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April 23, 2026

KELSIE LOCKYER:

All right. Good morning, everybody. And welcome back to our final day of this week's hearings.

As we discussed yesterday, today will be submissions from family counsel. As well, it will be -- we will have a half hour today from 11:00 to 11:30 to have Dr. Fallon and Dr. Black respond to any questions from the Commissioners.

That was their only time that they were available for today. So for the person -- for Mr. Lynch, if you're on the call at 11:00, if you're not concluded your submissions, we may just have to pause and then resume at 11:30 when Fallon and Black are finished. But otherwise, we'll proceed as we had laid out in the schedule.

So, just as a quick overview, first will be Adrienne Ding, then Scott Lynch. Then, as I said, we'll have Dr. Fallon and Dr. Black on. Then Robby Ash. Then Will Hiscock will go twice

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as he has two clients. And then finally, James Maher will end off the day.

So provided that there's no issues with that, we will -- I'll turn it over to the Commissioners there now to introduce the day before Ms. Ding gives her submissions.

Thank you.

COMMISSIONER IGLOLIORTE:

Good morning, everyone, and welcome to all of you. Thank you for continuing to support the Inquiry with your submissions and your presence. And we're very happy that you're able to make it today.

I'm not going to give a prayer today, but I will offer some reflection since this is the day when we hear from the lawyers for the families, and very likely where we reach the stage in the Inquiry where there'll be fewer of these kinds of submissions, either formal or otherwise. It is a time when, as the Innu have done, to thank you as legal counsel for your various parties for the

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work that you have given us. In the manner that Tshankuesh Penashue would do, Elizabeth Penashue, in the manner that Nastash, our Commissioner, would do in offering prayers, and the many other Elders, Penote Antuan, Joachim Nui, all these people, when you were present, you stood and heard their prayers.

And in many cases, they very graciously said, we're happy to see the lawyers involved. We're happy to see this Inquiry. Thank you for leading us into a good way into the future for Innu lives.

So it is with this thought in mind that on a -- on a day when we're going to hear from lawyers for the families, I also recognize all the lawyers who have been involved with this Inquiry. Lawyers for the Inquiry Commission, lawyers for the Innu leadership, lawyers for the Province of Newfoundland and Labrador, representing their client, the Government of Canada as well. Every one of you representing various aspects of work done by social workers and also by the -- by the

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Child and Youth Advocate. To each of you, we owe our gratitude.

We have stretched your understanding of what it means to attend at the judicial sessions. We have made you wait many times before we started on time. You have come to appreciate the concept of Innu time or Indigenous time, time and time again.

And we have placed you in positions where your job requires you to be the most proficient in English that you can, and we have required you to break that down into a way that can be translated and simplified into another language.

But in all of those time periods, you have heard Innu Elders, the ones that I mentioned, participants like Mr. Greg Rich, who tragically him and his wife contemplated taking their own lives because of the guilt they felt. But he was very gracious to you, to all of us, and he said, we're so happy that you're here doing this work on our behalf.

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So it's at this juncture that the Inquiry, the two Commissioners here with me offer our deep depth of gratitude to you. Thank you very much.

So with that, Counsel, you can continue.

KELSIE LOCKYER:

So unless other -- the Commissioners would like to have a few words before we open today, I'll now invite Adrienne Ding to begin her submissions.

SUBMISSIONS OF MS. ADRIENNE DING (KIRBY MISTENAPEO)

MS. DING:

Good morning, everyone. For those of you who don't know me, my name is Adrienne Ding. I am counsel for Kirby Mistenapeo's family, that being his grandparents, Sebastien and Mary Theresa Piwas, and Kirby's mother, Mary Georgette Mistenapeo.

Before I begin, I would just like to recognize the strength and resilience of the Mistenapeo and Piwas family following the loss of their

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granddaughter and daughter, Danita Mistenapeo, who was Kirby's younger sister. Danita passed away on March 29th in Hopedale, and she's greatly missed by her family.

And I want to note that even in the midst of this heartbreaking tragedy, the firm -- the family has continued to participate in this Inquiry and continues in Kirby's memory.

As a preliminary point, and on behalf of the family, I want to thank the Commissioners and the staff of the Commission, Commission Counsel, counsel for the parties, Innu Nation, the investigators, and all the participants at Kirby's circle hearings.

As you know, it's been a long road for everyone involved, but it's been extremely important work. We saw firsthand the enormous efforts made over the past few years so that we could tell Kirby's story. And there have been hundreds of documents of disclosure, many, many interviews and an investigation, and of course Kirby's circle

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hearings over a few days. Those proceedings brought together family members, community members, representatives from the federal and provincial governments, Innu Nation, the investigators in the Commission.

And I recognize that these proceedings have been no small feat and the family recognizes that. As the family continues to heal from their loss of Kirby, we recognize that this Inquiry has been an important part of their healing process. So thank you.

I'd like to give a bit of a background on Kirby before I make our final submissions. Kirby Snowden John Mistenapeo was born on December 6, 1998, to Mary Georgette Mistenapeo and Eddy Tshakapesh. He was the third of 13 siblings.

Kirby and his brother Eric were traditionally adopted by Sebastien and Mary at a young age, and they were raised in Natuashish. His grandparents remember him as being a good-natured boy who liked to joke around. He loved his family,

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music, hunting, and being in the country. And he would go to the country with his grandfather and learn traditional Innu ways of hunting and living on the land.

As Kirby entered his pre-teen age, and along with other children around him, Kirby began sniffing gas. And at the age of 13 his behaviours became difficult to deal with and his solvent abuse was getting worse.

So as his behaviours became more concerning, Sebastien and Mary tried to get help from the Healing Lodge, but was told Kirby was too young. And as a last resort, they sought help from CSSD to find treatment and support for Kirby.

Kirby went to care on two occasions. The first time to Broken Arrow Residential Treatment Services, or BARTS. And that was from September 2011 to March 2012. He also went to Quinte Children's Homes in February of 2014 to March 2015. BARTS and Quinte were two private for-profit residential treatment programs based

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in Ontario.

At BARTS, he was in a two-parent foster home in Norwood, Ontario. He was placed in a home close to his sister, Natasha, and he seemed to be doing okay in that placement.

He returned to Natuashish between March of 2012 and February of 2014. But when he returned home, he had very little support and he went back to sniffing gas and other risky behaviours quite quickly.

Kirby entered care again in February 2014, voluntarily from his grandparents. He was sent out of province again, this time to Belleville, Ontario, in the Quinte Children's Homes. And this was a group home setting with three to six other children. Kirby seemed to struggle a lot with this placement. There were numerous documented incidents, several of which he tried to run away.

During this time at Quinte, Kirby was assessed

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and supervised by a psychiatrist, Dr. Mark Voysey, and he was prescribed antipsychotic medications at the time.

In March 2015, when Kirby turned 16, he was discharged from Quinte and returned home to Natuashish. His family immediately noticed a change in him. He was distant and angry all the time, and he acted like he didn't trust anyone. He didn't enjoy any of the activities he used to enjoy, and instead he would go off into the woods alone for long periods of time.

Many nights his grandparents would have to go searching for him, and sometimes his grandparents would have to call the police to find him. Kirby seemed like a completely different person, and his grandparents were at a loss on how to help him.

On April 21, 2016, Kirby was reported missing. A large air and ground search took place to find him, and they found his body on May 2nd, 2016, on the ice outside of Natuashish. The cause of

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death was hypothermia. The family was profoundly affected and continue to grieve his death.

We make our final submissions today to assist the Commission by expanding upon what we've heard from the -- from the investigations of Kenn Richard and Tara Petti. The family accepts the findings in their reports, both the report on Kirby and the final report that was presented earlier this week. And we don't intend to repeat those reports, but we would like to add further points for this Commission to consider. And we do that through the lens of the family's experience.

So in addition to Kenn and Tara's conclusions, we have six main points that we hope will be helpful to you as the Commissioners and helpful to the Inquiry's final report. I'll briefly describe each point, and then I'll explain them in more detail.

So first is the systemic structure of gatekeeping services and resources. Kirby's case is a prime

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example of the structural failure of the child protection system, where capable parents seek help but can't access treatment and funded supports unless they consent to their child's removal. This really is an impossible choice for parents, and particularly Sebastien and Mary Theresa. And we know they ultimately made that painful decision. This issue, we argue, disproportionately affects Indigenous communities with limited access to services.

Our second point deals with the system's inability to detect, address, and prevent harm. The family firmly believes that Kirby was abused by a staff member while in care, and while there may never be a definitive confirmation of that abuse, what is clear is that the child protection network of agencies lacked the practical capacity to detect harm, thoroughly investigate allegations, and implement any safeguards.

Our third point relates to the failure to treat cultural harm as an important clinical risk factor. In Kirby's case, the record shows

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cultural continuity, such as family, language, and time on land, was treated as a secondary factor to physical safety.

As we see in hindsight, Kirby suffered significant harm from isolation and disconnection from his Innu culture.

Fourth, and this has already been raised by the investigators, there was a significant lack of communication in Kirby's case, and as a result, his family felt disempowered. There were a number of serious incidents that occurred while Kirby was in care, but the family were rarely informed.

Communication was often delayed or incomplete, and this caused a lot of frustration for the family.

Fifth is what I call the transitional cliff, or the immediate drop-off of support and services once Kirby turned 16 and came home to Natuashish. Despite his high needs, there was very little

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transition, planning, or discharge coordination. The family was essentially left to manage alone in a remote community with few resources.

And lastly, we point to the structural silence the family experienced after Kirby's death. For years, the family received no meaningful follow-up or post-death review.

Until this Inquiry, they went without basic information about Kirby's time in care, which really compounded their grief and inhibited their ability -- their ability to heal as a family.

So those are our six points. I'll get a little bit more into detail about each of the six.

So the first one is the gatekeeping of services and resources. What is apparent in Kirby's case is that the province's child protection legislation and framework simply does not contemplate a situation where parents who are fully capable of parenting are unable to care for the child because they don't have the means or

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access to the necessary resources and services. This was the situation for Sebastien and Mary Theresa.

Because Natuashish had very few services to help Kirby, and they had very limited means to help him, they were forced into what I think was an impossible choice, to either keep Kirby at home in the community and risk further harm from gas sniffing, or voluntarily giving up custody so that Kirby could get the treatment services he needed.

Documents show that Sebastien and Mary Theresa were extremely hesitant to involve CSSD. They worried about Kirby being gone for too long. They worried he would lose his language, and they worried that his rights would be violated.

They were acutely aware of the harms from residential schools, and they didn't want that for Kirby. But at the same time, they couldn't help Kirby without CSSD intervention. They eventually made the painful decision to consent

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to Kirby's temporary removal. But what they didn't expect was that once they consented to that removal, they no longer had any meaningful involvement in Kirby's care, any decisions, or any oversight. Outside of phone calls with Kirby, they didn't even receive regular updates about his health or his care.

Sebastien and Mary Theresa did not want Kirby to be sent away, but they understood that they had to voluntarily relinquish custody. Sending Kirby to Ontario seemed promising, as it would remove Kirby from the physical danger of solvent abuse. However, we know now that the Inquiry's proceedings and the investigators' report from those things, that the CSSD out-of-province placements were largely driven by a crisis response, and that an urgent need to find beds for these Innu children was top of mind.

None of the concerns that Sebastien and Mary Theresa had told CSSD about were even considered in his placement. He was being sent away to a different province for an indeterminate amount of

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time, to an English-speaking care home with very little cultural or language supports. We know that these care decisions were made without any input from Kirby's family, and were ultimately detrimental to Kirby.

This binary idea that services and supports can only be accessed if a child enters into care ignores the harm caused to the child and the family. It also disproportionately affects remote communities, like Natuashish, who experience poverty and service gaps.

Mary Theresa and Sebastien were loving and capable parents who were not treated that way by the system.

Given the profound impact of removal on children and families, we submit that child protection -- child protection policies should ensure that removal is a true last resort, and that the family -- and that family preserving access to services must be available to families without having to give up custody.

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I'll move to our second point, which is the system's inability to detect, address, and prevent harm.

As mentioned before, and this is very important to the family, the family believes that Kirby was abused while he was in care. They know that the investigators could not confirm with any certainty that this happened, and that it will always remain an area that they will never get closure on. But what is glaringly clear is that this system lacked the functional capacity to detect abuse and elicit reliable reports from Kirby, properly investigate allegations, and effectively address the identified issues in the home.

During Kirby's second placement in Quinte Care Homes from February 2014 to March 2015, Kirby would have regular phone calls with his grandparents and his mother, and he always asked to come home, and he told them that there was a worker that he didn't like.

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Over time, the family noticed that Kirby would call less, and he seemed not to want to talk much. When Kirby returned home in 2015, they noticed that dramatic change in his personality. He didn't want to talk about Ontario, he didn't want to see anyone, he was angry all the time, and he spent a lot of time by himself.

As a victim of abuse himself, Sebastien saw all the signs that Kirby had been abused. CSSD and Quinte records revealed to us that there was a parent therapist who was the main supervising person at the Quinte Lake Court home. According to those records, a particular care worker at the Quinte Lake Court home was involved in at least two documented incidents in the home while Kirby was living there.

The first incident was in December of 2014, where a complaint was made that a care worker was using unsafe restraint practices on a child in the home. Highland Shores Children's Aid Society, who was the partner agency to CSSD in Ontario, investigated that complaint. Ultimately, they

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didn't verify the concerns, and the care worker was returned to his regular duties. CSSD didn't investigate further, and it appears that the family was never informed of that incident.

The second issue occurred in January to March in 2015, with an investigation into two referrals against the care worker. One was that the care worker had physically pushed a child while swearing and yelling at him, and a second referral from a former resident claimed that she had been sexually abused by the care worker.

The care worker's alcohol consumption at the home was also raised as a major concern. Highland Shores proceeded to investigate those complaints through -- though we believe their investigation was very shallow. It involved speaking with all the children in the home, with the staff in the home, and with the care worker himself.

There was no formal report from Highland Shores on the investigation, and we just saw some scattered notes. Ultimately, the investigator

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did not verify that physical force had been used against a child, and did not verify that sexual abuse had occurred. However, Highland Shores did confirm the care worker's alcohol consumption was a problem, and there was risk of emotional harm to the children in his care.

The investigator confirmed that the care worker did drink on the job, with one report that he drank up to 12 drinks a day, which he denied. He defended himself by reporting that he had a high alcohol tolerance.

In one instance, it was reported that the care worker had six drinks while not on shift, returned to the home, relieved other staff, and proceeded to have two more drinks in the home. He told the investigator that he did not perceive that he was impaired.

On another occasion, he drank eight drinks while supervising children, while the investigation into his conduct was ongoing, despite his agreement not to consume alcohol on the premises.

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The alcohol consumption alone should have raised major concerns from Quinte, Highland Shores, and CSSD, yet Highland Shores reported no issue with the care worker returning to regular duties and resuming the primary caregiving role for Kirby. We think that there are some major failures that are apparent from these examples and this investigation.

The first being that communication between CSSD, Quinte and Highland Shores was very uncoordinated and insufficient. It doesn't appear that CSSD had the full investigation records from Highland Shores and Quinte. They seem to have only gotten verbal updates. There was a number of relevant documents that were produced by Quinte through this Inquiry's requests that CSSD did not have in the records.

The second is that the review of the Highland Shores investigation was inadequate. It seems that the investigation into the physical and sexual abuse allegations was dismissed at an early stage with very little probing. And even

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though the alcohol use was found to be a risk of harm, there was no meaningful disciplinary actions taken or any changes made to policy.

From CSSD's records, it appears that CSSD accepted the Highland Shores investigation at face value without examining the full investigative record and without doing their own investigation.

They didn't take issue with Quinte's policy that allowed alcohol consumption in the home, despite there being vulnerable children in the home. And they allowed the care worker to return to his regular duties on the basis that, and I quote, he had strengths and there were positives.

The third point is that disclosure to the family was not done in a thorough or timely manner. CSSD informed Sebastien one month after they had become aware of the investigation. They also didn't give much detail to Sebastien and Mary Theresa. The grandparents don't recall any lengthy discussion of the nature and particulars

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of these issues.

Fourth, it was apparent that the ongoing risks were simply being tolerated. There was no meaningful disciplinary action against the care worker. There were no change in policies, no probation or monitoring plan, and no contemplation of transferring Kirby to a different home.

This reveals a problematic level of risk that was, we would argue, normalized and accepted within the child protection network of agencies. As Mr. Richard and Ms. Petti observed, this level of risk tolerance was likely shaped by placement scarcity and the perceived absence of any viable alternatives for Kirby.

In the family's view, the result was a real failure to treat the incidents with the seriousness that was required to protect him.

My next point is about cultural harm as a clinical risk factor. This is another broader

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failure in the system that seemed to be persistent in the treatment of culture as a secondary concern rather than a core determinant of health and safety. It was acknowledged that Kirby's -- in Kirby's circle hearings that the department traded cultural safety for perceived physical safety, and that was certainly detrimental in Kirby's case.

While in care, Kirby did regularly speak to his family on the phone, and Sebastien and Mary Theresa were able to visit Ontario once for Christmas. But the distance was still far, and Kirby went long periods of time without physically seeing his family.

There was little in the way of Innu culture, cultural education, or exposure. Those just simply didn't exist in Ontario. Kirby certainly felt disconnected while he was in care. His family sent him an iPod with Innu music on it, and Kirby really cherished that iPod. However, there weren't any further efforts to ensure that Kirby had access -- continuing access to Innu

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music.

Kirby also didn't have access to Innu language and education support. Sebastien notes that when Kirby returned home in 2015, he seemed to have lost his language. He would have trouble understanding what Sebastien would say to him in Innu, which had never happened before.

Kirby simultaneously struggled with English and had issues understanding those around him. He became disengaged and didn't interact much with other children or caregivers. It was noted in multiple records that Kirby was at risk of losing language skills without support, and there was an urgent need for translation in his case. And these warnings were generally overlooked.

