# Summary

Report on

*the Beaumont Affair*

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# Foreword

## The acronyms and their meaning

The Director of Youth Protection **(DYP)** occupies a special position in Québec's child protection system under the *Youth Protection Act* **(YPA)**. The **DYP** is called upon to **exercise on an exclusive basis the strategic responsibilities** listed in the **YPA**:

> He determines whether or not the report on the situation of a child is admissible.
> If the report is admissible, he decides whether the safety or development of the child is compromised, after evaluating the situation.
>
> If the safety or development of the child is compromised, he decides the child's orientation, i.e. he either proposes the application of voluntary measures or seizes the Youth Division of the Court of Québec of the situation;
>
> At the conclusion of the application of voluntary or court-ordered measures, he revises the situation and decides whether it is appropriate to extend the application of voluntary measures, to seize the Court again of the matter or to terminate the intervention.

To exercise his exclusive responsibilities, the **DYP** has direct authority over members of his personnel who act on his behalf with the children and parents. The **DYP** may also **authorize** people over whom he has no direct authority to **implement the protection measures** that the members of the **DYP's personnel** have agreed upon with the parents or that the Court has ordered.

There are 19 **DYPs** in Québec, one for each administrative region. The only exception is the Montréal region, where two **DYPs** operate: one for the English-speaking population, and one for the French-speaking population.

The **DYP** is located in a social services establishment created under the *Health and Social Services Act* **(HSSA).** He is appointed by its Board of Directors and is under the direct authority of the Director General of the establishment.

During the period covered by the investigation, i.e. between 1981 and 1994, the designation and status of this establishment have changed.

> **From 1981 to 1992:** a **DYP** was appointed in each of the social services centres **(CSS)** created under the **HSSA**. In this case, the **CSS** concerned was the Québec City Social Services Centre **(CSSQ)**. As a result, the Québec City **DYP**, who had his own personnel to exercise his exclusive responsibilities, could also **authorize CSSQ** employees to provide services under the protection measures ordered by the court or agreed upon with the parents. The members of the **DYP** personnel and the **CSSQ** employees **authorized** by the **DYP** to provide services under the **YPA** also interact with the personnel of other community establishments, in particular the local community services centres **(CLSCs),** the reception and rehabilitation centres **(CARs)** and the community health departments (**DSCs**). In this case, the **CLSC** was the Jacques-Cartier **CLSC** and the **CAR** was the Centre d'accueil Mont d Youville. All these establishments are autonomous and the **DYP** has no direct authority over them: each is administered by a board created under the **HSSA**. The Minister of Health and Social Services and his department (the

**MSSS**) are accountable for the administration of all these establishments and for the application of the **YPA** by the **DYPs**.

**Beginning in 1992,** following a reform of the **HSSA,** the **CSSs** were replaced by child and youth protection centres **(CPEJs)** and the **CARs** were replaced by rehabilitation centres for young people in difficulty **(CRJDAs)**. In this case, for example, the **CSSQ** became the Québec City **CPEJ**.

> The main change, however, was that, since 1992, the **CPEJs** and the **CRJDAs** of any given region are administered by a single board, except for the Montréal region, which has two boards. According to the same logic, the establishments in a given region are managed by the same director general, appointed by the Board of Directors.

The boards of directors and directors general of these establishments have also agreed on a uniform designation throughout Québec: **Youth Centres,** preceded by the name of the region. For example, in this report, the Commission is making recommendations to the Board of Directors of the **Québec City Youth Centres**.

Each of the **Youth Centres** enjoys administrative autonomy, which it exercises in accordance with **MSSS** policies and guidelines. Each of the **Youth Centres** is allocated financial resources by the Regional Health and Social Services Board of its region, in accordance with the regional service organization plan **(PROS)** adopted by the Board.

Because the investigation deals largely with a period where the services were provided by **CSSQ** personnel, this appellation will be used when relating past events. However, in its recommendation, the Commission will use the current terms, i.e. the **CPEJs** and the **Québec City Youth Centres**.

## Personal identity

Under the *Youth Protection Act*, the Commission cannot disclose any information that could lead to the identification of the children involved in the *Beaumont Affair*. The children's names are therefore fictitious and were chosen by J.G.'s first wife. She also chose a name (Joyce), which we will use to refer to her throughout the Report. The names of the six elementary schools attended by the older child are not disclosed.

## The text printed in italics

Any part of the Report printed in italics is the transcription of testimony heard during the investigation or a quotation from a note or document in the file.

# *The case of the abused children of Beaumont*

The case of the abused children of Beaumont known as the *Beaumont Affair,* an expression used on March 22, 1995 before the National Assembly, came to its legal conclusion before the Superior Court of Québec on January 24, 1997. On that date, J.G., a 37-year old man, was sentenced to 22 years in prison for inflicting exceptionally severe abuse on the children and two women with whom he lived between 1981 and 1994. Throughout this report, the case will be referred to as the *Beaumont Affair*.

In the sentencing address, the Court observed that the following treatment was inflicted on Mathieu, the older of the children:

> *At the age of 1 month, you forced him to drink boiling-hot milk, causing severe injuries to the inside of his mouth. ---You scalded him by holding his hands under hot tap water (...) The scars are still visible today. --- You made him eat his excrements, his vomit. ---You deprived him of food on a daily basis. --You beat him every day with sticks and iron bars under the feet and on his body, hitting him all over with your feet and fists. --You struck him with a knife on one of his legs. He had to be taken to the hospital, where you forced him to say that he had hurt himself with an axe. ---You took him by the throat on numerous occasions, holding him until he weakened. ---You urinated on your son, forcing him not to wash himself during three days and to go to school with the same clothes. ---During a "beating" session, you caused open injuries to his head. Refusing to take him to the hospital, you forced your wife to sew him up with ordinary thread without anesthesia. ---While he was in his bed, you took him repeatedly by the genitals to lift him up. ---Taking your penis out and showing it to him, you told him: "if you want to eat, suck me." ---You constantly threatened him with death, either with a knife or with an axe. ---On a regular basis, as your son suffered from incontinence, you held his head in urine---You urged him to delinquency, inducing him to steal in a grocery store and in a clothing store ---You sequestered him on several occasions in a dark room.*

**This description of the abuse imposed on the older child provides a glimpse of the living conditions of all the children involved in the situation. Four of them, all boys, were also abused. The older child was prevented from living his life as a child; his father put him to work at a very early age, forcing him to take care of his younger brother and sister, preventing him from seeing friends or playing outside. Over the years, the children constantly moved from one place to another. Twenty different addresses are noted on the file between 1982 and 1994. As soon as the neighbours or the school began to see that bad things were going on, it was time to go, says their mother.**

Three months after the older child was born, his situation was reported to the Québec City DYP (Director of Youth Protection). After 13 years of escalating violence, marked by fifteen more reports, including ten about abuse on the older child, the unbearable nature of the living conditions imposed on the two women and seven children involved in this affair was finally recognized. Québec City DYP staff put an end to it in October 1994. They are now attempting to mitigate the impacts on the children's lives, to the extent that this is possible.

## The subject of the Commission's investigation

In September 1995, after an initial review of the facts, Me Céline Giroux, Interim President of the Commission de protection des droits de la jeunesse[1], felt she had reason to believe that the children's right to adequate social services had been violated. She authorized an investigation into the services provided from 1981 to October 1994. Section 8 of the Youth Protection Act, reproduced hereunder, deals with the right to such services:

> *A child is entitled to receive adequate health services, social services and educational services, on all scientific, human and social levels, continuously and according to his personal requirements, taking into account the legislative and regulatory provisions governing the organization and operation of the institution or educational body providing such services and the human, material and financial resources ant its disposal.*

Through its investigation, the Commission wanted to establish whether or not the right of the children to receive adequate social services was respected. In case of a violation, the Commission wanted to make sure that the situation had been corrected. It is important that the grave harm caused by the father during so many years be compensated by the personalized services to which the children are entitled.[2]

The Commission chose to reconstitute as faithfully as possible the relevant facts: a review of those facts was required to draw lessons regarding the rules governing the organization and operation of the CPEJ (child and youth protection agency) in the Québec City region as well as the CPEJs in the other administrative regions of Québec. The Commission believes that these facts should be considered in their context. The DYP and his staff do not exist in a vacuum: they interact with the resources in the community. The Commission therefore attached special importance to the linkages between the health network, the educational network and the social services network.

The *Beaumont Affair* began two years after the coming into force of an Act that everyone considered particularly modern and progressive, especially because of the primacy given to the rights of the child. It ended at a time when the Québec child protection system had to face up to major challenges in the wake of a general reorganization of health and social services.

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1 The *Commission de protection des droits de la jeunesse* became the *Commission des droits de la personne et des droits de la jeunesse* in the fall of 1995.

2 Since the Commission had no reason to believe that the Québec City DYP had violated the rights of the children of J.G.'s second wife from the time their situation was reported, it did not extend its investigation to the services provided to them from September 1994.

In response to the concerns of the population and decision-makers, and pursuant to the need to see what organizational or functional changes were required as a priority to improve the quality of services provided to children whose safety and development is compromised, the Commission wanted to shed complete light on what will forever remain a sad episode in the history of Québec's child protection system.

## The investigation

Instituted in 1995, the Commission's investigation was postponed because of pending legal proceedings from 1995 to January 1997. In March 1997, the three Commissioners responsible for the investigation[3] heard the testimony of nineteen people who had been called upon to intervene directly with the children or to supervise this intervention:

> The three unit heads who supervised the work of the Québec City DYP staff responsible for determining whether or not the safety and development of the children were compromised --- The two team leaders who supervised the work of the professionals from the Québec City Social Services Centre (CSSQ) --- The reviewer who reviewed the children's situation eight times between 1982 and 1989 to assess it as regular or special --- The person who exercised the same function five times in 1994 --- The four members of the Québec City DYP staff who assessed the situation in 1983, 1989 and 1993. --- The three professionals from the CSSQ who were authorized between 1989 and 1994 to provide social services to the children in accordance with the voluntary measures agreed upon between their parents and the DYP staff. --- The worker from the Jacques-Cartier CLSC (local community services centre) who provided services to the parents in 1989 --- The educator from Mont-d'Youville who provided family-based assistance services in 1989 and 1990. --- The school child care worker who provided regular services to the older child in 1990 and 1991. ---The school psychologist who intervened on behalf of the eldest child in 1989. --- The family physician who provided services from 1981.

The Commissioners also heard the testimony of Officers of the Québec City Youth Centers:

> Mr. Pierre Corriveau, Executive Director of the institution since 1993---Mr. Alfred Couture, Director of Youth Protection from 1979 to 1995---Mr. Camil Picard, Director of Youth Protection since 1996---Ms Marie Bouchard, appointed Director of Professional Practice Development in 1997.

At the conclusion of the first phase of their proceedings, the Commissioners decided to review certain elements of the file in a broarder perspective and to invite representatives of various organizations to present their point of view concerning the organization of child protection services. The following people were heard:

> Mr. Claude Bilodeau, Director General of the Québec Youth Centres Association ---Mr. Laurier Boucher, Mr. Jean-Luc Lavoie and Mr. René Page, respectively President, Vice-President and Executive Director of the Québec Professional Corporation of Social Workers. ---Mr. Robert Diamant and Ms Sylvie de Grandmont, respectively President and Vice-President of the Québec Professions Board--- Dr Jean Labbé, pediatrician attached to the CHUL Pavilion of the Québec City University Hospital Centre (CHUQ). --- Dr Monique Plante, pediatrician, and Ms. Ginette Grenier, nurse in charge of the Child Protection Committee of the Saint-François d'Assise Pavilion of the CHUQ. ---The Executive of the multidisciplinary committee of the Québec City Youth Centres, chaired by Mr. Gilles Bégin.

3 The three Commissioners were: Me. Céline Giroux, Vice-President of the Commission des droits de la personne et des droits de la jeunesse, Dr. Liliane Filion-Laporte, pediatrician, and Ms. Louise Fournier, psychologist. They were assisted by Marc Bélanger, researcher at the Commission's Research Department.

