**IN THE MATTER OF** the *Public Inquiries Act, 2006*
SNL 2006, c P-38.1

**AND**

**IN THE MATTER OF** a Commission of Inquiry
Respecting the Treatment, Experiences and
Outcomes of Innu in the Child Protection System
(the "Commission") and Final Submissions Regarding
the Death Investigation of Kirby Mistenapeo.

# Final Submissions Regarding the Death Investigation of Kirby Snowdon John Mistenapeo (Piwas)

## Introduction

1. The final submissions of Sebastian Piwas ("Sebastian"), Mary Theresa Piwas ("Mary Theresa"), and Mary Georgette Mistenapeo ("Mary Georgette") are offered to the Commission in memory of Kirby Snowdon John Mistenapeo-Piwas ("Kirby"), in recognition of the love and persistence his family dedicated throughout his life and after his death. These submissions are grounded in the extensive evidentiary record before the Commission, including the records gathered from CSSD, RCMP, Provincial Court, Quinte, BARTS, etc.; the Investigators' Reports; witness evidence throughout the Inquiry and the hearing circles; and the lived experiences shared by Kirby's family and community.

2. Kirby's family accepts the findings in Mr. Richard and Ms. Petti's Investigator's Reports (Report on Kirby Mistenpeo and the Final Report). The purpose of these submissions is not to reiterate the Investigators' findings. Rather, the family seeks to assist the Commission by expanding upon some of the investigation's findings and add further observation and commentary, specifically through the lens of the family's experience and cultural context.

3. Further to the Investigator's findings, the family wishes to assist the Commission with commentary on the following points:

    a. Gatekeeping Services and Resources;
    b. The Inability to Detect, Address, and Prevent Harm;
    c. Cultural Harm was Not a Clinical Risk Factor;
    d. Lack of Communication and Disempowerment of Innu Families;
    e. The Transitional Cliff; and

f. Structural Silence after Kirby's Death.

4. Taken together, these themes help explain how a system, regardless of its good intentions and best efforts, ultimately responded inadequately to the needs of Kirby and other Innu children, resulting in tragic outcomes that impacted the Innu community deeply. Kirby's family stand firm that his story demands not only examination, but accountability and change.

## Kirby's Life

### Early Life:

5. Kirby Snowdon John Mistenapeo (Piwas) was born on December 6, 1998, to Mary Georgette Mistenapeo and Eddie Tshakapesh. Kirby was the third of thirteen siblings.

6. At an early age, Kirby and his younger brother, Eric, were traditionally adopted by their maternal grandparents, Mary Theresa and Sebastian Piwas. The boys were raised in Natuashish and had regular contact with Mary Georgette. From the time he was a young child, Kirby's life was closely tied to his home, his family, and his Innu culture. His grandparents remember Kirby as a good-natured boy who liked to joke around. He loved his family, music, and being in the country.

7. Throughout Kirby's childhood, Sebastian and Mary Theresa did their best to keep Kirby safe and close, even as increasingly serious worries grew about his wellbeing. In 2011, when Kirby was 13 years old, CSSD and RCMP first reported that Kirby and his brother Eric were sniffing gas, sleeping outside, and setting fires. The family had serious concerns about Kirby's solvent use and behaviours that placed him at risk and they went to CSSD for help. There were documented and repeated efforts by Sebastian and Mary Theresa to find treatment and support for Kirby, but all were ultimately unsuccessful.

### BARTS (Sept 7, 2011 – March 22, 2012):

8. In September 2011, Kirby was removed from his grandparents' care with their consent and sent out of province to Ontario, to a Broken Arrow Residential Treatment Services (BARTS) foster placement.

9. The two-parent foster home was located in Norwood, Ontario the same neighbourhood as his sister, Natasha. Kirby was able to have regular visits with Natasha. Kirby's brothers, Wayne and Eric were placed in different homes, and Kirby was unable to see them much. Mary Theresa and Sebastian primarily stayed connected with Kirby through phone calls

and even travelled to visit him at Christmas in 2011. Kirby was discharged shortly after in March 2012, and returned home to Natuashish.

**Natuashish (March 23, 2012 – February 13, 2014):**

10. When he returned home, Kirby returned with very little support. This led to Kirby's resumption of solvent abuse and related risk behaviours. For nearly two years, his family attempted unsuccessfully to access treatment and supports in the community. They did manage to get Kirby into a treatment program in Sheshatshiu at the Charles J. Andrew Treatment Centre in late 2012/early 2013. However, Kirby had multiple altercations with other youth and staff, which led to his discharge from the program.

**Quinte (February 14, 2014 – March 28, 2015):**

11. In February 2014, Kirby entered care again, under the consent of his grandparents. Kirby was transported to Quinte Children's Homes in Belleville, Ontario, where he remained for more than a year. The Quinte Lakecourt group-home housed 3-6 other children. Unlike the BARTS foster homes, Quinte's employee Parent Therapists would work rotational caregiving/supervising roles.

12. The records from Quinte and CSSD noted how hard it was for Kirby to be away from home and how he did not wish to be there. Kirby was the only Innu child in the Quinte Lakecourt care facility and struggled with his English. He kept to himself most of the time and engaged minimally with other children at the home.

13. Records indicate that Kirby repeatedly requested to return to Natuashish. Documented incident reports reveal that Kirby attempted to run away (AWOL) from the home on multiple occasions. On one occasion, Kirby was found walking along the busy highway 401, intending to walk back to Natuashish. Kirby's medical and CSSD records show clinical concerns about his mental health and the long-term effects of solvent use, including paranoia/hallucinations. Kirby was treated with antipsychotic medication (Abilify). Across these entries, staff and clinicians consistently emphasized Kirby's need for steady structure, safety, and specialized supports.

**Natuashish (March 29, 2015 - Death):**

14. In March 2015, at age 16, Kirby was discharged from Quinte and returned to Natuashish to live with his grandparents. Again, Kirby returned to the community with very little support or resources despite the ongoing concern from family and service providers about his health and safety. While there were some continued efforts to connect him with nursing

services, mental health services, and psychiatry, these efforts were sparse and inconsistent.

15. Upon his return, Kirby's family immediately noticed a change in his personality. They remember him being angry all the time and refusing to talk to anyone about his experience in Ontario. All family members felt that when Kirby returned from Ontario, he seemed like a totally different person.

16. On April 21, 2016, Kirby was reported missing after last being seen the day before. A large air and ground search took place in the days that followed. On May 2, 2016, Kirby's body was found outside the community on the ice. Kirby's autopsy listed hypothermia as the cause of death.

17. Kirby's family was profoundly affected by his death. They have continued to grieve his death for years even in the absence of any information about his time in care.

