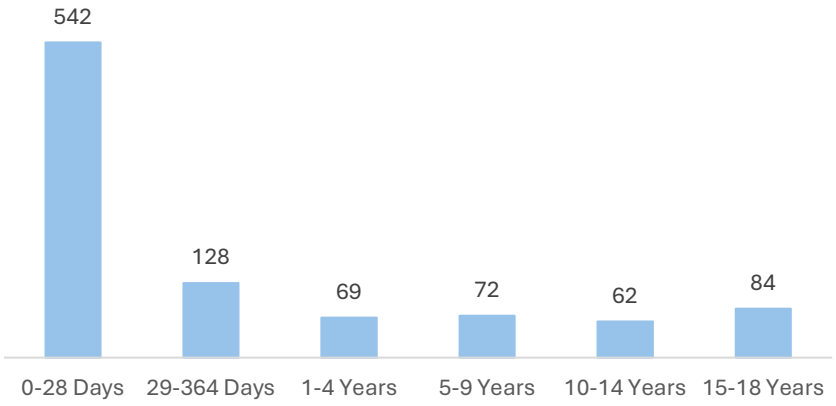



**Figure 7: Natural Deaths By Age Group, 2020-2024**




Over half (57%) of child deaths from natural diseases were neonates (0-28 days of age; 542 deaths). Of the 957 natural deaths, the leading causes of death include certain conditions originating in the perinatal period (49%, 467 deaths), congenital malformations, deformations and chromosomal abnormalities (20%, 195 deaths), and childhood neoplasm (10%, 99 deaths).

# Injury-Related Deaths

Total number of injury-related deaths: **466**.

Deaths from injuries were the cause of 30% of the 1,536 deaths reviewed.

- Accidental injury was the cause of 69% (322 deaths) of total injury-related deaths.
- Non-accidental injury, including suicide and homicide, caused 31% (144 deaths) of injury-related deaths.
- 63% (292 deaths) of injury-related deaths involved youth aged 15-18 years.

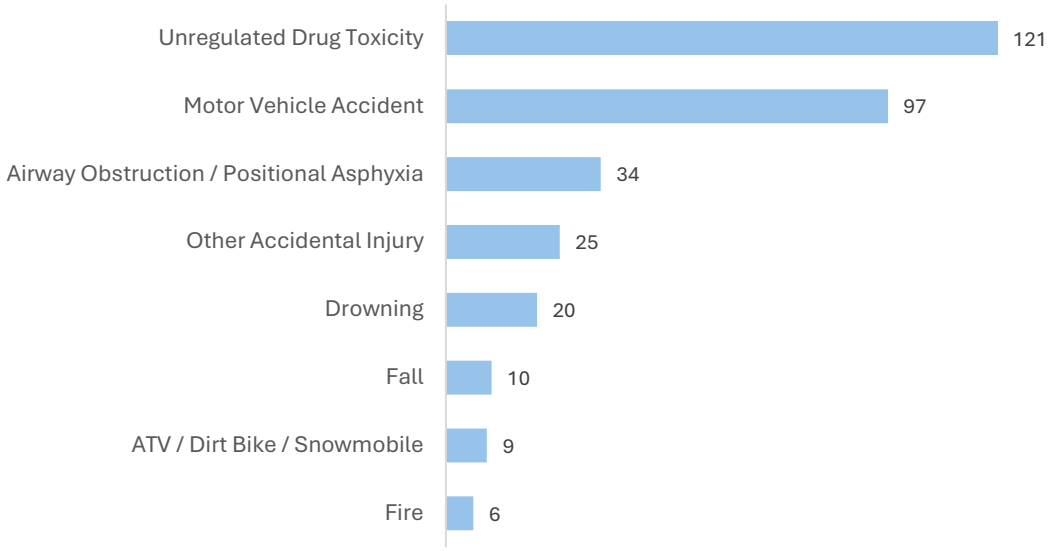
## Injury-Related Deaths: Accidental

**Table 4: Injury-Related Deaths - Accidental**

| | |
|---|---|
| Accidental Injury: Unregulated Drug Toxicity | • Unregulated drug toxicity was the leading cause of child deaths from accidental injury (38%, 121 deaths).<br>○ Of the 121 deaths, 86% (104 deaths) were youth aged 15 to 18 years.<br>○ Slightly more drug toxicity deaths occurred among females (51%, 62 deaths) than males (49%, 59 deaths). |
| Accidental Injury: Motor Vehicle Incident (MVI) | • MVI was the second leading cause of child deaths from accidental injury (30%, 97 deaths).<br>○ 62% (60 deaths) of MVI deaths involved youth aged 15 to 18 years.<br>○ 68% (66 deaths) of MVI deaths involved male youths and 32% (31 deaths) involved female youths. |
| Accidental Injury: Obstruction of Airway | • 11% (34 deaths) were from accidental obstruction of the airway and/or positional asphyxia not from MVI.<br>○ 88% (30 deaths) of the deaths involved children under one year of age, with unsafe sleep environment[8] risk factors identified. |
| Accidental Injury: Other Causes | • 6% (20 deaths) of the accidental injury-related deaths were from drowning and water submersion.<br>• Falls (10 deaths) and incidents involving an all-terrain vehicle (ATV), dirt bike, or snowmobile on off-road or non-public roadway (9 deaths) each accounted for approximately 3% of the accidental deaths.<br>• 2% (6 deaths) were from fire-related injuries causing death.<br>• 8% (25 deaths) were the result of other accidental injuries. Of the 25 deaths, 5 (20%) have both the cause and means of death still to be determined. |