# The living conditions of the children and the services provided to them between 1981 and 1994

## October 1981 / April 1982

### OVERVIEW OF THE SITUATION

In October 1981, three months after the child's birth, Mathieu's situation was reported to the Québec City DYP because his parents were not in a position to take care of him. They had given him up for adoption and taken him back twice. J.G. claimed that Joyce had already beaten the child on several occasions and wanted to *pitch him out of the window.* The DYP agreed with the parents on voluntary measures for a period of seven months. From October 1981 to April 1982, a DSC nurse visited the home to help the parents develop their parenting skills. According to the worker, this assistance by a nurse continued beyond April. Since the file is very incomplete, it has been impossible to reconstruct the contents of the intervention and its main components. In April 1982, the reviewer terminated the intervention by the DYP, submitting that the parents had created positive links with their child and that J.G. and Joyce had come out of their social isolation. The worker stated before the Commission that there had been no crisis during that period.

### SOME SIGNIFICANT FACTS

At the time of her child's birth, Joyce was a 17-year-old who had broken links with the members of her family, where she had experienced difficult living conditions. J.G. was 21 years old and stated that he had been a victim of abuse as a child.

To evaluate the situation, the worker made three visits to the parents. He also communicated with the staff of the adoption department. He did not establish the social history of the two young parents and did not carry out specific activities to evaluate their parenting skills.

According to the worker, J.G. had established normal contacts with Joyce's family during the period where he provided assistance. Furthermore, J.G. had demonstrated seriousness and a sense of responsibility. The parents had established links with some community services. For these reasons, the reviewer estimated that J.G. and Joyce were able to take charge, without surveillance or assistance under the YPA, of their responsibility for the care, maintenance and education of their child.

The worker recalled the general context of the intervention at the time. Emphasis on child protection was quite new, since the *Youth Protection Act* had come into force only two and a half years earlier. It was not easy to put your DYP hat on, he told the Commissioners. He summarized his approach in the following words: *when two young parents came to ask for help, you went to help and to take a look. When they wanted to be helped, we went from there: they had the benefit of the doubt.*

## July / October 1983

### OVERVIEW OF THE SITUATION

In July 1983, Dr. Gilles Berthelot[4] reported the situation of Mathieu, then aged 2 years and 11 months. He had treated the child for a contusion on the forehead. J.G. claimed that Mathieu had hurt himself on both sides of the forehead by falling from his bed. The physician also observed that the *bruises* dated back to different dates.

The file was given to the unit leader who had carried out the evaluation in 1981. It was placed on a waiting list for 14 weeks. At the conclusion of her evaluation, this young professional at the beginning of her career considered that J.G.'s version of the facts was plausible and closed the file. The unit head was not consulted and the physician was not informed of the decision, contrary to the provisions of the Act.

### SOME SIGNIFICANT FACTS

The physician also observed that the child seemed scared and reacted very little to stimuli. He noted that the child had been brought two or three times to the same hospital for slight but suspicious injuries. The DYP reception department recorded in detail these crucial pieces of information.

When the worker began her intervention, Joyce had been back home for only a short time, after a fourth stay in a psychiatric clinic. The physician's conclusions were depression and immaturity. Her family life was an important factor in her difficulties. The psychiatrist noted that the illness dated back o the pregnancy, *which had not been accepted by Joyce's parents, just as J.G. had not been accepted. During hospitalization, things apparently improved.*

For her evaluation, the worker went to the home once, where she met J.G., Joyce and Joyce's mother. Joyce *seemed to keep to herself*. Mathieu was close to his father and *in no way fearful.* She communicated by telephone with the psychiatrist who had provided care to Joyce, with her physician and with a psychiatric nurse. According to the worker's testimony, those were short conversations, in particular the conversation with the psychiatrist. She completed her activities by a discussion with the CSSQ worker who had provided services during the previous period. According to her, this worker went to visit Joyce at J.G.'s request. She did not remember the content of the observations made by her colleague, but remembered that she had been reassured by his words. The CSSQ worker did not remember that visit by his colleague.

As was the case for the previous worker, this worker did not establish the social history of the parents. According to the notes in the file, confirmed by her testimony, her evaluation of the child's situation included a review of the current health status of the mother, without any concern for the past. At the conclusion of her activities, she concluded that the version of the facts provided by J.G. was *plausible*, and she noted that Mathieu did not *appear to be a battered child*. She did not communicate with Dr. Berthelot.

After suggesting that Joyce continue to see her psychiatrist, she decided to close Mathieu's file. She retained the suggestion from the family physician that J.G. and Joyce would agree to *consult regarding their relationship.* The link that Joyce and J.G. had with their family physician seemed good to her. In the circumstances, she considered it was appropriate to limit intervention to *parent support with a view to personalized assistance*.

[4] The identity of Dr. Berthelot has been disclosed with his consent. In 1988, Dr. Berthelot had remained very active in the intervention in favour of abused children, particularly in the Québec City region.

## October 1983 / June 1989

### OVERVIEW OF THE SITUATION

The DYP file contains practically no information concerning Mathieu's living conditions after the brief DYP intervention in October 1983. The Commission checked to see whether people *called to provide care or any other form of assistance* would have been any quicker to detect the fact that Mathieu was abused in his family environment. In fact, it was not until six years later that the DYP was again informed of Mathieu's situation.

### SOME SIGNIFICANT FACTS

The files of the various hospitals in the Québec City region contain information that deserves to be mentioned. The following table provided an account of hospital visits following an injury.

| Date of the event | Hospital | Reason for the consultation<br>P | Physician's diagnosis, impression, observations, follow-up |
|---|---|---|---|
| 1984/01/08 | Christ-Roi | Pain in the right leg. Slid on a snowbank with his father who then noted that he limped and complained of pain in his ankle | Bruise, slight sprain |
| 1984/04/27 | Christ-Roi | Fell, with his throat falling on the edge of a toy truck, causing a bruise | Palpation of the trachea, no pain. Contusion in the neck |
| 1984/10/18 | Christ-Roi | Fell downstairs | Head injury, with signs of a bleeding. |
| 1985/11/13 | Christ-Roi | Fell on his head from a rocking chair. 2 cm wound. No nausea, no loss of consciousness. | Repair with 4 separate stitches. See again in 7 days. Seen on November 21, 1985. |
| 1987/05/26 | Saint-François | Fall from a bicycle 2 days ago. Pain in the left shoulder. | Bruises. |
| 1987/11/26 | Saint-François | Fell downstairs, no loss of consciousness. | Parieto-occipital wound, approximately 1 inch. Repaired with 3 simple stitches. Vaccines in order. |

The family physician stated that he had observed no signs that the children were neglected. *I may have been "bamboozled" or had the wool pulled over my eyes, but the father seemed to me to be a person who controlled the whole situation. His discourse was always credible.*

Looking back over the events, the physician admitted *that there might have been small clues that would have justified a report to the DYP.* When he discovered the real face of things in 1995, his reaction was the following: *I was shocked that I had not noticed anything and that it had gone on right in front of my eyes. I questioned my own awareness of abuse. I do not remember ever receiving any specific training on abuse.*

## June 1989 / September 1990

### OVERVIEW OF THE SITUATION

In June 1989, a few days before the end of the school year, Monique Vachon, a social worker at the Jacques-Cartier CLSC and the principal of the school attended by Mathieu reported his situation[5] because of the abuse observed for a number of months.

The DYP determined immediately that the child had suffered abuse and decided to remove him from his environment. One week later, he reversed this decision following pressure from J.G. During the summer of 1989, the child did not receive services from the CSSQ. In September, Monique Vachon, who had received no further news from the CSSQ worker, closed her file. Beginning in January 1990, an educator from Mont-d'Youville visited the home to help the child. From February to October 1990, the CSSQ provided practically no direct services to the child or to the parents. In May 1990, J.G. beat his child, but the DYP did not change the course of his intervention. In September Joyce was hospitalized and J.G. remained with his three children, Mathieu, 9, Luc, 22 months and Jacinthe 12 months. The CSSQ was nowhere to be seen.

### SOME SIGNIFICANT FACTS

In January 1989, J.G. justified as follows his application for CLSC services: *The parents want to be helped because afraid of losing control. The father is afraid of beating him because of his history. No more links with their respective families. (...) The father says he needs support before he cracks – he does not want to beat Mathieu but is afraid of his reactions. For the time being, they shout at him and spank him.*

In June 1989, the DYP believed it was possible to agree on voluntary measures with the parents. The social worker from the CLSC stated before the Commission that she insisted J.G.'s promises could not be trusted. *They did not believe me.* She also said she pleaded with the DYP staff that Mathieu *was scared, that he did not play, that he always had to take care of his little brother and that he was treated like an adult and he was prohibited from acting as a child would.*

In October 1989 J.G. complained to the CSSQ worker and told her that he *did not like the attitude of the school, which harassed Mathieu each time he had a bruise.* The worker made a home visit and observed Mathieu's living conditions, which she described as follows: *he is very much aware of where the problems lie. He knows what he has done (provoking his mother, provoking quarrels). He disturbs others in class but does not know why. He would like to change, does not have friends, does not go outside much. He plays by himself or with his 18-month old younger brother. He steals food and hides raw eggs in his room. This is a way for him to attract attention.*

In April 1990, the educator spaced out her visits. Only one day later, the situation deteriorated. According to J.G., Mathieu had taken drugs and been taken to hospital. He had made a fire in the schoolyard and the principal wanted to expel him[6]: *(...). The father beat Mathieu in a state of panic,* and asked that the *child be placed in care. The father feels guilty for the abuse and feels overwhelmed by the situation.* While recognizing that there was *physical abuse*, the reviewer decided that there was no need to change the protection measures. Following these events, no direct service was provided by the CSSQ staff. Joyce was hospitalized in mid-September for 38 days.

5 The identity of Ms. Vachon has been disclosed with her consent.

6 The investigation of the Commission reveals a totally different reality: the school did not want to expel him and the child did not receive any health service. J.G. had found an excuse for the fact that he had beaten his child.

## October 1990 / December 1991

### OVERVIEW OF THE SITUATION

A new worker was appointed on October 15, 1990. Three days later, the school child care worker reported that Mathieu had come to school with bruises on his face three times since the beginning of the month. On Friday, October 18, the worker was informed that Joyce had been hospitalized for a month and that the family climate was *very difficult*. He did not act. On Saturday, October 20, Joyce informed J.G. that she was leaving him and leaving the children with him. J.G. called *Parents Anonymous* and the three children were placed on an emergency basis by the DYP, who had intervened at the request of the Sûreté du Québec. The scheduled duration of the placement was one month. In fact, the worker brought Mathieu back home after only a few days in placement. Luc and Jacinthe were brought back after 30 days.

In January 1991, the worker concluded his evaluation of the crisis situation in October 1990. He concluded that J.G. *presented an excellent capacity for raising his children. When he was with his wife, he lacked self-confidence (...) He did not know how to deal with both his wife and his children.* He came to this conclusion without contacting the physician who was treating Joyce. The school staff, for their part, said they had told the worker they thought the child was abused. The worker did not mention it in his report.

As early as October 1990, the CSSQ worker put an end to the presence of the educator from Mont d Youville in the family, *to concentrate the father's attention and focus on a single worker*. In reality, after the conclusion of his evaluation in January 1991, he did not intervene much in the family until September 1991, except for a period of approximately one month and a half in April and May 1991, in response to crises. In April, Joyce[7] reported the situation of her children as abuse. In May, the situation was again reported in a context of emergency: Mathieu had apparently been *kidnapped* by the sister of J.G.'s new girlfriend. The girlfriend gave him ideas and the child *would say that his father pricked him with knives and subjected him to all kinds of abuse.* The worker did not give credence to these two reports. In May, he placed Mathieu in a foster family for 30 days, because he had become uncontrollable at home.

In September 1991, the worker realized that Jacinthe, who was two years old, had returned to live with her mother, in defiance of the measures agreed upon retroactively in June 1991 for the period from May 1991 to November 1991. He did not check on her living conditions. On November 19, 1991, the worker and his team leader recommend to the reviewer that all interventions with the children of J.G. and Joyce be terminated. The reviewer refused to close Mathieu's file. She agreed to close the files of Luc and Jacinthe.

### SOME SIGNIFICANT FACTS

The two workers gave the same description of the work session during which 20 files were transferred in October 1990: they spent one morning on this. According to the worker in charge from September 1989 to October 1990, Mathieu's file did not contain anything special and had been transferred without comment. The team leader did not take part in the operation.