## I. Gatekeeping of Services and Resources

18. The Province's child protection legislation and framework simply does not contemplate situations in which parents, who are otherwise loving and fully capable of parenting, are only unable to care for the child because they do not have the means or access to necessary resources and services. Parents seeking help are given the choice to consent to removal in order to access services and treatment. This was the case for Kirby's grandparents. Through this Inquiry's investigations, it is clear that the child protection system was designed in a way that forced parents to choose between keeping their child in their care (and risking further harm from solvent abuse or behavioural issues), or relinquishing care of the child to CSSD to get help. Like other Innu families, Sebastian and Mary Theresa made the painful choice to voluntarily consent to Kirby's removal, not because they lacked the capacity to care for him, but because it seemed to be the only pathway to treatment and funding.

19. This binary approach to child protection disproportionately affects remote communities like Natuashish; it effectively penalizes Innu and Indigenous families not for abuse, but for poverty and service gaps outside of their control. This approach also leaves little room for the family's involvement once they consent to removal. Kirby's case highlights the need for the system to meaningfully incorporate voluntary, family-preserving services without custody loss.

20. Kirby's first Temporary Custody Order was entered into on November 18, 2011 for a 6 month duration (ICC-KM-CSSD-0293, page 3). On December 12, 2011, Sebastian consented to Temporary Custody Order for Kirby (ICC-KM-CSSD-0128).

21. At the time, Sebastian and Mary Theresa felt that they could only get access to services to help Kirby if they consented to putting Kirby into care - an impossible choice. As survivors of residential schools, Sebastian and Mary Theresa were acutely aware of the potential harm of losing custody of Kirby, and they hesitated to make the decision. CSSD records from June 23, 2011 explicitly noted Sebastian's concerns:

> *Sebastien is agreeable to the idea of sending them out for help but Marie T is reluctant, Sebastien had approached healing lodge before if they could be sent out for treatment but was told they were too young. His other concerns were: - children tend to stay longer what was originally agreed upon. – children get apprehended after parents agree for child to send away to treatment. – children will lose their language if spent too long away from home. – children's rights are violated?... he mentioned something about residential schools… He is agreeable to sending them out as they don't listen to them and they also tend to sneak out when everyone is sleeping. He and his wife will talk it over and will let me know of their decision when I come back next week. (ICC-KM-CSSD-0332)*

22. In 2012 and 2013 when Kirby returned from BARTS and relapsed into gas sniffing, his family tried desperately to find him treatment that wouldn't involve relinquishing custody again. Kirby did attempt treatment at the Charles J Andrew Treatment Centre in Sheshatshiu, however, he was unable to finish that treatment program due to behavioural issues.

23. Unfortunately, his ongoing solvent abuse resulted in Kirby going back into care in 2014, this time to a Quinte group-home. The family consented to Kirby entering into care again on February 7, 2014 (ICC-KM-CSSD-0308, page 37). A warrant for removal and notice was issued on February 14, 2014 (ICC-KM-CSSD-0169). By that time, the family were resigned to the fact that that funding for programs and treatment would be contingent on putting Kirby into care again. CSSD notes from August 27, 2012 note a meeting with Sebastian:

> *... Sebastian advised that they have been seeking out treatment options for the boys and have been seeking support from the Healing Lodge in filling out applications for treatment. It is unsure if Kirby and Erik would get funding for treatment due to receiving services in the past. Sebastian is open to receiving services for Eric and Kirby and is in agreement that it would in the children's best interest to enter into Care so that they can receive the treatment and level of care they require to be safe. (ICC-KM-CSSD-0336, page 19)*

24. Despite the family's explicit concerns about surrendering custody of Kirby, it is apparent that on both occasions, Kirby was placed into the first care facility that could take him. During hearings, CSSD admitted that that the decisions to place Kirby in BARTS and Quinte were driven by crisis response. There was minimal review as to the whether those placements were appropriate or whether those placements adequately addressed

Sebastian and Mary Theresa's concerns. During Kirby's Circle Hearing, Kenn Richard stated:

> *… that's a theme throughout, is the crisis of we got to find a bed. Finding the bed was, in all these cases, the primary reason, not that it was selected through a clinical assessment. So both BARTS and Quinte are for-profit residential treatment centres, and with a history of a relationship with Newfoundland and Labrador. So, you know, two issues identified there was there was a problem with a lack of accountability in this particular case, because neither BARTS nor Quinte were publicly owned facilities and there was not a courtesy social worker that was from an authority. Instead, it was another private operator called Tuskers family services for BARTS particularly, not for Quinte. Quite simply, to round off that question's answer, there was not much else. There were existing relationships. There was a sister in southern Ontario for his first placement, but it was not a rational planned process.* (Inquiry Transcript January 27, 2026, page 6)

25. This was a foreseeable consequence of a system that used removal as the gateway to services. The option for an ongoing partnership mechanism between CSSD and the family was simply not contemplated or explored. Rather, CSSD treated voluntary consent for removal as grounds to preclude the family from all involvement in decision-making, updates, and day-to-day oversight.

26. The family received very little information about how the care facilities/programs were selected and what considerations were taken into account. The family believes that their involvement in canvassing all options to removal and looking at care alternatives would have been a valuable process for all parties involved. They believe that a meaningful consultation process would have kept CSSD accountable for what we now know were harmful placement/care decisions.

**Summary:**

27. A foundational, structural failure in Kirby's case was that the child protection system functioned as a gatekeeper to funded services and programs. At the very outset, the system effectively made custody loss the entry point to care – structuring all of the care decisions that followed. This failure caused harm in two ways: (a) it forced Kirby's family to make an impossible choice between keeping him at home without support and relinquishing custody to access help; and (b) once consent was given, it predictably and automatically stripped the family of voice, involvement, and oversight in key placement and care decisions. Given the profound impact of removal on children and families, child protection policy should ensure that removal is a true last resort, and that family-preserving access to services must be available without requiring removal.

## II. The Inability to Detect, Address, and Prevent Harm

29. An important area of investigation for Kirby's family was whether Kirby was harmed in care by staff or caregivers during his placements in Ontario. The family continues to believe that Kirby was abused, either physically or sexually during his placement at the Quinte Lakecourt home in Ontario (February 14, 2014 – March 28, 2015).

30. Even after the Inquiry's investigations and interviews with Quinte, it is unlikely that the family will ever get a definitive answer or closure on whether Kirby was abused. However, what is glaringly clear is that the system lacked the functional capacity to detect abuse, elicit reliable reports from Kirby, properly investigate allegations, and effectively address identified issues at the home. Kirby's case was also layered with complicating factors such as his cognitive limitations, language barriers, and dependency on caregivers. These factors effectively rendered him voiceless in a system that relied upon self-disclosure to report harm.

31. In their phone calls with Kirby while he was at Quinte, Kirby repeatedly told Sebastian, Mary Theresa, and Mary Georgette that he wanted to come home and that he did not like a worker at the Quinte group-home. A few months into Kirby's Quinte placement, the family noticed a change in Kirby's affect and personality during phone calls. Kirby stopped calling as regularly and didn't want to talk much when he did call.

32. When Kirby returned to Natuashish in 2015, the family observed that he was completely different. He was angry all the time, shutting himself off from everyone. Kirby had trouble sleeping and was often forgetful. When spoken to, he would sit quietly, without saying a word. Kirby distanced himself from his family and his friends, as if he no longer trusted anyone. He had no interest in hunting or any of the activities he used to do with his family as a child. Instead, Kirby would go into the woods for long periods of time by himself and the family would spend many nights searching for him. They frequently had no choice but to call the police to help them find him.