Kirby's family also emphasizes the importance of time spent on the land. During his time in care, there was no efforts to make sure that Kirby could attend the gathering or cultural trips in the country with his family.

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Sebastien spoke in the circle hearings about the importance and healing power of being out in the country. And I just want to quote the translation of what Sebastien had said, because it means so much to the family.

So the quote is, Sebastien said one time, they took the kids to nutshimit, out in the bush. He worked with Innu Nation, and they took the kids on the land. There was 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 the kids and his grandkids, the ones that were sniffing gas, and they took them to Kamestatin Lake. And he said, there were boys and girls.

He said, when we got there, they took the motorboat -- they took off in the motorboat, and they were gone. And when they came back, they had caribou, and they were hunting. They never sniffed gas out there while they were there. They were so busy doing hunting. They were there for three weeks, and they'd always -- when they

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were doing hunting, they got a lot of partridges, and they got caribou.

Sebastien is firm in his belief that maintaining regular trips to the country would have helped Kirby. The Innu traditions and culture that raised generations of Innu should have been factored into his care plan, for Kirby and for all other Innu children in care.

My next point is about the lack of communication and the disempowerment of Innu families.

Kenn and Tara have already spoken at length about the problems and the communication and the disempowerment of Innu families as a result. And I just want to highlight some examples from Kirby's case that illustrate the extent and the prevalence of these failures.

In one example, Kirby had been prescribed antipsychotic medications, specifically one called Abilify, and then later he was prescribed Haldol.

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CSSD had gone to speak with Sebastien to get him to sign consent forms to allow the administration of those medications. And Sebastien remembers that he did not understand what he was being asked to sign, but he felt pressured to sign out of concern for Kirby. He didn't know that Kirby was experiencing psychosis at the time, nor did he recall any explanation of the risks or side effects of those medications. He constantly worried and he felt guilt that he had made a mistake in consenting.

Mary Georgette also shared her concerns at the Healing Circle. She told the circle that she never felt good about the medications, and she felt that Kirby lost himself after taking them. She shared that CSSD never told her about the medications and never told her how he was doing.

One of the clearest and most serious examples of communication failure arose when Kirby repeatedly went AWOL or ran away from the Quinte Lake Court home. Over the course of a year, Kirby had at least eight to nine documented AWOL incidents and

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attempts spanning the time frame of a few months from February to June 2014.

Ontario police were involved in at least three of those AWOL incidents. In one incident, Kirby was found walking down Highway 401 in Ontario, which is a busy and dangerous highway. In another incident, he was found running alongside a fast-flowing river.

These were significant safety incidents that should have been reported to the family immediately. They were fairly frequent and had become a bigger problem, and the family was notified weeks after the incidents had happened without any details as to the seriousness of what happened.

My next point is the transitional cliff in services, and this is perhaps one of the most significant failures in Kirby's case, as there was a near total withdrawal of support and services following his discharge from care at the age of 16.

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Services just suddenly dropped off, and Kirby's family was left to manage on their own. They had minimal assistance from counsellors and social workers, and they often had to call police to help them with Kirby's behaviours.

Throughout Kirby's time in care, it was unanimously recognized by caregivers, medical professionals and social workers that Kirby required a high level of supervision and support.

There were some efforts to have Kirby admitted to the youth treatment centre in Paradise, but he was ultimately denied because the programme was unable to manage his special needs and his cognitive impairments.

It's also interesting to note that Dr. Voysey, who was Kirby's supervising psychiatrist at Quinte, was not actually aware that Kirby had been discharged at the time he had left. Dr. Voysey had written up a follow-up report after Kirby had been discharged, and the report made no mention of a plan to transition Kirby out

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of care. Dr. Voysey's evidence was that he was not informed that Kirby was returning home, so there was no care plan in place from Kirby's supervising psychiatrist.

The last point I will make is that there was a real structural silence after Kirby's death. The family emphasizes that the child protection system continued to fail their family, even after he died.

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. So for years, and 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 believe the system can and should do better in that regard.

I have just a few concluding remarks on behalf of the family. We've just gone through a number of ways in which the child protection authorities

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failed Kirby and his family. These points were raised in conjunction with the conclusions from Kenn and Tara.

And what is important for the family to say is that 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 and supports the calls for Innu self-determination in child protection services, specifically an Innu-governed child protection authority rooted in Innu values, language, community, and connection to the land.

This means prevention and family preservation before apprehension. It means culturally informed treatment. It means families kept fully informed and involved in their child's life, and real accountability to the community. Not just a distant bureaucracy who can overlook children who are placed out of province.

Kirby's story is undoubtedly a tragedy, but the family believes his story can be used for

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positive change. They want that change to be led by Innu people, resourced by the province, and built to keep Innu children safe at home.

Those are our submissions, and if there are no further questions -- if there are further questions, I'm happy to answer them.

COMMISSIONER IGLOLIORTE:

Well, I'm good. I'm good. No questions for me. Thank you very much, Adrienne.

COMMISSIONER DEVINE:

Thank you, Adrienne.

COMMISSIONER QUPEE:

Thank you, Adrienne.

BRIAN HARVEY:

Thank you.

KELSIE LOCKYER:

Thank you very much, Adrienne. So our initial schedule would have had you go until 10:00. So we'll just take a quick 10-minute break there now before we invite Scott Lynch to do his submissions.

COMMISSIONER IGLOLIORTE:

Thank you. Coffee time.

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(Off the Record)

KELSIE LOCKYER:

All right. Welcome back, everybody. We'll return now from our break, and we will begin. We'll invite Scott Lynch to give his submissions on behalf of the Poker family.

I will just note, everybody is allotted an hour to give their submissions. So I do have a little stopwatch running, and I'll give a 10-minute warning if we get there. The 10-minute warning wasn't needed for Adrienne because she was quite efficient with her submissions. So just in the event that you do go to the 50-minute mark, I'll let you know that you have 10 minutes left.

All right. So you can begin whenever you're ready.

SUBMISSIONS OF MR. SCOTT LYNCH (JAMES POKER)

MR. LYNCH:

Hi, everyone. My name is Scott Lynch. I'm

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making submissions on behalf of Thomas Poker regarding the investigation into the death of his son, James Poker.

James was born May 30th, 1997, to Thomas Poker and Suzanne Rich Poker. At age 2, James was adopted by his aunt and her husband. At age 10, James entered into the care of the Child Protection Services, where he remained until he aged out at 16.

James's early life saw him living with his own family. He was immersed in his own culture, and he was one part of a greater whole of a community. He was known to be a very charming and likable child.

In their report on James, the investigators for this Inquiry, Tara Petti and Kenn Richard, expressed that James belonged to a collective, a large extended family, rooted in Innu values and kinship.

I found that the investigators' phrasing of James

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being rooted in Innu values was very appropriate, because these aspects of someone's life, their family, their community, their culture, those are the roots that should provide a child such as James with the right conditions to be nourished, to grow, and to thrive.

These bonds of family and community, they empower people who share in them and who benefit from them. It means that you are connected to something bigger than yourself, and you are made stronger by this common sense of identity.

And I think that there is no greater testament to the importance and necessity of these roots and these bonds than the pain that is felt when these relationships get broken apart, and the harm that occurs in their absence.

James' experiences in care provide a very tragic illustration of that notion. James was someone who was faced with considerable challenges during his childhood and during his adolescence, and he needed and deserved support and protection.

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In these submissions, I'm going to go over the ways in which the Child Protection System and its treatment of James failed him and failed his family. In particular, I'm going to discuss the failure of child protective services to proactively identify issues that James was facing prior to entering care, the decision to transplant James to out-of-province placements where he had little to no roots, and finally, the significant lack of attention and foresight which characterized James' time in care as well as his transition out of care.

The first point I'd like to address is that child services, CSSD, had contact with James several times during his childhood and prior to him entering care. During these interactions, James demonstrated behaviours which ought to have prompted further investigation, or at least ought to have inspired greater concern than they apparently did. For example, on several occasions, James was found unsupervised in his community, sometimes late at night, and stated that he was afraid to return to his home where he

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lived with his adoptive parents.

In 2007, child services was made aware of an incident in which James was behaving in a threatening and sexual way towards three younger boys, and the RCMP interviewed James about this as well.

Shortly after the incident with the three boys, the RCMP found James again wandering within his community, unsupervised, and again stating that he did not want to return to his home and that he needed a place to sleep.

Years later, it was reported that James had suffered sexual abuse in the home of his adoptive parents. However, none of the incidents I've just recounted of James expressing fear of returning home, of him acting in a sexual and threatening manner towards other boys, of his pattern of walking around unsupervised at all hours, none of those prompted an appropriately thorough investigation from child services to ascertain what was actually occurring, or to

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inquire as to why a young boy might be fearful of returning to his own home.

Rather, these patterns were seen as issues with supervision, and the root cause underlying the behaviour remained undiscovered and unaddressed. This failure of child services to effectively assess and respond to the reality of what James was going through was a missed opportunity for intervention at a crucial young stage in James's life.

By the time it was known that James had been suffering sexual abuse as a child, he was already struggling, quite considerably, with both substance abuse and mental health issues. And so we can only speculate about what better outcomes he may have enjoyed with more proactive and diligent attention from CSSD during his childhood.

The next point I'd like to address is the impact of James being put into out-of-province placements from age 10 to 16. He first attended

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Broken Arrow Residential Treatment Centre in North Bay, Ontario, which Ms. Ding noted in her submissions was a private for-profit centre where James remained for almost four years.

This placement was chosen at least in part because James himself wanted to be with his older brothers who were in care at the same place. And it was partly chosen due to the fact that there were simply few options available. However, James's brothers left care as soon as they were able to, and James soon found himself considerably isolated from his family. His contact consisted of phone calls with his father, limited phone calls with his mother, and visits to family around once a year.

James's father, Thomas, initially believed that Broken Arrow was a treatment facility, and upon visiting realized it was more akin to a typical foster home.

Furthermore, Broken Arrow had no connection to Innu culture in any way, despite its name

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implying a connection to Indigenous communities. None of its programs were rooted in the Innu worldview or traditions. At Broken Arrow, James was truly displaced from many of the things that, until that point, had defined who he was on a fundamental level.

For the final 16 months of his time in care, James was at Ranch Ehrlo Treatment Centre for Mental Health and Addictions in Saskatchewan, where he was sent after reporting that he was experiencing audio and visual hallucinations.

James did not visit family while he lived at Ranch Ehrlo, nor did he receive visits, with his only connection to family members consisting of phone calls.

There was no indication in any of the records produced for this Inquiry that James ever formed a meaningful or lasting bond with any of the caregivers or professionals during his time in care. He was reported to have run away or gone AWOL from the centre on many occasions, dozens of

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times, sometimes being returned by the police.

Again, this failure to initially provide the necessary level of support to James during his childhood enabled the pattern of James running away and trying to escape to persist into his adolescence.

These centres were treating James' mental health issues and substance abuse in a reactive manner, responding to immediate crises. However, James was at this point almost entirely severed from his home and from any sense of belonging. The service providers at Broken Arrow and Ranch Ehrlo were incapable of appreciating or remedying the growing loss of identity, which was worsening James's many afflictions.

It was noted by our investigators, Ms. Petti and Mr. Richard, in the report of James, that rather than funneling what scarce resources that were available towards these out-of-province placements for James, those funds could have been more effectively allocated towards supports for

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James earlier in his life. And we echo that sentiment in these submissions.

Finally, I'd like to address the lack of attention and lack of foresight, which characterized James' time in care as well as his transition out of care. This primarily took the form of service providers failing to properly communicate with James's family during his time in care, as well as failing to demonstrate an appropriate level of concern for James's well-being as he transitioned out of care.

While James was at Broken Arrow and Ranch Ehrlo, reports to child protection workers were incomplete and often misleading. For example, James's father, Thomas, was not informed that James displayed a frequent pattern of running away, sometimes for days at a time. On the contrary, the reports received by Thomas depicted James as thriving and happy, which we submit is a dangerous misrepresentation of reality, which did not permit James's father and James's family the ability to fully understand the extent of his

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problems.

Despite James having a documented history of mental health issues and corresponding prescriptions for antipsychotics, there's no documented communication between Ranch Ehrlo and James's father or with anyone else in James's family. In fact, James' father was only made aware that James had permanently left care at Ranch Ehrlo and returned to Natuashish when he saw James walking on the road in the community.

James's father only learned that James was meant to take prescription medications to treat psychosis and depression when he discovered pills among James's belongings after his death.

The failure to communicate these details to James's father and to others weakened their ability to help James and to respond to his needs from then on. It points to a systemic lack of diligence and a short-sightedness that devalued James's worth and jeopardized his safety. Keeping James's family members apprised of any

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worrying behaviour and mental health issues in an open and transparent way would have better laid the groundwork to strive for a more sustainable and long-term support for James after leaving care.

In March of 2013, a psychiatrist at Ranch Ehrlo suggested that James continue taking medication and follow up with a psychiatrist in six months' time. As James was leaving care before that point, a referral for James to see a psychiatrist back in Labrador should have been arranged. No such referral is reflected in the documents, and this exemplifies the kind of incomplete and short-term level of care administered to James, treating very serious mental health issues without a mind to how James was meant to continue as an adult and be stable as an adult past his time in care.

James left care once he reached an age that he was able to do so. It was not because he no longer required treatment for his mental health issues. And furthermore, he was at that time a

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very lonely and emotionally adrift 16-year-old who was making these very consequential decisions about whether to continue his care without the necessary input from any family or loved ones.

Once back in Natuashish, James continued to experience hallucinations. He suffered from suicidal ideation. He was taking his medication irregularly and attending counselling sporadically.

After receiving regular treatment for mental health and substance abuse until age 16, James was then cast back into the world, still suffering, yet lacking the much-needed supports. By this time of his return home, the social and cultural disconnect had deepened and had changed him. He no longer had the benefit of treatment, yet he had also grown somewhat estranged from his community, his culture, and his roots.

James had not learned to navigate the environment as he would have had he remained in his home community. And he was quoted as saying to his

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father that he did not know anything of the country.

Despite this, there were no provisions made to ease his transition back to his home environment and community. There are no records of any discussions between the centres and James's family regarding the potential risks of James leaving care, nor any discussions about what would be required to sustain a level of security or well-being for James going forward in light of his mental health struggles.

These oversights and general lack of communication about crucial aspects of James's care point to a larger systemic indifference towards James's future. This sense of indifference characterized the somewhat superficial and reactive and crisis-oriented treatment received by James during his time in care, as well as the system's failure to contemplate a long-term future for James beyond his time in care.

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By February of 2015, James was suffering from untreated mental illness, was residing in a shelter in Natuashish. He left the shelter on February 10th, and he was found deceased on the ice of the Labrador sea on February 25th, 2015.

The central point of these submissions is as follows:

The child protection system must provide care to any children as a supplement to their family and community bonds, rather than supplanting, replacing, and erasing them.

In the case of someone like James, such an approach would require both properly diagnosing issues while the child is still living within that family support system, as well as preserving these social and interpersonal relationships as services are being administered.

It is submitted that the care needs to be provided in such a way that preserves the relationships that support a sense of identity,

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with a priority placed on the significance of the bonds between family members, and a recognition of how cultural values and customs uphold a person's well-being.

A significant factor is the timing of services and to what end resources are deployed. In James's case, in particular, child welfare services ought to have been provided earlier in his childhood, at a time when he still resided within his own community.

More robust services during this time may have eliminated the need to then later allocate resources for out-of-province placements, placements which saw James spending the majority of his adolescence outside of his community, disconnected from his identity, and contending with a system that was not equipped to care for him on a deeper level.

If child services are to be of any true help to any children in their care, the connection to family and community context must occupy a

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primary role in its approach, and transparency between service providers and families must be strongly prioritized.

I'd like to conclude my submissions by quoting the words of Thomas Poker, James's father, who said as follows: None of this would have happened if James had remained with his family and community. I wish he had never been taken away from his culture, traditional values, and way of life. When the child welfare system apprehended him, they should have found him local housing and worked with our family and community members instead of sending him elsewhere. The system failed James. After long periods away, he returned to Natuashish at age 16, lost, unprepared, and unable to fit back into the community.

He was robbed of his language and family bonds. My hope is that things will be different for families in Natuashish and Sheshatshiu in the future. I want the system to work with families and community members to keep them together and

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offer the support needed to reunite them rather than tearing them apart.

It is essential that the governments of Newfoundland and Labrador and Canada change legislation, policies, and regulation to align with the Innu way of life in both communities. Such changes are necessary to ensure that colonial practices are no longer perpetuated in this province.

That concludes my submissions.

KELSIE LOCKYER:

Thank you very much, Scott. I'll now turn it over to the Commissioners for any questions they might have for you.

COMMISSIONER IGLOLIORTE:

Thank you very much for your presentation. Given the submission that we've just heard with respect to the father's desire for a new system of child protection, do you believe that it can be done within the present framework of legislation by the province, or do you believe that it requires a fundamental shift from what has been the

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situation in the past?
MR. LYNCH:
I think that it would require a fundamental shift. The extent of the failures of the current system are an indictment of its -- of its capabilities and lay bare the limits of what can be achieved.

And so I think to remain within the current system would be to leave the lives of children and youth at hazard as we've seen bear out with tragic consequences. And so I think that to work with Innu communities and families would require a more fundamental shift and would not be responsible to remain within the current system that has been allowed to fail so egregiously.
COMMISSIONER IGLOLIORTE:
Thank you very much. That's all my questions.
COMMISSIONER DEVINE:
No questions from me. Thank you very much, sir.
KELSIE LOCKYER:
Excellent (phonetic).
COMMISSIONER QUPEE:
Thank you.

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KELSIE LOCKYER:
Thank you very much, Scott. You are now free to go or remain on the call to listen to the rest if you would like.

To other counsel on the call, the next thing within our schedule was meant to be Dr. Fallon and Dr. Black at 11:00 to 11.30. It's my understanding that Dr. Fallon and Dr. Black wouldn't be able to go any earlier. This is the only time that would fit into their scheduling.

