Public Inquiry Respecting the Treatment, Experiences and Outcomes of Innu in the Child Protection System

IN THE MATTER OF the Investigation into the Treatment, Experience and Outcome in the Child Protection System of THUNDERHEART TSHAKAPESH (deceased on May 24, 2017)

BEFORE Commissioners James Igloliorte, Anastasia Qupee and Dr. Michael Devine

Submissions on Behalf of Simeon and Ruby Tshakapesh Re Investigation into the Death of their Son Thunderheart Tshakapesh

Picture this! If we as Innu people, took your child away from you, and took that child into our care, and took him to the country, to our culture, had them speak our language, served them our food to eat, taught them how we do things in the country, would that affect how you sleep, would that affect your mind, would that affect your feelings, your worry, your safety? How are they being treated, taken care of? Does he get a shower? Does he brush his teeth?

Imagine if we took a non-aboriginal child, a teenager, took them into the bush with no communication. How would your life be? Would you be able to do and enjoy the routine things you did with your child when they were in your care?

How do you think me and my family felt? Thunderheart was supposed to be in a safe environment. When Thunderheart took his own life, part of us died with him. When he died, we died too. What happened to Thunderheart we really don't know. We really want to know, we want closure.

Simeon Tshakapesh, Circle Hearing, February 25, 2026

Overview

1. Thunderheart Tshakapesh, or as his family affectionately called him "Napew", died by suicide on May 24, 2017. He turned 16 only 4 months earlier, therefore "aging out" of the Government of Newfoundland and Labrador child protection system. His case file was closed in April 2017 without any plan in place for his care and support. Within a month, he was dead. His parents, Simeon and Ruby are devastated by his loss. It has affected their mental and physical health and, at times, challenged their own struggles with addiction.
2. The Terms of Reference for the Inquiry Respecting the Treatment, Experiences and Outcomes of Innu in the Child Protection System Order. (O.C.2022-103) provided that in addition to an inquiry into the treatment, experiences and outcomes of Innu children, youth and families in the child protection system, the deaths of Innu children who were or had recently been in care be investigated:

> *(2) In addition to those matters referred to in subsection (1), the inquiry shall investigate the death of an Innu child, youth or adult who experienced time in care or custody and who meet the following criteria:*
>
> *(a) the child, youth or adult was under the age of 25 at the time of death.*
>
> *(b) the child, youth or adult died on or after September 30, 2007; and*
>
> *(c) a parent or, where appropriate, other next of kin of the child, youth or adult consents to the investigation and attests to the belief that the child's, youth's or adult's time in care or custody contributed to their death.*

3. On December 23, 2022, Simeon and Ruby Tshakapesh, the parents of Thunderheart, were granted Limited Standing to participate in the Formal Hearings of the Inquiry, and full rights of participation in the Formal Hearing in relation to the death of their son.
4. The following documentation was provided and reviewed:
    a. The CSSD file for Thunderheart, including pre-apprehension contact, records relating to his time in care, and Youth Services.
    b. Records from Ranch Ehrlo Society relating to the time Thunderheart spent in care in Saskatchewan;
    c. Records from the schools he attended in Labrador;
    d. Provincial Court Records including Youth Court records;
    e. Medical records relating to care and treatment which Thunderheart received in Labrador throughout his life;
    f. RCMP records; and
    g. Records from the Office of the Chief Medical Examiner relating to Thunderheart's death.
5. Following the review of the records, and in consultation with Thunderheart's parents, the parameters of the death investigation were defined by a Nature and Scope Order. It was directed that the following areas be investigated:
    a. What services did Thunderheart Tshakapesh need, what services were available and what services did he receive while in care?
    b. Thunderheart's experience at Ranch Ehrlo Society and services provided there.
    c. Did lack of access to services or inadequacies in these services, if any, contribute to Thunderheart Tshakapesh's death?
6. The Investigation Report Thunderheart Tshakapesh was prepared by Lead Investigator, Kenn Richard, MSW, MSC and assisted by Tara Petti, MSW, RSW, respecting their findings on the systemic issues in Thunderheart's experience while in care. Mr. Richard and Ms. Petti reviewed documents and interviewed witnesses,

including Thunderheart's parents and his sisters. Their report discussed how the following issues contributed to Thunderheart's death:

a. The Legacy of Colonialism
b. Lack of Services in Natuashish, including prevention services, and those dedicated to screening and planning for children with complex and urgent needs
c. Disempowerment of Innu Youth
d. The Erosion of First Nations Parental Rights
e. Lack of Cultural Safety in Out of Province and Island Placements
f. CSSD and Innu Communication Issues
g. The Absence of Mushuau Innu Land Based Treatment Options
h. The Persistence of Gasoline Sniffing
i. The Lack of, the Irrelevance to, and the Inappropriateness of CSSD Services in meeting the needs of Innu
j. Unsustainable Service Planning and Clinical Assessment Recommendations
k. The Absence of Contextual Protocols and Guidelines
l. Poor Restraint Techniques
m. Limited Early Intervention and Prevention Services in Natuashish
n. Child Removal as Trauma/Doing Harm
o. Medication Management, Consent, and Oversight
p. The Need for Post Care Planning and Support

7. For the investigation of Thunderheart's death, Simeon and Ruby chose a healing circle instead of a formal court-style process. Between February 24 and 27, 2026, Thunderheart's family, representatives from CSSD, Ranch Ehrlo and Hope Valley Treatment Centre gathered to share their experiences feelings, memories, questions and lessons learned from their involvement with Thunderheart. The circle was emotional, respectful and meaningful. The Healing Circle discussions addressed several of the systemic issues that led to Thunderheart's death. The findings of the investigators on these issues should be accepted as an accurate

description of the systemic failures within the child protection system during the years when Thunderheart was in care.

8. Both Mr. Richard and Ms. Petti are expert witnesses in Indigenous child welfare. In their subsequent report and testimony on March 31, 2026, they provided a cumulative summary of the common issues that prevailed in Natuashish between 2015 and 2020 and identified the systemic issues which contributed to each of the deaths. This final Investigator's Report echoed most of the issues found within their earlier report relating to Thunderheart Tshakapesh:
    a. colonial legacy of intergenerational trauma;
    b. Disempowerment of Innu families and youth.
    c. The persistence of gasoline sniffing.
    d. Service gaps and crisis-driven interventions.
    e. Over-reliance on out-of- province placements.
    f. The lack of, the irrelevance to, and the inappropriateness of CSSD services to the needs of Innu families and children.
    g. Mental health and clinical care deficiencies.
    h. Governance, oversight, and accountability failures.
    i. Communication breakdowns.
    j. Reintegration; aging out, and aftercare failures.
    k. Cultural disconnection and the absence of land-based healing; and
    l. Fiscal and ethical issues related to for-profit, out-of-province placements of Innu youth.
9. The investigators described systemic issues as part of the common experience of Innu in the child protection system and discussed how the various components of the system acted in such a way that they could cause harm, or harm was caused. This submission will highlight lack of early intervention, out of labrador placements, communication failures and breakdowns, poor transition planning, the legacy of colonialism and the lack of culturally relevant services as factors relevant to Thunderheart's treatment, experience and tragic outcome as an Innu child in care.
10. It is recognized that in the decade since Thunderhearts' death there has been significant legislative reform which recognizes the rights of Indigenous peoples and

the responsibilities of Government. Many issues of concern have already been addressed, and constructive work is continuing with the hope that tragedies such as this can be avoided in the future.

Interventions Before Entering Care

11. Thunderheart's physical health needs appear to have been adequately met. His records show numerous assessments of typical childhood health issues. The first noted indication of mental health issues was in April 2011 when his mother Ruby reported that Thunderheart repeatedly spoke of wanting to harm himself. A month later in May it was noted that he is making suicidal comments, gestures and pictures almost daily. Following a suicide in the community, he was fixated on suicide. In June 2011, he had two counselling sessions.
12. The first reported incident of gas sniffing was On October 21, 2012. The file summary states that there is no documentation that this referral information was investigated even though it was classed as high priority. There were other reports through 2013 of Thunderheart taking part in gas sniffing. Again, the file summary notes that there was no documentation that the referrals were investigated.
13. There were interactions between CSSD and the Tshakapeshs, but no indication of a plan to assist a young child exhibiting mental health issues and engaging in solvent abuse, an activity known to cause brain damage and other serious health issues.
14. On April 7, 2015, Simeon approached CSSD requesting treatment for his son. From this point, things moved rapidly. On April 13, 2015, a 6-month protective care agreement was signed and Thunderheart was sent for treatment to the Ranch Ehrlo Society in Saskatchewan.
15. In their statements at the Circle Hearing, Simeon and Ruby expressed the reluctance they had to take this step. They knew they were making a mistake by sending Thunderheart out of province, "to a different culture, to a different society." They knew no meaningful services were available in Natuashish or anywhere else

in Labrador, therefore out of province placement was the only option. Their hope was that protection would mean he would get help.