33. The family strongly suspected that Kirby experienced abuse at the Quinte home, but could not get him to talk about it. Family members, who themselves experienced sexual and physical abuse, immediately recognized the changes in Kirby's personality as indicators of abuse.

34. Through the Inquiry's disclosure of CSSD and Quinte records, several documents reference a parent therapist, JB. This man was the primary parent therapist (PT) supervising the residents at the Belleville Lakecourt Quinte home, where Kirby resided with a few other children (ICC-KM-CSSD-0338 at pages 82-85 and ICC-KM-CSSD-0225). According to the records, JB was involved in at least two documented incidents at the home, which occurred while Kirby resided in the home: (a) the December 14, 2014 unsafe restraint incident; and (b) the January-March 2015 investigation of two referrals.

**December 14, 2014 Incident:**

35. An Incident Report involving JB indicated that an investigation was opened by the Highland Shores Children's Aid Society ("HCAS") regarding a community member reporting JB for using "*unsafe restraint practices*" with another resident at the Quinte home. The exact nature and description of the incident is not clear in the records. HCAS found there were "*no verified concerns provided by HCAS following their investigation.*" JB was "*required not to be a solo foster parent provider over the course of the 1 day investigation and returned to full foster parent responsibilities.*" (ICC-KM-Quinte-0068, page 1). CSSD did not investigate the incident further and immediately accepted the findings of Quinte's investigation.

**January-March 2015 Investigation of Two Referrals:**

36. According to Quinte records, in a letter to JB on March 11, 2015, HCAS conducted an investigation into:

> *…two referrals received with concerns regarding the safety of children in your care. The initial investigation alleged that you had physically pushed a youth in your care while yelling and swearing at him. A second investigation began late in January, when the agency received an allegation, by a former resident of Q.C.H. that you had been inappropriate with her in a sexual manner. In both of these allegations, the referent expressed concern regarding your alcohol consumption in the home. Several interviews were conducted with residents, former residents and staff of Q.C.H, as well as you and your family. These interviews revealed some concerns regarding your consumption of alcohol in front of, and/or while caring for, youth. Concerns also arose regarding the use of intimidation with the youth in the form of yelling and getting into their faces."* (ICC-KM-Quinte-0068, page 27)

37. The letter does not indicate when the two reported incidents were reported to have happened, but the HCAS launched an investigation into the two reported incidents. An HCAS investigator went to the Lakecourt home to interview the children, JB, and other staff members. There was no formal report written by the investigator. The records contained the investigator's scattered notes, letters to JB, and an Employee Personal Improvement Plan for JB.

38. HCAS ultimately did not verify that physical force was used with a youth and did not verify the sexual abuse allegations. HCAS did, however, verify concerns regarding JB's alcohol consumption and the risk of emotional harm to youth in JB's care.

39. The Quinte record titled "Overall Investigation comments" (ICC-KM-Quinte-0068, page 31) indicates that multiple interviewees told the investigator that JB would drink while working and one interviewee noted that he sexually assaulted her. Three children reported that JB

drank up to 12 drinks per day. JB denied the amount consumed, stating that he would be too intoxicated with 12 drinks and claimed he had 17 beers per week, that he had a "*high tolerance for alcohol*" but was not addicted to alcohol. HCAS found that there was a night at the Lakecourt home where,

> *…it was acknowledged that [JB] ingested 6 drinks while not on shift, returned to the home, relieved a staff member of their duties, had 2 drinks with the staff and sent the staff home. This did place him within the home overnight while everyone was asleep as the responsible adult in the home following 8 drinks. [JB] does not perceive that he was impaired if an emergency arose and that he knew the oncall support system if required.* (ICC-KM-Quinte-0068, page 33)

40. In another note, HCAS wrote that:

> *Fact: inappropriate decision one night in the middle of this investigation and following the stress of his marriage breakdown where 8 drinks were consumed and he was solely responsible for the program.* (ICC-KM-Quinte-0068, page 32)

41. CSSD notes on January 28, 2015 state that the HCAS contact in Ontario emailed CSSD regarding an investigation into Quinte Homes:

> *[K] advised that the investigation is being handled by a neighbouring CAS office… She stated that she plans to see Kirby on Friday afternoon, however, she has been in contact with staff and they report he is doing well. [K] advised that the staff member in question [*redacted*] is having personal issues and in the investigation came from concerns regarding [*redacted*]. She stated she would contact with updates, however, at this time the information is limited.* (ICC-KM-CSSD-0338, page 82)

42. Nearly a month later, CSSD notes from February 24, 2015 state that:

> *Allegations that a staff member [*redacted*] had put the children at risk of emotional harm (yelling, intimidation, shouting) and had consumed alcohol while working in the Lakecourt Home. Several children interviewed. Kirby was interviewed. Lead investigator reported that Kirby was non interviewable as to details as he responded yes or no to most questions. Outcome of the investigation verified that there was risk of emotional harm and a caregiver with a problem. This case conference was for CAS and other child protection agencies working with Quinte. CAS has not yet provided the details of the investigation to Quinte… At this time, the staff member is still employed by Quinte and is present in the Lakecourt Home, however, [*redacted*] is supervised while there and is not in a direct caring role (no discipline). He has also agreed not to consume alcohol.* (ICC-KM-CSSD-0338, page 84)

43. Further notes indicated that:

> *[K] and I reviewed the investigation. She stated that Quinte was contacted this afternoon and will be provided with recommendations. She advised that although there was some concerning/inappropriate actions taken by the staff person, this person also has strengths and there are positives. I was in agreement…* (ICC-KM-CSSD-0338, page 84)

44. The notes indicate that a social worker spoke with Kirby and noted no issues, stating he was "happy." A further interview in Innu was conducted with Kirby and Bernadette Nui as translator. CSSD notes on February 25, 2015 indicate that:

> *Kirby advised that he has been doing well since returning to Quinte following Christmas break but wants to return home. He reported no particular reason to why he wants to come home just that he does. Explored his relationship with [*redacted*]. Kirby advised that he likes [JB] although he provided no further details. When asked, Kirby reported that he has never felt scared or afraid of [*redacted*] or of anything else/one while at Quinte. Explored drug and alcohol use. Kirby stated that he has never seen anyone (staff or other youth) use drugs or alcohol while at Quinte… Inquired if Kirby has any concerns/issues that he wanted to share. He stated he is fine he just would like to know when he is coming home…* (ICC-KM-CSSD-0338, page 85)

45. CSSD notes from February 26, 2015 state that the social worker discussed the Quinte investigation with Sebastian and Mary Theresa. The social worker states that she,

> *…advised that a staff person [*redacted*] had been investigated re/ risk of emotional harm and concerns around alcohol use…it does not appear that Kirby was emotionally harmed or exposed to any alcohol use, however there was potential… I expressed my concern around this.* (ICC-KM-CSSD-0338, page 85)

46. She further stated that:

> *Discussed with Sebastian's his impressions of Quinte and the staff person when he visited. He stated that at the time he noted no issues and advised that Kirby has never disclosed anything concerning.* (ICC-KM-CSSD-0338, page 85)

47. Ultimately, JB was not formally disciplined, but was only directed to not have alcohol on the premises of the Lakecourt home for 6 months (to be reviewed monthly by a Supervisor on random visits). Quinte did not make any recommendations about JB's alcohol intake when JB was not at work as a parent therapist responsible for the children. They only specified that, when he had care and supervision of the children, he could have no more than four alcoholic drinks in his system.