With that said, though, we do have 45 more minutes until that. So if there's any counsel on the call right now who would like to go -- to jump ahead of their turn and are available to do so, we can do that just with the understanding that we will have to switch to Dr. Fallon and Dr. Black at promptly 11 o'clock.

Barring any counsel, you know, wanting to do their submissions now, I think we would just have a break until that time.

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COMMISSIONER IGLOLIORTE:
So go one by one with the next person. Ask them specifically who's next.
KELSIE LOCKYER:
All right. So the next person would be Robby Ash on for the family of Faith Rich.

So Robby, if you were available and ready to go now, we absolutely can. Absolutely no worries if not. We can go with yours on scheduled time at 11:30 after Dr. Fallon and Black, if you're wanting to use the full time or, you know, would like to go without being interrupted.

Now, I will say if we do go now, you will have 15 minutes to conclude after Fallon and Black. It's just that is a very strict time for them.
ROBBY ASH:
Thank you. I would -- I'd prefer to use my time slot. I have to get my client connected. And also, I'd rather not break things up for her, if that's -- if that's okay.
KELSIE LOCKYER:
Yes, absolutely. That's understood.

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I believe, I'm not sure if -- I think Will had some matters in court this morning, so I'm not sure if he's on the call quite yet. Will would be the next person to go and his would either be for the family of Jacob Collins or for the family of Wally Rich.
COMMISSIONER DEVINE:
So it sounds like we should break.
COMMISSIONER QUPEE:
Yeah.
KELSIE LOCKYER:
As well, the final submissions were to be from James Maher for the family of Thunder Tshakapesh. So if -- James, if you would like to go now, you absolutely can. Again, it's entirely understood if you would rather take the time that you had scheduled.

So not hearing any response there, I'll say that now that we'll break and we'll have about a half hour break. We'll come back for promptly 10 o'clock -- or 11 o'clock Newfoundland time when Drs. Fallon and Dr. Black will be available for

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questions by Commissioners.

COMMISSIONER IGLOLIORTE:

Thank you.

(Off the Record)

KELSIE LOCKYER:

Welcome back, everybody. I hope you enjoyed your extended health break. And I will say that that is to make up for the lack of breaks yesterday.

So we are now ready to proceed with the questions from the Commissioners for Drs. Fallon and Black. So we will begin with questions from Commissioner Devine.

QUESTIONS FROM THE COMMISSIONERS FOR DR. BARBARA FALLON AND DR. TARA BLACK

COMMISSIONER DEVINE:

Okay. I'm looking this way at you, but you're seeing me. I'm not looking at you. So I'll have to. I'll look at you. You can look at my side.

Anyway, good morning, Drs. Fallon and Black. It

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was great to hear your presentation, read your report. I did with great interest. There was a few questions that I did have, and they got answered along the way, or I was figuring it out as it was going on.

The -- just a few things. First, a few comments, I guess. Because I think the report has really given us some good information. You know, it's really unfortunate that it's such a short time frame. And I have to say I'm disappointed that there was, you know, such a short time frame that was available to you.

But we work with what we have. And some of the report -- some of the findings that you have were very interesting because, you know, there was a number of questions about, well, what could account for that? And from my perspective, that's part of what the Inquiry takes from there. When you look at the higher rates, then we need to, or we need to direct some people to actually find out what's happening there, what's accounting for that, and try to remedy the

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situation so that it gets better and doesn't happen again.

It's really interesting what you talked about, the whole sensitivity versus specificity, and I'll get back to that in a minute. But, you know, part of the higher rates, for example, I made a few notes at the beginning of, you know, what might account for it. I mean, it's a whole -- and some of it has -- a lot of it has been talked about, I think, but it's that whole colonialism part of it that is still there. That's not something that's past. The Innu are still living that today, the colonial legacy, if you like.

And I don't like using the word "legacy" because it kind of almost suggests that it's past, but I just want to be clear that it's very much present. Certainly, trauma, I think, is a very large part of that, and intergenerational trauma that continues. And we've seen that, we've heard that, and certainly the Innu have talked about it.

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Prevention services are -- you know, started in 2017. And so we can, I think, account for part of that, that the -- those services are in place and developing, as well as in the community.

The other thing is the fly-in/fly-out model, and that's a whole, I think, separate part in itself. And we certainly have been looking and that -- at that and will continue to.

The other thing, like, for example, is the shortage of social workers. There's a shortage in the province, but a larger shortage, of course, in Labrador, and that's a big problem. I'm not sure what the answer is to that one. Language, culture.

And just going back to the social workers also, many of the social workers who go to Labrador, and there's a long history of it, are inexperienced. So you know, I've always maintained that, you know, social workers really shouldn't -- new -- newly graduated social workers really shouldn't go into child welfare

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until they've had about five years' experience.

The reality, certainly in this province, is that new social workers, more often than not, go into child welfare. And when you add going to child welfare in Labrador, it's an even bigger challenge for the social workers.

So I just want to kind of mention those things. I think I've covered that. The -- I guess to the -- I'm finally getting to the question.

One of the things that I was wondering about, and I have a copy of the departmental manual here on structured decision-making system that they have, and you know, it's fairly big. There's a lot of pieces to it. And I wanted to ask you, if you're familiar with it, do you have any thoughts about how that system and that model that's been used, when you talk about sensitivity and specificity, like the -- do you have any comments about how that model might work for social workers in practice in doing assessments, risk assessments, safety plans, and that sort of thing?

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I know it's a broader question, but can you begin to tackle that? Are you familiar with it?

DR. FALLON:

So thank you so much for having us. And as Tara and I both talked to one another about how privileged and honoured we are to work and to contribute in any small way to the Commission. So thank you very much for having us.

So as you know, it does go beyond what we submitted to the Commission. So structured decision-making in child welfare, certainly it's a controversial topic in the child welfare literature and the child maltreatment literature.

The -- it depends, of course, on the transportability of structured decision-making into environments and whether or not there have been psychometric properties or reliability and validity data compiled when a jurisdiction decided to adopt them. Because sometimes the construct of risk is very difficult to translate into the environment that your -- that the instrument is being used for.

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One of the -- one of the comments that we made in general about child protection systems is that the definition of what falls under a mandate or what is considered to be child maltreatment has become very amorphous. Where the risk of, as opposed to an event of, is being investigated by child protection systems more and more often in Canada. And that's where, if you haven't been able to establish the veracity of the structured decision-making kind of suite of instruments in the environment you're using them in, then potentially you're going to return some outcomes that aren't optimal for the communities you're working with.

In theory, what the tool should do is to help with the sensitivity and specificity issue. So it should aid the social worker with making a determination about essentially when a situation warrants an investigation and when it doesn't. So that's one of the things you may want to monitor as you continue on with this very important work about the sensitivity and specificity.

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I think we'll give over the code to whoever would like it and to ensure that that calibration, that tension between the two is monitored as you have more and more data using the structured decision-making approach.

COMMISSIONER DEVINE:

Okay. Thank you. Because that's the -- I guess, the other part that you talk about is the sensitivity and specificity. And it's a real, I guess, balance trying to have people high (phonetic) and implications of not are not insignificant. So if you miss a case that actually is maltreated -- treatment, or if you're interfering with people's lives, particularly in a community where there's a lot of trauma and history.

DR. FALLON:

Exactly. And that analytic tool really reflects the broader tension in child welfare services where the challenges, of course, the over inclusion and under inclusion. We would never want to miss a child that needs protection, and we would never want to include a family in an investigation where it wasn't warranted. So that

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is really the tension in child welfare and where to calibrate the intervention and the interaction with the child welfare system.

COMMISSIONER DEVINE:

That's basically what I -- the only question that I had. But once again, thank you. It's a very important document for the Inquiry to have. And certainly, as I said at the beginning, going forward to ensure that there's follow-up on some of the variables that might account for what's happening there and how to ameliorate that. So thank you both.

DR. FALLON:

Yeah. Yes. Well, Tara, I don't know whether you have anything to add to what I said. But just again, thank you for -- we really feel very honoured that, you know, anything that we do can be helpful in part to this very important work.

COMMISSIONER DEVINE:

Thank you.

COMMISSIONER IGLOLIORTE:

Thank you, Michael. Nastash?

COMMISSIONER QUPEE:

I'd like to echo what Commissioner Devine said

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about like, this is important information. And it brings me back to when -- during our hearings, when an Elder spoke and we did this timeline of the communities, both communities. And she said that when our people were settled in the communities, there's a lot of chaos, there's a lot of drinking, and it was a -- high numbers of people in the community that drink.

And then when we went to the timeline and going over the years of how the community developed and what happened to the families, it really brought discussions of people looking at, okay, this is what happened in our communities. And this is what happened with governments. And this is what the government was doing was so that we couldn't plan or prepare when we were in the communities. It was all just about from getting by to another day.

And that struck me when I was looking at the report, and how people didn't get a chance to even take a breath and see where they were at, and what was happening, and what needed -- what

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needed to happen in order for them to talk about -- to talk about what healthiness looked like, what well-being looked like for the families. I think about that, and this is really good work in terms of like, you work -- you work with what you had.

And I think that both communities need to -- and I think that -- I believe that they are starting to really look at data management and the demographics of our communities, because we do have a high number of birth rates in our communities.

And in saying that, and that's why it's important to use these tools and bring back to the communities and talk to them about it. That's how you generate those discussions and listen to people in our language, talk and generate those discussions in Innu.

And I guess kind of the analogy that I would use in terms of that is that you give people the flashlight in the dark, and the flashlight isn't

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going to make that decision for you. It's going to give you a path. And whatever path you choose is the things that you need to use in order to bring that light. And I think that it is important work.

So I really want to thank you for your presentation yesterday, and I thought about it last night. So for me, that'll be my guide as well. So I appreciate the work that you guys, both of you have done.

And I say in my language, thank you. Tshinashkumitin.

DR. FALLON:

Thank you. It's such an honour.

COMMISSIONER IGLOLIORTE:

And I think you probably have my question. Thank you, Nastash.

But basically, I'm saying thank you very much for your quantitative data. We all realize and know, over -- learning over the past few years that the federal government, particularly for them, data

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is really a validity for programs and policies that they -- that they hand out to communities like this.

I really like your optimism when you say from a quantitative perspective that these numbers support Innu self-determination.

So my question is, moving to the qualitative side, when you see results and conclusions like you have, from a qualitative perspective, what does an Indigenous community and their efforts look like versus the quantitative side you've told us about? Not because you may have spent a lot of time in Innu communities, but maybe other Indigenous communities doing similar kind of work.

DR. FALLON:

So I guess I would say we can't answer that question. It's not up to us really to say what it does look like. Other than, you know, our very clear data limitation section, where we say these data represent service trajectories, it really doesn't represent the experience of an

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Innu family or child in child welfare.

And that's really where I think that our, you know, report really points to the necessity of understanding these data within those very important data and really prescient and primary data, which are the experience of Innu families and children, not only within the child welfare system, but in all structures that continue the legacy of colonialism.

The only recommendation we would have is that, you know, the Commission does exactly that and is exactly -- you're doing that, you know.

The quantitative data, as was so eloquently said, it has -- it shines a light on one piece of it, but not on the whole picture. That would be our only recommendation. I am not a qualitative researcher.

I don't know, Tara, whether you have anything to add or not.

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COMMISSIONER IGLOLIORTE:

No? Well, thank you very much. We are encouraged by your findings and we're encouraged by your direction that the Innu are working towards self-determination in child protection, child welfare. And that's really, I think, the type of recommendation that we want to be part of. Thank you so much.

Go ahead.

DR. FALLON:

I was just going to say, I think that the -- you know, the definition, the well-being and child protection, we measure the deficits and the well-being part of what could be child welfare is really the opportunity for nations to really, you know, tell us what that is and what that looks like and how children and families can thrive, right?

So you know, in provincial and territorial systems, we talk about protection, but in every act, it's the well-being part that we're really silent about. And that's where First Nations,

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Métis and Innu communities, I think mainstream agencies have so much to learn from the way they understand children as the centre of their communities. So that's all.

KELSIE LOCKYER:

Okay. Thank you very much. Thank you to Dr. Fallon and Dr. Black for your time today, and all the time and work that you've put into the report and presenting it to us. It was very, very helpful and I'm sure it will be used going forward. So thank you both very much.

I understand you both were available until 11:30, but you're good to go there now. So we will take a quick 10-minute break there now before we resume with Robby Ash's submissions on behalf of the family of Faith Rich.

DR. FALLON:

Thank you again. Bye-bye.

COMMISSIONER IGLOLIORTE:

Thank you.

(Off the Record)

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KELSIE LOCKYER:
All right. Welcome back, everybody. We will now invite Robby Ash to give his submissions on behalf of the family of Faith Rich. If...

Robby, are you good to go there?

ROBBY ASH:
Yes. Can everybody hear me?

KELSIE LOCKYER:
Yes. Thank you.

SUBMISSIONS OF MR. ROBBY ASH (FAITH RICH)

ROBBY ASH:
Perfect. Thank you.
Good morning, everyone. My name is Robby Ash. I represent the family of Faith Rich. And so we present these submissions today. We thank you for this opportunity. We present these submissions today, I guess, in honour of Faith, but also today we're thinking about her father, Steve Rich, who passed away in December. Steve was very instrumental in bringing Faith's case to the forefront, and we feel that should be

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recognized today.

We'd also like to acknowledge the work of the investigators in this case. Very difficult work, but a very thorough job, and the Rich family very much appreciates the efforts of the investigators in this case. And also the Commissioners.

The work done by the Commissioners in this case is really something which the family very much appreciates, having such uniquely qualified Commissioners to preside over these proceedings.

So after considering all the evidence, all of the information that's been gathered, and all the information that was shared at the circle, at Faith's circle, the family of Faith is -- see that is -- this case, and also the other cases that have been before the Commission, is not one about isolated errors. This is about systemic disempowerment, and the predictable harm that follows that disempowerment.

Now, Faith's case is a little bit unique, in the

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sense that we not only have an opportunity to review Faith's experiences with the child protection system as a child, but Faith also had some documented experiences with the child protection system as a parent. And this is something that the Commission ought to consider, and it's an opportunity to provide some insight into how the interactions between the child protection system and the families and the parents of those children that are involved in the system, how that can affect the outcomes of the children that are in the system, and also the parents who are ultimately charged with caring for the children once they are out of the care of the child protection system.

So here's a roadmap for where -- what I'm going to talk about today. First, I'm going to give a bit of a brief overview of Faith's involvement with the child protection system. Then I'm going to secondly discuss what we feel is the central theme here in this case, and that is disempowerment.

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It is something that was touched on by Ms. Ding in her submissions as well, and I think that you'll see that theme coming through each of the investigations in this case.

Next, we'll discuss the consequences -- or sorry, next we'll discuss how that theme manifests in the evidence that the Inquiry has heard, and then the consequences.

Lastly, and this was in my written submissions, I'm not sure if you had an opportunity to review all of them yet. But lastly, we will be proposing a very focused, practical recommendation for the Inquiry to consider when putting together its final report.

Again, I'm not sure if it's our place to be doing that at this stage, but from the perspective of Faith's family, the whole reason why they wanted to bring this matter forward and participate in this Inquiry was to ensure that these sorts of things and these experiences are not had by any other families, Innu families in the future.

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And so part of that will be suggesting maybe some solutions.

Now, I want to turn briefly to just a brief chronology of Faith's life, her interaction with the child protection system. I'm not going to revisit every fact. I'm not going to recite everything that was mentioned in the investigation report. You have those to refer to. But what I want to demonstrate is that there's a consistent pattern that emerges from the facts, and indeed, you'll see that pattern emerge, I suspect, in other cases.

After hearing the submissions of my friends, I think you'll see this pattern arise. And you see it particularly arise when those facts are viewed through the lens of disempowerment and communication failures.

From the beginning, Faith's life was marked by instability. Within weeks of her birth, I believe it was 20 days, she was moved out of her mother's care and placed with some extended

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family. And what followed from there was a series of rapid informal placements. Many of these placements were unvetted by the child protection system, and many of them were unsupported by the child protection system.

At this early stage, the system relied heavily on the family, but it did so without bringing them into the process as partners. And that's a key theme that you'll see throughout all of what happened to Faith and, I suspect, the other families.

These families that cared for Faith were expected to provide care, but they were not given authority. They were not given structure, and they were not given support. Communication with the caregivers was fragmented, and there is little evidence of clear explanations, coordinated planning, or continuity between the placements.

And so the pattern begins here, that there was responsibility placed on the family without the

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power or the information to carry out that responsibility.

In Faith's early childhood, that pattern, it seemed to intensify, if I'm -- you know, as I read through the investigation report, you can see this. She was placed with caregivers despite some known concerns that were highlighted, such as overcrowding, alcohol use, instability. And when these issues arose, including when there were disclosures of harm, responses from the child protection system were delayed or they were incomplete, not followed up on.

And again, family members were used as caregivers for Faith in her early childhood, but they were not engaged, again, as decision makers. They were not meaningfully informed, and they were not supported, again.

And so this is -- this is disempowerment in practice. This is what it looks like. The system depends on the family, but does not equip them.

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As she moved through her childhood, by the time she was a young child, Faith's instability became the norm. She moved repeatedly between homes. There were ongoing reports of neglect, hunger, poor hygiene, lack of supervision. These things were highlighted in the investigation report.

And importantly, at this stage, when Faith was sort of starting to come into her own to be able to speak for herself, she herself, it's documented, expressed a desire to leave certain placements. Yet there was no evidence that her voice altered the course of any of the decisions that were made in a meaningful way.

Communication across the system was fragmented and episodic. Concerns were raised, but not integrated into any sort of plan. The result was not necessarily a lack of information, but it was a failure to act on that information in any type of coordinated way.

As she moved into, I guess what I'll call the pre-adolescent years of her life, the risks for

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her began to escalate. There were reports of solvent abuse, lack of supervision, and sometimes that her whereabouts were unknown. Yet it seems as though, based on the record that we have, at precisely this stage, the system appeared to withdraw.