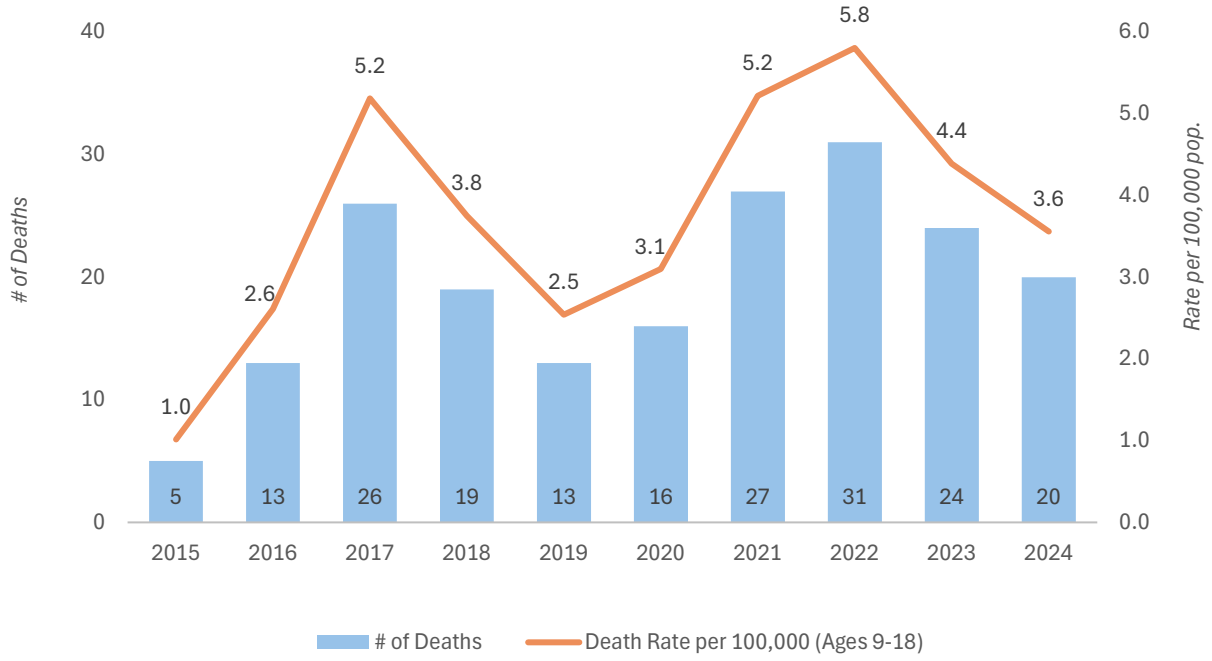
[8] Co-sleeping, sleep position, sleep surface and sleep environment are some of the risk factors known to cause or contribute to infant deaths.

**Figure 8: Accidental Injury-Related Causes of Death, 2020-2024**



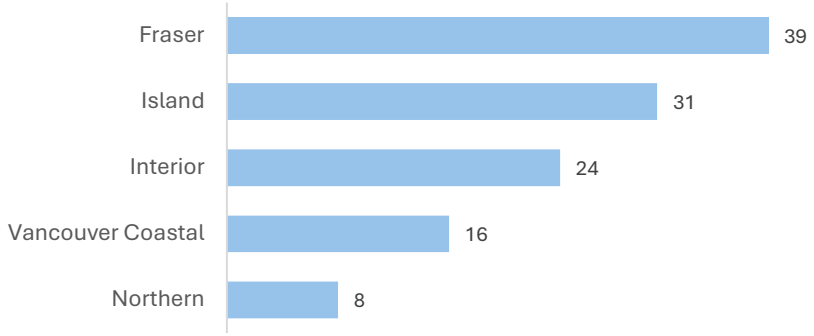

*Accidental Injury-Related: Unregulated Drug Toxicity Deaths*

**Figure 9: Accidental Injury-Related Deaths from Unregulated Drug Toxicity & Death Rate per 100,000 Pop. Aged 9-18 Years, 2015-2024 [1]**




*Note: The count and rate of death for accidental exposure to unregulated drug toxicity are now calculated for children aged 9-18 years. Children under 9 years are excluded due to very small numbers, with one death occurring in each of 2020, 2021, and 2023.*

**Figure 10: Accidental Drug Toxicity Deaths in Children Aged 9-18 Years, by Health Authority of Residence, 2020-2024**

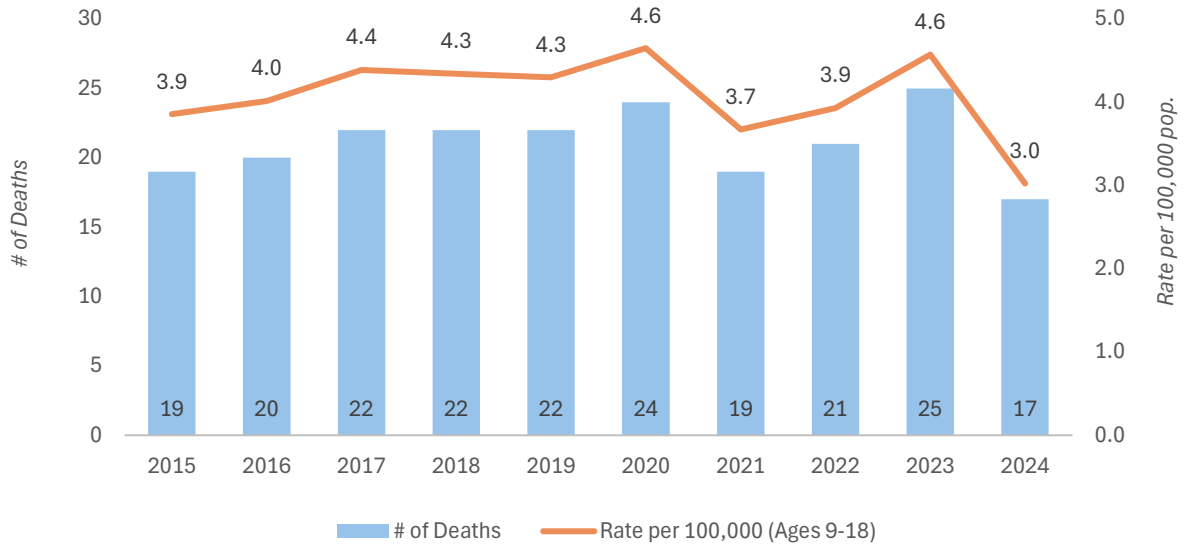



- Between 2020-2024, the total number of deaths of children aged 9-18 years due to unregulated drug toxicity increased by 55% from the previous five-year period (from 76 deaths in 2015-2019 to 118 deaths in 2020-2024) (fig.9).
- The 5-year average annual death rate per 100,000 population of children aged 9-18 years due to unregulated drug toxicity increased by 46%, from 3% in 2015-2019 to 4.4% in 2020-2024 (fig.9).
- Fraser Health had the highest number of deaths in children aged 9-18 years due to unregulated drug toxicity (39), followed by Island (31) and Interior Health (24) (fig.10).