48. Quinte seemingly based its four-drink-maximum policy from literature by the Ontario Ministry of Health Alcohol Usage Standards and the NSW Department of Community

Services in Australia, on parental alcohol use and impacts on children. This report deemed six drinks, three times per week to be low risk. JB was also directed to take an intervention training refresher and review the social history files of all of the children under his care.

49. JB quickly resumed his primary role in Kirby's care until Kirby's discharge on March 28, 2015. Despite the investigation's confirmation that JB had committed emotional harm to children in the home and had problematic alcohol use in the home, there were no documented concerns from CSSD about JB's ongoing role as a parent therapist. There were also no documented requests for further monitoring or review of JB.

**Handling of the JB Incidents**

50. In light of what the record reveals about CSSD's response to the JB incidents, the family raises the following issues:

a) **Communication between CSSD, Quinte, and HCAS was uncoordinated and insufficient:**

It is not clear that CSSD was fully advised of the two referrals regarding JB (the sexual abuse allegation and the physical/verbal abuse allegation). It does not appear that CSSD was provided with a copy of the investigation notes and interview comments for proper review. These records were not contained in the CSSD disclosure, but were only produced when the Inquiry issued a further subpoena to Quinte. CSSD notes do not indicate that CSSD made efforts to request or review the full HCAS and Quinte investigative records.

b) **The HCAS investigation and the review of the investigation was inadequate:**

Though the sexual abuse allegations were not verified by the HCAS investigation, the investigator did conclusively determine that JB's alcohol use was problematic and the intimidation concerns were verified. Though Kirby did not say that he had been abused in his interviews with the investigator or CSSD, HCAS/CSSD should have recognized that Kirby had been under the primary care of JB for quite some time and may not have felt safe enough to speak honestly. Regardless of the interviews, it was incumbent on CSSD to take further steps to investigate the referrals and satisfy itself with the quality and findings of the investigation.

Had CSSD asked for all investigation materials or sought to conduct its own investigation, it would have been alerted to some major red flags, such as JB's ongoing alcohol issues, the lack of appropriate disciplinary measures, and the problematic alcohol policies and oversight structure at Quinte. CSSD appears

only to have received a verbal report from HCAS regarding the results of the investigation and simply agreed with HCAS that JB should return to his role because he "*also has strengths and there are positives.*" (ICC-KM-CSSD-0338, page 84)

The family strongly questions the depth of HCAS' investigation of the abuse allegations. The sexual and physical abuse allegations appeared to be dismissed at an early stage based solely on the social histories of the child complainants and very shallow interviews with residents. Even if the allegations were properly investigated and dismissed, at the very least, there was a clear pattern of JB consuming alcohol during working hours, while supervising vulnerable children. On at least one occasion JB came to work having consumed alcohol, proceeded to drink more and sent all other staff home, such that he was supervising the children on his own. On another occasion he drank eight drinks while supervising children, while the investigation into his conduct was ongoing. His high tolerance for alcohol and pattern of alcohol consumption during working hours clearly indicated an alcohol addiction, yet there was no substantive action taken by Quinte or HCAS. Quinte continued to allow JB to consume alcohol on the premises while working with vulnerable children, despite confirmed concerns and signs of alcoholism – this should have been a major concern for CSSD.

Quinte further justified their allowance of four drinks during working hours, citing academic studies and provincial standards that were plainly not applicable in this child protection facility/environment, working with vulnerable children (ICC-KM-Quinte-0068, page 34).

The HCAS investigator commented that:

> *[HCAS] believes that a caregiver should be sober at all times **** we have homes with no alcohol ingestion and if an agency wishes that for their child then a specific referral can be made.* (ICC-KM-Quinte-0068, page 32)

It is not clear why Quinte's alcohol consumption policy was not properly vetted by CSSD at the time of Kirby's placement or even after the 2015 referrals were being investigated. It is also not clear that CSSD knew that a specific referral had to be made for an alcohol-free home. However, given Kirby's substance abuse history and social history, CSSD should have ensured that Kirby was not at risk of exposure to any substance abuse whatsoever.

c) **The family was not informed of the investigation and issues at Quinte in a thorough or timely manner:**

CSSD informed the family of the investigation a month after CSSD had knowledge of the investigation into JB's conduct. This is an unacceptable amount of time to delay informing the family about potential harm to their child.

It also does not appear that Sebastian and Mary Theresa were provided with sufficient information about the incident and investigation. Sebastian does not recall any lengthy discussion or meeting about the issue. It appears that Sebastian was only informed that there was investigation and there was a risk of emotional harm to Kirby. There was no discussion of the specific nature or particulars of the referrals and JB was not mentioned by name. CSSD also did not advise of the confirmed drinking that took place at the home and the lack of appropriate disciplinary action taken. Had the family been advised of the details of the referrals and the concerns raised about JB's behaviour, they would have had the opportunity to push for further investigation, appropriate disciplinary action, or request that Kirby be removed from the Quinte Lakecourt home. CSSD's lack of action and communication deprived the family of material information about Kirby that they feel could have prevented harm.

d) **Ongoing material risks were tolerated:**

The response of the child protection authorities to the JB incidents reflects a troubling tolerance for verified risk. Rather than treating the confirmed concerns as requiring heightened safeguards, decision-makers appear to have reframed them as acceptable and manageable, relying in part on references to JB's "strengths" and "positives" to justify inaction. As Mr. Richard and Ms. Petti observed, this level of risk tolerance was likely shaped by placement scarcity and the perceived absence of viable placement alternatives. In the family's view, the result was a failure to treat the incidents with the seriousness required to protect Kirby.

**Summary:**

51. What emerges from the JB incidents is a clear illustration of the system's inability to meet the basic duties of detecting, addressing and preventing harm. Where there were allegations as serious as physical abuse, sexual abuse, intimidation, and alcohol consumption, an overseeing authority must be able to obtain the complete investigation record, gather information, evaluate the harm, and independently determine whether safeguards are adequate. Here, the record suggests that the network of child protection authorities failed Kirby in multiple ways. As a result, Kirby was kept at Quinte and in JB's care, without a properly documented, rigorous investigation or assessment of whether JB could safely remain in a primary caregiving role.

## III. Cultural Harm was Not a Clinical Risk Factor

53. Another broader and well-documented failure in the system was the persistent treatment of culture as a secondary or peripheral concern, rather than as a core determinant of health and safety for Indigenous children. For Kirby, cultural disconnection was a clinical risk factor that blatantly materialized, evidenced by his disengagement, distress and behavioural issues. The family believes that CSSD's failure to treat cultural continuity as essential care directly worsened Kirby's outcome.