Indeed, at this stage of her life is when her file was closed and certain reports were not investigated. And this was a critical moment of disempowerment. Faith's family and her extended family were left managing increasingly serious risks without any meaningful ability to trigger any sort of intervention.

So communication, I guess, existed in form in this -- at this stage in the sense that there were reports that were being made, but it didn't exist in substance. There was no response, no feedback, no engagement. In 2011, though, the system did intervene.

The first of Faith's two out-of-province placements occurred. Faith was placed in a

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structured treatment program in Ontario, Broken Arrow. Ms. Ding also referred to this same program in relation to her client.

At Broken Arrow, something important happened for Faith. She seemed to stabilize. She attended school, she formed relationships, and she functioned within that structure.

Now, there were some questions that arose, and we don't -- we don't -- we never had participation from Broken Arrow at Faith's circle, but certainly there did not appear to be much of an emphasis on her Innu culture while she was there, which was to her detriment.

But the evidence of her participation at Broken Arrow, it seems, based on the record that we have, shows that with the right supports, Faith could succeed if she had the right supports. But even here, the pattern still persisted, in that her family was not meaningfully integrated into the treatment process. There was no effective communication of how that success that she

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attained at Broken Arrow could be sustained when she came out of treatment.

When Faith returned home in July 2012, the systems failure became a little bit more obvious. She was returned without a transition plan, without supervision, without implementation of the very recommendations that had supported her progress at Broken Arrow.

Responsibility was essentially handed back to the family. But it was handed back without any tools, without any preparation for the family, for her return, without any clarity as to specific needs and specific actions that could be taken to continue her success. So this was a time when we see in the record one of the clearest examples of a communication failure.

The system knew what Faith needed, but it simply did not communicate that, and it certainly did not operationalize that, did not implement that. So what followed was, sadly, predictable. Within weeks of her return home, there were repeated

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reports of solvent abuse, lack of supervision, the same type of at-risk behaviours that were exhibited earlier.

These reports were made, and they repeatedly, at least we can see in the record, it doesn't appear that they were investigated. The system was aware, but the system didn't respond. And for the family, this represents profound disempowerment. They could raise concerns, but they couldn't generate action.

So communication, again, existed only on paper between the powers that be. The family and Faith were, rather than being, you know, key players in Faith's -- in Faith's development and in decisions, they were rather subject to the system. They were not the -- you know, they were not part of the driving force of the system. They were subject to it and seen as peripheral players.

In 2013 is when Faith had her second stint in out-of-province care. The system intervened

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again and sent her to a place in Saskatchewan this time called Ranch Ehrlo -- Ehrlo, sorry. And she showed some progress in treatment again. But even here, the pattern didn't change.

After treatment, again, there was little evidence of follow-through. There was limited transparency with the family about decisions that were being made. And there was no sustained coordination between intervention and the outcome. The intervention occurred, but again, there was a lack of continuity and a lack of communication.

Faith again returned home. And we heard from the representative from Ranch Ehrlo at Faith's circle. And he acknowledged that they could have done better to implement the Innu culture into Faith's treatment program. They could have done better to put together a discharge plan, which better recognized the limitations of the resources available in her community and the people that would be available to carry out those treatments.

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In 2017, at the age of 18, Faith became a parent herself. And she encountered the same system, but now from the other side. Her first child, Quinn, was raised informally by her -- in her informal-type arrangement by her grandmother, Christine.

Her second child, Anne, was born shortly after. And she was apprehended by the -- by CSSD, despite availability of family to care for her. And once again, the family was sidelined. This time in relation to Anne, but also in relation to Faith.

Once again, communication broke down. And there's evidence of this, again, in the record that we have. A breakdown in the communication surrounding the apprehension, surrounding access between Faith and her children, and around planning for access.

And so this is where Faith's case sort of takes a little bit of a different turn than the other investigations that we -- that this Inquiry has

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looked at. This is when we can start seeing her interaction with the system as a -- as a young parent. And not just as a young parent, but as a young parent who herself is a product of that system.

The family, again, including Faith this time, were treated as players on the periphery, rather than the central figures that they should have been. The system dynamics that shaped Faith's early childhood and her formative years were now being reproduced in her parenting.

In the final period of her life, Faith was experiencing what I would call, I guess, an acute vulnerability. There was a failed access visit that happened in 2021. It's very poorly documented, about what exactly happened. We tried to piece together what happened by speaking with the family, looking at some scant records and emails from the -- that CSSD maintained.

But what was -- what clearly happened was that there was an access visit that was arranged, and

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it was arranged in Goose Bay. Travel and accommodations were arranged, the time for the access visit. And it fell through. It appeared to fall through because of some allegations that Faith may have consumed alcohol or something like that, which resulted in her visit being cancelled. And this became a critical moment for her. This is a point where communication and coordination for Faith as a young parent in the system was needed the most. And not only for Faith, but for Faith's children who are now the subject of that same system. This is the time when communication and coordination were needed most, but they were absent. The system did not respond in any way that re-engaged Faith or stabilized Faith at that time.

While there were obvious needs that she had -- and they knew about them. The system knew about the needs that Faith had at that time. She was clearly suffering from some mental health issues and clearly suffering postpartum issues. Postpartum issues that were in all likelihood, it would be reasonable to suspect that they were

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exacerbated by the interaction that she had when her child was apprehended.

Shortly after this access visit, Faith was reported missing and she was later found deceased, suspected that she had taken her own life.

So when viewed chronologically, this is not a series of isolated events or breakdowns in communication. This is a continuous pattern of disempowerment, of communication that failed to translate into action. The pattern began in infancy, 20 days after she was born, and it remained unchanged right into adulthood, up until the time of her death.

Now these facts that I just, you know, summarized as best I could, the details that were revealed in the investigation, they're not in dispute. The nature of Faith's experience is not dissimilar to other Innu children that were the subject of these investigations at the Inquiry or the other families.

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The question that the Rich family has at this juncture is, you know, what explains that pattern? And how can we keep this from happening to other families?

For the family, as I mentioned, the unifying theme of all of these events is disempowerment. It underlies everything that happened with respect to Faith and her family.

This was a very frequent theme that arose in Faith's circle. There were more than one participant in Faith's circle who made comments such as, we have no power, we had no power, we had no say. There was no meaningful participation for the families other than being subject to the child protection system. No access to information or consultation. No influence over the decisions that were being made. The power was essentially exercised unilaterally by the system.

So the family's feeling of disempowerment is justified. And it's corroborated by the evidence

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before this Inquiry. Family were consistently sidelined, caregivers had no voice, and decisions were imposed on them rather than -- rather than bringing them into the decision-making process.

These characteristics of the system were reinforced by bureaucratic processes, the use of threatened law enforcement, the use of the RCMP, language barriers, and a profound cultural disconnection, which I think we've all recognized by now.

So it's clear then that the disempowerment caused distress. But it was not just emotional distress that the family suffered. This disempowerment had operational consequences. Because the family can now see a causal link between the disempowerment that occurred and the negative outcomes experienced by Faith, both as a child and a parent involved in the child protection system. The mechanism of the disempowerment was primarily the deficiencies in the communication.

This is primarily how the disempowerment actually

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occurred. There was a withholding of information, families being informed late or indirectly of decisions or important events. There was no sharing of progress reports, discharge plans, reintegration strategies. Families were excluded from decision-making.

There were issues with the manner of communication. And we heard this at the circle as well, that when there was communication, it was often adversarial. And it was adversarial really for just a number of reasons. Obviously, there are the emotions that are tied up with having a child removed from your family. But there's also -- you know, the adversarial nature of the communication was not helped by the fact that these families were asked to navigate a child protection system, you know, with rules and you know, players that played certain roles and not other roles in a bureaucratic system, which they didn't really know anything about the inner workings of.

Communicating not in their own language. The

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families were also being asked to communicate with the very point of the system with which they were in conflict, which did not make it easy.

And we also heard from the perspective of the social workers, interestingly, that this was also something which they found difficult. Because understandably, you know, someone working as a social worker in a community, if you have to pick up the phone or visit a house, a home, to speak with someone that you know that you're in conflict with, well, there's going to be a little bit of a disincentive to pick up the phone or make that visit or have that meaningful, lengthy conversation that would be required. And when they -- when they did, you know, it is taxing on social workers as well, which results in increased rates of burnout, which results in areas being understaffed and underserviced. And the whole thing is a cycle that just simply, you know, one problem builds on itself.

And so we need to find a way to stop that cycle. And it would be in the best interest of not only

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the families and the people involved in the care, but also the system itself would be improved. And the social workers' lives and their work would be able to be more meaningful. And the results for everyone would be more positive.

The system didn't only fail to initiate proactive supports for Faith and her family. The system, because of those things I mentioned, actually at times appeared to disengage from the families. The family did not experience -- did not just experience poor communication at times, they experienced systemic non-communication.

There are, of course, the compounding factors, which the Commission will take into consideration. That being, you know, the colonial legacy is the backdrop here. The intergenerational trauma is something which, you know, this Inquiry has examined. That exists in the mix of all of this.

There was a lack of culturally appropriate services. We're aware of that. And there was a

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failure to prioritize family care, family placements. There was a failure to prioritize community knowledge. And ultimately a failure to prioritize the Innu perspective.

So the consequences then, with the record that we have before us, we can -- we can draw a clear causal chain. We can see that for Faith, the systemic problems that I just discussed resulted in a lack of trust in the system, which led to increased isolation for her and her family. Isolation from the system, which had the capacity to help her, but didn't.

And maybe not because they didn't want -- maybe not because the system didn't want to help her, but because of the way the system was set up, it didn't. It result -- and then that isolation further resulted in reduced engagement of Faith and her family with the system, and the system with Faith. And this clearly resulted in emotional harm. And the emotional harm was compounded for Faith by mental health challenges, including postpartum issues. Which were again

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exacerbated by the actions of the system.

For Faith's family and her caregivers, the systemic problems resulted in an inability to support Faith effectively. And it resulted in the family and the caregivers having a fractured relationship with the system, when what they needed was to be in step with the system, to support Faith. And as a result of all of this, there were missed opportunities for intervention in Faith's life. And these missed opportunities for intervention resulted in increased vulnerability for Faith.

So Faith's death was not an isolated incident. It was not something that just happened because she was experiencing mental health challenges or something like that. Her death was the culmination of systemic failure.

Now, the question that we are going to ask ourselves at the end of my submissions here is not whether there are more programs that are needed. Because more programs are always needed.

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You know, the government knows how to set up addictions programs. There are -- there are certainly some things that could be -- could be implemented. Those are more sort of long-term solutions addressing the root causes of some of the difficulties that some families are having specifically.

It's more of a long-term solution. But the question is, what is needed at the moment of contact with the system? At the moment of crisis, what's something that can be done right now that would have made a difference?

This is where Faith's case is -- Faith's perspective is unique and valuable to this Inquiry. Because we can see that something was needed to support Innu parents and Innu families involved with the child protection system. Especially those who, like Faith, have had their formative years shaped by that same system. So they have that sense of isolation. They have that sense of sitting on the sideline, that sense of disorientation, of not knowing -- not knowing

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where to go or what to do, which translates into an adversarial relationship with the system.

So again, I wasn't sure when I made my submissions if it's our place to be making recommendations. But from the Rich's family perspective, if we aren't here to propose solutions, to make things better for other Innu families, for future generations, then what are we here for? For Faith's family, this was the whole point of the Inquiry for them. It was to turn Faith's tragedy into progress and into something that can make a difference in future generations.

And so here's just one concrete, practical solution that we propose after considering all of the needs that came through all of the information that was received at this Inquiry. And just for the sake of my submissions, you can call it whatever you like, but I came up with the term "Innu Parent Advocate." And this presents a practical, targeted approach which is responsive to the evidence that we heard at this Inquiry.

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So just to give you some idea of what I'm talking about here, an Innu Parent Advocate would be someone that a parent could call, who has an Innu parent could call, who is having an issue with or is in contact with the child protection system. Someone to call in a moment of crisis. You know, someone -- it could occur in a moment of crisis when the RCMP have left the house with your child and you're crying, sitting in your porch, wondering what to do next. You know, You're not going to pick up the phone and have an argument with the social worker. You need someone to call to get advice from a knowledgeable person who can relate and someone who can do something.

It could also be not only in a moment of crisis, but also as part of an ongoing file where there are follow-ups being needed or referrals being made or complaints about certain foster care placements which need to be looked into. So to manage the parental relations, basically, with the child protection system from an Innu perspective.

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This advocate, I would submit, would need some sort of statutory authority. So we need some sort of legislation which would give some teeth to this office, that would clothe the advocate with the right to obtain information from CSSD, the right to speak with certain players in the child protection system, and the right to receive responses from the child protection system within a certain time.

And it would be, of course, an Innu person with ties to the community who speaks the Innu language. They would be educated on the processes and the players in the child protection system. And they would act, importantly, as kind of like a buffer between two parts of a system that are in conflict.

If there -- if there is -- you know, we've identified points of friction in the circle. We can see where the friction exists in the system between the Innu and the -- and the players in the child protection system.

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This office would act as a buffer between those players, which would allow for there to be better communication between the Innu families and those involved in the child protection system without these -- without such adversarial communications. Without -- and also with an understanding of how the system works and who can do what and when.

So it solves a number of problems. It solves the communication breakdown issues. Especially if given the legislative authority, it solves a power imbalance. It solves the issues of having a cultural disconnect between the families and the -- and the system. And it de-escalates conflict.

So the you know -- the advocate would be not necessarily focused on community services or being a community service worker in general, but the focus would be on parenting in the context of child protection. And they would act as sort of an information conduit, a translator at times, translating these -- you know, the decisions, speaking the Innu language to the Innu parents.

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There would be an advocate and an advisor in some high conflict moments and provide support during removals or access disputes or system navigation, or rather, navigating the system.

They would have a formal relationship with CSSD and a right to access information. For families, this would provide them with clarity. It would provide them with a voice. It would empower them. It would allow them to trust, have some trust in an element of the system.

Commissioner Qupee said at Faith Circle, I remember, I wrote it down when she said it. It was on -- it was on the last day, I think. She said, "How can you provide supports if you don't have a relationship with the family, if there is no trust between the family and the entity providing support?"

This would fill that gap. For the system itself, it would also receive some benefits of better communication, reduced conflict, less burnout of social workers, and improved decision-making,

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because it would be hearing the Innu perspective when decisions are being made.

And so the reason why this works is that it targets the point of failure, the point of friction that we have identified, that this Inquiry has identified, surrounding disempowerment, surrounding communication. It does not require a whole overhaul of the system in order to implement this change.

This is not an abstract reform. This is a practical solution aimed directly at the core failures identified in this case. And it can act as a legacy to Faith and her family and all the other Innu children and families who have been involved with the child protection system.

So I don't know how much time I have left, but just in closing, at its core, Faith's case was about disempowerment. There were -- we aren't looking at individual faults of individual social workers or individual breakdowns in communication. This was a system design issue,

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and we can see that now.

If the -- if the system continues to operate this way, in a way that excludes the very people that it is meant to support, the outcomes that we have seen in Faith's case and in other cases will not be exceptional. They will be inevitable.

An Innu parent advocate that we have suggested is a meaningful, relatively low-cost step forward toward change. It may even be a bridge to full, true self-determination of the Innu in child welfare.

And unless you have any other questions, Commissioners, those are my submissions.

COMMISSIONER DEVINE:

Any response? Sure, I'll start.

Well, thank you, Mr. Ash. Thank you, Robby, for your presentation. I certainly wanted to comment on your recommendation and that on behalf of the family. It's a very interesting one.

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We have been considering and looking at different types of positions that might help with that, and that one, I would say, kind of fits within, you know, some of the discussions that we have. So thank you for doing that. Appreciate it.

COMMISSIONER IGLOLIORTE:

Thank you. Nastash, anything?

COMMISSIONER QUPEE:

I'd just like to say thank you, Robby, for your presentation and also doing such good work in working with the families as well. And I appreciate seeing that at the circle, and thank you again.

ROBBY ASH:

You're welcome. Thank you.

COMMISSIONER IGLOLIORTE:

And my comments are of a more summary nature of the work of all counsel, and that is, to a person, each of the loyal families in their advocacy told us how they were humbled by their understanding of the grace that people showed under the most devastating hardships that they suffered and the trauma that they had experienced.

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And like them, we encourage people to put aside their biases and to get to know the people on an individual basis, on the basis of their culture, and the strength that they have by expressing love for their families and the life that they had in the bush, in nutshimit. All this, as the lawyers have told us, is what sustains them.

So thank you very much for your presentation and your participation at the Inquiry.

ROBBY ASH:

Thank you.

KELSIE LOCKYER:

Thank you very much. Thank you very much, Robby, for your submissions and for everything you've done to get to this point. It's been much appreciated.

So we will now conclude for our lunch break. We will return at 1:30 p.m., at which time, Will Hiscock will present on behalf of the family of Jacob Collins, and then on behalf of the family of Wally Rich, before we finish up with James Maher presenting on behalf of the family of

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Thunderheart Tshakapesh.

So we will take a break now until 1:30. Thank you all very much for your attention this morning, and enjoy your lunch.

(Off the Record)

KELSIE LOCKYER:

Good afternoon, everybody, and welcome back. I hope you've had a nice lunch break. We'll now resume with our submissions from family counsel.

So next, we'll be hearing from Will Hiscock on behalf of both the families of Jacob Collins and of Wally Rich.

So, Will, you'll have an hour for each of those, and we'll take a short break in between your submissions. So I'll let you decide which one you would like to begin with, and I'll turn it over to you there now.

WILL HISCOCK:

Okay. There's quite an echo there, but -- just

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give me one second.

BRIAN HARVEY:

Will, there is also a Will Hiscock in the room. Is that potentially the source of the echo?

WILL HISCOCK:

Yes. Is it possible you could close out the other one?

BRIAN HARVEY:

I will give it a try. Okay. Please retry.

WILL HISCOCK:

Is this better? Yes. Okay. Thank you. I apologize. I'm not exactly sure. I guess it opened two windows or something there.