## Injury-Related Deaths: Non-Accidental

| | **Table 5: Injury-Related Deaths – Suicide and Homicide** |
|---|---|
| Suicide | • Suicide accounted for 23% (106 deaths) of injury-related deaths in children.<br>○ 75% (80 deaths) of deaths by suicide involved youth from 15-18 years.<br>○ More deaths by suicide occurred in males (59%, 63 deaths) than in females (41%, 43 deaths).<br>○ 60% (64 deaths) of deaths by suicide were caused by asphyxiation due to ligature strangulation or hanging. |
| Homicide | Homicide accounted for 8% (38 deaths) of injury-related deaths.<br>• 53% (20 deaths) of homicide deaths involved youth from 15-18 years.<br>• 71% (27 deaths) of homicide victims were male, and 29% (11 deaths) were females. |

**Figure 11: Non Accidental Injury-Related Deaths From Suicide & Death Rate per 100,000 Pop. Aged 9-18 Years, 2015-2024 [1]**




*Note: The count and rate of death for suicide are now calculated for children aged 9-18 years. Children under 9 years are excluded due to no cases.*

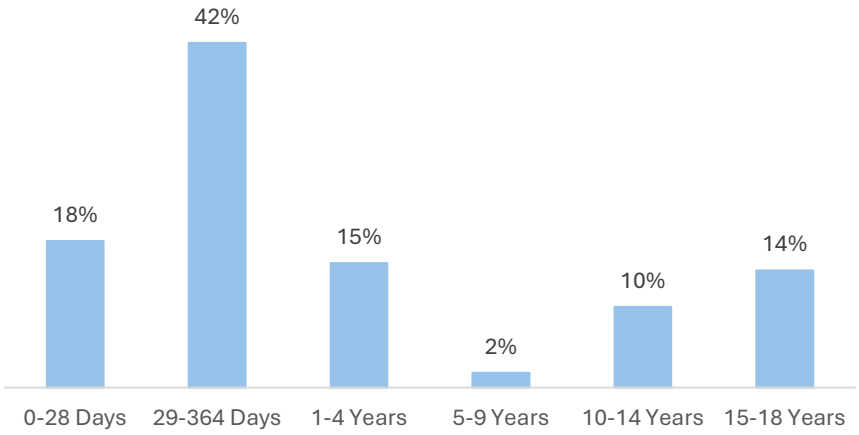
- The average number of deaths by suicide per year were similar in the 5-year periods from 2015-2019 and 2020-2024 (21 deaths).
- The 5-year average annual death rate per 100,000 child population aged 9-18 years caused by suicide decreased from 4.2 in 2015-2019 to 4 in 2020-2024.

## Undetermined Causes of Death

Total number of Undetermined deaths: **113**

About 7% of all child deaths were classified as Undetermined. It is worth noting that 60% of these deaths remain under investigation at the time of data extraction, and are therefore subject to reclassification as investigations are completed and causes of death are determined.

**Figure 12: Undetermined Deaths By Age Group, 2020-2024**




Children under 1 year old are the age group in which the Undetermined classification is most frequently applied. In instances where otherwise healthy infants under one year of age die suddenly and unexpectedly, often in their sleep, risk factors associated with sleep are examined. Co-sleeping, sleep position, sleep surface and sleep environment are some of the risk factors known to cause or contribute to infant deaths.

In June 2012, The BC Coroners Service joined with the majority of Canadian chief coroners and chief medical examiners in agreeing to adopt the classification “Undetermined” to describe unexpected infant deaths where no cause is identified following complete autopsy, examination of the death scene, and review of the clinical history.

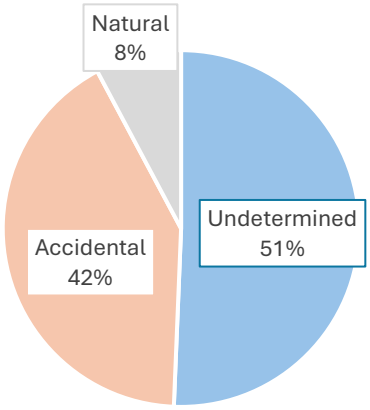
There was agreement that terms such as Sudden Infant Death Syndrome, Sudden Unexpected Infant Death and Sudden Unexplained Death in Infancy had a tendency to create confusion rather than clarity, as they are all reflections of an undetermined cause of death. Further to that, this terminology is not useful in understanding the risk factors and preventative measures associated with infant sleeping death (BC Coroners Service, 2024).

To address preventable risk factors and improve knowledge about infant safe sleep environments, the Coroners Service works with provincial partners to update safe sleep resources for parents and caregivers. Perinatal Services BC (2024), part of the Provincial Health Services Authority (PHSA), provides safer infant sleep practice resources. PHSA and others continue to use SIDS/SUDI/SUID terminology while recognizing the Coroners Service’s shift to the terminology “undetermined”.

## Sleep Environment

**Figure 13: Child Deaths With Sleep Environment and Co-Sleeping Risks Identified, 2015-2024**


**Figure 14: Percentage of Child Deaths Involving Sleep-Related Risk Factors By Classification of Death, 2020-2024**




- The average number of child deaths with identified risks related to sleep environment and co-sleeping declined over the 5-year periods, decreasing from 17 deaths in 2015-2019 to 15 deaths in 2020-2024 *(fig. 13)*.
- Amongst the deaths with identified risks related to sleep environment and co-sleeping, slightly over half (51%, 39 deaths) were classified as undetermined deaths *(fig. 14)*.

# Part Three: Characteristics of Child Deaths

## Deaths of Children Under 12 Months of Age

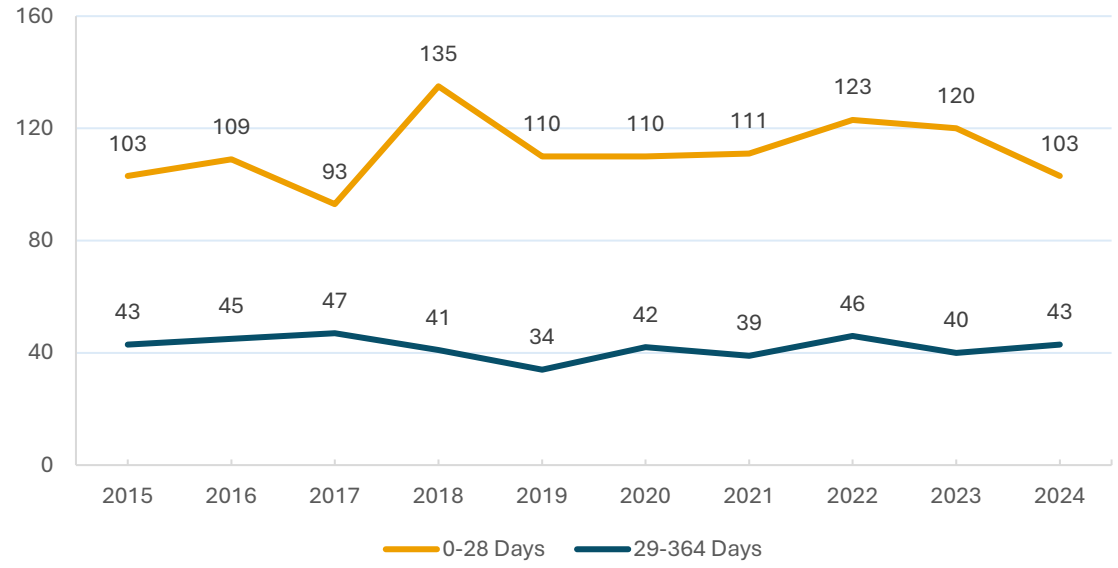
Total number of deaths, 2020-2024: **777**