Non-Labrador Placements

16. Thunderheart was in care for about 20 months. He had 2 placements with Ranch Ehrlo Society (RES in Regina, SK) and 2 with Hope Valley Treatment Centre (HVTC) in Grand Falls-Windsor. The Investigation Report states that neither of these agencies provided anything related to Innu culture. At the Circle Hearing, the representative from RES stated that "our knowledge of Innu culture was woefully inadequate." An HVTC representative stated at the Circle Hearing that Thunderheart was not allowed to speak Innu on the floor for safety reasons. It was not an Innu program, and their approach was based on Western practices. Although they had received some cultural sensitivity training, they did not feel prepared to treat and counsel Innu youth.
17. The File Summary for Thunderheart's placements are replete with statements from him of being homesick, lonely and wanting connection with his family. Ruby, when speaking at the Circle Hearing, emphasized the message they received from Thunderheart during his placement at RES:

> *"I feel so homesick please I just want to go home." "I am losing my language here", "I don't want to live like a white boy I just want to live like an Innu boy again", "I have been down for a couple of days I 'm starting not to eat, I just want to go home".*

18. The removal of Thunderheart from his family and community was traumatic for him and his parents. Although undertaken with good intentions by all, it proved to be less efficacious than expected. As a CSSD representative stated, the placements were physically safe, but not culturally safe.

Communication Issues

19. The thread that runs through many of the systemic issues identified by the investigation is communication. However, as Mr. Richard stated at the Circle Hearing, communication was often miscommunication. In addition, he said the cross-cultural nature of the communication fostered mistrust in the parents. The systemic issue of the Legacy of Colonialism is inextricably connected to the communication issues experienced by the Tshakapeshs.
20. At the Circle Hearing, Simeon described his experience as a child in school where he was forced to speak English. If he tried to speak his language, he was yelled at, threatened to have his mouth washed out with soap and beaten. He felt powerless. Simeon stated that for him, “that’s how communication began, that’s not communication.”
21. The Tshakapeshs felt that communication with CSSD was affected by the cultural differences between them and those providing the services. They often felt disrespected, invisible, voiceless and powerless. Their experience as individuals who were very involved in their community has resulted in distrust of those authorities. Ruby described those working in child protection as, “monsters who wanted to destroy everything we wanted to do.” The Investigation Report captures the feelings of Simeon clearly when it states, “he knew what had happened when Innu trusted government to do the right thing.”

The Ranch Ehrlo Incident

22. The Investigation Report stated that a significant Communication concern for the family was a physical altercation between Thunderheart and a staff member of RES which occurred on May 15, 2016, during his second placement. The incident resulted in Thunderheart hitting his head and being taken to hospital by ambulance. The significance of this incident to Simeon and Ruby was obvious from their statements at the Circle Hearing.