SUBMISSIONS OF MR. WILL HISCOCK (WALLY RICH)

WILL HISCOCK:

I'd like to begin, perhaps, with submissions on behalf of the Rich family. I think this will be the longer of the two. And so, I anticipate that the Collins' submissions will be shorter in nature.

So these are submissions being made in respect to

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the death of Wally Rich on behalf of the family, and specifically Etienne and Nympha Rich.

On May 22, 2020, Wally Rich, an Innu child died by suicide in his bedroom at the Labrador Group Home. Wally was 15 years old. His family members, including his parents, Etienne Rich and Nympha Rich, continue to deal with this profound loss.

While Wally's brother, Donnie Rich, was not a party to this Inquiry, he deserves special mention. Donnie was Wally's older brother and was at the Labrador Group Home when his brother died. I know that his death and this Inquiry has been especially impactful on him. And I know that our prayers are with him and the rest of his family today.

On March 2nd, 2026, through to March 6th, 2026, Etienne and Nympha Rich participated in a healing circle, a hearing circle, in relation to the investigation of Wally's death. That circle built upon the investigators' report.

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And when I speak to the report for the remainder of this presentation, I'm speaking to that report, the investigators' report.

We will now discuss the systemic issues in that report and how Wally's life and death can help us build a better child protection system for Innu children. I'll address some of the systemic issues.

And the first of those issues is the availability of services for parents and children in Natuashish. The investigators' report identified two systemic issues regarding the availability of services in Natuashish for parents and children.

And I will, throughout this presentation, focus on the systemic issues that come from Wally's death and not specifically on the -- on the particulars of his demise. Though, those obviously inform the investigators' report and inform and provide an example and shed light on the systemic issues that we're discussing. But those systemic issues in relation to the

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availability of services for parents and children in Natuashish, the two issues raised by the investigators' report. First was the absence of reunification-focused family supports. And secondly was the poor coordination of services and family connection.

The first systemic issue, the absence of reunification-focused family supports, was clear in the situation of Wally and his parents. As Etienne and Nympha have noted, they undertook years of treatment and programs, which has been -- had been recommended to them by CSSD in the interests of family reunification. And yet they did not get their children back.

It was only in the wake of Wally's death that their other children were returned to them. The investigators' report highlighted chronic staffing shortages, high caseloads, and limited service options in Natuashish. These conditions constrained social workers' ability to provide sustained engagement with families, reducing the opportunities for prevention, stabilization, and

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family planning -- family reunification planning.

The second systemic issue, the poor coordination of services and family connection, was also evident. It was particularly acute after the COVID-19 epidemic hit on March 18th, 2020, when travel restrictions prevented in-person access between Wally and his parents.

As noted in the report, the final summary indicates limited evidence that alternative, structured supports were implemented to maintain family connection during this period. Family access planning during this period remained inconsistent, poorly integrated into overall care planning.

The investigators' report also identified the failure to operationalize cultural and land-based supports. While Wally was a resident at Labrador Group Home, a cultural connection plan was developed with input from his parents to support Wally's connection to his family, his community, and the Innu culture and language. However,

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Wally didn't sign the plan until May 19th, 2020, and it was only three days before his death. And as such, the plan's recommendations were never implemented.

The details in the investigators' report suggest an additional systemic issue regarding the availability of services in Natuashish for parents and children, an absence of early preventative family supports to help keep the families together. Etienne and Nympha Rich reported that they did not receive counselling or meaningful assistance before Wally was taken into care. And that support only became available, really, following his death.

The report on Innu services underlines a general lack of availability of child and family services in Natuashish during the majority of Wally's lifetime, which suggests a fourth systemic issue regarding the availability of services in Natuashish for parents and children. And that is an absence of long-term placement facilities. There were no Innu services, no funding, and no

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program staff in Innu child and family services.

Greater availability of services and facilities in Natuashish will allow more Mushuau Innu children to remain with their families in Natuashish, or in Innu-managed and operated facilities in Natuashish, which will enable closer contact between the Innu children and their parents.

Had a hybrid home or a group home existed in Natuashish in 2019, Wally might have been able to live in his community of Natuashish, within walking distance of his parents and his family, rather than having to live in a group home in Happy Valley-Goose Bay, hundreds of kilometres from his home and his family.

The next large grouping of systemic issues that I'd like to address in relation to Wally's case, and it comes from the report, is the effects of the approach taken by group home placement.

The investigators' report identified three

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systemic issues regarding the effects of approach taken by the Labrador Group Home. The first was the custodial institutional model, and that that was misaligned with child welfare model. The second was the lack of individualized programming and cultural safety. The third was structural constraints and unresolved operational deficiencies.

The first systemic issue, the misalignment of the custodial institutional model with child welfare, was a glaring issue and one that both Etienne and Nympha raised as a concern.

The investigators' report states, "Multiple witnesses, including Wally's parents, raised concerns about the Labrador Group Home's historical origins as a youth correctional facility and questioned whether the transition to a child welfare model in 2015 resulted in a substantive shift in practice."

Parents described a lingering corrections mentality characterized by punitive responses,

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rigid rule enforcement, and limited empathy. Some examples of this lingering connections -- corrections mentality identified by Etienne and Nympha included the fact that whenever Wally called them, the lengths of the calls would be restricted by the Labrador Group Home staff, and the fact that snacks for the children were locked up.

I would note as well that this concern around the corrections mentality in that institution was one that was shared by most of the people who testified in the circle. That included former employees of the Labrador Group Home, as well as social workers who had direct involvement with the home, all of whom noted this and noted that the staffing, the staff who were there, had really been trained and brought up in the culture of the Labrador Group Home as a corrections culture and not a foster care culture, not a child protection culture.

At the Labrador Group Home, residents, including Wally, were supervised, but the investigators

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characterized this supervision as custodial, reactive, and focused on maintaining routine rather than addressing underlying emotional and psychological needs.

They noted that the approach taken by the Labrador Group Home during Wally Rich's placement was predominantly custodial rather than therapeutic. And this approach significantly limited the home's capacity to meet the needs of a youth with complex trauma, neurodevelopmental vulnerabilities, and emerging mental health risks.

This issue had a particular personal importance to Etienne. In his youth, Etienne had resided at the Labrador Group Home when it was a youth corrections facility. The idea that decades later, his son Wally was now residing in that same place, exposed to similar corrections mentality and environment, was very painful for him. He had experienced a lot of racism in that home, and he feared that his son would experience the same.

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The second systemic issue, the lack of individualized programming, the lack of cultural safety, was clear in general at the Labrador Group Home, and specifically in relation to Wally.

Regarding the lack of individualized programming, the investigators noted that programming was minimal and largely confined to meeting basic needs such as food, shelter, and supervision. There was little evidence of individualized care planning, structured therapeutic activities, or developmental programming appropriate for a Level 4 placement.

Over the course of the six months that Wally resided at the Labrador Group Home, the group home logs indicated signs of Wally's declining mental health. And yet, as the investigators note, these changes, quote, were not followed by meaningful clinical response or adaptation of care, unquote. The lack of cultural safety was emphasized by Etienne and Nympha.

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And as noted in the investigators' report, again, quoting, Etienne and Nympha Rich described staff as predominantly non-Innu and non-speaking Innu -- and not speaking Innu-aimun, and expressed concern that language restrictions and lack of cultural understanding contributed to Wally's sense of alienation.

Etienne further alleged differential treatment of Innu children compared to non-Innu children, framing the Labrador Group Home's approach as discriminatory and inequitable.

There is no indication that Wally's cultural safety was a priority at the Labrador Group Home. As a resident there, he could speak Innu-aimun with his brother Donnie, who was also a resident of the Labrador Group Home, but English was the dominant language of the facility.

One of the few intentional uses of Innu-aimun by Labrador Group Home staff was after the onset of the COVID-19 pandemic, when the Group Home coordinator obtained a video in Innu-aimuk --

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aimun, sorry, explaining the COVID-19 pandemic.

The video was presented at the Labrador Group Home, and although the Group Home coordinator noted that both Wally and his brother Donnie were very responsive -- or were very responsive to this video, Wally was offered no further programming or activities in Innu-aimun.

Concerns were raised in interviews with members of the Labrador Group Home staff regarding the home's -- or the Labrador Group Home's, quote, limited cultural responsiveness, and inability to create a sense of belonging for Indigenous youths placed far from their communities, unquote.

The third systemic issue -- I'd just like to stop for one second and just emphasize there that, you know, we're talking about a young boy, and his suicidal ideation, you know, originated from a sense of alienation, from not belonging, for not having close connections and care of people who cared for him, that sense that he had while he was in a group home.

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I think the investigators' report draws that connection, but it should be emphasized just how -- just how alienating it would have been for him to be in a group home where his own language and his own culture really had no representation amongst the staff. And he had no ability to speak to others in his own language. Very restrictive, very alienating. And the role that that played in his sense of alienation is something we will never know, but it does seem a very natural link, and I just want to emphasize that connection drawn by the investigators there.

The third systemic issue in this area, structural constraints and unresolved operational deficiencies were very apparent to many people. For residents like Wally with complex needs, this issue emerged at the very outset of the child's contact with the Labrador Group Home -- with the child's placement at the Labrador Group Home in the very first instance.

As noted by the investigators' report, quote, The service agreement governing the Labrador Group

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Home required the home to accept referrals when vacancies existed, limiting its ability to assess, fit, manage group dynamics, or tailor programming to individual needs. Staff and investigators noted that children placed at the Labrador Group Home often had complex and competing needs. Yet the home lacked the flexibility or resources to adapt its approach accordingly. End quote.

As a result, children might end up being placed at the Labrador Group Home even if the Labrador Group Home was not a suitable environment for their care. The Labrador Group Home's unresolved operational deficiencies were continual and well documented.

According to the monthly reviews of Labrador Group Home during that period, that Wally was a resident, that's from November of 2019 through to May of 2020, in any given month, Labrador Group Home failed to adequately meet between five and eight of the standard requirements for placement resources, including five standards that were

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never met during the entirety of Wally's placement at the group home.

During the hearing, we discovered that the group home had not been licensed at the time that Wally was there and that the licensing was unable -- they were unable to achieve it because of how many of these standards were failing to be met consistently. As is pointed out, between five and eight of them -- five were never met at any point that he was there.

The third grouping or subject area in which there were several systemic issues is the mental health services or the lack thereof that were provided to Wally while at the Labrador Group Home. The report identified three systemic issues within this broader subject matter, broader heading regarding the mental health services provided to Wally.

The first was the absence of proactive embedded mental health care. The second was inadequate crisis response and policy noncompliance. The

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third was fragmented monitoring, documentation and continuity of care.

The first systemic issue, the absence of a proactive embedded mental health care, was a significant issue during the entirety of Wally's placement at the Labrador Group Home.

Before he arrived at the group home, Wally had a number of documented cognitive and psychological issues. He had a history of trauma, substance use, emotional dysregulation and involvement in high-risk behaviours. However, despite these known issues, the investigators noted that there is no evidence that this information informed individualized mental health planning or access to specialized supports.

And during the entirety of his placement at the Labrador Group Home, at no point was Wally assessed by a psychologist or psychiatrist. The general approach of the Labrador Group Home to mental health access for its residents was dependent on youth initiation or consent, rather

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than proactively offered as part of a comprehensive service plan.

And further, youth were often encouraged to seek help independently through external services such as wellness lines or health centres, rather than being supported through direct, on-site mental health intervention.

The result of this approach is that Wally was not proactively offered services through the Labrador Group Home, but was rather expected to shoulder the burden of one, identifying himself as if he needed mental health services, two, navigating the process of accessing services for himself. And this seems like an entirely unreasonably heavy burden for a child, much less a child dealing with a number of cognitive and psychological issues.

I'll remind the Inquiry that the government had taken this child, and their duty to this child was of a reasonably prudent parent. And expecting a young child to self-diagnose, then

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assess their needs for treatment, and then arrange their own mental health treatments, I think falls well outside of the standard of any prudent parent. Any prudent parent who had a child dealing with the kind of strain and the kind of issues that Wally was dealing with, any prudent parent in that situation would be proactive in terms of getting them access to the treatment that they needed. And I think that's a very clear failure in this case.

The lack of proactivity of Labrador Group Home's approach is evident in the few documented situations where the possibility of mental health services for Wally was contemplated, but was not achieved.

In December of 2019, Wally attended hospital for a medical concern, during which a hospital social worker recommended follow-up with mental health services due to concerns about drug use and behaviour. The file indicates that this recommendation was not acted upon.

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And a few months later, again quoting from the report, "On May 14th, 2020, Wally declined counselling when asked -- stating he would talk to his parents when he was sad. There is no evidence that alternative trauma-informed engagement strategies were attempted following that refusal, nor that Wally's decision was contextualized within his developmental stage or known difficulties with emotional regulation."

Moving on to the second systemic issue in this category, the inadequate crisis response and policy noncompliance.

This was a general issue at the Labrador Group Home. This issue was acutely evident in the Labrador Group Home's response to Wally's suicidal ideation, which he expressed on May 17th, 2020. It was his mother, Nympha, who informed the Labrador Group Home on that day, May 17th, 2020, that Wally had expressed suicidal ideation to her -- or sorry, to a friend online, who then informed her.

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This prompted two members of the Labrador Group Home staff to go upstairs to talk to Wally, whereupon he expressed suicidal ideation again, saying that no one cared about him and he wanted to die.

Wally then left the Labrador Group Home, after which the Group Home staff called the RCMP and the CSSD on-call social worker. The Labrador Group Home staff left the placement in search of Wally, and he eventually returned to the Group Home around 5:30 that evening.

Upon Wally's return to the Labrador Group Home, one of the Labrador Group Home staff called the CSSD on-call social worker to update her on the situation. And per the Labrador Group Home incident report, the CSSD on-call social worker gave direction that the Labrador Group Home staff should, quote, check on Wally and see if he wanted to go to the hospital, call the Mental Health 1-800 number, or see anyone for further help, end quote. Check his room to ensure that there wasn't anything he could use to harm

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himself and to check on him periodically, end quote.

When Labrador Group Home staff spoke to Wally, after receiving this direction, per the incident report, Wally said that he was fine and he wanted to be left alone.

As noted in the report, quote, CSSD and the Labrador Group Home actions during this period contradicted policy requirements mandating a mental health assessment following suicidal ideation. There is no evidence of clinical follow-up, psychiatric consultation, or therapeutic interventions between May 17 and Wally's death on May 22, 2020. No mental health assessment was completed.

The manner in which Labrador and Group Home staff checked on Wally after a suicidal ideation intersects with the third systemic issue, the fragmented monitoring, the fragmented documentation, and fragmented continuity of care.

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Suicide prevention was reduced to visual checks, which were inconsistent carry -- inconsistently carried out, sorry, and poorly documented. Interviews with the staff made it clear that in some cases these checks were not even visual. It simply involved the Labrador Group Home staff members listening from a different room on a different floor to determine if Wally was making any sounds in his room.

The lack of proper monitoring of Wally was a great concern to Etienne and Nympha, and for good reason, given its clear inadequacy.

Issues with -- at the Labrador Group Home with documentation and continuity of care were particularly glaring in this crucial period between Wally's suicidal ideation on May 17th and his death on May 22nd.

Mental health documentation was described as poor, unclear, and inconsistent. Reliance on shift notes without structured handover or shared situational awareness contributed to gaps in

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continuity of care. Since Wally never received a clinical assessment following a suicidal ideation, and since the Labrador Group Home staff in general lacked training and expertise in mental health, staff members relied on subjective impressions of Wally's mental state in the days leading up to his suicide, rather than being able to rely on structured clinical assessment that could inform a proper course of care for Wally.

I would like to make one additional point in relation to the failings to check on Wally, just to emphasize how poorly these were made, just how inadequate they were, which is the fact that when Wally's body was found, he had been dead for quite some time, and rigor mortis had set into the body.

There was supposed to be hourly checks we're told. There was listening from another floor of the building to hear if there were any noises, any sounds. But we have to, I think, even doubt that that level of checking was occurring, because it is impossible that he could have been

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dead that long had those checks been being carried out, even auditory check, which was grossly inadequate that those could not have been carried out as planned.

I just wish to add that to the written comments that I had submitted. So I think it emphasizes just how inadequate those checks were, physical evidence of that inadequacy.

The fourth group of issues, systemic concerns that the investigators' report addresses, and that we wish to contextualize here, is the support and resources provided to the Labrador Group Home placement by CSSD. So the report identified three systemic issues regarding support resources provided to LGH by CSSD.

First, ineffective oversight, licensing and accountability. Secondly, insufficient clinical and multidisciplinary support. And three, reactive rather than preventative system responses.

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The first systemic issue there, ineffective oversight, licensing and accountability, existed long before Wally arrived at the Labrador Group Home. Although the Labrador Group Home operates a Level 4 placement under a service agreement with CSSD, which was effective as of October 5th, 2015, Labrador Group Home was not licensed when Wally arrived at the placement in November of 2019. And it was not licensed at any point during Wally's placement there.

Issues with ineffective oversight and accountability were apparent and well documented during the entirety of Wally's placement at the Labrador Group Home. Monthly reviews and compliance reports repeatedly identified deficiencies in critical areas, including safety, programming, crisis intervention, record keeping, and residential planning.

These deficiencies persisted over time without evidence of any meaningful corrective action or enforcement by CSSD.

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The second systemic issue, the insufficient clinical and multidisciplinary support evident in part from how little evidence there was of a -- of robust support.

As noted in the report, CSSD, and I'm quoting, quote, CSSD support to the LGH was largely administrative rather than clinical. There was little evidence that CSSD provided sustained clinical guidance, therapeutic oversight, or multidisciplinary support to assist the Labrador Group Home in caring for high risk youths.

Case conferences and clinical meetings were absent or undocumented and decision-making related to safety and mental health was not consistently informed by clinical expertise, end quote.

The investigators also noted that roles and responsibilities for service coordination were unclear, contributing to gaps in mental health, education and crisis response.

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The third systemic issue, which is reactive rather than preventative system responses, is evident by the changes and improvements that occurred at Labrador Group Home in the wake of Wally's death rather than the years that preceded the tragedy.