**Table 6: Infant Deaths Under One Year By Health Authority of Residence, 2015-2024**

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Fraser** | 55 | 61 | 53 | 66 | 60 | 71 | 66 | 77 | 68 | 70 |
| **Vancouver Coastal** | 24 | 33 | 28 | 34 | 27 | 34 | 23 | 34 | 25 | 19 |
| **Interior** | 28 | 23 | 25 | 26 | 21 | 12 | 27 | 17 | 25 | 24 |
| **Island** | 18 | 25 | 21 | 30 | 23 | 20 | 24 | 21 | 25 | 20 |
| **Northern** | 19 | 11 | 7 | 17 | 11 | 12 | 10 | 16 | 14 | 11 |
| **Out of Province** | 2 | 1 | 6 | 3 | 2 | 3 | 0 | 4 | 3 | 2 |
| **Total** | **146** | **154** | **140** | **176** | **144** | **152** | **150** | **169** | **160** | **146** |

During 2020-2024, 73% (567 deaths) of deaths in children under 12 months of age occurred within the first four weeks of life (the neonatal period). Given the higher mortality numbers, neonates are considered separately from infants aged 29-364 days.

**Figure 15: Child Deaths Under One Year, 2015-2024**



## Neonates (within 28 days of age)

Total number of deaths in 2020-2024: **567**

**Figure 16: Neonate (0-28 Days) Deaths, 2015-2024**

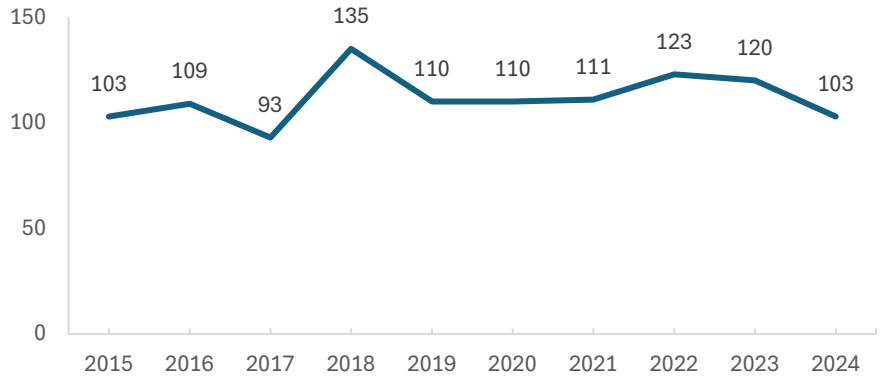


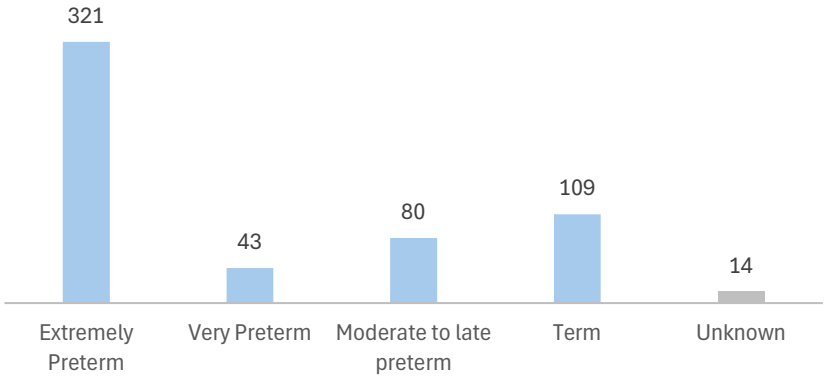

**Figure 17: Classification of Neonatal (0-28 Days) Deaths, 2020-2024**


Natural disease was identified as the cause of 96% (542 deaths) of neonatal deaths. The leading natural causes are certain conditions originating in the perinatal period (e.g., prematurity, complications of pregnancy, labour and delivery), and congenital malformations, deformations, and chromosomal abnormalities.

The World Health Organization (2025) defines prematurity (preterm) as babies born alive before 37 complete weeks of pregnancy. The sub-categories for preterm birth are based on gestational age as below:

- Extreme preterm: less than 28 weeks gestational age
- Very preterm: 28 to less than 32 weeks gestational age
- Moderate to late preterm: 32 to 37 weeks gestational age.

**Figure 18: Neonatal (0-28 Days) Deaths by Gestational Age, 2020-2024**




More than three quarters (78%, 444 deaths) of the neonatal deaths occurred amongst neonates born preterm, including over half (57%, 321 deaths) were extremely preterm, 8% (43 deaths) were very preterm, and 14% (80 deaths) were moderate to late preterm.

| Table 7: Causes of Death, Neonate (0-28 Days) | |
|---|---|
| Natural | • Most deaths in neonates were from natural diseases (96%, 542 deaths).<br>  ○ Certain conditions originating in the perinatal period (P00 – P96; ICD10) were the leading cause of all deaths in neonates, accounting for about 75% (423 deaths).<br>  This includes preterm births; complications of pregnancy, labour, and delivery; birth trauma; other disorders; and infections related to the perinatal period.<br>• Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99; ICD-10) caused 18% (102 deaths) of all deaths in neonates. |
| Undetermined | • Undetermined causes accounted for 4% (20 deaths) of deaths in this age group. |
| Accidental | • Accidental injuries accounted for 1% (5 deaths) of deaths in this age group. In the 5 deaths, 3 were from positional asphyxia and 2 died from a motor vehicle incident. |

### *Stillbirths*

Stillbirth is defined by HealthLinkBC (2022) as "the loss of a baby after 20 weeks of pregnancy but before the baby is born. It can happen during the pregnancy or during labour". There is no requirement that stillbirths be reported to BC Coroners Service, nor is there jurisdiction for the Coroners Service to investigate stillbirths.