54. As this Inquiry has revealed, institutional decision-making and risk assessments tend to focus on observable and immediately quantifiable factors: physical safety, substance abuse risk, and behavioural management. Cultural disconnection, by contrast, is rarely seen as a clinical risk, even where the child's identity, belonging, and emotional regulation are deeply interwoven with culture, language, land, and kinship. CSSD social worker Lindsey Stanford spoke to this at Kirby's circle hearing:

> *I think when I reflect back to that period of time when children were being sent out of province, especially to Ontario, you know, the department traded cultural safety for perceived physical safety, when I think the Innu always knew a way to have both, and for probably many different reasons and many systematic failures or under support or lack of support, we weren't doing that. We didn't see that as a viable option at that time.* [Emphasis added] (Inquiry Transcript January 27, 2026, page 23)

**Time with Family**

55. Where Kirby was placed in Ontario for both of his placements, access to his family was very limited. At the BARTS foster home, Kirby's foster family ensured that he had phone calls with his family and made efforts to facilitate regular visits with his sister Natasha, who was placed at a BARTS foster home nearby. He also had regular phone calls with his grandparents.

56. In December of 2011, Sebastian and Mary Theresa were able to visit Kirby and his brother Eric in Ontario for Christmas. Sebastian remembers the joy of seeing his grandchildren and being able to take them to a movie and eat meals together. However, when it was time to leave in Ontario and return the boys to their foster homes, Sebastian and Mary Theresa found it to be an incredibly painful experience for the whole family. Sebastian distinctly remembers that everyone cried as the boys pleaded to come home. The pain and guilt was overwhelming.

57. During Kirby's placement at Quinte, he had regular phone calls with his family, but no in-person contact until he was able to go home for Christmas in December 2014.

**Connection with Innu Culture**

58. Particularly during Kirby's time at the Quinte Lakecourt home, it was clear that Kirby was lacking connection to his culture and that there was very little support to provide that connection. In one instance, Kirby's family sent him an iPod with Innu music, which he cherished. Staff noted multiple times that the music was significant and meaningful to Kirby (ICC-KM-CSSD-0336, page 50). In another instance, staff reported that "*Kirby does search things on the computer in Innu."* (ICC-KM-Quinte-0049, page 7). It was obvious from these examples that Kirby felt disconnected, however, very little was done to ensure Kirby had better access to Innu music or culture.

59. In a July 7, 2014 In Care Progress Report by CSSD, staff at Quinte advised that they had contacted a reserve nearby to arrange cultural programming, however the Indigenous band there did not speak the same language as Kirby. This indicates that Quinte and its staff had a very limited understanding of the Innu language and culture, and a very limited understanding of Indigenous peoples and cultures in general. The Investigator's Report also recognized this gap in understanding of cultural programming.

**Language**

60. Kirby's disconnect from Innu culture also resulted in the loss of his Innu-aimun language skills in the absence of any Innu-aimun language education and supports. At the same time, language barriers were created by forcing Kirby to speak English while in care. Outside of phone contact with his family during his two placements, Kirby was only exposed to staff and other children who spoke English. None of the involved child protection entities made any efforts to ensure that Kirby was maintaining his Innu language skills.

61. Sebastian and Mary Theresa understood that in Kirby's BARTS placement, he was not allowed to speak Innu-aimun. When they went to visit Kirby for Christmas in 2011, Sebastian and Kirby were instructed by the supervising staff members not to speak Innu-aimun with Kirby. Sebastian and Mary Theresa recall this experience as being very upsetting for them.

62. The family further observed that when Kirby returned to Natuashish in 2015, he seemed to have lost some of his language. Sebastian noticed that Kirby had difficulty understanding some of the things Sebastian would say in Innu-aimun and spoke in English a lot more. This was alarming to Sebastian as Kirby had never had this issue before.

63. While his Innu-aimun language skills diminished, Kirby also experienced difficulties with the English language barrier while in care. These difficulties were noted in multiple reports and records (eg. ICC-KM-Quinte-0049, page 12; June 25, 2014: ICC-KM-Quinte-0013, page 56); December 2, 2014: ICC-KM-CSSD-0201, page 2 and 4). Many of the Quinte

and CSSD social worker conversations with Kirby were limited to “yes” and “no” responses from Kirby. Despite noting this pattern, it does not appear that much effort was put into ensuring that Kirby had translation services when speaking with social workers and care staff.

64. Of particular importance is the commentary in Dr. Mark Voysey’s March 24, 2014 report to Quinte. Dr. Voysey specifically stated in his March 24, 2014 report that translation was necessary for Kirby to understand his situation:

> *I am concerned he may have some form of culture bound syndrome: he could be responding AS IF he was a Residential Schools victim… This would explain his “paranoia”… <u>He somewhat urgently needs an Innu translator to explain this situation to him</u>. Interestingly, I believe it might be impossible for his actual Grandparents to reassure him if they had a direct Residential Schools experience themselves. Likewise, I am concerned that a non-Innu native may not be ideally suited to explain this to him as well...* [Emphasis added] (ICC-KM-Quinte-0038, page 3)

65. Prior to Kirby’s discharge from Quinte, it was noted that loss of language skills was a risk for Kirby. A March 26, 2015 an academic review conducted by Jeffrey Wapiak, Clinical Director at Quinte, stated:

> *It has been identified that Kirby will easily lose information and knowledge when he does not regularly engage in its use. He would be encouraged to continue some form of educational program upon his return home where he has an opportunity to advance not only in his native tongue, but English as well.* (ICC-KM-CSSD-0231)

66. Despite these clear directions to provide Innu-aimun language support, Kirby only ever interacted with others in English while he was in care.

**Nutshimit**

67. The family also emphasizes that Nutshimit was a significant part of Kirby’s life and an integral part of Innu culture, yet there were no substantive efforts to ensure that Kirby could attend the Gathering or any other cultural trips in the country with his family. Connection to Innu traditions and time spent on the land should have been a priority for Kirby’s care plan and for any other Innu child.