On Friday, October 19, 1990, the worker recorded the family situation as follows, after a conversation with the Mont d Youville child care worker: *Joyce has been hospitalized for about a month. The CLSC has been providing home support 3 days a week. Luc is hospitalized and Jacinthe is sick. Mathieu steals food at home, he eats toothpaste. He thinks he is*

[7] Joyce has authorized the Commission to disclose that she had reported on the situation of her children.

*responsible for his mother's hospitalization. Therefore he steals food to give himself a bellyache. He punishes himself. A very difficult family climate.* This description of the situation was consistent with the note made in the file by the child care worker following a conversation with Mathieu: she noted that Mathieu had said*: My parents will split because of me. I am good for nothing; I am not normal*.

On October 22, the day after the announcement of their separation, the psychiatrist who was treating Joyce noted an *improvement secondary to the resolution of situational problems.* Finally, on October 26, the psychiatrist signed the medical discharge: *Patient (...) admitted because of suicidal ideation, depressive symptoms and severely disturbed family context. Observation enabled the elimination of a real emotional disorder. The character disorder has taken on significant dimensions (...) The state was resolved with an improvement in the family context. The husband, after proffering threats of suicide and infanticide, is now being treated at Enfant-Jésus. The DYP has placed the children. No external follow-up.*

In fact, the day Joyce was discharged from hospital and agreed to the placement of her 3 children in a foster family for 30 days, the CSSQ worker agreed to let Mathieu return to live with his father, at the latter's request. Before the Commission, the worker recognized that he was not aware of the decisions made by the DYP staff in June 1989 and previously. He based his intervention on the perspective formulated in January 1990 by the worker who had preceded him and by the reviewer: the mother was rejecting her child, she was likely to abuse him because of this rejection, while the father loved the child but could not remedy the problems caused by the mother. Without any formal intervention plan, the worker focused his work on the child's difficulties at school and the support to be provided to the father. Mathieu's placement was a respite measure for his father, to allow him to regain strength.

In May 1991, Mathieu was severely beaten by his father. D.B., the new companion of J.G., was frightened. She called her sister-in-law and decided to leave with her children. J.G. agreed to let Mathieu leave with her and his sister, so that everybody could take a rest. Mathieu then revealed the abuse that his father had inflicted on him since he was a small child. He showed scars on a leg and on his head. He told how his mother had sewn his head without anesthesia. Back at home a few days later, he was again hit by his father, who blamed Mathieu for *stooling* on him. D.B.'s sister-in-law stated that she had talked to the worker on the telephone, probably three times. She stated that she had reported to him the words of Mathieu about the abuse inflicted on him. She was telling him: *Why don't you listen to the child? Why don't you believe him?* The worker did not record those communications and the reviewer did not hear about them.

In his review report in November 1991, the worker claimed that he was acting because of tensions between adults and because of the negative consequences on the children. There was no mention of abuse. *J.G. hides the truth behind lies and incoherent statements. The psychological attitude of the parents with their children seems to be primary. They do not understand the impact of what they say to their children. Currently, the couple is trying to resolve Mathieu's difficulties in school through contacts with the principal. Nothing new to report with the other children. (...)* In this context, he felt he could terminate the intervention. The reviewer refused.

## January 1992 / August 1992

### OVERVIEW OF THE SITUATION

Following the reviewer's refusal to close the file, the worker did not propose any new voluntary measures. He acted sporadically until August 1992, in reaction to the events. He considered that D.B. was a threat to the children. In January and February, he was informed that Mathieu had committed small thefts. In February, he looked for J.G., who had moved. In March, he realized that J.G. had left his companion. In April, he noted that J.G. had resumed his relationship with her. In May, he responded to a request for information by a school educator. In June and July, he again looked for J.G., who had moved.

Finally, on July 24, he managed to trace J.G. and his companion. He contacted the reviewer by telephone. She agreed to terminate the intervention, justifying her decision by sending him the following note: *we are closing the file although the situation is not ideal, especially because of the father's decision to resume living with D.B. The father no longer wants any more services, and we do not have any evidence indicating that Mathieu's situation is compromised for the moment. We therefore close the file, while keeping in mind – as you mentioned – that the situation could deteriorate, and your suggestion that, if this happens, the Court should be seized of the matter.*

### SOME SIGNIFICANT FACTS

**On March 3 and April 23, the worker noted his perception of the situation in the file:**

> *The fact that J.G. is alone with his children means that they are safe. If D.B. returns to live with J.G., then the children are vulnerable because of her abuse. J.G. is motivated; he wants the best for his 2 children. (...) J.G. will need outside help because he will have difficulties in his parental role; he is not adequate in his statements to the children.*
>
> *J.G. admits that, when D.B. is there, he can no longer cope. (...) J.G. is trying to end this relationship (...) Mathieu clearly says when interviewed that he feels more comfortable with his father alone. D.B. has also blackmailed Mathieu.*

**In his final report on August 21, 1992, he wrote the following:**

> *Mathieu is experiencing a number of problems at school (academic marks, lack of self-confidence with the other students) and his family situation does not make things any better. Mathieu has a terrible lack of self-confidence, and is afraid of asserting himself in front of others. He is a very responsible child for his age and has great potential for organizing things. (...) They do not see any need for a follow-up on our part. That is why he has not responded to my suggestion that we should meet.*

At the beginning of the 1992-93 school year, Mathieu enrolled in a new school. Between October 1992 and June 1993, he was absent twenty times.

On 17 occasions, it was noted that there was no answer at the number dialed. On January 15, 1993, there was no service at any of the 4 numbers given. In September 1993, the home-room teacher told a colleague that she had observed signs of abuse on the child. The DYP was not informed.

## April 1993

### OVERVIEW OF THE SITUATION

On Friday, April 30, 1993, at 10:30, Joyce reported Luc's situation to the DYP. She went to J.G.'s and found her five-year-old child shut away in a darkened room, pale and thin. He had a bruise and a cut over his eye. She had not seen him for a year and a half because of the difficulties with J.G. Joyce reported J.G.'s constant moves and the fact that he called his children vegetables. She evoked his violence towards her and the abuse inflicted on Mathieu, whom J.G. treated like a dog. The decision on admissibility was made on the next Monday and the file was assigned the same day for evaluation. The worker began her work the next day and went to J.G.'s with a colleague – a professional – and two *officers,* in case she had to remove the children. J.G. attributed the injury to a blow inflicted by one of D.B.'s children with a plastic guitar. The worker did not ask for an examination by a physician. She checked with members of the family and acquaintances. She did not consult the child's health record although she observed that J.G. was lying about a visit to a physician. She did not take into account Joyce's statements about Mathieu's living conditions. D.B.'s mother revealed to her that the children were abused and that she was ready to testify in court. Later this person, who was more than seventy years old, stated that she would not be able to go to court while reaffirming what she had said about the children. The worker limited interactions with D.B.'s mother to two telephone conversations. The unit head was consulted. With the worker, he decided to close the file on May 19: *We are aware that the situation is not "clean", in particular because of revelations and information received* (from the previous worker). *The father is lying and is denying today things he had previously told the case worker. He sometimes contradicts himself when with me. We are closing the file "by default", for lack of evidence.*

### SOME SIGNIFICANT FACTS

**The examination of the child by the two workers was limited to a single direct observation, during the first interview with the parents.**

> One of the two workers wrote: *I observed that Luc was quiet, the mark was still apparent. Young, he did not seem fearful. Height relatively OK. Size: small. Head is not proportional to the body. Alert, he smiled and sought the connivance of D.B.. Articulate. Even said that he was spoiled.* Her male colleague wrote: *Luc is thin but not overly lean or rickety: We have not been able to detect any sign of neglect, abuse or emotional rejection in the child's words, attitudes, behaviours or physical appearance. Luc talked to us about almost everybody in his family in affectionate terms, giving positive reports, i.e. without any reference to anything negative or traumatic.*

**In her final report, the worker recorded her observations about the parents:**

> *J.G. denied the situation at all levels. He was aggressive towards the DYP's intervention. He also proffered a number of threats, lied, gave contradictory versions, was easily carried away, etc. J.G. adopted very much the attitude of a victim, which is becoming very suspicious. He takes no responsibility for what happens to him. As for the mother, she has demonstrated quite contradictory attitudes. For example, she has denied her mental health problems, although her file provides clear indications of past troubles in this respect. (...) She finds reasons for not enforcing her right to have contact with her two sons as ordered by the Court. We therefore question her parenting abilities.*

## September 14, 1993 / September 15, 1994

### OVERVIEW OF THE SITUATION

On September 14, Mathieu's face was marked with bruises. The school principal[8] reported his situation and that of Luc: J.G. reproached Mathieu's teacher for asking the child whether he ate well and whether he experienced incest at home. Actually, the teacher had not asked such questions. The DYP staff determined that the report about Luc was not admissible. Mathieu's file was immediately assigned to a worker who began her evaluation the next day. She removed the child from his home and placed him temporarily in a foster family.

On September 16, D.B. admitted that she had seen J.G. beat Mathieu because he had urinated in bed. During an interview in the presence of D.B., J.G. admitted that he had beaten Mathieu. He admitted that he needed help and agreed with the proposed voluntary measure of social monitoring for two years. On October 1, the worker brought Mathieu back home. His father denied what he had admitted 15 days earlier: he now said that the wound had been accidental. The worker and his unit head made a compromise and agreed on voluntary measures. *Let us take into consideration that he has admitted hitting Mathieu but that the facts were unclear. J.G. agreed the next day to sign the agreement on those terms and was ready to correct the situation.* In mid-October, the file was given to a team leader responsible for implementing the measures agreed upon with J.G. She placed the file in a waiting list. On October 27, she was informed that J.G. had not fulfilled his commitment to begin therapy at the CLSC. She did not take action.

On November 20, Mathieu ran away and alluded to suicide. The file was assigned to a worker who accompanied the child to a psychiatrist, who observed that his behaviour revealed a *need for guidance.* A follow-up was initiated, but J.G. did not proceed with it. In December, the school principal turned up again: he had learned that J.G. was beating the children on the soles of their feet so as not to leave marks. The worker checked, a bit hastily. No follow-up action was taken. On Thursday, February 3, 1994, Mathieu entered Mont d  Youville under an emergency measure*. Police had to intervene at school. Mathieu was threatening two first-grade kids with a knife*. On March 17, he returned home on the reviewer's decision. The reception centre staff had recommended such a return, with an external follow-up by a child care worker, while the CSSQ worker and the psychiatrist had recommended that he finish the school year in a reception centre.

A child care worker began her work in April and concluded it in June, for lack of cooperation by J.G. A review was made in June, during which there was talk of referring the matter to the Court, but nothing came of this.  The CSSQ worker did not provide any direct services from March to June 1994. In June, she resumed contact with J.G. and, in July, told him by certified letter that she was considering referring the matter to a court if she had not received any news upon her return from vacation. On September 15, the CSSQ worker was informed by J.G. that the situation had exploded: D.B., under the influence of drugs and alcohol, had attacked him. She was under arrest. The worker then took the initiative of reporting the situation of all the children involved in the case.

8 The principal consented to the Commission revealing that he had reported the situation, as did the CSSQ worker who made the report on September 15.