As the investigators noted, quote, several witnesses described improvements implemented after Wally's death, including enhanced training, reduced bed capacity, increased access to counselling and crisis resources. While these changes are relevant for future practice, their post-incident nature underscores that CSSD intervention occurred reactively rather than proactively, following, in this case, a fatal outcome.

The fifth broad category of systemic issues in this case is the appropriateness of the skills, training and supervision of the Labrador Group Home placement staff.

Before I begin this, I would like to emphasize

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something that came out of the circle, which is we had a former worker of the Labrador Group Home who came into the Healing Circle, in this case, took time off of his new job, came down because he wanted to have it heard that he had left there in part because nobody was properly trained in his view, that he was the only appropriately trained mental health care worker who was on site there at the time, and that he -when he had left, he didn't think there was anybody there who could fill his shoes.

So this is something that only comes out of the investigators' report, but was emphasized by witnesses in Goose Bay when we were there.

The report, however, identified four systemic issues regarding the appropriateness of skills, training and supervision of the Labrador Group Home staff.

The first, inadequate training for high-risk complex care. That was Wally's case. Secondly, weak governance, weak accountability, and weak

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executive oversight. Third, weak clinical governance, oversight and supervision. And fourth, normalization of noncompliance and regulatory drift.

The first systemic issue, the inadequate training for high-risk complex care, was abundantly clear in this case. Although the Labrador Group Home was a Level 4 placement, and its service agreement with CSSD specified that Labrador Group Home would provide, quote, services including specialized individual and group programming to children and youth with complex social-emotional behaviour and developmental needs, end quote, the Labrador Group Home staff were not hired for expertise in providing such services, and they were not provided with training sufficient to develop these expertise.

Many members of the Labrador Group Home staff have been working at the Labrador Group Home since it was a youth corrections facility, and without a significant amount of specialized training. It is clear that such staff members

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were poorly equipped to deliver high-risk complex care.

As a result, the Labrador Group Home staff were ill-equipped to respond appropriately to Wally's suicidal ideation, a concern that was raised by Etienne and Nympha. As the investigators noted, parents raised concerns that staff with corrections-based backgrounds lacked the specialized training required to respond to mental health crises and suicidal ideation. This gap between the abilities of the Labrador Group Home staff and the skills required to provide adequate care for high-risk children with complex needs is part of why Etienne and Nympha believe the Labrador Group Home should no longer operate for fear that a situation like Wally's could re-occur, the same tragic results.

The second systemic issue, weak governance, accountability, and executive oversight, is apparent in the repeated failures to address persistent, well-documented issues with the Group Home.

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The report noted, quote, the organization operated under a board governance model. However, there was no evidence that the board provided active oversight of clinical standards, safety practices or compliance with child welfare expectations. Persistent deficiencies in licensing, programming, supervision, and safety were identified repeatedly through monitoring reports. They were identified repeatedly through the monitoring reports and through compliance reviews, yet corrective action was not enforced or sustained.

This indicates a governance failure to ensure that risks identified at the operational level were escalated, addressed, and resolved. Etienne and Nympha Rich raised a concern that is further evidence of the weak governance and oversight of the Labrador Group Home. Wally was being bullied by a member of the Labrador Group Home staff.

Somewhat shockingly to me, when this allegation came out during the circle hearing, it wasn't denied or questioned by the social workers and

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the staff who had dealt with the group home. Rather, it was enforced that they had seen activities themselves that gave them concerns about staff bullying children.

It goes without saying that such behaviour is completely inappropriate for an adult who is meant to be providing care to a child. The fact that such behaviour not only occurred at the Labrador Group Home, but apparently was not addressed is indicative of failure of governance and oversight.

The third systemic issue, weak clinical governance, oversight and supervision was evident in the general absence of clinical guidelines and guidance at the Labrador Group Home.

As was noted in the report again, quote, there was an absence of consistent clinical leadership, multidisciplinary case review, and therapeutic oversight throughout the relevant period. Case conferences, clinical reviews, and coordinated planning meetings were rare and undocumented.

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Decisions regarding safety, privacy, supervision, and risk were made without clinical guidance and were often inconsistent and ineffective, relying instead on subjective judgment of individual staff members.

A result of this approach -- end quote, sorry. A result of this approach was that high-risk situations like Wally's were not managed therapeutically, and the response and actions of the Labrador Group Home staff in the days following his suicidal ideation were grounded in the subjective judgments of staff members who lacked training in how to care for suicidal children.

They didn't have the guidance. They didn't have the training. They didn't know what to be doing frankly.

Supervision was also inadequate to the Labrador Group Home, which was arguably one of the consequences of the first two systemic issues. The investigators described supervision at the

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Labrador Group Home as quote, primarily custodial, focused on routine compliance rather than reflective practice of clinical decision-making -- or clinical decision-making. There was little evidence of regular supervision that included case discussion, risk assessment, or therapeutic planning, end quote.

Further, staff lacked structured guidance to interpret behavioural changes, escalating mental health risks or cumulative impact of trauma and loss. This gap left staff unsupported in managing complex clinical situations and it contributed to inconsistent responses during critical periods.

Given the inadequate training of the Labrador Group Home staff, many of whom had a background in corrections rather than social work, psychology or counselling, and the lack of active oversight from the board concerning clinical standards, safety practices or compliance with child welfare expectations, it is not surprising that the Labrador Group Home ended up with a

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deficient approach to supervision.

It couldn't have been otherwise. The net effect of the systemic issue on Wally is stark in particular during the period between his suicidal ideation and his death. As noted above, during a period when Wally was believed to be suicidal, suicide prevention ended up being a mix of visual checks, auditory checks from outside his bedroom or even on another floor of the building. During a period when clinical supervision was most needed, it did not occur.

The fourth systemic issue, the normalization of noncompliance regulatory drift was evident in the repeated pattern of Labrador Group Home deficiencies being identified and documented but not addressed.

As noted in the report, despite repeated identification of deficiencies through monthly reports, compliance reviews and investigations, systemic noncompliance persisted at the Labrador Group Home.

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Deficiencies in training, programming, supervision, safety and documentation were repeatedly flagged without enforcement or remediation. The home continued to operate without licensing and without meaningful corrective action. Oversight mechanisms existed but failed to function as safeguards resulting in regulatory drift and normalization of unsafe practice.

As the investigators emphasized with noncompliance normalized, quote, unsafe practices became routine rather than exceptional, end quote.

A fifth systemic issue not identified in the investigators' report is also evident from Wally's case in this area, though. And that's connected to the lack of cultural safety identified above in section 2 and the third contextual systemic issue. Inadequate language training of the Labrador Group Home staff and Innu-aimun.

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Although Wally could speak English, his first language was Innu-aimun. During the period between his suicidal ideation and his death, Wally's communication with the Labrador Group Home staff was not only occurring without clinical guidance but it was occurring in a second language. In a period of crisis such as the day a child voices suicidal ideation and in the days that follow, it seems advantageous to have at least one staff member who could communicate with the child in the language that is most comfortable for the child, partly for the comfort of the child but partly so that the staff member can have a more accurate understanding of what the child is feeling and thinking.

It's difficult to think that the group home staff could have known how Wally was when there was a significant language barrier that existed between them. Trying to do an assessment of a child's needs in a complex and tragic situation or potentially tragic situation, a child who is expressing the desire to kill themselves, surely at that moment we need as clear communication as

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possible. And that could not occur in this case because nobody on staff spoke his language.

There is no indication in the records that any of the staff were fluent in the first language of at least two of the Labrador Group Home residents, Wally and Donnie. Having even one staff member who is fluent in Innu-aimun would not only provide Innu children with day-to-day contact with a person who could help the children to continue to use their language, but it could help develop stronger bonds of trust between the child and the staff member who shares their language. This bond could prove helpful during a time of crisis if the child would know that there is an adult in the place with whom they can speak openly and comfortably.

For children like Wally whose suicidal ideation included a stated belief that nobody cared about him, having a staff member fluent in their language who the child feels comfortable talking to might even avert certain crisis before they happen.

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The next large category of systemic issues identified in the investigators' report is communication between the group home placement, CSSD and the parents while Wally was at the Labrador Group Home. The report identified two systemic issues regarding communication between LGH, CSSD and Wally's parents while he was at the Group Home.

First, the pandemic conditions exposed system fragility rather than causing the failure. And secondly, chronic communication breakdown and information loss. The first systemic issue, pandemic conditions exposed system fragility rather than causing failure is apparent when one examines the regular communication failures that -- failures to be examined in more detail below.

As noted in the report, quote, while COVID-19 exacerbated service limitations and communication challenges, the investigation finds that core systemic failure predated the pandemic. Pandemic conditions exposed and intensified existing weaknesses rather than creating them.

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The system lacked contingency planning to protect vulnerable children during crisis and pandemic restrictions were frequently cited to justify inaction rather than to prompt adaptive safeguards.

That second systemic issue, chronic communication breakdown and information loss, is not -- is -- is clear, sorry, not just between the group home, CSSD and Wally's parents but within the group home itself. And as noted in the report, several witnesses described reliance on shift notes and informal communications within the Labrador Group Home, contributing to poor continuity between staff and across staff, shifts, between shifts. This reliance increased the risk that critical information would be missed, particularly during periods of heightened risk.

Staff uncertainty during the days preceding Wally's death suggests a lack of shared understanding about his mental health status. Communication between the group home and CSSD was also poor. And the report indicates that the

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final review reveals minimal evidence of regular case conferences, clinical meetings, or coordinated planning between the group home and CSSD. Critical information including changes in Wally's behaviour, access arrangements during COVID, and suicidal ideation was not consistently shared or escalated.

Incident reports processes were inconsistently followed. And where reports were submitted, they did not reliably trigger follow-up or clinical review. This resulted in gaps in situational awareness and continuity of care. This situation unfortunately persisted during the crucial period between Wally's suicidal ideation and his death. Several CSSD witnesses acknowledged that they were unaware of key incidents until after Wally's death.

Etienne and Nympha have been clear that their communication with the group home was inadequate. As noted in the report, Etienne and Nympha Rich reported that they were not consistently informed about Wally's mental health status or the level

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of concern following suicidal ideation. They described being reassured that monitoring would occur and yet observed limited follow-through.

Parents also raised concerns that their observations and knowledge of Wally were not adequately integrated into care planning or risk assessment, despite their ongoing contact and their insight into his emotional state. Etienne and Nympha thus found themselves in a situation where they were not consistently receiving information from the group home that was important to them concerning Wally. And it's unclear to them whether the information that they were providing to the group home was being used to best care for their son.

Etienne emphasized that the communication he received from both the group home and CSSD concerning Wally was poor. Information received seemed to indicate that everything was fine with Wally when, in fact, we know it was not. The breakdown in the communication between the group home and Wally's parents was particularly acute

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for Etienne and Nympha in the immediate aftermath of Wally's death.

When they initially heard of Wally's suicide they got the impression from one source that he had killed himself in his bedroom near his window, and from another source that he had killed himself in his bedroom near -- in his closet. The contradiction -- contradictory accounts were the source of much confusion and anguish for Etienne and Nympha. And incompatible accounts suggesting to them that someone -- suggested to them somebody must have been lying about Wally's death or that someone was attempting to cover something up.

It destroyed the trust in the Labrador Group Home and it added an unnecessary additional layer of pain and fear when they were already dealing with the loss of their son.

A third systemic issue is suggested by this situation akin to the fifth issue identified in Section 5, inadequate language supports for Innu

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parents. Innu-aimun is the first language of both Etienne and Nympha.

Etienne can understand when somebody is speaking in English, but he cannot speak English very well himself. Nympha has become increasingly fluent in English but Innu-aimun remains the language as she feels most comfortable understanding and speaking.

Having all their contact with CSSD and with the Labrador Group Home occur in English creates barriers to mutual understanding and arguably exacerbates a situation in which the exchange of information was already very poor.

Frankly, it's unacceptable that these parents would have CSSD and the Labrador Group Home communicate with them in English when that's not their language. It's completely unacceptable. And it's an issue that's arisen in many of these cases, but it's particularly acute I feel in this case.

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To address a summary of some additional systemic issues, Etienne and Nympha submitted -- submit their four further systemic issues contributed to Wally's death which fall under three parameters of the investigation. Regarding the availability of services for parents and children in Natuashish, they raised one, an absence of early preventative family supports to keep families together, and two, an absence of long-term placement facilities.

Regarding the appropriateness of skills training and supervision of group home staff, they identify inadequate language training for the group home staff in Innu-aimun.

And regarding communications between the group home, CSSD and the parents while Wally was at the group home, they again indicate the inadequate language supports for Innu parents.

The recommendations from Etienne Rich and Nympha Rich. In light of their tragic experiences with the group home, Etienne and Nympha offer four

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recommendations that they hope will lead to better outcomes for children and parents and prevent occurrences of future tragedies.

First, the Labrador Group Home should be shut down, demolished and replaced. Etienne and Nympha emphatically recommend that the Labrador Group Home should be shut down, demolished and replaced.

They are not confident that the group home was ever a safe adequate placement for children such as Wally, and they are not confident that any reactive change in the wake of Wally's death has transformed the group home into a safe adequate placement.

Instead Etienne and Nympha recommend building a brand new group home. By beginning from a fresh start, Etienne and Nympha believe that a new group home designed to provide a home-like environment, that is fully licensed when it opens and that hires staff specifically to meet the standards of a level 4 group home, who do not

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take a custodial approach to care, will offer better, safer outcomes for any children who should be placed at this new group home.

Second, that Wally should be memorialized. Etienne and Nympha want Wally to be memorialized in the group home that replaces the Labrador Group Home. Wally's name and memory would provide a consistent reminder to the placement staff of the importance of the children who reside in that placement, the importance of keeping them safe.

There are different options to memorialize Wally. The new group home could be named after Wally or the new group home could feature a prominent piece of art that reflects Wally's life. Whatever form the memorialization takes, it would remind the staff of their sacred duties and the responsibilities to the children they care for. If Wally's legacy can save lives that is what Etienne and Nympha want.

Third, placements that house -- placements that

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house the Innu children should employ staff with fluency in Innu-aimun and understanding of Innu culture to improve children's access to Innu language and culture.

When Wally resided at the Labrador Group Home none of the staff members were fluent in Innu-aimun or deeply familiar with Innu culture as noted above. Wally's access to Innu-aimun and Innu culture at the Labrador Group Home were practically non-existent.

During the six months of -- that Wally lived at the Labrador Group Home, the only exposure he had to his language was officially offered through the group home in a video in Innu-aimun about the COVID-19 pandemic. Although a cultural connection plan was developed for Wally while he resided at the group home, the plan's recommendations were not implemented before his death. And he had been there six months at that point.

Wally deserved better as any Innu child finds

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themselves living in a placement. As noted above, since 2018 Innu-led staff residence facilities have been opened in Sheshatshiu and Natuashish which are run primarily by Innu staff and are based on the Innu-care approach.

As the Innu Round Table Secretariat explained in *A Guide to Innu Care Approach*, Innu-aimun and Innu culture are integrated into the Innu care approach in culture and language standing as foundations of Innu children's well-being.

Describing this approach at page 3 of their guide, they note that parents, extended family, community, Innu services, culture and language, and Elders are like -- and I'm going to butcher this -- tshuap poles building this caring -- t-s-h-u-a-p poles, building in this caring environment around our children, standing on nutshimit and woven together by the Innu healing values.

Although we can be confident that a child placed in an Innu-led staffed residential facility will

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have access to Innu-aimun and Innu culture, Etienne and Nympha are concerned that children placed in other residential facilities in the province will lack comparable access as Wally did. The IRT has been clear that staff in residential facilities outside Sheshatshiu and Natuashish providing service to Innu children should be fluent in Innu-aimun and knowledgeable about Innu culture.

Etienne and Nympha echo the IRT's call for staff at residential facilities that are not Innu-led should nonetheless be fluent in Innu-aimun and knowledgeable about Innu culture, such that any Innu child placed in such facility will have access to their culture, access to their language as they should and as Wally did not at his time at the Labrador Group Home.

The fourth recommendation is that placements that house Innu children should offer greater Innu-aimun language supports for their parents. Just as Wally had to communicate with the group home staff exclusively in English rather than in

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his own language, so, too, were Etienne and Nympha required to communicate with the group home staff in English rather than Innu-aimun.

As noted above, Etienne can understand English when some people speak it, but he cannot speak English well. And although Nympha has gained increasing fluency in English, Innu-aimun is still the language that is most comfortable for her to understand and to speak.

It is difficult enough to be separated from one's child by great distances, unable to see them every day, uncertain of what sort of care the child is receiving, to add a language barrier, separating parents from the staff providing their children's care does not make the situation any easier. And Etienne and Nympha have hope that no other Innu parents will have to -- will be required to endure these circumstances as they were.

Following Etienne and Nympha's recommendation would certainly help in this regard, following

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the requirement (inaudible) -- their third requirement. Yeah. Five minutes.

KELSIE LOCKYER:

Ten minutes, sorry, Will. Didn't mean to interrupt you there but ten minutes.

WILL HISCOCK:

No, I'm -- we're well under five minutes. I'm about two minutes out. I think the timing on this will be perfect so we should be good.

For residential facilities that do not yet have staff members fluent in Innu-aimun, access to interpreters would be helpful for parents. Although it is difficult to improve upon mutual understanding between parents and staff in the parents' first language, interpreters fluent in Innu-aimun would at least provide an improvement over the situation Etienne and Nympha faced in their communication with the group home.

Conclusion. The tragic death of Wally Rich should not have occurred. It is the sincere hope of Etienne Rich and Nympha Rich that by addressing the systemic issues identified by the

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investigators, Kenn and Tara, in this report, by addressing these additional systemic issues identified as well in these submissions, and by following Etienne and Nympha's recommendations set out in these submissions, it is our hope that the -- that in the future fewer Innu children will be separated from their parents. And those Innu children that are placed in residential placement will receive a high level of care sensitive to their needs from staff fluent in Innu-aimun with robust access to Innu culture, even if such placements are not Innu-led.