68. In Kirby’s circle hearings, Sebastian shared that taking children to nutshimit and teaching them the old Innu ways was noticeably healing for them:

> *[Translator] He said one time they took kids out to Nutshimit, out in the bush. He worked with the Innu Nation; they took the kids out to Nutshimit. There’s about 10 kids. They were all gas sniffers and they were chronic gas sniffers.*

> *He said, when we got there, they stopped sniffing gas. He said he took his kids and his grandkids, the ones that were sniffing gas, and they took them to Kamestastin Lake, and he said there were boys and girls. He said, when we got there, they took the motorboat – they took off on the motorboat and they were gone and when they came back, they have caribou and they were hunting. They never gas sniffed out there, while they were there. They were so busy doing the hunting. They were there for three weeks and they'd always – when they were doing hunting, they got a lot of partridges and they got more caribou…* (Inquiry Transcript January 27, 2026, page 19)

69. Lyla Andrew echoed this:

> *I think when I think about the Innu developing a system, it needs to go beyond land based, although we have to make Nutshimit the place of many of our programs, and that costs money. So hard decisions have to be made. But Innu have to find ways to support any family to go to the country, to have that experience, and I think that's one of the principles of an Innu child and family wellbeing system, is that children will be given the opportunity to have experiences on the land, to learn their language, to learn their history and to experience being Innu from the generations that have come before.* (Inquiry Transcript January 28, 2026, page 25)

**Summary:**

70. Kirby's experience shows that cultural continuity (language, land, kinship, and Innu-specific supports) was treated as ancillary rather than a consideration that was clinically significant. Minimal, ad hoc efforts simply could not address the foreseeable harms of prolonged cultural and linguistic disconnection during out-of-province placement, particularly for a child with cognitive and communication barriers. Kirby's case demonstrates the requirement of care plans and risk assessments that centre cultural continuity as a core determinant of health and safety, equally important to physical safety. Access to Innu-aimun interpreters and support personnel should have been provided to Innu children in care. Funded pathways for time on the land (nutshimit) should be prioritized, including family participation.

## IV. Lack of Communication with and Disempowerment of Innu Families

71. Mr. Richard and Ms. Petti's Investigator's Report has already identified the routine exclusion of families from meaningful participation in their child's life in care. The Investigators found that there was a pattern of cases where parents were inadequately informed about their child's care. Kirby's case falls squarely in these patterns. The family feels that they did not receive sufficient information from CSSD at any point in Kirby's care

– not even essential incidents and updates. Much of the information revealed over the course of this Inquiry was information that the family learned for the first time.

72. The lack of communication effectively excluded the family from meaningful participation in any decisions affecting Kirby's care, safety, and health. Language barriers and staff turnover also hindered communication, leaving the family to decipher updates from Kirby directly. Over time, this systemic issue undermined both trust of the system and effectiveness of CSSD's intervention.

**Medications:**

73. The family was particularly troubled by the lack of communication and education around Kirby's medications. According to CSSD records, Kirby was prescribed the following medications during his time in care and after exiting care:

    a. Abilify tablets: May 2, 2014 to [date uncertain]
    b. Haldol injection (haloperidol): March 2, 2016 to April 8, 2016 (monthly) (ICC-KM-RCMP-0001, page 86; ICC-KM-CSSD-0248, page 12)

74. Abilify was first proposed by Dr. Mark Voysey in his March 24, 2014 letter to Quinte:

> *I have proposed low dose Abilify (Aripiprazole) – working up slowly to 2mg twice per day (full dose being 30 mg per day of this particular AAP) to assist with his psychotic features, since he already sleep well, and I do not want to expose him to more than necessary Atypical Antisychotic (AAP) side effects of metabolic syndrome (weight gain, diabetes, lipid abnormalities and so forth).* (ICC-KM-Quinte-0038, page 5)

75. On May 2, 2014, CSSD social workers asked Sebastian to sign consent forms for the proposed psychotropic medications and medicals:

> *Purpose of today's visit was to discuss Kirby and the recommendation that he begin Abilify tablets re: concerns of organic brain damage and psychosis. It was explained that the medication is recommended for the following: Better reality testing: less hallucinations/delusions/paranoia. Better thinking capacity: reduced thought disorder. Better behavioral functioning: school and reduced AWOLS…* (ICC-KM-CSSD-0336, page 43, ICC-KM-CSSD-0338, page 23, ICC-KM-CSSD-0177)

76. Sebastian recalls the May 2, 2014 meeting where he was asked to sign the medication authorization form. He remembers not understanding what he was being asked to sign, but he felt pressured to sign out of concern for Kirby. He did not feel empowered to challenge the decision that had been made by CSSD and the psychiatrist. Sebastian does not recall being told that Kirby was experiencing psychosis at the time, nor does he recall any explanation of the risks/side effects of the medication. Immediately after signing the

consent form, Sebastian worried that he had made a mistake in consenting to the medications. As communications about Kirby continued to be sparse, the family felt frustrated that they were not getting comprehensive updates on Kirby's health and how the medications affected him.

77. The CSSD records regarding Kirby's prescription demonstrate that the clinical decision-making process for Kirby's medications was not well documented and likely was not substantial at all. There was very little information regarding Kirby's treatment plan and follow up. According to CSSD notes:

> *On March 2, 2016, Kirby saw a doctor in the community who made a referral to Psychiatrist Dr. White and also gave Kirby an injection of "Haldol", but no other information was documented as to reason the injection was provided. The name of this doctor was not documented in the file."* (ICC-KM-CSSD-0293, page 5)

78. Another CSSD note indicates that:

> *It is difficult to assess clinical decision making in this file as involvement with Kirby was only for a short period of time and documentation was in reference to a couple of contacts with Kirby and consultation with mental health regarding referral to psychiatry.* (ICC-KM-CSSD-0293, page 7)

79. The family's lack of understanding about the medications they consented to affected them deeply. In Kirby's circle hearings Mary Georgette shared her experience:

> *[Kirby] said: Mom, they gave me pills, medication, but he never – after that it's different, that he's changed…*
>
> *I knew he – but about those pills, I don't feel good about those, and that's when I felt like that's when he lost himself and don't know what he's doing sometimes. He don't remember. I knew that because almost all of my kids were out. And he used to also fight his little sisters and brothers, but he wouldn't remember that he did that. I didn't feel good about these pills, the medication, to be given to my other kids too. No one tells me that this was going on. No one ever come to see me to say – to tell me how he is doing. The CSSD never tell me anything about my children…*
>
> *I'm not really comfortable to talk about my son. I wanted to know why did they give him the pills, the medication they give, and I don't like that. I'm – it upsets me.* (Inquiry Transcript January 27, 2026, pages 20-21)

**AWOL Incidents:**

80. One of the clearest and most serious examples of communication failure arose when Kirby repeatedly went absent without leave ("AWOL") from the Quinte Lakecourt home. Over

the course of a year, Kirby had at least eight to nine documented AWOL incidents/attempts:

a. February 14, 2014 (ICC-KM-Quinte-0020);
b. March 11, 2014 (ICC-KM-Quinte-0011);
c. March 12, 2014 (ICC-KM-Quinte-0020);
d. March 20, 2014 (ICC-KM-Quinte-0011, ICC-KM-CSSD-0338, page 12);
e. March 21, 2014 (ICC-KM-Quinte-0011, ICC-KM-CSSD-0338, page 13);
f. March 22, 2014 (attempt) (ICC-KM-CSSD-0338, page 15);
g. May 13, 2014 ("minor blip") (ICC-KM-Quinte-00031, page 31); and
h. June 5, 2014 (2 incidents) (ICC-KM-Quinte-0009)

81. It should be noted that at least two AWOL incidents were not recorded in CSSD records, but were contained in the Quinte records. It is unclear if CSSD had full knowledge of all AWOL incidents, which speaks to the coordination and communication issues between Quinte, HCAS, CSSD, and Kirby's family.