## SOME SIGNIFICANT FACTS

### The school principal stated to the Commission that, in his 33 years of experience, *he had never seen such a clear case of an abused child:*

> *Because of the severity of the blows dealt to the child, the visible marks, and Mathieu's behaviour: when asked about his living conditions, he became closed, evasive, embarrassed. It was obvious that he was hiding something. Asked in the presence of his father about his life at home and his relationship with his father, Mathieu answered with his head low, looking at the corner of the room, that he loved his father and that his father loved him. Moreover, in September 1993, Mathieu had given two different explanations about his bruises, while J.G. had given a third.*

### The physician who had examined Mathieu in September 1993 sent a personal report to the DYP staff:

> *Face: hematomas on the right cheek (10x5cm) spreading from the ear to the external edge of the eye and on the cheek with a uniform bluish colour (...). The forehead bears the mark of a small healing hematoma. Neck: several petechiae spread all over the neck and over the shoulders. There are two more obvious marks (...) approximately 1 by 2 cm. The rest of the examination is relatively normal with a few bruises on the legs and a more important bruise of 2 by 5-6 centimetres on the right thigh. All the lesions are healing well. Scars of old wounds to the right hand and left leg are also visible (...).*

### The worker who had agreed with J. G. on voluntary measures described the situation as follows:

> *J.G. seemed very affectionate towards Mathieu. (...) J.G. himself was the victim of physical abuse in his family and never dared talk about it at the time for fear of being beaten even more by his father. (He) does not allow Mathieu to have friends at home or to go to parties outside the home. (He is) very strict. J.G. admitted that he had problems in controlling his aggressiveness. (...) J.G. seemed very motivated to correct the situation. Following our intervention, he himself took steps to contact GAPI (a self-help group for impulsive people) and the Jacques-Cartier CLSC for help. We perceived in this couple a great need for help, and both adults wanted to embark on a marital therapy process. The Jacques-Cartier CLSC is available to receive the couple. The school psychologist is ready to receive the child for follow-up.*

### The assignment of the file to a new worker in November 1993 took place as follows:

> The team leader had not read the previous file. *I cannot read all the files; I manage approximately 350 files. I was made aware of this file by the evaluation worker.* The team leader did not know that this was the tenth report on the situation. *It would have been possible to find out. But I did not do it. I knew it was a case of family violence, and so I knew that people were hiding things from us, that we had to be vigilant.*
>
> For her part, the worker pleaded as follows before the Commission: *I did not read all the previous file. I started with the file as presented (*in a policy group). *I noted that D.B. could be violent and that J.G.* was weak and *unable to confront her*. *My mandate was to intervene in respect of Mathieu's situation, but I knew that there were 6 children there and that worried me.*

### The worker who provided services from December 1993 commented as follows on her work:

> *Any intervention in the family was particularly demanding (...) The chances of seeing Mathieu alone were very slight: I saw him alone only once in March 1994. (...) In April 1994, I was not able to visit the home. I tried more than once. I remember I felt powerless in this file. In March 1994, I went to see Mathieu. Luc was playing with the other small kids in a room where the blinds had been lowered. I entered the room and went closer, and I saw that Luc had a black eye. Luc told me: I was hit by a piece of ice. It was plausible, but it was not reassuring. I felt worried and I called the school back. The teacher had not observed anything. (..) I talked to the reviewer on a number of occasions: according to him, I always mentioned things from the past. I had no current facts, he told me.*

.

## September 16, 1994 / September 25, 1994

### OVERVIEW OF THE SITUATION

On September 16, 1994, the situation of the six children of J.G. and D.B. was reported to the DPJ in the Chaudières-Appalaches region, in which the town of Beaumont is located, due to D.B.'s behaviour. A person in the immediate family circle told the DPJ that she was violent and aggressive, and that she consumed alcohol and drugs. J.G. said he was unable to protect the children when the mother was in a crisis situation, and there was a risk that the mother would go back to the father.

That same day, a worker from the detox centre at which D.B. was staying contacted the staff of the Chaudières-Appalaches DPJ and reported D.B.'s point of view : D.B. did not want to leave her one-year-old child with J.G., saying the child was in danger with him. He had already burned Mathieu's hands, urinated on him and threatened him with a knife.

From Monday September 19 to Friday September 23, 1994, the Chaudières-Appalaches worker carried out a number of verifications, first with D.B.'s children, who told her everything, and then with members of D.B.'s family and Joyce's family. She also contacted present and past school principals. At the end of the process, she was convinced of one thing : J.G.'s children were abused, even if they denied the facts.

On Friday, September 23, it was established that J.G. and D.B. were preparing to go back to live in the Quebec City region. Having ensured that no emergency intervention was required, the Chaudières-Appalaches staff handed over responsibility for action to the Quebec City DPJ staff.

### SOME SIGNIFICANT FACTS

#### D.B.'s children were the first to tell the facts to the Chaudière-Appalaches DPJ worker.

> In the language of a 4-year-old, D. told the following story: D. said J.G. hit them with an iron bar, with his fists and with a broom. D. was hit on the legs. We asked D. to describe the iron bar. Was it small, large, round, square, rectangular, did it have holes in it, and so on. D. said it was as big as the sky and there were holes in it.

#### J.G.'s children said their father was fine but D.B. was not.

> *(...)Mathieu completely denied that his father was violent towards him. His father had been violent when the DPJ report was made, but the situation had never been repeated. Mathieu said it was D.B. who was violent. She was the one who had burned his hands in washing-up water. His father had never hit him with an iron bar. Once D.B. had decided not to let him eat for a whole day. She also did not want him to see his mother Joyce. D.B. often chastised them and shouted at them. She made Mathieu and Luc drink beer. She called Mathieu a vulva, a vagina, etc., because he had wet his bed. We asked Mathieu to name one thing he did not like about his father. He answered "his great generosity". Mathieu said his father took very good care of them.*

## September 26 1994 / October 5 1994

### OVERVIEW OF THE SITUATION

As of Monday, September 26, the staff of the Québec City CSSQ became responsible for protecting the children. A new case worker was appointed to evaluate the situation of D.B.'s four children, while the case worker responsible for the services provided to Mathieu was also asked to evaluate the situation of Luc, J.G.'s second child. The two case workers pooled their efforts to prepare the removal of the three children still in J.G.'s care. On the Wednesday, they notified the Social Emergency department to prepare for all possibilities. J.G. threatened to run away with the children if the DYP continued to be present in his life. On Friday, September 30, the case workers drove the three children to Dr. Jean Labbé's surgery, and from there they went into a foster family. In the following days, the Court of Québec was seized of their situation.

### SOME SIGNIFICANT FACTS

**Following his examination on September 30, 1994, Dr. Jean Labbé wrote the following report:**

> *Mathieu is 13 2/12 years old, but seems much younger. He measures 141 cm, which (…) corresponds to the average size of a child of 10 4/12 years old. He weighs 28.4 kg, which (…) corresponds to the average weight of a child of 9 2/12 years old. One is immediately struck by the many linear scars measuring between 3 cm and 4 cm. The scars have no specific direction, but are present mainly on the right arm (at least 5), the left elbow (at least 4), and there is one in the middle of his back. There is also another one on the side of his face, near his right eye (…) Mathieu also has a scar on the left side of his head, and his hair has not yet grown back (…) Mathieu told me he hurt himself falling downstairs when he was in elementary school. He also has bruises of different ages on his legs (…) Although non-specific, the number of injuries and their appearance are such that they may have been caused by blows. In addition, the injuries to the left elbow, because they are linear in shape, are not consistent with the explanation given (fall from a bicycle);*
>
> *Luc is 6 9/12 years old, measures 106.8 cm and weighs 20.7 kg. His size corresponds to the average size of a boy of 4 and a half years old. His weight is in the 25$^{th}$ percentile group for his age, and corresponds to the average weight of a 6-year-old boy (…) On his skin, there is a small bruise on his lower abdomen, which the child says was caused by a pant button. There is also a 1.2 cm linear white scar on the middle part of the left leg. The medical problems identified are as follows : 1. Failure to thrive – I am uunable to say what may have caused this, because I do not have sufficient information on the growth curve, size at birth, height of parents, etc. There are several possible causes, in addition to abuse. 2. Two scars on the left leg. These inuiries are not specific but may have been caused by blows.*

**In November 1996, Dr. Jean Labbé reviewed the hospital records of five of the seven children involved in the *Beaumont Affair*. He made the following observations:**

> *One element that is so unusual as to be suspect is as follows : the frequency of convulsions. (…) Febrile convulsions affect only 3 to 4% of children in general (…) The risk of a second reoccurrence is between 11 and 30%, depending on the child's age. The risk of more than three convulsions is only 9%. Here (…) one child has had one convulsive episode, another at least three episodes, another at least five episodes and yet another at least eight episodes. This challenges the laws of probability to such an extent that serious questions must be asked about the true origins of the convulsions. One possibility is that actions were taken to deprive the children of oxygen (strangulation, head held underwater...).*

## October 5 1994 / January 1998

### OVERVIEW OF THE SITUATION

On Wednesday, October 5, 1994, the DYP filed a motion for protection with the court. Mathieu was sent to a rehabilitation centre, and Luc was returned to his mother. The conditions governing contact between J.G. and his children were stipulated. In November, the court sent Luc to live with a foster family and forbade all contact between the parents and the two boys.

On September 12, 1995, Judge Lina Bond ordered as follows: *That Mathieu be sent to a rehabilitation centre for a period not extending beyond June 21, 1996, and that he be subsequently sent to live with a foster family (…) for a period extending until the time he attains full age. That Luc be sent to a foster family (…) until September 1, 2000. The ruling also included a number of provisions concerning specialized services for the children, and the conditions governing contact between them and with their parents*.

On May 24, 1996, the DYP asked that Mathieu's residential care be extended in a group-type residential resource. The motion was heard on June 26, and the court ordered: *That Mathieu be entrusted (…) to an institution operating a rehabilitation centre until he is placed with a foster family (…) where he will stay until he reaches full age.*

### THE CHILDREN'S PRESENT LIVING CONDITIONS

The Commission ensured that the Québec City DYP took the steps required to correct the immense harm done to the children, as far as this was possible. It also ensured that the three children were finally able to enjoy living conditions appropriate to their needs. It points out that the Superior Court of Québec, at Joyce's request, ordered the forfeiture of J.G.'s parental authority over the three children born of their union:

> The living conditions of Mathieu, the oldest of the children, now 16 years of age, have stabilized. He lives with a foster family, which has been able to satisfy his great need for security and attention. He is gradually rebuilding his relationship with his mother, with whom he maintains regular contact. He does not wish for any contact with his father. From March 1996 to June 1997, he received individual therapy, the main goal of which was to allow him to accept and understand the events of the past. In June, he decided to terminate his sessions with the psychologist, and was informed that if he wished to resume the meetings he need only say so. He attends a secondary school on a regular basis;
>
> Luc, now 10 years of age, is also living in a much more stable situation. He has been with the same foster family since April 1995. The possibility of an adoption is currently being studied, with the consent of his mother. He has also been receiving individual support from a psychologist since May 1997;
>
> The third child, Jacinthe, 8 years old, has been living with her mother since 1992. Her living conditions are stable and adequate, and the Québec City DYP continues to provide advice and assistance to her and her mother.

## Summary of Relevant Facts from the *Beaumont Affair*

Between the month of October 1981 and September 1994, the Québec City Director of Youth Protection was alerted on at least 16 occasions[9] to the living conditions of one or other of J.G.'s children. Despite the major problems noted in the health records of the children of J.G.'s second spouse, none of the people asked to give help considered it necessary to report the situation to the DYP. The CSSQ professionals who intervened on behalf of J.G.'s children between 1991 and September 1994 did not consider the living conditions of the children, although they stated that J.G.'s second spouse constituted a threat to the security and development of J.G.'s children, in particular because of her violent behaviour:

> Fourteen of the alerts were considered by the DYP to be reports within the meaning of the Youth Protection Act, with the resulting service requirements. Ten of the 14 concerned the abuse suffered by Mathieu;
>
> On three occasions in 1989, 1990 and 1993, the school personnel sent a report or alerted the DYP to Mathieu's situation. These reports were some of the key events in the entire intervention. They clearly show that schools are in an excellent position to detect unacceptable living conditions imposed on young children;
>
> Only one health sector professional reported Mathieu's situation to the DYP in 1983. On more than one occasion, other physicians recorded their concerns in the children's records, but did not provide follow-up;
>
> The mother personally reported the ill-treatment suffered by her two sons on three occasions in 1991 and 1993.