That concludes my presentation on behalf of the Rich family. I don't know if there are any questions or further comments before we take a break.

COMMISSIONER IGLOLIORTE:

Do you want to go first? Do you want to go first?

COMMISSIONER QUPEE:

I want to thank you, Will, for the report. And I'm sure that it's something that -- for me I certainly take to heart. So thank you for the

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work.

WILL HISCOCK:

Thank you, Commissioner Qupee.

And I just want to also thank my colleague Alexander Packman who worked closely with the Rich family and worked heavily on this report with me when I was busy in another matter. He's moved on and is practising law in Ontario now, but I know that this had a tremendous impact on him. And you know, he contributed very greatly to this. So while he hasn't been part of the presentation today, I don't want to take false credit for a lot of work that he put into this. So my thanks as well to my colleague Mr. Packman for the work that he did for the Rich family as well on this.

COMMISSIONER QUPEE:

Thank you.

COMMISSIONER IGLOLIORTE:

Thank you, Nastash.

Commissioner Devine, any questions?

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COMMISSIONER DEVINE:

No. Just to say thank you, Will, for your presentation today, for your report and for your good work on -- with this family. And we look forward to your next presentation after we take a break.

WILL HISCOCK:

Thank you, Commissioner.

COMMISSIONER IGLOLIORTE:

Thank you. Mr. Hiscock, I sent some written questions but really I only have one after your presentation.

We interpreted our mandate to do no further harm, as well as to try and expose systemic issues by using a circle hearing process. And I'm just wondering, given the nature of the case that you had to do would a more court-oriented way of dealing with your case have worked, or are you satisfied and is your -- is your -- are your clients satisfied that the circle hearing process worked?

WILL HISCOCK:

That's that's an excellent question. And I have

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two parts to that answer. First was that this is the second -- or third, actually, hearing that I had been involved in that had taken place in the circle, and so I knew what to expect coming into this a little bit more than I had the first time around. I have been a convert to the circle hearing process.

I -- when this Inquiry began I had some reticence about proposing that to my clients in part for never having experienced it or dealt with it before. But I don't think we could have achieved the level of honest discussion that did occur, the level of healing that was possible, the level of insight and understanding between the parties that occurred. No process is perfect but this was highly preferable, I think, to a formal hearing that we had originally envisioned.

I have been completely converted to believing in the circle and the healing circle, the hearing circle as a way for parties to be able to meet with human understanding, to drop some of the titles and formalities that can create barriers

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to understanding, and to meet each other as human beings on equal footing and speak directly without somebody, like myself, intervening to be in the middle of the conversation. And so I think there's tremendous value to that.

I think there's still a role for lawyers in terms of advising and so on, but allowing the clients to take the front seat and to be in charge of the process to a much greater degree than they ever can in a formal hearing process, I think has provided healing to the family that couldn't have been achieved otherwise.

And I do think it also provided insight and honesty from some of the witnesses that they might not have felt that they could, if it wasn't for that openness of the circle. So I'm really, really glad that we went this route. I can't imagine it having worked out nearly as well in a more formal process, Commissioner Igloliorte.

KELSIE LOCKYER:

Thank you very much. I believe that concludes the questions from the Commissioners on this

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matter.

Thank you very much, Will, for your work and dedication on this. I know, you know, you being involved definitely made a difference to the family. So thank you very much for this and the other files.

Before we invite you to give your submissions on your -- one of your other files, we will take a quick 10-minute break.

WILL HISCOCK:

Thank you.

KELSIE LOCKYER:

Yeah.

(Off the Record)

KELSIE LOCKYER:

Welcome back, everyone. Thank you for bearing with us on a little extended little break there that time. But we will resume now with Will Hiscock once again. This time we'll be hearing from him on behalf of the family of Jacob

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Collins.

So, Will, once again, it will be an hour. I'll start the timer and I'll give you a heads-up if you get to the 10-minute mark. So you can go ahead whenever you're ready.

SUBMISSIONS OF MR. WILL HISCOCK (JACOB COLLINS)

WILL HISCOCK:

Thank you very much. I appreciate that. This will be a slightly shorter presentation so we won't be going -- we won't -- we won't be approaching our hour mark this time.

I have the honour today to give a presentation on behalf of two families, and we've just heard in relation to the death of Wally Rich. Both of these families lost sons by suicide in early 2020. And Jacob Collins, who I wish to speak about now, died on February 6th, 2020, at the Labrador Correction Centre. It was his cousin, his relative, actually, who died on May 22nd, who we just spoke about, Wally Rich at the Labrador

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Group Home.

Following Jacob's death, his mother, Virginia Collins, began seeking answers to how the system had failed Jacob since he -- they had taken him into care many years before. He was returned to his mother's care, but after he returned to his mother (sic) care, he was in deep distress and experienced serious mental health challenges.

After he aged out of care, the only people who Virginia could turn to for help were the RCMP. And the final failure of the system was the inability to keep him safe, even within the LCC, the Labrador Correction Centre after he was placed there.

During the week of July 14th to the 18th of 2025, the Inquiry had a hearing scheduled which took the form of a circle in this instance. The circle hearing was a vulnerable, emotional and challenging experience for Ms. Collins, but one which she is grateful to have experienced. She felt heard and acknowledged in a way that a

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formal hearing could not have done. Ms. Collins wishes to thank all those who participated and contributed in that hearing.

While the death of Jacob was and is a private tragedy, the reason it is part of this Inquiry is so that his life and his death could be a case study into the worst-possible outcome for a chile who is put through the child protection system in this province. The goal of the investigation was to use Jacob's situation to highlight systemic issues affecting Innu children and their families when they leave care.

Jacob's case was investigated by Kenn and Tara who did the rest of the death investigations in this Inquiry and who have been mentioned in relation to the other investigation.

As we did in our submissions, I want to walk through the systemic issues they have highlighted and emphasize how Jacob's life and death speaks to those broader issues.

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The first systemic -- category of systemic issues was the option to meet Jacob's needs for mental health services and support whether there were alternatives going into care and going out-of-care -- and going into out-of-care -- out-of-province care.

The investigators accurately canvassed these issues at pages 5-8 of their report. It is clear from their report that Ms. Collins was not engaged with the CSSD in a way that served to prevent her children from coming into care. Instead of supports, Ms. Collins found a system that offered no support to her or her son, other than placement outside of the home.

Virginia Collins badly wanted care for Jacob who was experiencing increasingly worrying behaviour and had dealt with addiction issues. After a few short-term placements, it was decided he should be placed at the Broken Arrow Treatment Centre, BARTS, for short, in Ontario. The systemic failures are discussed in the investigators' report and we adopt those comments and the

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criticisms of the investigators.

The issue of the lack of services available for Innu in Labrador takes on special importance, in Jacob's case, I believe. In this case, we heard about the total lack of appropriate services for a boy like Jacob. It was determined that the only facility available in Newfoundland and Labrador was the Hope Valley facility in Grand Falls. But even this was seen as insufficient because it did not incorporate Innu cultural considerations.

In the result, BARTS was selected. And we will deal first with that placement -- or sorry, we will deal with that placement at BARTS shortly, but it is clear there was a need for a facility like Hope Valley in Labrador. A facility that did have strong connection to the Innu language and culture Ideally, this would be led and staffed with well-trained Innu staff in their own community.

There should have been supports like this

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available to Ms. Collins. She was and is an intelligent and dedicated parent. There were absolutely no complaints or concerns with her care of her son. Removal should not have been encouraged in this case, but rather, treatment for Jacob and support for Ms. Collins should have occurred. That option would have been better for every person involved.

I would not have wasted significant resources in a system desperate for funding. Instead of supporting her, Ms. Collins was made to feel -- well, like a failure to CSSD staff -- by CSSD staff. The only solution offered to her was removal of Jacob from her care.

Jacob's experiences -- next issue I wish to address is system issue. Jacob's experience in out-of-care placements, including BARTS, and the mental health services available.

The experience Jacob had at BARTS and the experience that was reported back to Ms. Collins were drastically different. Ms. Collins was told

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of a happy boy who was well-integrated and thriving in Ontario. He was playing soccer and deeply engaged in cadets. She was repeatedly told how well Jacob was doing in Ontario, and she was made to feel that he was being treated better and being given opportunities she could never provide for him.

Time and again, Ms. Collins consented to Jacob remaining in care because she thought he was doing so well. The truth was very different. Jacob was deeply homesick and unhappy. He felt alienated in his foster home and he was treated as a small child despite being a young man. He towered over his foster mother. He tried to run away but was returned. He had alarms on the doors and windows of his room and was treated as a prisoner. He was monitored all day with a private worker at school.

Despite being an underweight adolescent boy, his diet and his food was closely monitored to the point that he was disciplined. An example of this was an incident report was made because he

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put two -- put an extra spoonful of jam on his toast. That was reported on the child welfare system, and was punished for having an extra spoonful of jam.

When interviewed by the investigator, social worker Linda Farrell noted that BARTS was selected as they, quote, were seen as more appropriate as they promised more emphasis on culture and family, end quote.

This view was misleading. While the Broken Arrow Residential Treatment Services, which is the name of it, implied an Aboriginal connection and a residential treatment program, neither was true. BARTS was really just a foster home with a poorly trained support worker who went to school and activities with Jacob.

There was no Innu cultural connection. Jacob was forbidden to speak Innu-aimun except calling his mother, calling home to his mother. Jacob's family had very little and very limited contact with him. His mother had to fight to visit him

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and his calls at home -- his calls home were strictly monitored.

His mother -- sorry, he lost his connections with his cousins and his uncles who were close with him. He was given no chance to maintain any friendships or any connections in his life, other than occasional calls with his mother, the only person he was given access to.

There was only one single psychological assessment. He never attended addictions or other counselling during all of his years in Ontario. Both the Aboriginal connection and the treatment services implied by the BARTS name appeared to be more skillful marketing than a reality in Jacob's experience. He needed cultural connections. He needed real treatment. He needed counselling. He was consistently denied all of these while in care.

As soon as Jacob was allowed to make his own decisions he left BARTS and returned to his mother's care. While he missed soccer and

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cadets, that he had started in Ontario, his desire for genuine culture and family connection and the lack of a positive relationship in the foster home made him want to return to Natuashish.

Upon his return, he began experiencing psychotic episodes. And Ms. Collins is still unsure if this was evident while he was in Ontario or not. If it was, then his mental distress was untreated or even undetected there.

The third area of systemic issues was the barriers to CSSD monitoring and supervising of the BARTS foster home and the lack of courtesy social workers while he was in Ontario.

This issue has been canvassed in the investigators' report. Ms. Collins' concern was not whether Ms. Oakman or someone from a Children's Aid Society reported to CSSD. Rather, her concern is that she was effectively misled by CSSD based on selective nature of the information that was provided to her. For example, incident

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reports made by CSSD never reached the family in many instances.

While a courtesy social worker may have provided CSSD more information as to how Jacob was doing, we doubt it would have helped in this case. Because CSSD seemed primarily concerned with ensuring Jacob remained in care rather than accurately informing Ms. Collins about his situation.

I say this isn't the primary concern of the parents, and I would say it's because we don't know that CSSD would have done any better at informing Ms. Collins, even if they had been better informed by BARTS.

The next systemic issue, however, is something which Ms. Collins cares deeply about, which is whether the long-term BARTS foster home caused harm to Jacob. Because of his placement at BARTS, Jacob Collins' connection with his family, community and culture was harmed. He was restricted from speaking his own language at the

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home. He was treated like a convict followed, monitored all day with alarms on his doors and his windows at night.

He was forced to be subservient to a foster mother who failed to treat him in an age-appropriate level of independence and respect.

Most critically, he was not given the much-needed counselling, which might have shown early warning signs and would have provided support for the serious mental illness he was developing.

The investigators' report rightly points out -- points to the mental distress caused by a placement in southern Ontario. They know, quote, his early onset mental illness must have been exacerbated by this move, end quote.

Ms. Collins agrees. The opportunities provided to Jacob during his placement were certainly beneficial to him. He did enjoy soccer and he also enjoyed cadets. But that cannot negate the

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serious harm done to him during his placement at BARTS. While at BARTS, Jacob was not allowed to communicate with his aunts or his uncles or his cousins or his close friends. He was only allowed to call his mother and these calls were limited.

He was homesick and he was lonely. The isolation and degradation of all of his -- and degradation of all of his important relationships seems cruel and counterproductive.

When CSSD allowed Ms. Collins to visit Jacob in Ontario she had to go alone. She had no support. And Jacob was not able to re-establish any other relationships during his visit. When Ms. Collins witnessed Jacob's fear of being heard speaking Innu-aimun and saw the alarms on his doors, the restrictions on his food, she was very angry. She said she wanted to immediately remove him, to take him home. She was alone in a distant province. She was afraid she would be arrested and she felt powerless to help him in those circumstances.

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The next issue we wish to address is the reintegration planning and support for Jacob when exiting care and custody of the Manager, including any youth services.

Jacob returned to Natuashish with no plan in place for him. He had not been given any opportunity to remain connected to his community while he was away. He was given no chance to speak with his close friend or friends during his years away. When he returned he had to struggle to regain the connections that had been lost.

Losing those friendships made reintegration more difficult than it should have been. He would have stayed in care, but for whatever reason, there was an unwillingness to move him out of the home where he had been in constant conflict with the foster mother.

He had wanted to change homes for years but was consistently ignored. He appears to have felt that the only way to be heard and to be respected was to leave care. As soon as he returned to

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Natuashish he lost his connection with Tuskers and BARTS.

Jacob should have been home frequently for visits if he had to move away from Natuashish at all. While leaving was a shock, returning years later, after so many crucial developmental years away was also difficult.

His mental illness was undiagnosed in Ontario and no support was provided to him for this. While the government had been willing to pay for a one-on-one worker to be with him all day and even to attend school with him while he was in Ontario, they offered no similar support to Ms. Collins. Jacob spiralled out of control in many hospital visits and he experienced hallucinations and suicidal thoughts. He was clearly in deep distress.

The investigators noted the known impact of severe dislocation on Jacob's mental health in relation to his placement in Ontario. The same must be true of his chaotic and unplanned return

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to Natuashish after many years away, without language or cultural supports or sufficient and widespread family connections.

Maintaining a widespread and strong connection with the community and the extended family is especially important in the context of Innu communities. Jacob should have been given greater access to his extended family during his stay in Ontario, both through frequent visits home and regular contact with family during a routine week in Ontario. This is important to ensure a child's transition is as natural and stable as possible.

In Jacob's case, there clearly needed to be an additional mental health and behaviour support provided to Ms. Collins when -- she was asked to take over the task of several full-time staff. Several full-time staff had been working on just days before.

Ms. Collins could have been offered similar supports in terms of a worker to what had been

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available, at least on an interim basis when Jacob returned. And that could have been gradually reduced to assist both the mother and the child and to give the return the best chance of success. They should have included some counselling for both the child and the primary caregiver. Such counselling would have increased the chance of a smooth transition.

In Jacob's case, it might have -- also have identified the nature of his emerging mental health crisis, which had gone undiagnosed while he was at BARTS.

Ms. Collins has reflected that absolutely no transition supports were given to her. When Jacob returned, it was unclear whether he would stay in Natuashish or return to BARTS. Ms. Collins noted he was dropped off, quote, like a hot potato, a problem that CSSD was quick to leave with her and forget.

There was no plan, no support, and seemingly no interest in Jacob, once he decided he did not

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want to return to the acrimonious relationship with his foster mother.

When we look at Jacob's case, it is especially tragic because it is clear that both he and his mother worked hard to make that transition a success. But they did so unsupported and against a backdrop of Jacob's sinking deeper and deeper into his psychosis. Jacob's mental illness made reestablishing his relationships more difficult.

If he had been allowed to maintain his close friendships while he was away, he would have returned to a community where he already had a peer support network, but CSSD denied that to him. Now he was trying to rebuild that, rebuild those friendships while going through the naturally alienating experience of a deep psychosis. Likewise, his deep connections with his great uncle Damian and his uncle Gabriel had been weakened by many years where there was no communication. This again reduced the connections he had and felt, and which could have been a great comfort to him in this time of

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struggle.

Ms. Collins worked to successfully provide a stable home despite the trauma that she had endured in their early years. She succeeded at this and led a life which could be an example for Jacob. For his part, Jacob brought his love of soccer back to Natuashish with him and he encouraged others.

Despite his hospitalizations and his own challenges he successfully graduated high school in his own community, and both Jacob and Ms. Collins put tremendous effort into making his return successful. Even if other supports had not been present, we are left to wonder if he might not have lived if better mental health support being there for him when he first got home.

The next systemic issue to address are the communications and barriers to communication between CSSD and Jacob and CSSD and the applicant, is how it's put in the reports, but

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we're talking about Ms. Collins.

The investigators' report accurately describes issues of communication that occurred due to the use of English. It was part of the communication failure by CSSD toward both Jacob and Ms. Collins, but it was also a symptom of a department that did not really want their opinions and did not care to listen.

Jacob spent years explaining the difficult relationship he had with his foster mother. His concerns were never taken seriously. He was left in this unhealthy relationship with no means to advance his independence or his self-autonomy.

He had been seriously contemplating returning to BARTS due to his attachment to soccer and involvement in cadets, but the resistance to finding him a compatible home stood in the way.

He sensed that CSSD did not care what he thought or how he wanted to live contributed to his chaotic return to Natuashish because he was not

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fully open with his plans. It appears he may not have fully discussed -- sorry, it appears he may not have fully discussed or freely discussed his return to Natuashish, even when he had decided to return. Because he did not want to give CSSD the opportunity to convince him to stay at his -- at his BARTS foster home.

Ms. Collins also notes the communication failure with CSSD. This has been one of the most distressing aspects of his death investigation for Ms. Collins, was realizing the falsely positive portrayal of Jacob's life in Ontario that she was given, once she started reviewing the documents as part of this Inquiry.