23. The statement of the CSSD representative at the Circle Hearing was that they received information by email from RES about this incident On May 16, 2016, but because she was in a fly in/fly out position, she left Natuashish that day without seeing the report. Therefore, she did not see this email until her return to Natuashish on May 30, 2016. The CSSD records indicate that she did not convey this information to Simeon until June 12, 2016, at a meeting at his office. Furthermore, the records state that the meeting was at Simeon's request and not initiated by CSSD. The records also indicate that Simeon claimed to be already aware of the incident from communication with Thunderheart. The record went on to state that other issues related to Thunderheart's placement at RES were discussed. Simeon has a different recollection of this meeting. CSSD were at his office to discuss an issue with another community member and Thunderheart was not discussed.
24. On June 14, 2016, Simeon wrote an email to CSSD expressing dissatisfaction with RES. It is significant that the focus of this email is concern about RES not informing him of Thunderheart being possibly charged with theft of an automobile. As a secondary concern, Simeon mentions Thunderheart claiming his head was pushed into a wall.
25. In June 2021, Simeon received an email from a former RES resident who was present when the altercation between RES and Thunderheart took place on May 15, 2016, which provided a significantly more vivid account of the incident than either RES or CSSD. Simeon and Ruby were so upset by this information that they requested a criminal investigation. The results of this investigation remain unclear.
26. This incident highlights the systemic issue of communication breakdown between CSSD and the family and also CSSD and RES. Although there are different perspectives on the nature of the altercation, at its' core it was a child receiving a head injury serious enough to require an ambulance to take him to hospital. Mr. Richard stated at the Circle Hearing, "however it unfolded, that boy was hurt". Although RES conveyed some information to CSSD on May 16, 2016, neither made direct contact with the parents. Furthermore, the CSSD notes of June 12,

2016, meeting with Simeon make no mention of Thunderheart being taken to hospital. The Investigation Report stated:

> *The placing agency, in this case CSSD, must be informed and parents fully briefed on what happened to their child. This is a requirement of all the service agreements between CSSD and out of province placements.*

27. This did not happen. Mr. Richard observed at the Circle Hearing that this incident remains murky, the communication from all parties was just not there. CSSD acknowledged at the Circle Hearing that they did not directly receive a critical incident report from RES. Furthermore, CSSD never followed up to obtain the report.
28. Also at the Circle Hearing, the representative from RES acknowledged that staff should not have put hands on Thunderheart in that situation. There were opportunities to have done something different. He simply wanted to get his guitar. It was an opportunity missed that might have led to a different outcome. RES also acknowledged that there were opportunities to engage with the family differently that were missed.
29. The family continues to be concerned about the absence of documentation. As noted, CSSD did not receive the critical incident report, neither CSSD or RES worked with the family to obtain the hospital records and the nature and extent of the police investigation is not known. Mr. Richard observed at the Circle Hearing that in a case like this all the records should be available, a clear line of communication from RES, a conversation with CSSD including an assurance that the information was conveyed to the family and there was a loop back to RES to ensure accountability.
30. The impact of this communication breakdown on the family is regret for what they may have done if they had been fully briefed about the incident, especially his hospital treatment and possible head injury. At the Circle Hearing Simeon said, if he had known, he would have taken a very different approach, I would probably have sought more assessments and a more thorough explanation. The family noted that Thunderheart was never the same following his return from RES in

2016. He was not himself and had lost interest in music and other positive things in his life. During the Circle Hearing, representatives of HVTC, who had worked with Thunderheart before his 2016 placement at RES, commented that he had changed and he was not the same kid.

31. Also, if Simeon and Ruby had known about Thunderheart hitting his head at the time of his death, they would have asked for more medical examination at the time of the autopsy. These questions continue to haunt Simeon and Ruby as they are left to question if they had done all that they could for Thunderheart, therefore compounding their already profound grief.

Medication Management, Consent and Oversight

32. The Investigation Report identifies the prescribing of medication as another example of the broken communication issues between Simeon and Ruby and those charged with their son's care. During his placements at HVTC and RES the use of medication was a point of contention. Psychiatrists and other agency staff were promoting it and at times Thunderheart felt that the medication was helpful.
33. Simeon and Ruby communicated on numerous occasions their objection to the use of antidepressants. They described incidents where they believed antidepressants were the cause of other suicides in their community. They had personal experience in their own lives of having been prescribed antidepressants and their effects. The expression of these feelings is noted but not very much about how or whether these concerns were seriously considered by CSSD. The Investigation Report states:

> *Effective communication goes beyond the simple exchange of information. It requires that all parties not only receive information but also fully comprehend it, resulting in a shared understanding. Agreement is not necessary. What matters is that everyone involved has a clear and common grasp of the facts and implications. This mutual understanding is foundational to sound decision-making. Without it, the process of providing*

help is severely undermined, leading to negative consequences for families and CSSD alike.