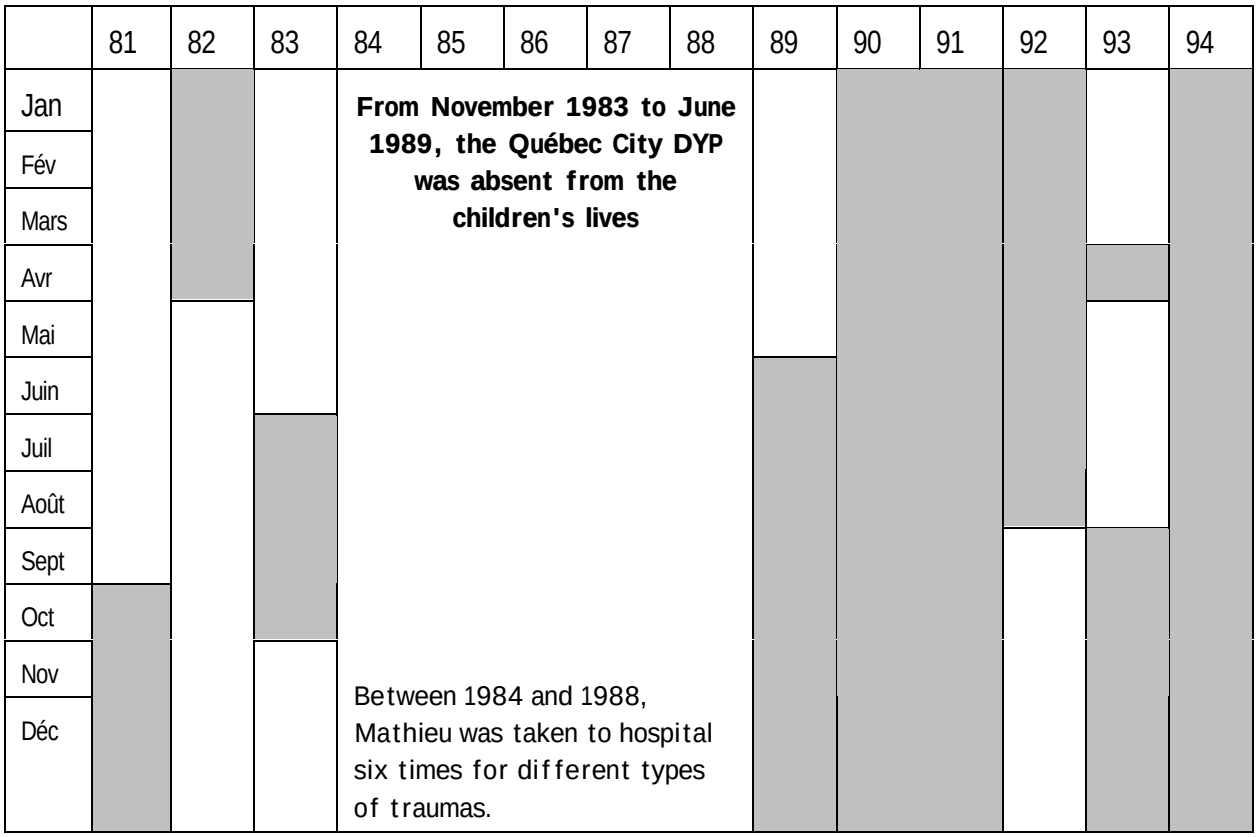
The staff of the Québec City Social Services Centre (CSSQ), alerted on 16 occasions, provided services over long periods before recognizing that the children were severely and systematically abused by their father, and taking the steps required to protect their integrity. The table on the following page provides a graphical illustration of these intervention periods.

Before the birth of the oldest child, the CSSQ staff had been called in to assist the young parents. Some months after his birth, the Québec City DYP staff were brought in. They, together with CSSQ professionals, intervened over a 64-month period between 1981 and the fall of 1994. In all, just over 50 people from the institution intervened directly or indirectly on behalf of the children, in functions of a clinical nature.

Fourteen case workers from the CSSQ played a major role in providing direct or indirect clinical services, in their capacity as officers in charge of evaluating the children's situation, as officers authorized to give assistance, advice and support to the children and their parents, or as officers responsible for supervising the work of the preceding two groups. At one time or another in the course of the intervention, these 14 people were all informed of the fact that the oldest child was subjected to abuse, or that his father was not allowing him to live the life of a child.

9 This number excludes the reports of September 15 and 16, 1994, which eventually led to a complete discovery of the situation. The term "alert" is used because of its clear descriptive meaning. It includes the information sent to the DYP concerning major events in the children's lives, although such information was not considered to be a new report.

**Québec City DYP Interventions between 1981 and 1994**




**Key**: The shaded areas show the months during which the Québec City DYP had a file open for one or other of the children. The white areas show the periods during which the parents carried out their parental duties with no supervision or assistance from the DYP.

Between 1981 and September 15, 1994, the oldest child was removed from his parents on four occasions, always for short periods, and following major crises. In 1989, the decision was made to remove him for an extended period, to review the situation and protect the child at the same time. The decision was immediately overturned following pressure by J.G.

Despite the major problems encountered by the CSSQ staff in their interventions with J.G., despite the fact that J.G. did not keep the promises made in the voluntary measures agreement, and despite the fact that he lied constantly about facts and events that were easy to check, the Québec City DYP staff did not apprise the court of the children's situation until October 1994. Between 1981 and September 1994, no notes were placed in the file by the DYP staff concerning discussions about the possibility of taking the matter before the courts.

The Commission identified contributions from 15 members of the school community in the intervention carried out pursuant to the Youth Protection Act. As teachers, education providers, school principals and psychologists, these people dispensed educational services to the older boy between 1988 and 1994, and to the younger one from 1993 onwards.

Between 1982 and 1994, 11 physicians were required to treat Mathieu in hospital following various traumas. In 1983, one physician concluded that the reasons given by the child's father did not satisfactorily explain the injuries suffered.

Between 1984 and 1989, a period in which the child was left in his family environment without protection, physicians were required to treat him on six occasions because of traumas. Some of the injuries were quite serious : head trauma with signs of bleeding on one occasion, wounds requiring stitches in November 1985 and November 1987. According to Dr. Jean Labbé, an expert in the field, the facts reported by J.G. during one such visit to the hospital did not constitute a satisfactory explanation in view of the nature of the wounds inflicted on the child .

Two psychiatrists were asked to treat the children's mother, in 1983 and 1990. In 1983, the physician diagnosed nervous depression and immaturity. In 1990, the physician set aside the diagnosis of emotional disorder, and diagnozed a character disorder instead. Both physicians observed that the disorders were associated with a difficult marital relationship and family life. Joyce said she told the hospital of her living conditions and those of her children in the final days of her hospital stay, in October 1990. The situation was revealed after the DYP removed the children from the care of their parents.

Communications between the CSSQ professionals and the health professionals who treated the parents took the form of brief exchanges, except in 1990 and 1994, when Mathieu received infant psychiatric services over a period of several months. During these periods, communications with CSSQ staff were regular.

Three professionals working for a CLSC or a children's rehabilitation centre were asked to complete the work done by the CSSQ staff : in the summer of 1989, from January to October 1990 and from April to June 1994. On each occasion, their contribution went unacknowledged because no service plan had been drawn up.

In 1991 and 1992, custody of the children was decided by the Superior Court of Québec. In February 1991, the father was granted custody of all three children. This arrangement had been proposed by the CSSQ case worker in an evaluation report dated January 1991, and was confirmed in the voluntary measures established in June 1991.

Two months later, the father sent the little girl back to his ex-spouse. The case worker did not intervene. In 1992, the Superior Court ratified the situation. The CSSQ took no part in the debate.

## The Commission notes that the children's right to receive adequate social services was violated

**THE COMMISSION OBSERVES** that between October 1981 and September 1994, the DYP was alerted to the children's situation on 16 occasions, mostly by people acting in the course of their duties. On ten occasions, abuse was reported. The facts were recorded properly by the DPJ's reception service which, except for one occasion in September 1993 when it declared a report concerning Luc to be inadmissible, made decisions that were consistent with the interest of the children and respectful of their rights.

WHEREAS:

Despite the serious facts brought to their knowledge, the staff of the Québec City DYP did not, in the opinion of the Commission, produce a single adequate evaluation of the situation and living conditions of the children at the beginning of each intervention period;

The DYP staff and CSSQ case workers did not, in the opinion of the Commission, properly evaluate the situation and living conditions of the children following receipt of new reports when protective measures were being applied;

Because the situation was evaluated inadequately, the staff of the Québec City DYP made inadequate decisions concerning the security, development and orientation of the children, in particular by not advising the court of their situation in June 1989;

The staff of the Québec City DYP agreed on voluntary measures that were poorly suited to the situation, as a result of their inadequate evaluation of the children's situation;

Because no intervention plan had been drawn up, the CSSQ case workers placed themselves in a position where they were forced to react inconsistently and without the required intensity to events, to J.G.'s mood swings and to his changes of address ;

Because the situation of the children had been inadequately evaluated, and because no intervention plan or service plan had been drawn up, the CSSQ case workers and the staff of the Québec City DYP were placed in a position where their review of the situation, during or at the end of each intervention period, was also inadequate;

**THE COMMISSION OBSERVES** that, in the period October 1981 to September 15, 1994, the children of J.G. and Joyce did not receive the adequate social services to which they were entitled under the *Youth Protection Act*.

# The factors determining that rights were violated

Given the DYP's central and exclusive responsibilities in Québec's child protection system, the Commission has tried to understand why the staff of the Québec City DYP did not recognize the true living conditions of all the children involved in the *Beaumont Affair* at a much earlier stage in the proceedings.

Yet, the CSSQ staff form part of much broader intervention systems, and cannot fulfill their responsibilities without a sustained contribution from the other players. The Commission therefore appraised the interactions it observed between the various service systems in the Québec City region and the CSSQ staff.

## Interventions by partners of the CSSQ

### SCHOOL PERSONNEL

The investigation revealed that, from the time the oldest child began to attend school, most of the reports came from school personnel. The Commission emphasizes the quality of these reports and the determination of the individuals concerned. A detailed examination of the facts shows that:

> From January 1989 to May 1991, the teachers at the elementary school attended by Mathieu played a vital role in protecting him. In addition to reporting the child's situation in 1989 and 1990, some members of the school personnel, in particular the child-care worker, were in regular contact with the social worker responsible for enforcing the protective measures agreed between the DYP and Mathieu's parents;
>
> In the fall of 1993, the personnel of the school attended by Mathieu and Luc were quick, on two occasions, to take the steps required to protect the children. When the family moved into the area served by another school, the former principal informed the new principal of the exceptional nature of the situation.

Yet, the school community's generally positive contribution to the protection of the children must be qualified by two less positive elements :

> During the 1992-1993 school year, Mathieu encountered persistent difficulties, at a time when the DYP was no longer involved in overseeing his living conditions. Despite the fact that he often bore the marks of the blows he received, despite his frequent absences and despite the fact that the school staff were unable to contact his father, the Commision notes that no reports were made to the DYP during this period;
>
> At no time was direct contact established between the professional staff of student services and the people acting on behalf of the Québec City DYP, even though four school psychologists had intervened on Mathieu's behalf between 1989 and 1992. The Commission points out that a direct communication between a psychologist and the DYP staff, in particular concerning a child's behavioural disorders, does not constitute a repetition of what may have been observed by the teachers.

**COMMUNITY RESOURCES**

Between 1989 and 1994, the staff of the Jacques-Cartier CLSC and Mont d'Youville were required to complement the DYP's services in one way or another. **The Commission observes** that, on each occasion, these people fulfilled their commitments to the CSSQ staff and their duties towards the child. However, the CSSQ staff did not coordinate the intervention as it should have done – as we will see later.

**HEALTH PROFESSIONALS**

In 1983, a physician reported Mathieu's situation. However, the DYP staff did not take account of his clinical observations which led to the conclusion that the explanation given by the father was false. In 1994, the psychiatrist treating Mathieu maintained regular contact with the CSSQ personnel accompanying the child in his request for services.

Apart from these two elements, the health professionals dispensed their services parallel to the protection system, rather than in concert with it. **The Commission observes** that this compartmentalization had negative effects, both as regards the child's access to protection services and the adequacy of those services, especially during the following periods:

> From 1983 to 1989, the child did not have access to any protection measure, at an age where he was particularly vulnerable. His family physician did not see him. The child was taken on several occasions to hospitals with no protection committee for abused children, and was treated regularly by physicians and nurses who took care of his injuries but did not realize that they formed part of a much longer chain of traumatic events;
>
> In October 1990, the family broke up in a context of conjugal violence which took place even in hospital. Joyce was admitted to a hospital by a psychiatrist, and remained there for 38 days. Despite the length of her stay, during which family conflicts played a key role, no contact was established between the health professionals involved and the youth protection staff. The notes in the patient's record and the statement by the patient herself both show that no attempt was made to establish such a contact, either by the physicians or by the DYP staff. The result was unequivocal : the mother abandoned her three children in a context that was extremely unfavourable to their well-being, mainly to escape the clutches of a tyrannical husband.