82. Ontario police were called for at least three of the AWOLs. During a particularly dangerous AWOL incident on March 20, 2014, Kirby was picked up walking down major Ontario Highway 401, with the intention to walk back to Labrador. A day later, on March 21, 2014, Kirby was found "*Running by the side of a fast flowing river. Concerns with Kirby's safety given where he was running and near water/ice.*" (ICC-KM-CSSD-0338, page 12). These were significant safety incidents that should have been reported to the family immediately.

83. There did not seem to be any indication that CSSD advised the family of the AWOL incidents in a reasonable time frame. The first documentary reference of CSSD notifying the family appears to be on April 10, 2014 - weeks later, when a social worker met with Sebastian regarding his consent to Kirby's temporary custody order. The April 10, 2014 CSSD notes indicate that reporting the AWOL events to Kirby's family was not even the primary reason for the call. The notes state:

> *[Sebastian] advised he applied for a lawyer today and asked how long Kirby would have to be in treatment. I advised I would not be able to answer same and that it would depend on how well Kirby is doing. I advised several weeks ago, there were some incidents re. Kirby running away however in reports, he has been doing better…* (ICC-KM-CSSD-0336, page 40)

84. This lack of communication around the AWOL events was also contrary to the Quinte Out of Province Placing Agency Service Agreement between CSSD and Quinte. The section on Absence without Leave (AWOL) states that "*The resource [Quinte] agrees: 5) To consult with the Agency [CSSD] re notification of child's parents where applicable*" (ICC-KM-Quinte-0036).

85. Had the family been properly advised of the frequency and nature of the AWOLs, they could have pushed for Kirby to be removed from the home, insisted on improvements for

his care at Quinte, or sought to get Kirby transferred to a different placement. Without this information, they were essentially deprived of the ability to advocate for Kirby while he was in care.

**Medication Administration Error Incident:**

86. In another example, on October 2, 2014, Kirby was mistakenly administered medication intended for another resident (125 mg of Lithium and 50 mg of Lamictal) (ICC-KM-Quinte-0011, page 23). Quinte staff documented that they consulted poison control and a nurse. However, the records do not indicate that the error resulted in any staff discipline or that medication administration processes were reviewed or amended to prevent a recurrence.

87. There is no indication in the records that Kirby's family was informed of this medication error, and the family does not recall being notified.

**Incidents Involving Parent Therapist JB:**

88. As discussed in Section II, the family continues to have serious concerns about how incidents involving Quinte staff member JB were communicated and handled while Kirby resided at the Lakecourt home. The family was not provided timely, detailed information about the nature of the complaints/referrals concerning JB, the scope and outcome of the January–March 2015 investigation, or the decision to permit JB to return to regular supervision duties. In the family's view, these communication failures deprived them of opportunities to raise concerns, request safeguards, or object to JB continuing to provide care to Kirby.

**Summary:**

89. The evidence in Kirby's case shows a pattern of delayed and incomplete communication that deprived Kirby's family of meaningful input and oversight. The harm was especially acute in relation to Kirby's medication. The family signed medication consent forms without a clear explanation of diagnosis, purpose, dosage, material risks, or expected side effects. They were left with ongoing fear and distress about what was administered. Significant safety concerns while Kirby was in care were also not communicated to the family. These breakdowns in communication predictably compounded the family's trauma and undermined trust. Families should have access to all relevant documentation and medication counselling before consenting to any medications so that they can fully understand their child's diagnosis/rationale, medication dosage, expected benefits, risks/side effects, monitoring plan, and alternatives to the medication. Critical-incident notification protocols should have been in place for families to be informed of serious incidents such as AWOLs, police involvement, allegations of abuse, and investigations.

## V. The Transitional Cliff

90. One of the most significant failures in Kirby's case was the near-total withdrawal of supports and services following his discharge from care at the age of 16 – a transitional "cliff" at a particularly vulnerable juncture in his life. Despite unanimous recognition from medical experts and care providers that Kirby could not safely function independently and was a suicide risk, proper reintegration supports were not available to Kirby or his family upon his return to Natuashish. The family believes much more could have been done to support Kirby in the community after he returned home.

91. Though CSSD's decision making process was not particularly well-documented, it seems apparent from CSSD's records that once Kirby turned 16 and "sign[ed] himself out of care" (ICC-KM-CSSD-0336, page 52), CSSD no longer pursued any intervention. Unfortunately, CSSD's policy also seemed to apply to all services/support after Kirby turned 16. While there was some involvement by a counsellor and occasional visits/follow ups from rotational social workers, Kirby was not offered any substantial services and support in Natuashish.

92. In an August 11, 2014 Clinical Summary by Jeffrey Waplak, Clinical Director at Quinte, Mr. Waplak clearly stated that:

> *As previously seen with Kirby if discharged from a structured setting too soon he will revert back to previous patterns of behaviour. The risk is that the neurological consequences will continue to increase significantly as now he will be at further and easier risk of additional harm… With the family's support it is best that Kirby be provided access to continued residential services for at least the next year. He would likely benefit from continuation of services until 18 years of age and then a subsequent transition to adult service support systems. It is acknowledged ideally Kirby would be provided service in his home community, but this service plan should at least match current structures…* [Emphasis added] (ICC-KM-CSSD-0202)

93. Quinte staff member also indicated this concern during a November 13, 2014 Plan of Care Meeting:

> *We discussed supports and services available to the family should Kirby choose to return home and [J] also reviewed the level of supervision and structure Kirby will need. He cautioned that if Kirby is left unsupervised for as little as 2 hours he will likely make a poor choice or engage in risky behaviour…* (ICC-KM-CSSD-0204)

94. CSSD social workers acknowledged concern that there would be insufficient supports in Natuashish: In a CSSD Report dated November 1, 2014:

> *[B] advised that when Kirby returned to the province, a visit can be arranged and then Kirby will attend the treatment centre. Bill emphasized that when Kirby does visit, it will only be a visit and that he will need to go to treatment.* [Emphasis added] (ICC-KM-CSSD-0336, page 47)
>
> *… [B] expressed his concern that the level of care required for Kirby cannot be implemented in Natuashish.* (ICC-KM-CSSD-0336, page 51)

95. In September/October 2014, prior to Kirby's discharge, CSSD did make an attempt to get Kirby admitted to a new Youth Treatment Centre located in the Province. Unfortunately, Kirby was not admitted because of his significant cognitive impairments and special needs. However, there did not seem to be any further efforts to find Kirby an equivalent treatment program in the Province or elsewhere. Rather, it was made clear to the family that there would not be any supports if Kirby returned to Natuashish under the care of his family. A November 19, 2014 CSSD Case Note states

> *"Myself, and CS, [LF] attended Healing Lodge to meet with [B]. Upon arrival, discussed Kirby's cognitive functioning and discussed whether he is able to sign himself out of care. [B] requested a letter for Sebastian stating he will care for Kirby and be protective of him. We advised we are not able to write that letter for Sebastian and he will have to write it himself. Also discussed that once Kirby signs himself out of care, he is no longer involved with CYFS and given that he will be over 16, CYFS will not have any authority to assist in helping Kirby return to Quinte if he returns home and then wishes to go back.*(ICC-KM-CSSD-0336, page 52)

96. It was also apparent in the Inquiry's proceedings that Kirby's discharge was not well-coordinated with his medical service providers. Dr. Mark Voysey was Kirby's psychiatrist while Kirby was in care at Quinte. Dr. Voysey was engaged through an affiliate of Quinte's Clinical Director. In Dr. Voysey's evidence, he referenced two main reports: an initial report on March 24, 2014, and a second follow up report on April 10, 2015.