34. The Tshakapeshs were engaging with the issue of medication when their son was out of province. They had limited opportunity to observe Thunderheart, to assess how he was doing or to truly appreciate how the medication was working. It has been their experience that the side effects are often inadequately explained. Not only did they not have the necessary understanding, but when they raised concerns, they did not feel seen or heard by CSSD and others.
35. Mr. Richard, in his testimony, stated that overreliance on Western medicine was a failing of the system. The West and the Innu have much to teach each other. In the Investigation Report, it is noted that the land as medicine is often dismissed by professionals. In his view, Innu culture is seen as a liability and not an asset.

Simeon's Position in the Innu Community

36. A recurring theme in the File Summary notes are comments about Simeon's position as an Innu leader and his readiness to contact and complain to authorities and the media. CSSD found this problematic. The Investigation Report summarized it as follows:

> *The fact that Simeon Tshakapesh was Deputy Grand Chief while at the same time having a child whose mental health was in chronic distress, with behavioral issues and suicidal ideation beginning in his tenth year, introduced both a confusion and an urgency to their case.*
>
> *The confusion related to a lack of clarity about which Simeon Tshakapesh was engaged in the case management of Thunderheart, the Deputy Grand Chief, or a father trying to ensure his child's welfare? In his political life, Chief Tshakapesh was required to be an advocate for his people, and in his private life, Simeon was afraid for his son. These dynamics caused confusion and resulting stress that seemed to compromise the entire service process and prevent a good working relationship between the family and the CSSD.*

37. Simeon was first and foremost a father. This should have been clear to CSSD staff. Like many other fathers with a child in crisis, he was going to use any tools in his possession to seek help for his child. Again, this should have been obvious to CSSD. They did not have to separate the father from the Deputy Grand Chief, they were the same person seeking the same outcome, a healthy child living in a healthy community.
38. This issue highlights the systemic failure of the fly in/fly out model of servicing Natuashish. The Investigation Report stated, “Most CSSD staff were rotated in and out of Natuashish and were not typically experienced with the Innu community, its context and its protocols.”
39. At the Circle Hearing, Simeon unapologetically described himself as having “a big mouth and a big heart”. He saw himself as the voice for his family and the voice for others who were unable to speak for themselves.

The Need for Post Care Planning and Support

40. On September 30, 2016, following a placement of approximately one month, Thunderheart was discharged from HVTC. He was to live with his brother Vincent in Sheshatshiu. On discharge from HVTC, it was recommended he follow up with his family physician, and a relapse plan was reviewed. On his return to Sheshatshiu, a counselling referral was made, but there is no documentation that this was pursued further.
41. The records indicate that there was minimal contact with CSSD and no indication of any supportive services being in place or the existence of a discharge plan to reintegrate him into the community. On January 18, 2017, Thunderheart turned 16 and would no longer be followed under the CSSD protective services program. He received no further intervention, his file was closed in April, and he died on May 24, 2017. The Investigation Report bluntly concluded:

It seems all parties gave up when given the chance to do so and Thunderheart was left alone, the worst scenario given his death a short time later.

42. In his testimony for the Inquiry on March 31, 2026, Mr. Richard was of the view that aging out of child protection at a specified age was an arbitrary legislative requirement. Children do not age out of the need to be cared for. At the age of 16, Thunderheart was still a child. He had complex needs. He had some successes in his 20 months of care but clearly required ongoing care and treatment. He wanted to be home, and he wanted to be well.

Conclusion

43. Simeon and Ruby are grateful for the Inquiry and the investigation into Thunderheart's time in care. They endorse the findings of the investigation, although they have some lingering questions. They seek Innu based services that are not without the hallmarks of oppression, assimilation and disempowerment. Their view is clearly expressed by Simeon in his concluding words in the Circle Hearing,

> *"We must embrace our culture, our language, our identity, our spirituality, our beliefs, we integrate those into any programs we work with, and that's how we are going to be successful. "They also recognize that implementation of a new approach to child protection will be the hardest part of changing the future for Innu children.*

44. On January 18, 2001, when his son was born, Simeon Tshakapesh visited his grandmother and asked her what he should name his child. She replied, have you ever heard thunder and lightning, heard the power of that noise? Simeon and Ruby do not want the power of Thunderheart to be forgotten and more importantly that the power of his spirit to be heard and acted on by the Government of Newfoundland and Labrador and the Government of Canada.

Dated on April 10, 2026, at St. John’s, Newfoundland and Labrador.

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