## Infants from 29-364 days

Total number of deaths 2020-2024: **210**

**Figure 19: Child Deaths, Infants 29-364 Days, 2015-2024**

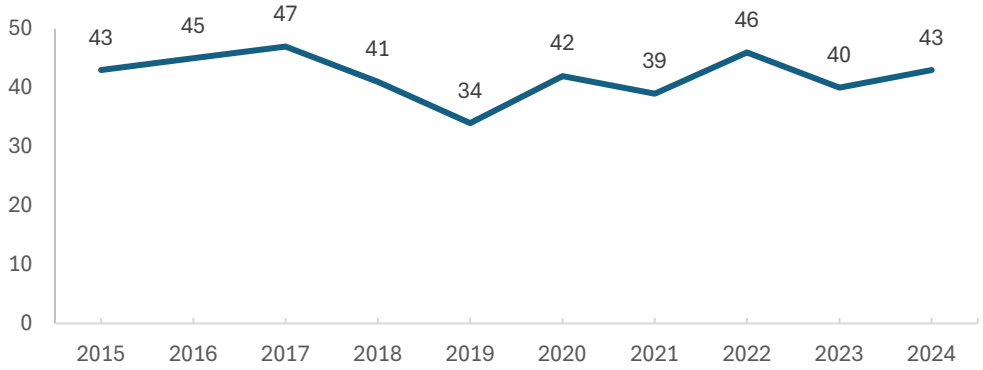
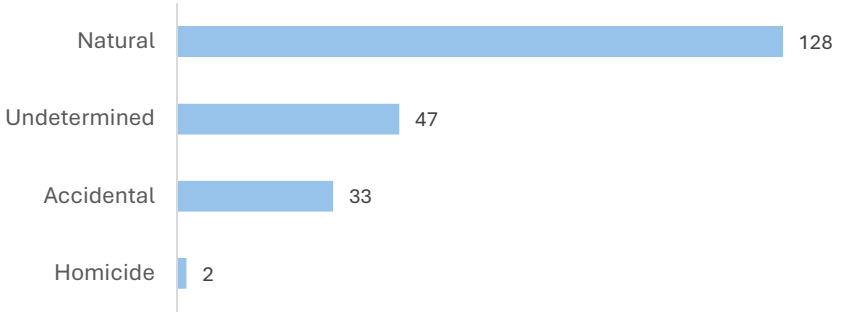



**Figure 20: Classification of Death, Infants 29-364 Days, 2020-2024**




| Table 8: Causes of Death, Infants from 29-364 Days | |
|---|---|
| Natural | • Natural diseases caused 61% (128 deaths) of all deaths in infants 29-364 days.<br>○ 39% (50 deaths) of the 128 natural deaths were from congenital malformations, deformations and chromosomal abnormalities (Q00Q99; ICD-10).<br>○ 32% (41 deaths) of the 128 deaths were from conditions originating in the perinatal period (P00 – P96; ICD-10), including preterm deliveries and perinatal complications. |
| Undetermined | • 22% (47 deaths) of the deaths in infants 29-364 days were classified as undetermined.<br>○ 6% (3 deaths) of the 47 deaths classified as undetermined were from exposure to unregulated drug toxicity. |
| Accidental | • 16% of the deaths in this age group were from accidental injuries (33 deaths).<br>○ 82% (27 deaths) of the 33 accidental deaths were from obstruction of the airway and/or positional asphyxia. |
| Homicide | • 1% of the infant deaths were due to homicide (2 deaths). |

# Deaths of Children Between 1 and 4 Years

Total number of deaths 2020-2024: **127**

**Figure 21: Child Deaths, Children 1-4 Years, 2015-2024**

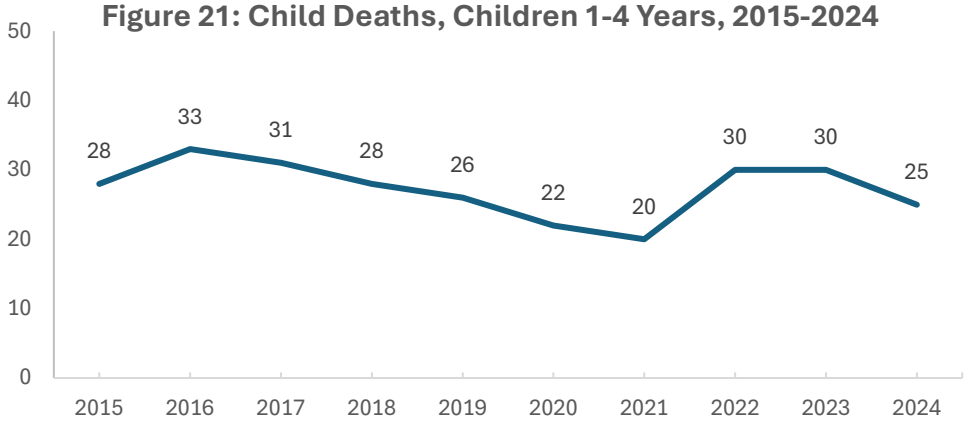
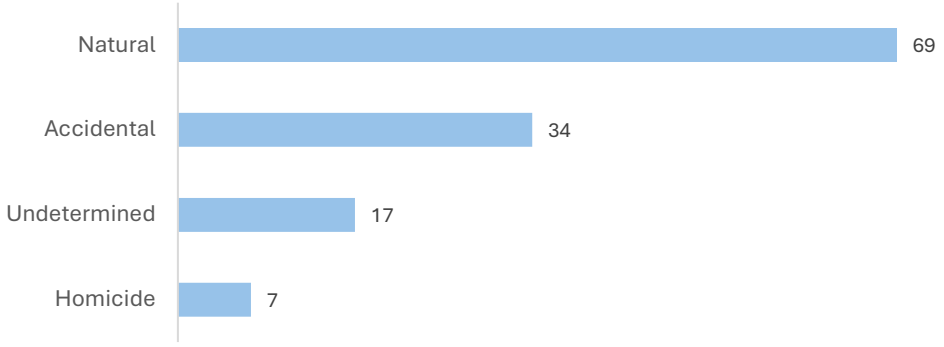



**Figure 22: Classification of Death, Children 1-4 Years, 2020-2024**




| Table 9: Causes of Death, Children 1-4 Years | |
|---|---|
| Natural | • Natural diseases caused 54% (69 deaths) of the deaths in children aged 1-4 years.<br>○ Neoplasm (C00-C97, D00-D48; ICD-10) was the leading cause of natural deaths (23%, 16 deaths) in children aged 1-4 years. |
| Accidental | • Accidental injuries represented 27% (34 deaths) of all deaths in children aged 1-4 years.<br>○ The most common cause of accidental deaths were motor vehicle incidents (11 deaths), followed by drowning (6 deaths) and fall from height (5 deaths).<br>○ Accidental exposure to unregulated drug toxicity accounted for 3 deaths in this age group. |
| Undetermined | • 13% (17 deaths) of the deaths in this age group were classified as undetermined. |
| Homicide | • 6% (7 deaths) were the result of homicide. |