## The organization and operation of the CSSQ

What emerges from these observations is that physicians who were more sensitive to the problem of abused children and family violence would probably have alerted the DYP staff more frequently. In such a context, the DYP staff would have been forced to act earlier, since they would have had stronger evidence. Nevertheless, the Commission believes that this argument cannot be invoked to explain the fact that it took so many years, dramas and family crises before the children were finally protected in accordance with the provisions of the Youth Protection Act.

Despite the quality of the reports issued by the DYP's reception service, and despite the considerable amount of resources devoted to the children over the 64-month period, the work teams at the centre of the protection system did not see a situation that, in the Commission's view, was becoming progressively evident. In fact, the Commission notes that, at least from 1989 onwards, it was patently clear that Mathieu's case was a typical example of a systematically abused child, in particular as regards the following aspects:

The facts reported were unequivocal, and were confirmed with each report. The reporters were credible due to their impartiality and their experience with children. They were direct witnesses of the facts they reported;

The parents were part of a high-risk group due to their own past and their social isolation. They moved house frequently – a fact that, when combined with the other elements of the situation, should have alerted the DYP staff. The record shows that J.G.'s behaviour towards his children was typical of an abusive parent: he did not consider his children to be normal. They were diminished in some way. They were liars, not to be believed. In 1989 he described Mathieu as having a balance problem that caused him to fall down frequently, and as simultaneously slow, retarded and highly intelligent. In 1993, his vocabulary was somewhat more categorical: the children were vegetables;

Mathieu's behaviour was inexplicable except as a reaction to an unhealthy family environment. This was observed by a school psychologist at the beginning of an intervention in 1989. The child exhibited signs of distress that required immediate attention; in January 1989, he tried to cut his wrists; in October 1990, he ate toothpaste during the night, to give himself indigestion, and in 1991 he ate cleaning products, saying he was « good for nothing ». In addition, very early in his school life, he was aggressive towards other children, broke things and constantly disturbed the class. In 1994, he threatened some younger children with a knife;.

The child regularly gave inconsistent or odd explanations for the marks on his body. This element, combined with the other features of the situation, was clear evidence of the pressure he was under from his family environment, and the fact that it was impossible for him to tell the truth. The people responsible for evaluating his situation should have been aware of this. Failure to reach a proper clinical understanding of the facts cannot be justified by the fact that it was difficult to obtain the truth from the child, or by a « conspiracy of silence ».

In a failure of this scope, with its incalculable effects on the lives of several children, the Commission believes that three pitfalls must be avoided at all costs:

Trivializing the affair or trying to forget it by claiming that the DYP and its staff have, in many equally complex cases, successfully protected children, sometimes quite remarkably. From this standpoint, the *Beaumont Affair* would be nothing more than an unfortunate incident, the exception that confirms the rule. The Commission does not share this view, in particular because 16 people, divided into six separate work teams, were involved in providing services over a period of 13 years. The fact that none of these 16 people detected or recognized the children's living conditions and acted accordingly shows that the problem is a systemic one, and not an isolated incident;

Recognizing the scope of the failure but blaming one person in particular – someone who did not consider, record and inform management of key information reported by credible witnesses;

Amplifying the affair and concluding that it provides tangible evidence of a protection system that is unable to protect children whose living conditions are nothing less than intolerable. From this standpoint, the *Beaumont Affair* would illustrate the need for an in-depth review of the organization and operation of Québec's entire child protection system. The Commission does not share this view. It does not believe that the basic principles of the system – for example, the fact of entrusting a social authority with responsibility for receiving and evaluating reports – should be reviewed.

Instead, the Commission believes that this failure should be seen as an alarm signal by everyone involved in the ongoing process of improving the quality of Québec's child protection system. It should result in an in-depth examination of certain elements of the organization and functioning of the body in question. The alarm should also lead the authorities concerned to examine the governance of the protection system throughout Québec. Section 8 of the Youth Protection Act states that the right to adequate services must take into account the organization and operation of the body providing those services, as provided in the Act and the regulations.

The in-depth examination should include a detailed analysis of the probable causes of the failure observed in the *Beaumont Affair*. In light of what it has heard, and following an analysis of the available information, the Commission concludes that the profoundly inadequate services received by the children in this case was due to a whole set of inter-related factors.

## THE CONTINUITY AND INTENSITY OF THE INTERVENTION

The Commission believes that the factor which contributed most to the inadequate nature of the intervention was as follows : over the years, the DYP staff and CSSQ personnel **clearly did not take into account the lessons that should have been learned from preceding reports and past interventions**.

These people, in particular as a result of a narrow understanding of the concept of protection within the meaning of the law, considered only the incident in question at the time, and failed to see that it was part of a long sequence of events involving other children.

All the people who were in close contact with the parents and the children said they had communicated with the preceding case workers. Yet, the Commission notes that such communications were superficial in nature and extremely brief, **and were designed mainly to obtain the opinions and clinical impressions of the colleagues in question, rather than to review the previous file and assess the scope and meaning of the new facts as a continuation of previous events, and where necessary with the courage to challenge the wisdom of the previous intervention**.

A second factor, related to the first, will also be emphasized : on more than one occasion between 1989 and 1994, the type of activities carried out and the intensity of the interventions were both deficient.

Clearly, the interruptions in the services, due only partly to the waiting lists, compromised the adequacy of the services dispensed during each intervention period.

## COORDINATION OF INFORMATION AND SERVICE PLANS BY THE DYP

Enforcement of the Youth Protection Act, especially as regards the adequacy of the services dispensed, depends to a large extent on the coordination of information and service plans. In the case in question, this was the responsibility of the DYP staff and CSSQ personnel authorized for the purpose by the DYP.

The Commission observes that on three separate occasions between June 1989 and July 1992 and in the spring of 1994, the provision of adequate services demanded complementary objectives, a joint procedure for assessing the results obtained, and a systematic sharing of information between the CSSQ officer acting on behalf of the DYP and the CLSC or Mont d'Youville case worker. Clearly, these requirements were not respected, and this had serious consequences for the overall quality of the intervention.

## STAFF TRAINING

The Commission examined the professional qualifications of the 14 CSSQ staff who were called upon to play key roles in the provision of direct or indirect services to the children. **None of these 14 people were specifically trained to work with abused children**. In the Commission's view, this lack of specialized training, either at university or in the form of professional development, was a key element in the fact that the evaluation reports paid so little attention to understanding Mathieu's behaviour over the years, his denials of abuse, and J.G.'s attitudes towards his children, as mentioned earlier.

## SUPERVISION, PROFESSIONAL AUTONOMY AND THE EXERCISE OF AUTHORITY

The introduction of various professional structuring mechanisms was suggested by almost all the people heard by the Commission. The amount of autonomy granted to professionals and the exercise of authority, in particular as regards appraising the quality of professional practice, were also mentioned by several people. The Commission notes that deficiencies in these areas contributed significantly to the fact that the children were deprived of proper services.

> The team leaders and unit leaders were unanimous in denouncing the exhausting nature of their workload and its negative effects on the quality of supervision;
>
> The team leaders and unit leaders all admitted, with certain qualifications of their own, that they do not read the information contained in the child's record, regardless of the stage at which they intervene. The case load makes it impossible to supervise all workers regularly. In fact one of the most serious of all decisions – whether or not to return a child to his or her family for a provisional period – is not supervised systematically at all;
>
> The youngest and least experienced case workers were unanimous in deploring the lack of proper support during their learning period. Many, regardless of their experience, agreed that it is impossible to do quality work with abused children without being able to step back from personal and subjective reactions to the situations;
>
> Between 1990 and 1992, the exercise of review responsibilities, defined as an appraisal and control of the impacts of the intervention on the child's living conditions, failed repeatedly due to the fact that the demands of the reviewer had no effect whatsoever on the production of reports or on the intervention itself..

## INFORMATION MANAGEMENT

The Commission observed that inadequate management of information relevant to the intervention and decision process pursuant to the Youth Protection Act contributed to the inadequate nature of the services and their lack of continuity.

In particular, the Commission notes as follows:

> **The file does not contain a single intervention plan or service plan for any of the intervention periods between 1981 and 1994**;
>
> From January 1994 onwards, an internal document signed by the head of the review service formalized a practice that had been common for some time. The following lines are taken from the document : (…) several reviews are currently carried out at a meeting between the authorized person and the reviewer (…) **the case worker is no longer required to produce a review report in situations not requiring an appearance before the Youth Division**.;
>
> On a number of occasions during the investigation, the Commissioners, case workers, team leaders and unit leaders looked at the effective contribution of supervisory staff to the decisions made under the Act over the years. With only a handful of exceptions, there was no written evidence of any such contribution. **Most of the people questioned did not remember what had happened. The case workers said they must have consulted their immediate superiors, and the superiors did not remember.**

## INSTRUCTIONS AND WORKING TOOLS

The Commission observes that the CSSQ personnel have, since the early 1980s, had plenty of policies and internal instructions designed to guarantee the quality and consistency of the professional work performed.

The Commission also notes that the use of internal or external specialists at the evaluation stage in complex situations has been expressly stipulated for some years. It also observes that this was never done in the case in question here, despite the obvious complexity of the situation. This raises a number of serious questions.

The CSSQ authorities also sent two practice guides that have been available to case workers since the early 1990s.[10]

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10 I.C.B.E. Manuel d utilisation et d interprétation de l inventaire concernant le bien-être de l enfant en lien avec l exercice des responsabilités parentales. Under the direction of the Eastern Townships CPEJ with the support of the ministère de la Santé et des Services sociaux. 1993, 123 pages. *Sur le Vif. Programme d intervention sur la violence intrafamiliale*. Assises théoriques et Modèle de pratique (prémisses - techniques - outils - activités). CSSQ, July 1992, under the coordination of Hélène Martin of the Child-Family Branch.

**The Commission notes that none of these practice guides was used as a reference by the case workers involved in this case. Given this fact, the procedure depends entirely on their sense of observation, the clinical judgment of the case workers and their sense of professional responsibilities**.

**In its investigation, the Commission did not find a single case where a case worker and the team leader or reviewer, at any time in the decision process within the meaning of the Youth Protection Act, used or referred to an analysis grid or a standardized instrument applicable to a specific phase of the intervention.**

The Commission examined this situation with Alfred Couture, Director of Youth Protection, Québec City, from 1979 to 1995. He emphasized the following:

> Although the problem of abused children gave rise to the protection system in force in Québec since 1979, it has become clear that in Québec's Youth Centres, there are very few guidelines for intervening with these children. This situation is recognized by all directors of youth protection, who have agreed to go further in order to remedy the problem.

# Measures taken by the directors of Québec's Youth Centres

*The Beaumont Affair* was revealed in February 1995. It was followed by an investigation, and the conclusions of the investigation led to a number of significant changes to the organization and operation of the Québec City CPEJ:

The establishment sub-regionalized its services, in particular to enable it to integrate its psychosocial services more completely into its rehabilitation services;

A single file is now opened for the child. This change eliminates the double file practice – i.e. the file of the case worker responsible for applying the protection measures, and the file of the DYP staff;

The work of the reviewers has been changed to make reviewers responsible for ensuring regreater continuity of service;

In contrast to the situation that used to prevail, the lawyers who represent the Director of Youth Protection before the courts are directly responsible to him;

Between 1992 and 1995, the DYP exercised line authority over all CSSQ staff who were authorized to apply protection measures, in accordance with section 33 of the Youth Protection Act. The DYP also had line authority over the members of his own staff. This organizational situation was criticized by Alfred Couture, who said he himself had been submerged in administrative problems. His successor, Camil Picard, has line authority over the people stipulated in section 33 only, and says he is able to take care of the children, the results of the intervention and the change in mentalities within the body and in the community, in particular by convincing partners to co-operate with the DYP.

In addition to these changes in service administration, a number of other changes have been made since 1995 to the conditions in which professional duties are carried out:

Interventions with children subjected to physical abuse is gradually becoming a specialized activity, in particular as regards evaluation. The organization recognizes these case workers' special need for help, support and clinical assistance ;

Despite budget cutbacks , the Québec Youth Centres increased the financial resources allocated to clinical support activities for staff, and to professional development. Until quite recently, training sessions were made available available for case workers. Now, however, they are required to take this training, and the number of sessions has increased in the last few years;

Rules have been introduced concerning the management of the single file and the promotion of the child's history at the DYP; the case history covers one page and is given pride of place in the file;

A social and juridical round table has been created in the region, and regular contacts are now maintained between the DYP and the judge responsible for the administration and proper operation of the court in the Québec City region.