97. The March 24, 2014 noted among other things that Kirby's risk of suicide was "above average". This was noted again in Dr. Voysey's April 10, 2015 report.

98. Notably, Dr. Voysey's April 10, 2015 report was written after Kirby's discharge from Quinte on March 28, 2015, yet Dr. Voysey's report did not mention an imminent discharge or make any recommendations for long term supports or care. Dr. Voysey's evidence indicates that he had not been informed that Kirby was (or was about to be) discharged at the time he wrote the April 10, 2015 report.

> *A. DING: Okay, and you were never asked specifically to say… Kirby's being discharged…What would you recommend for his care after he leaves this residential treatment program? You were never specifically asked to give recommendations on that?*

> *M. VOYSEY: I'm pretty sure I'm going to call [the April 10, 2015 Report] follow-up. I don't have any recollection of that, which is not so much a comment on my memory is you're probably correct that I was not asked to address that so much as what did you do in this period of time and what would we recommend 'cause I think there are a number of very clear recommendations, but that's different than that targeted, comprehensive master plan that's focused with times and SMART, right – specific, measurable, achievable, realistic and timely targets.* (Inquiry Transcript January 29, 2026, page 24)

99. The fact that Kirby's psychiatrist was not informed of his discharge - and was not asked to provide recommendations or participate in a plan for ongoing care - was a significant failure and a clear example of the "transitional cliff" Kirby encountered. Safe transitions are not achieved by simply ending services; they require a purposeful, planned handover, including timely communication between providers and a coordinated plan that addresses follow-up, monitoring, medications, and supports. Yet here, the record indicates that Kirby's discharge proceeded without the involvement of the clinician most responsible for his psychiatric care, and without a documented plan to bridge him from a highly structured, supervised setting to a remote community with limited services. In practical terms, this meant that once Kirby turned 16, CSSD effectively withdrew from planning and accountability at the precise moment continuity of care and coordinated supports were most critical.

**Summary:**

100. Reintegration planning and supports were severely lacking after Kirby exited custody, at the age of 16. Although Quinte clinicians and CSSD records repeatedly recognized that Kirby required sustained structure, close supervision, and a planned transition to adult supports, Kirby's discharge proceeded without an equivalent in-province placement, without a comprehensive transition plan, and without meaningful continuity of clinical care. The record also indicates that key medical providers were not engaged in discharge planning or asked to provide targeted recommendations despite the known risks and the limited service environment in Natuashish. After Kirby returned home, social workers visited occasionally, but Kirby's family experienced the day-to-day burden of care largely alone. When community treatment options were unavailable, there appears to have been minimal follow-up or alternatives to bridge those gaps. The family further emphasizes that these deficiencies were compounded by loss of trust: given the harms Kirby experienced in the system, they did not feel able to rely on CSSD supports or to re-engage with the same structures that had previously failed him.

## VI. Structural Silence after Kirby's Death

101. Lastly, the family emphasizes that the child protection system continued to fail their family even after Kirby's death. The family received no meaningful follow-up from CSSD, and there was no structured review or investigation of Kirby's death in partnership with the family.

102. For years, until this Inquiry was called, Kirby's family was left without access to basic information about his time in care and the decisions that shaped his trajectory. They suffered with unanswered questions about why he changed so profoundly when he returned home, what medications he received and why, and whether he experienced abuse or other harm while in care. This prolonged absence of information deprived the family of accountability and healing.

103. The family maintains that CSSD decisions placed Kirby in a situation of foreseeable risk, without adequate protection or supports for the family. Where child protection materially shapes a child's living conditions, treatment/service access, and exposure to harm, the responsibility of the child protection authority should not end at discharge and should even not necessarily end at death. At minimum, a child's death following recent child-welfare involvement should trigger a documented, independent, learning-oriented review that (a) gathers the relevant records across agencies, (b) examines decision points and systemic contributors, and (c) includes meaningful family participation so that questions are heard and answered.

**Summary:**

104. The events following Kirby's death reflect a continuation of the system's structural failures: there was no meaningful follow-up with the family, no indication of a structured CSSD review or investigation, and until this Inquiry, no access to the basic information needed to understand what happened to Kirby while he was in care. Where a child's death follows recent child-welfare involvement, a documented, independent, learning-oriented review should be triggered, with meaningful family participation so that questions are heard and answered. In Kirby's case, the absence of any such post-death review compounded the family's loss and represents a further structural failure.

## Conclusion

105. From the start, child protection authorities failed Kirby and his family. CSSD acted as a gatekeeper to services, making custody loss the price of accessing treatment for Kirby's solvent addiction. Once Kirby was removed, Kirby's family was left without updates or information about Kirby and without any meaningful participation in decisions about his care. When serious safety concerns arose in placement, the system lacked the capacity and urgency to investigate thoroughly and implement safeguards.

106. Kirby's story also makes a point that child protection authorities have been slow to learn: for Indigenous children, maintenance of their culture is not optional: It is safety. The record shows institutions focused on behaviour and compliance, while the harm of isolation and being far from family, language, and land, was treated as secondary. For a child who struggled to communicate and who depended on the adults around him, it was predictable that the system would misunderstand him, miss warning signs, and fail to provide the supports that would actually help him stabilize and heal.

107. The system's failures continued when Kirby returned home. At 16, the system stepped back almost entirely, leaving a "transitional cliff" where planning, continuity of care, and continued substance abuse treatment was needed. Kirby and his grandparents were left to manage in a remote community with limited services, without a coordinated discharge plan and without key medical providers. After Kirby's death, his family faced years of silence with no access to the information that they needed to understand what happened. That lack of accountability compounded their loss.

108. If this Inquiry is going to matter, it must make meaningful recommendations to overhaul a system that has repeatedly harmed Innu children. The family advocates for significant changes that enable Innu self-determination in child protection services, specifically an Innu-governed child protection authority rooted in Innu values, language, community, and connection to Nutshimit. This means prevention and family preservation before apprehension; culturally informed treatment; families kept fully informed and involved; and real accountability to the community - not a distant bureaucracy who can overlook children in out of province placements. Kirby's story is a tragedy but the family believes it can be used for positive change – change led by the Innu people, resourced by the Province, and built to keep Innu children safe at home.

**DATED** at the City of St. John's, in the province of Newfoundland and Labrador, this 23rd day of April, 2026.

**SUBMITTED** to the Commission of Inquiry this his 23rd day of April, 2026.



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