# Deaths of Children Between 5 and 9 Years

Total number of deaths, 2020-2024: **98**

**Figure 23: Child Deaths, Children 5-9 Years, 2015-2024**

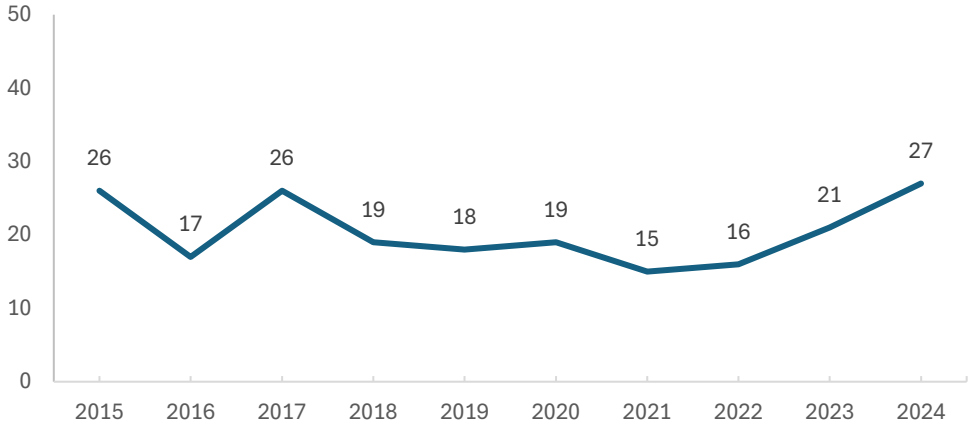
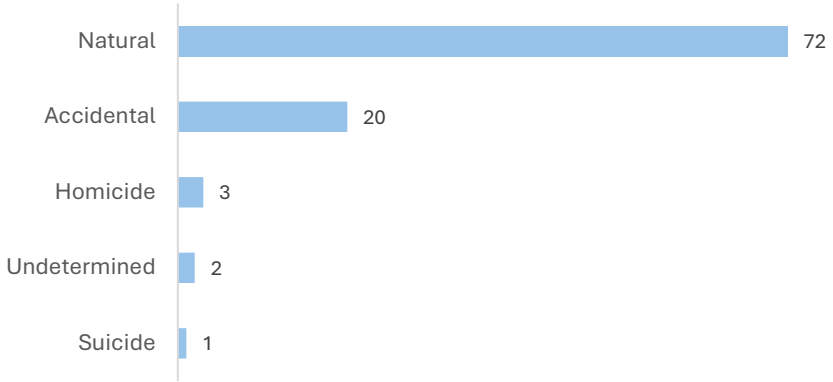



**Figure 24: Classification of Death, Children 5-9 Years, 2020-2024**




| Table 10: Causes of Death, Children 5-9 Years | |
|---|---|
| Natural | • 73% (72 deaths) of the deaths in children aged 5-9 years were due to natural diseases.<br>  ○ Neoplasm (C00-C97, D00-D48; ICD-10) was the leading cause of natural deaths (39%, 28 deaths) in children aged 5-9 years. |
| Accidental Injuries | • 20% (20 deaths) were from accidental injuries.<br>  ○ The most common cause of accidental deaths were motor vehicle incidents (10 deaths).<br>  ○ Drowning accounted for 3 deaths, and fall and fire-related injury each resulted in 2 deaths in this age group. |
| Other Causes | • Homicide accounted for 3% (3 deaths) of all deaths in children 5-9 years.<br>• Undetermined deaths accounted for 2% of deaths in this age group (2 deaths).<br>• Suicide accounted for 1% of deaths in this age group (1 death). |

# Deaths of Children Between 10 and 14 Years

Total number of deaths, 2020-2024: **142**

**Figure 25: Child Deaths, Children 10-14 Years, 2015-2024**

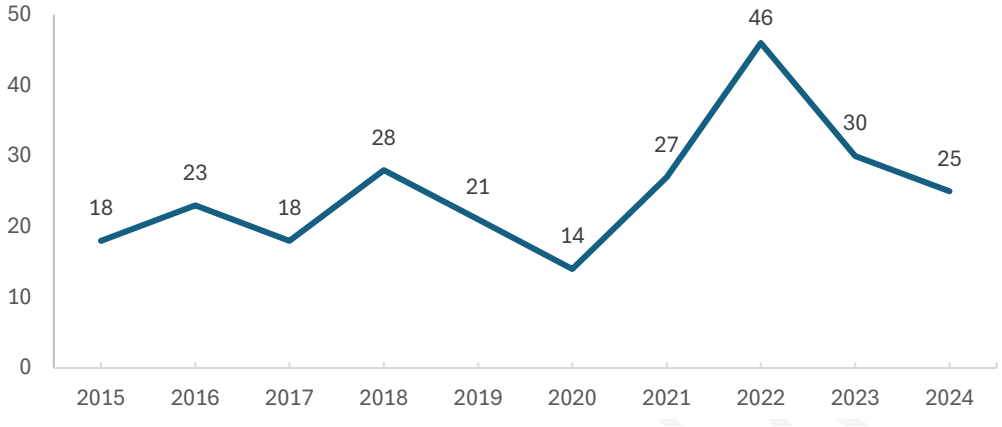
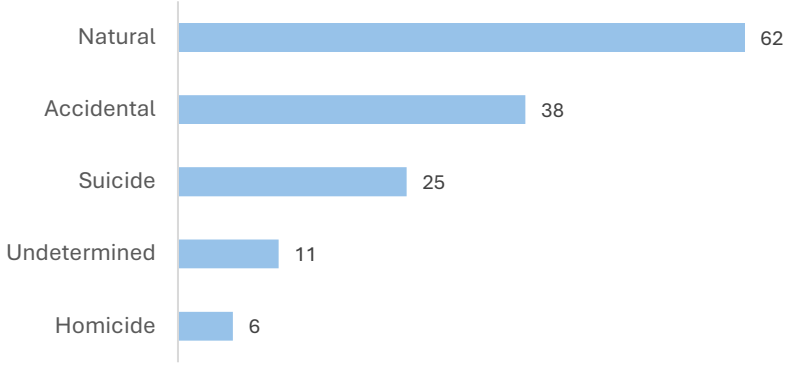



**Figure 26: Classification of Death, Children 10-14 Years, 2020-2024**




| Table 11: Causes of Death, Children 10-14 Years | |
|---|---|
| Natural | • Deaths due to natural causes were the leading cause of death for children aged 10-14 years (44%, 62 deaths).<br>  ○ Neoplasm (C00-C97, D00-D48; ICD-10) was the leading cause of natural deaths (34%, 21 deaths) in children aged 10-14 years. |
| Accidental | • Accidental injuries accounted for 27% (38 deaths) of the deaths in this age group<br>  ○ Amongst the 38 accidental deaths, 37% (14 deaths) were from exposure to unregulated drug toxicity, and 32% (12 deaths) were from motor vehicle incidents. |
| Suicide | • 18% (25 deaths) of the deaths were from suicide.<br>  ○ Among the suicidal deaths, there were more males (52%, 13 deaths) than females (48%, 12 deaths). |
| Other causes | • 8% of the deaths were classified as undetermined (11 deaths).<br>• 4% of the deaths were due to homicide (6 deaths). |