## Supervision exercised by the Commission

The scope and gravity of the problems identified in this investigation are sufficient to justify the exercise by the Commission, which is responsible for ensuring by all appropriate means that the right of the child to receive adequate social services is promoted and respected, to supervise the implementation of the measures having an immediate impact on the adequacy of the services provided.

The Commission feels it is important to ensure that the measures produce the expected results. It will therefore, over a period of one year, carry out three separate examinations of a sample of files, to ensure that the steps taken by the Québec Youth Centre leaders are complied with in the following areas : the child's case history at the DYP, the parents' social background, and drafting of intervention plans and service plans. In addition, the Commission will check to see whether or not the general organization of the file allows any individual who may be required to make a decision within the meaning of the Youth Protection Act to do so, by giving easy access to all relevant information, and in particular to information on prior facts and interventions.

Finally, the Commission will ensure, during these periodic examinations, that appropriate follow-up action has been taken in respect of the recommendations relevant to the intervention and to the managmeent of information.

# Recommendations addressed by the Commission to the directors of the Québec City Region Youth Protection Centres

The Commission has noted the corrective measures applied by the Directors of the Québec City Youth Protection Centres to ensure continuity of service, an essential prior condition if adequate services are to be provided. The Commission nevertheless considers that additional steps must be taken to consolidate these corrective measures, and to provide an adequate response to all the factors that led to failure in the *Beaumont Affair*.

## CASE REVIEW

THE COMMISSION REQUESTS that the director general of the Québec City Youth Protection Centres :

Cancel immediately the policy under which the authorized persons do not report in writing to the DYP staff members responsible for reviewing the case of each child, since the policy is inconsistent with the rules governing reviews.

## INVOLVEMENT OF TEAM LEADERS AND UNIT LEADERS IN THE DECISION-MAKING PROCESS

THE COMMISSION RECOMMENDS that the director general of the Québec City Youth Protection Centres :

Issue, without delay, a directive specifying that any involvement by a team leader or unit leader in a decision within the meaning of the Youth Protection Act will be entered in the record of the child concerned by the team leader or unit leader. The entry made in the record will state the subject of the decision, the contribution made by the unit leader or team leader, and the reasons on which the decision is based.

## PROVISIONAL REMOVAL OF A CHILD FROM, AND RETURN TO, THE FAMILY ENVIRONMENT

THE COMMISSION RECOMMENDS that the Québec City Director of Youth Protection :

Take the necessary steps immediately to ensure that any decision made to remove a child from the family environment or to return a child to the family environment receive the prior approval of a youth protection staff member, namely the unit leader or the reviewer, depending on the case; [11]

A reviewer who is unable to participate in the decision, because of the urgency of the situation, must be informed of the removal of the child from the family environment in order to proceed with a special review of the situation before the child is returned to the family environment.

## ON-GOING TRAINING OF DYP STAFF

THE COMMISSION RECOMMENDS that the Québec City Director of Youth Protection :

Take the necessary steps to ensure that every person who intervenes in the case of an ill-treated child has the professional background required to perform the work;

Implement, by November 1, 1998, if possible in collaboration with the representatives of the Collège des médecins du Québec, the Ordre des psychologues du Québec and the Ordre professionnel des travailleurs sociaux having developed specific expertise in this area, an on-going training[12] plan for all its current and future staff members who are called upon to exercise exclusive DYP responsibilities concerning physically ill-treated children.

## CONCEPT OF PROTECTION

The investigation showed that on several occasions CSSQ staff members acted on the basis of a restricted understanding of the concept of child protection and of their own professional responsibilities towards children, for instance by ignoring the living conditions of D.B.'s children, while stating that D.B. was violent and constituted a danger for J.G.'s children.

11 This does not apply where removal from the family environment forms part of the intervention plan.

12 The expression "on-going training" is used with the meaning defined by the Québec professions board (Office des professions du Québec) in its report entitled "Avis au gouvernement sur l'obligation de formation continue et le maintien de la compétence des membres des ordres professionnels au Québec. June 1996, pp. 11-14.

THE COMMISSION RECOMMENDS that the Québec City Director of Youth Protection :

Send to all members of his staff, a policy statement in which he reminds them that the concept of protection has its source in the recognition of the fondamental rights of children protected in the Québec Charter of Human Rights and Freedoms, especially the rights to life, security, integrity, dignity and assistance;

In recognition of the fondamental rights of children, the Québec City Director of Youth Protection should, in doubtful cases of children possibly exposed to physical abuse, encourage his staff members to take the position which is the most favourable to the children's interest, the least risky for their security and the most likely to ensure their development within the meaning of the Youth Protection Act.

## SUPERVISION AND SUPPORT OF STAFF MEMBERS AND STAFF INTERVENTION

THE COMMISSION RECOMMENDS that the Boards of Directors of the institutions comprising the Québec City Region Youth Protection Centres :

Take the necessary steps to ensure that by November 1, 1998, a set of in-house rules is adopted concerning the supervision and support of clinical staff members.

The rules must take into account the particular needs of the staff members who intervene in the case of physically ill-treated children.

## RECORD KEEPING

THE COMMISSION RECOMMENDS that the Boards of Directors of the institutions comprising the Québec City Region Youth Protection Centres :

Integrate, as part of the in-house rules of each Child and Youth Protection Centre, the policy adopted by the management of the centre concerning the single record to be kept for each child;

Specify, in the in-house rules, the expectations of the institution concerning the recording and organization of the relevant information for the purposes of the Youth Protection Act, according to the situation of each child.

## Recommendations addressed to the Minister of Health and Social Services in connection with the application of the Youth Protection Act

The *Beaumont Affair* began two years after Bill 24, as it was known at the time, came into force. The Affair was brought to light thirteen years later and, as the first Québec City DYP pointed out to the Commission, it constitutes a timely reminder of the need for a system of protection.

Alfred Couture also emphasized that in 1974 the National Assembly had to pass a special law to provide for the protection of ill-treated children[13] since the law in force at the time, the Youth Protection Act of 1960, did not provide adequate protection. The new law, the Act respecting the protection of children subject to ill-treatment, was drawn up in a concerted effort between professional workers from the hospital sector and the organizations devoted to the promotion of children's rights; among other provisions, it specified that any professional providing care to a child suspected of having been ill-treated was required to notify the authorities.

The legislation in force in Québec has continued to evolve. The year 1979 marked the coming into force of a new Youth Protection Act, whose provisions established an authority empowered to receive notification of ill-treatment and to protect all children, including those subjected to the most severe forms of ill-treatment. This new authority was assigned exclusive responsibility for assessing whether or not a particular situation should be referred to the courts, or whether a series of voluntary measures should be imposed to protect an ill-treated child.

The Commission, as it indicated earlier in this report, does not believe that the facts brought to light by this investigation, however serious, indicate the need for a complete revision of the system of protection. This does not mean, thought, that lessons cannot be drawn from the case and major improvements made in the legal provisions that govern professional practice in all Québec Child and Youth Protection Centres.

The presentation of the Commission's report comes at a time when it is becoming increasingly difficult to exercise exclusive DYP responsibilities, as set out in section 32 of the Youth Protection Act. The DYPs, which since 1979 have been integrated within service-dispensing institutions, are once again facing the challenge of having to define and defend their exclusive jurisdiction, both inside and outside the institution, because of the transformations and major upheaval that have resulted from the general re-configuration of the Québec health and social services system.

> THE COMMISSION REITERATES its conviction, as it has done many times since the early 1980s, that protecting the rights of children, and especially their right to adequate social services, is largely dependent on an on-going effort to improve the quality of the services provided by, and under the exclusive responsibility of, the staff of all Québec DYPs.

13 Act respecting the protection of children subject to ill-treatment (S.Q., 1974, chapter 59)

However, the Commission considers that this responsibility is becoming diluted as part of a broader series of changes that include the assimilation of child protection services, in particular as regards ill-treated children and the victims of sexual abuse, under the umbrella of the support services provided to young people and to their families. The Commission recognizes that the move to offer preventive and support services to young people and to their families in the community, with the assistance of all the resources already present in the community, is basically well-intentioned.

The Commission nevertheless considers that the facts brought to light in the *Beaumont Affair* underline the urgent necessity of preserving DYPs as a separate institution, one of the cornerstones of the Québec youth protection system, and of equipping them to deal with situations in which protection can be offered before family support services are provided, although it will still constitute an important element of such support services. Reducing the role, or the powers, of the DYP would, in the view of the Commission, mean reverting to the situation prevailing prior to 1974.

With these facts in mind, the Commission addresses the following recommendations to the Minister of Health and Social Services, who is responsible for the application of the sections of the Youth Protection Act that deal with the organization and operation of institutions operating child and youth protection centres.

## THE NEED FOR INTERVENTION PLANS AND SERVICES PLANS

**Whereas:**

The inquiry into the *Beaumont Affair* has revealed the constant lack of intervention plans and individualized services plans for the children, more particularly between 1989 and 1994;

Section 5 of the Youth Protection Act, as interpreted by the courts,[14] does not create a legal obligation to prepare an intervention plan;

Under paragraph 27 of section 505 of the Act respecting health services and social services the Government may, by regulation, **designate the classes of users for whom intervention plans and services plans must be prepared**;

**And whereas, in the view of the Commission,**

The preparation of individualized intervention plans and services plans constitutes an essential step in the process of providing adequate services;

14 C.Q. (Trois-Rivières), 400 41-000157-962, Slater J., 29 January 1998

THE COMMISSION RECOMMENDS that the Minister of Health and Social Services

Recommend to the Government the adoption of a regulatory provision to make the preparation of an intervention plan and, where applicable, a service plan compulsory for users registered with or admitted to an institution in order to receive services from a child and youth protection centre, a rehabilitation centre for children, an intermediate resource connected with the institution, or a foster family.

## IN-HOUSE RULES OF INSTITUTIONS OPERATING A CHILD AND YOUTH PROTECTION CENTRE

### Whereas

Section 6 of the Regulation respecting the organization and administration of institutions[15] adopted under section 505 of the Act respecting health services and social services, does not require institutions operating a child and youth protection centre to adopt rules concerning the application of the provisions of the Youth Protection Act;

The application of the main provisions of the Youth Protection Act constitutes an intervention by the authorities in the private lives of individuals and has an impact on their dignity and autonomy, and must therefore be conducted in accordance with specific rules that define clear boundaries and orientations;

### Whereas, in the view of the Commission,

The use of community resources by youth protection staff, in accordance with the principles of the Act, must be consistent with the rights of children and parents;

Reliance on community resources must not compromise the responsibility of youth protection staff for coordination and intervention, and the accountability that arises from the restricting nature of any intervention under the Youth Protection Act;

There is an urgent need for each DYP in Québec to acquire an instrument to assess, at each step in the intervention process, the degree of risk incurred by a child left in the care of the parents when it is suspected or believed that the child has been ill-treated;

THE COMMISSION RECOMMENDS that the Minister of Health and Social Services

Recommend to the Government that changes be made to the current Regulation to ensure that every institution that operates a child and youth protection centre is required to adopt in-house rules governing the situation of children subjected to physical ill-treatment or who are the victims of sexual abuse, within the meaning of subparagraph *g* of the first paragraph of section 38 of the Youth Protection Act.

15 The Commission reproduces the text of a draft regulation entitled "Projet de règlement sur l'organisation et l'administration des établissements", published by the Minister of Health and Social Services in the Québec Official Gazette on 5 May 1993, that has yet to be adopted by the Government.

The Regulation must determine the standards and criteria relating to the making of a decision under the Youth Protection Act, the tools needed to direct and support the decision, and the boundaries of the exclusive responsibilities of DYPs within youth centres and within the community.

## HEALTH SERVICES PROVIDED TO CHILDREN SUBJECTED TO PHYSICAL ILL-TREATMENT

### Whereas

The DYP staff involved in assessing the situation of a child subjected to physical ill-treatment must, in order to give effect to the right of each child to receive adequate health and social services, exercise their exclusive responsibilities in close collaboration with the health care professionals who have a specific role to play in interventions concerning ill-treated children.