# Deaths of Children Between 15 and 18 Years

Total number of deaths, 2020-2024: **392**

**Figure 27: Child Deaths, Children 15-18 Years, 2020-2024**

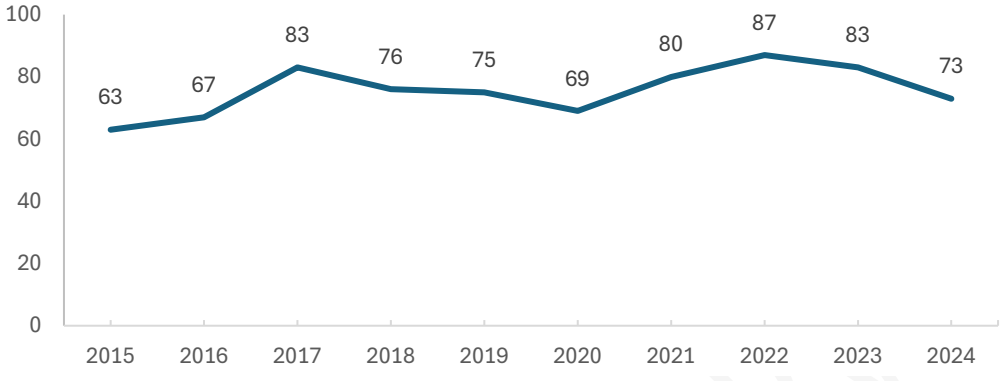
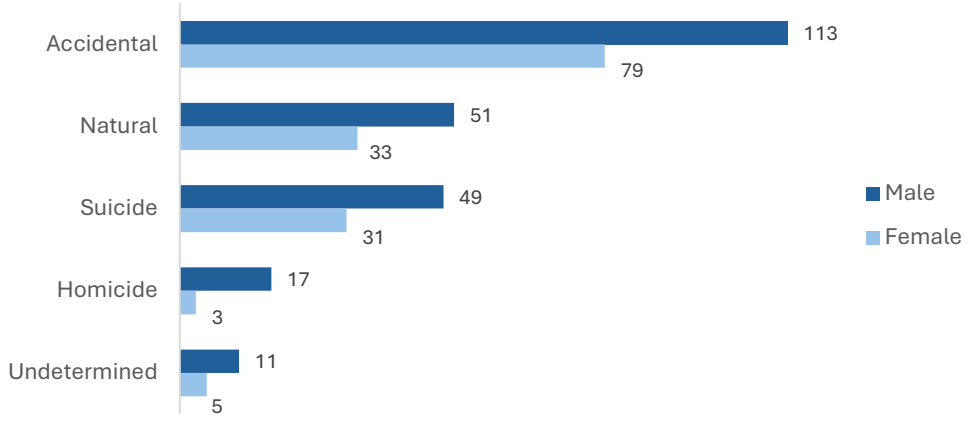



**Figure 28: Classification of Death By Sex, Children 15-18 years, 2020-2024**




| Table 12: Causes of Death, Children 15-18 Years | |
|---|---|
| Accidental | • Accidental injuries caused 49% (192 deaths) of the deaths in this age group. Amongst the 192 accidental deaths:<br>○ 54% (104 deaths) were from exposure to unregulated drug toxicity, comprising 52% females (54 deaths) and 48% males (50 deaths).<br>○ 31% (60 deaths) were from motor vehicle incidents. |
| Natural | • Natural diseases accounted for 21% (84 deaths) of the deaths in children aged 15-18 years.<br>○ Neoplasm (C00-C97, D00-D48; ICD-10) was the leading cause of natural deaths (29%, 24 deaths) in children aged 15-18 years. |
| Suicide | • 20% (80 deaths) of children in this age group died from suicide.<br>○ More males (61%, 49 deaths) died by suicide than females (39%, 31 deaths). |
| Homicide | • Homicide accounted for 5% (20 deaths) of deaths in this age group. |
| Undetermined | • Undetermined deaths accounted for 4% (16 deaths) of deaths. |

# Part Four: Ministry of Children and Family Development (MCFD)

Slightly over one-third (35%, 534 deaths) of all children and youth who died between 2020 and 2024 were in receipt of services from the Ministry of Children and Family Development (MCFD) at the time of, or within the year preceding their death.

**Figure 29: Deaths of Children 0-18 Years Receiving MCFD Services Within The Year Preceding The Death, 2020-2024**

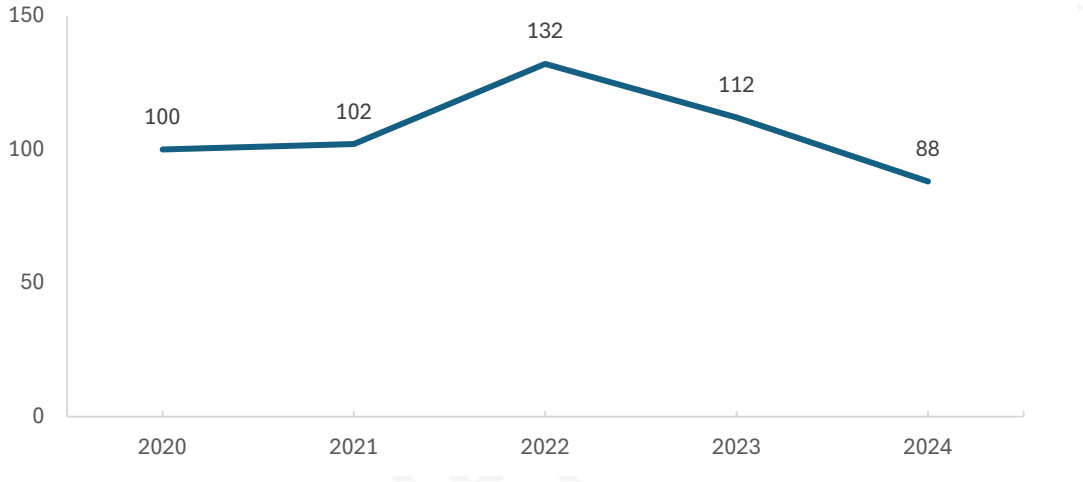
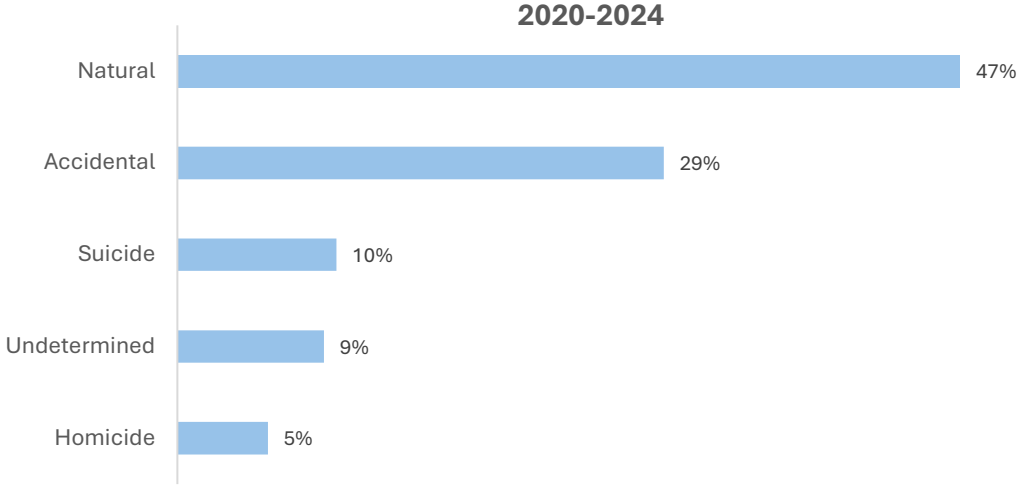



**Figure 30: Percentage of All Child Deaths Receiving MCFD Services Within The Year Preceding The Death, By Classification of Death, 2020-2024**




Almost half (47%, 251 deaths) of the children recipients of the MCFD services died from natural causes *(fig. 30)*. Many of these children and youth were referred for services and benefits based on diagnosed health conditions.

**Figure 31: Deaths By Age Group of Children Receiving MCFD Services Within The Year Preceding The Death, 2020-2024**

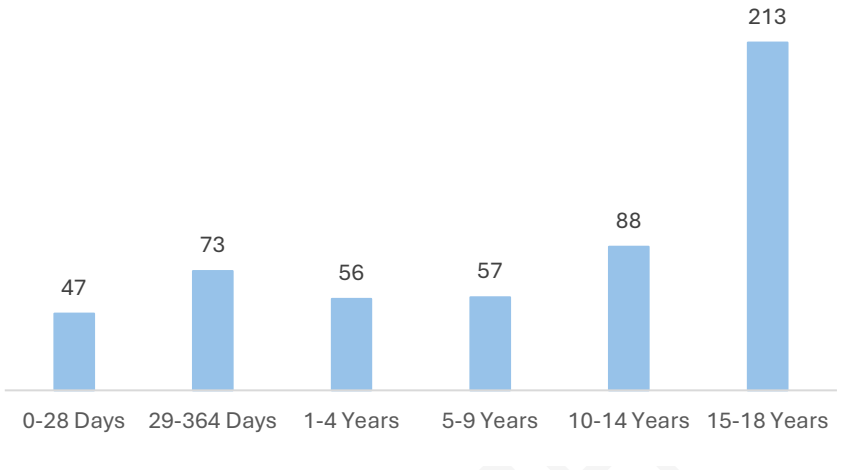
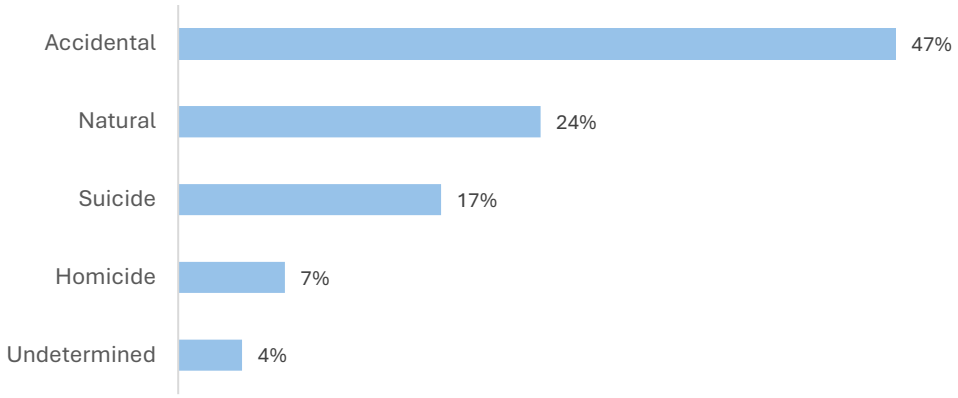



**Figure 32: Percentage of Deaths of Youth 15-18 Years in Receipt of MCFD Services, By Classification of Death, 2020-2024**




MCFD-involved youth aged 15 to 18 years were the age demographic that experienced the most deaths *(fig.31)*.

- Within this age group, accidental injuries were the most common cause of death *(fig.32),* and over three quarters (77%, 78 deaths) of those were caused by unregulated drug toxicity.

# Glossary

**Aggregate**
Presentation of individual findings as a collective sum.

**Death investigation – complete**
The investigation of the death has been completed. Post-mortem testing is complete, and results finalized. A Coroner's Report is released.

**Death investigation – in progress**
Circumstances of the death are still under investigation and/or awaiting additional information such as medical records, post-mortem testing results, or toxicological findings that will support the completion of a Coroners Report.

**Health Authority**
The five regional health authorities in British Columbia govern, plan and deliver health care services within their geographic areas. Their responsibilities include but are not limited to identifying population health needs, planning appropriate programs and services, ensuring programs and services are properly funded and managed, and meeting performance objectives.
Regional health authority breakdown can be found at BC Government: Regional Health Authorities, last updated June 9, 2021.

**Motor Vehicle Incident**
Includes accidents involving motor vehicles, passenger vehicles, and off-road vehicles happening on public or non-public roadways. Excludes ATV, dirt bike, and snowmobile accidents on off-road or non-public roadways. Excludes pedestrian conveyance (e.g., pedal cycling) incidents not involving a motor vehicle or passenger vehicle.

**Sleep Environment Risk Factor** includes:

- Co-sleeping (sleeping arrangement in which a newborn or infant shares the same sleep surface with an adult or sibling).
- Other sleeping arrangement which the newborn or infant is put on an unsafe sleep surface; for example, adult bed, sofa and household furniture, and car seat.

**Unregulated Drugs Inclusion Criteria**
The unregulated drug overdose category includes the following:

- Controlled and illegal drugs (e.g., heroin, cocaine, MDMA, methamphetamine, unregulated fentanyl, etc.).
- Medications not prescribed to the decedent but obtained/purchased from unknown means or where origin of drug is not known.
- Combinations of the above with prescribed medications.

# Note

1. Population estimates were taken from *BC Stats: Population estimates & projections for British Columbia, release date on July 21, 2025*
2. Number of live births were taken from *BC Vital Statistics: Births, reporting date September 1, 2025*