THE COMMISSION RECOMMENDS that the Minister of Health and Social Services

Assign responsibility to each of the regional boards, in accordance with paragraph 6 of section 346 of the Act respecting Health Services and Social Services, for the establishment by November 1, 1998 of an interdisciplinary team of health care professionals to exercise the following responsibilities, among others:

At the request of DYP staff members, dispense or order the dispensing of the health care required by the condition of children subjected to physical ill-treatment or following abuse or neglect, in particular the health services required when a situation is assessed and reviewed by the DYP;

On the basis of agreements entered into with the child and youth protection centre in the region, ensure that physicians qualified to act as consultants for youth protection staff members during case examinations are available;
Contribute to the implementation of programs to train health care professionals to intervene in cases involving children subjected to ill-treatment;

Jointly with the Director of Youth Protection, design a program for the region to inform and raise awareness among key players in the judicial process concerning the problem of ill-treated children;

Establish agreements with the directors of the judicial services in the region to facilitate the giving of testimony by physicians acting as expert witnesses, in particular as regards summons to appear in court.

## INSTITUTIONAL ACCREDITATION

### Whereas

A system to accredit institutions is currently under examination by the Association des Centres jeunesse du Québec and the Conseil québécois d'agrément d'établissements de santé et de services sociaux, and is expected to be implemented in coming months;

THE COMMISSION RECOMMENDS that the Minister of Health and Social Services

Ensure that the accreditation system currently under examination include consideration of the exclusive responsibilities of the DYP, as specified in the in-house rules of each institution;

Ensure that all institutions operating a child and youth protection centre apply for accreditation as soon as possible.

## Recommendations addressed to the Minister of Justice, responsible for the administration of the Acts governing the professions.

EXCLUSIVE DYP RESPONSIBILITIES AND MEMBERSHIP IN A PROFESSIONAL ORDER

**Whereas**

The specific contribution made by the professional orders to the quality of the services dispensed has been highlighted by the task force set up by the Minister of Health and Social Services to examine the respective responsibilities[16] of the various stakeholders in the health and social services system;

Current legislative provisions prevent the professional orders from contributing significantly to the evaluation and on-going improvement of professional practices in child and youth protection centres by means of professional evaluation, as revealed by the Commission's investigation into the *Beaumont Affair*;

The professional orders, established in order to protect the public, play no role in defining relevant standards for the application of the Youth Protection Act;[17]

The Office des professions du Québec filed a report with the Government in June 1997, entitled Avis concernant l'Adaptation du système professionnel québécois à la réalité du XXIe siècle (Adapting Québec's professional system to the realities of the 21st century);[18]

The Office, in the report, proposed that certain activities and acts become reserved activities and acts, that only duly qualified members of one or more orders would be entitled to perform;

16 Examen des responsabilités respectives du Ministère de la santé et des services sociaux, des régies régionales et des établissements. Réflexions et propositions. A report filed with the Minister of Health and Social Services on 9 December 1996, p. 107.

17 There is one exception to this general rule: section 72.3 of the Youth Protection Act stipulates that the evaluation criteria used in international adoption stem from an agreement between the DYP, the Order of Psychologists, and the Order of Social Workers. Similarly, the evaluation carried out prior to an adoption legalized outside Québec is a reserved activity to be performed by a member of one of the above Orders, selected by the adopting parent from a list of names supplied by either order.

18 Le système professionnel québécois de l'an 2000. L'adaptation des domaines d'exercice et du système à la réalité du XXIe siècle. Avis au gouvernement du Québec transmis au ministre responsable de l'application des lois professionnelles. Office des professions du Québec, June 1997.

The exclusive responsibilities of the Director of Youth Protection constitute an activity within the meaning given to that term by the Office, and the activity is recognized as exclusive in the Youth Protection Act;

**Whereas, in the view of the Commission,**

The exclusive activities of the Director of Youth Protection constitute an act of a public nature, liable to affect the rights, interests and well-being of the population[19] and in particular of children, a particularly vulnerable group;

It is essential, given the far-reaching and on-going changes affecting the health and social services system and the redefinition of the service-providing role of the DYP on a regional basis, that the responsibilities of the directors of youth protection be exercised in a coherent manner, since they have a determining influence on the rights of children and of their parents;

Input from the professional orders would help to ensure the introduction of standard criteria for the making of decisions by DYP staff members throughout Québec, and the collection of significant data on child protection;

The accountability of the persons who make decisions under the Youth Protection Act must be stated unequivocally, and effective measures must be implemented to guarantee their accountability;

The application of the notion of reserved activity to exclusive DYP responsibilities would include a requirement for on-going training for every professional exercising those responsibilities;

The professional orders can make an important contribution to the on-going training of the persons who exercise exclusive DYP responsibilities throughout Québec;

THE COMMISSION RECOMMENDS that the Minister of Justice, responsible for the application of the Acts governing the professions :

Ensure that the exclusive DYP responsibilities become a reserved activity within the meaning of the report filed by the Office.[20]

19 Office des professions du Québec, June 1997. Document cited above, p. 36 and 37.

20 The recommendation presupposes that the notion of reserved activity will be approved by the Government.

## Recommendations addressed to the Institut national de la santé publique du Québec

**CONSOLIDATION OF INTERDISCIPLINARY EXPERTISE WHEN INTERVENING TO ASSIST CHILDREN SUBJECTED TO ILL-TREATMENT**

**Whereas**

The need to consolidate interdisciplinary expertise when intervening to assist children subjected to physical ill-treatment was clearly demonstrated during the Commission's inquiry;

The development and social adaptation of children, especially children victimized within their families, fall within the field of public health and constitute one of the provincial public health priorities formulated by the Minister;

The Government of Québec has, in order to consolidate and coordinate public health expertise at the provincial level, established the Institut national de la santé publique du Québec, whose mandate includes providing support for the work of the Minister and the regional boards;

**Whereas, in the view of the Commission,**

The implementation by each regional board of an interdisciplinary team to support the exclusive DYP responsibilities requires the development of tools for the systematic collection of significant data throughout Québec, the monitoring of interventions and the evaluation of their impact on the health and well-being of children subjected to ill-treatment;

THE COMMISSION RECOMMENDS that the directors of the Institut national de la santé publique du Québec:

Develop, without delay, the tools needed to establish and operate interdisciplinary teams of health care professionals responsible for supporting the work of the DYP in each region;

Ensure that the introduction of new information technologies in the health field results in rapid relief for ill-treated children, in particular by detecting ill-treatment in a manner consistent with the principles of the Charter of Human Rights and Freedoms such as the right to confidentiality;

Discharge diligently their duty to provide the public with objective, enlightened information on the state of health and well-being of children subjected to ill-treatment, and on emerging problems in the field, their causes and the most effective ways of dealing with them.

## Recommendations addressed to the Collège des médecins du Québec

## MEDICAL CARE FOR CHILDREN SUBJECTED TO ILL-TREATMENT

### Whereas

The Commission sur l'exercice de la médecine des années 2000 (Commission on the practice of medicine in the year 2000)[21] set up by the Collège des médecins du Québec, recognized the existence of vulnerable groups, including the general group of persons who are victims of abuse;

The specific group of children subjected to ill-treatment, and the legal obligation for physicians to notify the DYP of ill-treated children that has existed since 1975, were not addressed directly by the Commission;

Doctor Jean Labbé[22] confirmed to the Commission that many physicians remain reluctant to notify the DYP of cases where children are ill-treated, even today, for several reasons including their personal discomfort when faced with ill-treatment, their refusal to believe that parents have ill-treated their children, their desire to find a plausible, less distressing explanation, previous negative experiences with the DYP, fear of appearing before the courts, of wasting precious time or of not being taken seriously, and a lack of basic training and awareness of the problem among physicians.

The Collège des médecins du Québec has stated publicly that it strongly supports all the recommendations of the Commission on the practice of medicine in the year 2000, and has made the following commitments: to evaluate the quality of medical practice (...) with emphasis on the overall coherence and continuity of the medical care provided to patients, to begin immediately to help Québec physicians acquire, develop and maintain the necessary skills, and to instigate an examination of the best way of encouraging physicians to consider the overall coherence of medical care and to work in interdisciplinary teams;

### Whereas, in the view of the Commission,

A major effort must be made to raise awareness among physicians of the situation of ill-treated children, and help them overcome their continuing reluctance to notify cases to the authorities, 20 years after the adoption of the Youth Protection Act;

THE COMMISSION RECOMMENDS THAT the Collège des médecins du Québec :

21 Nouveaux défis professionnels pour le médecin des années 2000. Rapport de la Commission sur l'exercice de la médecine des années 2000. Collège des médecins du Québec, 1998, 277 pages.

22 A pediatrician at the Laval University hospital centre, founder and director of the child protection clinic at the hospital since 1984, expert adviser to the Québec City Youth Court, and member of task forces and associations for better complementarity and quality in the services provided to ill-treated children, Doctor Jean Labbé has also published several studies and brochures on ill-treated children.

Ensure, by accrediting training programs, medical licence examinations and on-going medical education activities, that general physicians, pediatricians and emergency specialists are prepared to work with ill-treated children;

Collaborate in the implementation of the Commission's recommendations addressed to the Minister of Health and Social Security concerning the establishment of interdisciplinary teams of health care workers in each region of Québec, in particular so as to ensure that all the teams are provided as soon as possible with the tools needed to collect uniform data from all regions of Québec;

Develop, as soon as possible, the tools required to evaluate the quality of the care provided by physicians to children subjected to physical ill-treatment;

Ensure that the tools are designed also to remind physicians of the requirement to notify cases of ill-treatment to the Director of Youth Protection concerned.

## PSYCHIATRIC CARE AND THE PROTECTION OF CHILDREN SUBJECTED TO ILL-TREATMENT

### Whereas

The investigation has shown that the flow of relevant information, in accordance with the rules governing confidentiality and professional secrecy, between DYP staff and psychiatrists was minimal in 1983 and inexistent in 1990 despite the duration of the hospitalizations, the obvious family-related component in the problems and the conjugal violence formally identified during the second hospitalization;

A considerable and growing number of situations are reported to the DYP in which one parent is receiving psychiatric care;[23]

THE COMMISSION RECOMMENDS that the Collège des médecins du Québec

Begin discussions with representatives of Québec's Youth Protection Centre to create better coordination between health care professionals in cases where the parent of a child whose situation has been notified to the DYP is receiving psychiatric care.

23 This statement is based on the testimony of a team leader working in a Québec City child and youth protection centre. It is confirmed on page 117 of a recent publication by the Montréal-Centre regional health and social services board, entitled "Choisir des solutions d'avenir pour améliorer nos services", December 1997. The available data indicates that in 20% of the cases notified to the authorities in Montréal, one parent has mental health problems. (Régie de Montréal-Centre, Orientations pour la transformation des services de santé mentale, septembre 1997, p. 46).

## Recommendations addressed to the Ordre des infirmières et infirmiers du Québec

### THE CONTRIBUTION OF NURSES TO THE CHILD PROTECTION SYSTEM

**Whereas**

Nurses who, in the course of providing professional care to a child, have reasonable grounds to believe that the child has been subjected to physical ill-treatment because of excessive violence or neglect are required to notify the situation without delay to the DYP;

Nurses are making an increasing contribution as members of interdisciplinary teams providing services of children subjected to physical ill-treatment;

**Whereas**

Specialized training is necessary in order to deal effectively with ill-treated children;

THE COMMISSION RECOMMENDS that the Ordre des infirmières et infirmiers du Québec

Ensure, by accrediting training programs, nursing licence examinations and on-going education activities, that nurses are prepared to work with ill-treated children;

Collaborate in the implementation of the Commission's recommendations addressed to the Minister of Health and Social Security concerning the establishment of interdisciplinary teams of health care workers in each region of Québec, in particular so as to ensure that all the teams are provided as soon as possible with the tools the need to collect uniform data from all regions of Québec;

Develop, as soon as possible, the tools required to evaluate the quality of the care provided by nurses to children subjected to physical ill-treatment;

Ensure that the tools are designed also to remind nurses of the requirement to notify cases of ill-treatment to the Director of Youth Protection concerned.