She feels she was misled and bamboozled into repeatedly signing her son away under voluntary custody agreements. She was told how great -- in great detail how well Jacob was doing in school, soccer, cadets. She was repeatedly told how happy he was and the opportunities he was getting. To her, it felt as if she was being told that she could not do for him what he

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needed.

Her interactions with CSSD and its social workers consistently made her feel like a failure of a mother unworthy of caring for her own son. We should remember that nowhere in the file was Ms. Collins' ability to parent Jacob questioned. She was consistently referred to as a dedicated and competent parent. And despite this reality that was not the message that Ms. Collins received.

CSSD was supposedly consulting with Ms. Collins about whether Jacob would remain in care. His placement was voluntary in theory, but that's not how it appeared to Ms. Collins. She was always alone when dealing with CSSD. She never had support.

The social worker would arrive, not to consult her for her genuine opinion, but for her permission for what they already planned to do. Ms. Collins has described how the social workers always arrived with the paperwork and the orders

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ready to be signed. They made her feel as if she had no choice. They did not offer any real choices. Rather, they simply wanted her to rubber stamp the course of action they had already chosen. This is not consultation or reciprocal communication.

The documents were always in English. And it was not made clear that there were any real choices. If workers wanted to give parents a real choice, then either the documents should have been crafted after the meeting to reflect the choice the parents had actually made, or multiple documents could have been offered to the parents, either to consent to the placement or to refuse to consent. Anything less can feel like real compulsion to a parent dealing with CSSD, especially given the colonial legacy and the complex relationship many Innu had with the child protection system.

Ms. Collins was not told about the full extent of Jacob's challenges at BARTS or the depth of his homesickness. He was not given the freedom to

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speak in his own language. Ms. Collins felt that he was told not to bother his mother or concern her. She only realized his fear of speaking Innu-aimun around his foster mother and the alarms on his doors and windows when she want to visit him in Ontario.

CSSD also failed to communicate with Ms. Collins about regular visits. She was consistently the one who had to push for the visit to happen. CSSD failed to keep up with Jacob. And so even when in care it was Ms. Collins who bought him -- brought him clothes -- bought him clothes. And other things that needed in Ontario. Otherwise, he was simply given clothes he did not want to wear to school. Even the basic level of communication and respect was lacking. Obviously this is important to a 14- or 15-year-old boy. He's worried about making a good impression at a new school in a strange community.

The most critical failure to communicate, however, must be the failure to have someone with a close counselling relationship with Jacob.

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Whether through CSSD or BARTS, he needed to discuss the trauma that he had witnessed and experienced as a child. That relationship -- a counselling relationship was never offered and that work was never done. It would have offered the best opportunity to have a -- and to have diagnosed and managed Jacob's mental illness at the early stages of its development.

Ms. Collins highlights what is perhaps the most shocking communication failure, the failure of the foster mother in Ontario to speak with Ms. Collins directly, or to report it to BARTS and in turn, CSSD. The foster parents did not call Ms. Collins and inform her of what was occurring, as would be normal practice. And as, I note, had occurred when Jacob had been place anywhere else in the short statement -- stays he had gone into before BARTS.

Ms. Collins was left only with Jacob's perspective and he hid his pain. He saw himself as the man of the house and he was protective of his mother and her emotions. He didn't want to

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worry or upset her. It is incredible to imagine that Ms. Collins could have her son live with this family for years, and yet have to rely on the flawed third-party reports to know what was happening inside the home.

Communications failures plagued every aspect of this case and are found at every level of the system in this case.

Final systemic issue to discuss is Jacob's access to in culture land -- cultural land-based activities, Innu language and community connections and family connections. I'm certain that the importance of nutshimit, Innu culture, more broadly, and family connections has been understood by all participants in this Inquiry, after the many articulated and passionate addresses that we have all heard from the Innu community.

The investigators' report notes the lack of Innu culture when Jacob was at BARTS. Jacob was totally divorced from his home and no trace of

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his culture was accessible to him, not even his own language.

It was also noted by the investigators that Jacob was not given -- sorry, not given anything close to sufficient time with his family and community. This was addressed under previous headings. But the importance of this, above all other issues, should be noted. It is terrible to have a young Innu boy find himself, quote, a stranger in a strange land, as the investigators put it, when he was away from his community.

But it must be ensured that they are never made to feel a stranger, to feel disconnected from their own land, their own family, their own people. When Jacob worked at -- while Jacob worked at reestablishing his connections when he got home, it was an added worry and challenge that he should not have been handling. And its impact on his fragile mental health will remain (inaudible).

I don't think that it can be overemphasized how

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important it would have been for Jacob to maintain his connections with his uncles, with his cousins, with his friends, with his community, with his culture and with his language over his years in Ontario.

We can all hope that no child will find themselves placed outside of the Innu communities and certainly outside of the province in the future. But if it does happen and if it must happen, there must be incredible efforts made to ensure that a smooth transition home remains possible and that a sense of alienation that he might feel when he's in Ontario is not duplicated because when he comes home he's also a stranger in his own land, and he has no land left at that point. I think that that is a sense that many of these Innu children have been placed away for long periods of time without the right connections and then come home feel naturally.

I just want to emphasize that I think that nothing in this case is as important as the fact that he was divorced from his own people, his own

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community, his own language, his own culture, so many of his own friends and family. A connection with his mother was important, but it cannot substitute for all the other connections in the child's life. And those were ignored by -- completely ignored by CSSD and BARTS in this instance.

I also think that it's incredibly important that we talk about the fact that BARTS was not Indigenous and was not really a treatment facility. And that that false sense that seems to have been shared not just by my client but by members of the social workers when CSSD persisted and it was misleading to what Jacob could expect when he got to Ontario and what he experienced when he was there.

Take a couple of minutes to go through some conclusions. Ms. Collins has put a lot of energy into this Inquiry in the year since it began. For her, it is not only about her son Jacob. She is still living with the effects of this system and her other son who was also sent away to

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Ontario is living out the same pattern of addiction, self-harm and repeated incarceration as Jacob did.

Even now her younger son is incarcerated at the Labrador Corrections Centre, and she is left the agonizing worry that se will -- that he will take his life in that building the same way as his brother did. Those worries, combined with the uncertainty and guilt any parent would feel after the child's suicide, have put her in a very dark place over the years since Jacob's death.

I say that because the Healing Circle that we went through was the most healing experience that has happened since Jacob's death. That circle made her feel free to fully share without fear of judgment, shame or condemnation. She felt totally supported and safe. And this may be the greatest accomplishment of this Inquiry.

Ms. Collins still struggles with the darkness and grief of this tragedy, obviously. And that may always be the case. But she has found it easier

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since the circle. She still gets angry at the way she and her son were treated. But that is balanced by a greater understanding of those failures and by the hope that this Inquiry can make the changes that they need.

I really want to thank all of the Commissioners and everybody who was involved in that circle. The healing work that happened in that circle was incredible. And the sense that my client had of being heard, really heard, really listened to for the first time ever, was profound and had a profound impact on her.

Frankly, it had a profound impact on me. When I spoke earlier about having been a convert, it was that week in Natuashish last summer that was my conversion experience, I guess you could say. Because I came in to that Healing Circle not knowing what to expect, and I left so deeply relieved at the relief my client had felt and that I had seen -- the change I had seen in her over the course of that week, that I still think that those Healing Circles -- if this Inquiry, if

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all of the -- and we pray this is not the case, but if all of the recommendations of this Inquiry were ignored and government completely took the report and threw it in the trash, and we all hope and pray that that's not going to be the case, I know, but this Inquiry would not have been in vain simply for what that week produced and what those other weeks of the Healing Circles produced.

That has been incredible work, and I think it's incredibly valuable work, not necessarily for the whole population of the island or even for all of the Innu, but for the families that have been going through this grief.

I want to really thank the Commissioners and the Inquiry staff who made those Healing Circles possible, because I think that incredible work was done in those weeks. And on behalf of the families, that the relief I have seen and the healing that happened in those weeks was incredible. I have never seen any legal process ever produce anything like it.

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Those are my only comments, unless the Commission has questions for me.

COMMISSIONER IGLOLIORTE:

All good. Thank you very much.

COMMISSIONER QUPEE

Thank you, Will.

COMMISSIONER DEVINE:

Thank you very much, Will.

KELSIE LOCKYER:

Thank you very, very much, Will. Thank you for your submissions in this and in the case before.

And I, as well -- well, I know that James Maher from your office will be doing submissions on Thunderheart. I also want to thank you for your representation in that one. You made the hearing -- you made a great difference to that hearing and to the other ones as well.

So thank you very, very much for all your dedication and the compassion and everything that you've showed towards the family. That echoes as well for the other counsel on the call. It's been a great honour to do this work, but it is

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quite heavy. So thank you very, very much.

We will take a quick 10-minute break now just before we invite Mr. Maher to do the final submissions regarding the family of Thunderheart Tshakapesh. So we'll have a quick 10 minutes and we'll see everybody back here at 3:25 or so, Newfoundland Time.

(Off the Record)

KELSIE LOCKYER:

Welcome back, everybody. I hope you enjoyed your short health break there.

We will now invite James Maher to give submissions on behalf of the Tshakapesh family. And this will be our final submissions for today. So as I said to the others, Jim, you'll have an hour. I'll put on a timer and I'll let you know by the 10-minute mark, if you get to that point. So you can go ahead now whenever you're ready.

JAMES MAHER, K.C.:

Okay. Thank you. Can I be heard?

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KELSIE LOCKYER:
Yes.
BRIAN HARVEY:
Yes.
JAMES MAHER, K.C.:
Perfect. Yes, my name is James Maher. I'm here today to represent the family of Thunderheart Tshakapesh, in particular his parents, Simeon and Ruby. Before I get underway, I just want to make a personal comment for my own comfort. Many familiar names on this list today, so they already know this, but for those of you who don't, I'm blind.

So I only raise this for three selfish reasons. One, I'm in the frame of the camera. Two, I'll do my best to look in the -- look at the camera. And number three, my delivery may not be as fluid as other counsel. There's a voice in my computer that talks to me, and I'll be relying upon that to go through my notes for my remarks today. So I -- okay. There we go. I haven't started my --
KELSIE LOCKYER:
I just want to let -- your video's not on there.

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Oh, perfect. There you are.
JAMES MAHER, K.C.:
Okay. Yeah. So therefore, see my -
KELSIE LOCKYER:
You're perfectly --
JAMES MAHER, K.C.:
- two earlier comments. Pardon me?
KELSIE LOCKYER:
You're perfectly in frame. You're good.
JAMES MAHER, K.C.:
Good, okay.
KELSIE LOCKYER:
Yes.
JAMES MAHER, K.C.:
So as I was finishing up there, so hopefully -- I beg -- just beg your patience with me as I try to listen in my ear and talk at the same time.

SUBMISSIONS OF JAMES MAHER, K.C. (THUNDERHEART TSHAKAPESH)

JAMES MAHER, K.C.:
I'm in a different position than other counsel here today who have been involved in this Inquiry and have been doing, as has been commented on a number of times today, fabulous work over the past number of years. I've only become involved in the last four or five weeks when I was approached to represent Simeon and Ruby today. So I've done my best to get up to speed in that period of time, but have not had the benefit of much of what you have all heard over the many months that this Inquiry has been going on.

As I said, I'm representing Simeon and Ruby, but before we start, I would also like to recognize their other family members who have been a part of this journey with them. Thunderheart's sisters, Angela and Nicole, who participated in the circle hearing and also participated in the investigation. Thunderheart's late brother Vincent, who was, during Thunderheart's life, was involved in his care, and the many extended family who also participated in the circle hearing.

Unfortunately, my involvement in the case came after the occurrence of the circle hearing. I have had the -- I have had the opportunity to

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review the recordings of the circle hearing, and I, like Will before me, although I wasn't personally present, I was very impressed and very moved by that process and what occurred. So I want to begin my remarks today by trying to paraphrase remarks made by Simeon at that circle hearing.

They struck a chord with me, certainly as someone coming late to -- late to this process and trying to -- trying to digest the information and the impact that child care or the child welfare system has had on their lives and the lives of the Innu people. And paraphrasing Simeon, he said, picture this, that we as Innu people took care of your child, your non-Indigenous child. We brought them into our care. We brought them to our land. We brought them to the country. We had them live the way that we live, speak the way we speak, eat the food we eat, had them speak our language, limited their communication, how would you feel? What would your mind be like? Imagine how worried you would be, are they being cared for?

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And for me, that statement really put this whole process into perspective, because in each of these cases, and particularly in Thunderheart's case, that's what happened.

So throughout the presentation, I'm not going to go through it maybe as in as much detail as some of the other counsel here today, but going to focus on some of the themes that have emerged and have kind of woven through many of the things that have -- that occurred in Thunderheart's life.

Thunderheart Tshakapesh, he was born on January the 18th, 2001. He spent 20 months in the child welfare system. He entered the system at age 14, and he had a number of placements during that time, two at Ranch Ehrlo in Saskatchewan, and another two at Hope Valley Treatment Centre in Grand Falls, Winter -- Grand Falls, Windsor, I'm sorry. When he was about 15 and a half years old, his last placement ended, and he was returned to Labrador.

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On January the 18th, 2017, he turned 16, and according to the child welfare legislation at that time, he aged out of their system. His file was closed in April of 2017. The next month, on May 24th, 2017, he was dead. He died by suicide in the woods, not far from his home in Natuashish.

So in relation to the -- some of the themes that have been identified, and in particular talking about the legacy of colonialization and intergenerational trauma, the lack of -- the absence of or lack of services, and the lack of culturally sensitive communications -- and communications. These themes come up in a number of areas in Thunderheart's journey, and I just want to touch on some of them for a few moments.

So first, to focus on some things that happened to him before he went into care. Thunderheart seemed to have a relatively typical childhood, as the report - and I'm referring to the report of Kenn Gerard (sic) and Tara Petti - note that he seemed for the first few years of his life, his

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interventions were mostly related to his physical health and were generally unremarkable. However, by age 10, there's the first reports of -- that he was expressing suicidal ideations and suicidal thoughts, and also around the same age were the first reports of him participating in gas sniffing.

The records don't seem to reflect that very much was done in relation to that. And certainly, based on what we know, and that the community's experience with the scourge of gas sniffing, it seems that an opportunity was missed here, as there was little, if any, intervention, some indications of counselling, but nothing really happened.

And three or four years go by without really -- without really, again, anything really seemed to happen -- happening to take place. And it wasn't until April of 2015, at the instance of his own parents realizing that he was in crisis, that they sought help by going to CSSD to seek assistance. This was not a decision, I think,

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that was made lightly. Certainly in hindsight, was not considered to be easy.

As is probably very well known, Simeon was a very outspoken voice in his community. He had been involved in it politically, had been a former deputy grand chief, and was very familiar with the issues in his community, and it was a very difficult decision for him to do this.

Similarly, Ruby, also involved in her community, both of them having had their own experiences, knew that they had to do this, but weren't necessarily sold on that it was the right thing to do.

As this report and other reports of the other children kind of reflect, this is often a decision that is made out of crisis and desperation. And, of course, the response of the system at that point in time, because I think as Simeon and Ruby knew and everybody knew, the services that in -- limited, if any, services that were available in Natuashish at that time

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were not adequate for Thunderheart's needs. And they knew that this very likely meant an out-of-province placement. And that's what happened. This resulted in Thunderheart being taken thousands of kilometres away to the Ranch Ehrlo Treatment Centre that we have heard about today in connection with other families.

This decision then led to the series of off Labrador or out-of-Labrador placements that I referred to earlier. The -- both of these placements were for relatively short periods of time, sometimes a matter of months, and sometimes just a month. And, again, as has been referenced through previous submissions, neither of these facilities -- although I think Ranch Ehrlo probably, according to reports from Mr. Richard, had the services that it was well-versed in treatment of other Indigenous groups, but not for the Innu people. Innu group -- Innu First Nations may have some factors in common, but they are not interchangeable. And Thunderheart wound up at a facility where that cultural connection could not be maintained.

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As -- and at the circle hearing, the representative for Ranch Ehrlo did admit that they were -- services were woefully inadequate when it came to the treatment of Innu children.

Similarly, at Hope Valley, on the island, at the circle hearing, their representative spoke and admitted that they were not set up to provide culturally sensitive services. Their representative who was there said, you know, they didn't -- they didn't get any training. They spent, I think it may have been, a week or two in Labrador before the facility opened. I think they spent some amount of time in Sheshatshiu. Although I think there was an expectation by government that they could take on this treatment task, they were not set up to do so. And one of their representatives acknowledged at the hearing that Innu children who were there, like Thunderheart they were not permitted to speak their language on the floor apparently for safety reasons.

The comment that runs throughout some of the

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reports is that these placements were physically safe, but they were not culturally safe. No doubt that these placements provided services but there seemed to be an overall lack of a plan, coordination of services and communication between individuals. What it seemed to be was that service chaos was the norm.

Language barriers were also an issue. And this was acknowledged by Ranch Ehrlo that some of the issues that arose there, first of all, in relation to some of the assessments that were done on Thunderheart may not have been accurate as a result of language difficulties. Also, Thunderheart went through periods of being very happy in placements or felt that he was being -- the treatment was working to times where he was totally resistant to it.

And, again, Ranch Ehrlo seems to recognize that the language barrier and being able to communicate effectively with Thunderheart may have been a factor in how his placement there ultimately turned out.

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Thunderheart's perspective on all of this is captured in the -- in the report and also mentioned by his mother, Ruby, when she testified at the circle hearing. During his time at Ranch Ehrlo, Thunderheart just wanted to be home. There are references in the records numerous times in relation to him being homesick.

Thunderheart sent his parents a message. He said, "I'm so homesick. I'm losing my language here. I don't want to be a White boy, I want to be an Innu boy."

I think that is very telling as to Thunderheart's state of mind and in relation to the whole situation that was arising of being somewhere where he had issues communicating. He wanted to be -- he had a good family. He wanted to be close to his family. And that's where he -- that's where he wanted to be. And although I think he may have had some insight into getting well, he just could not see it happening there.

The other issue that comes up kind of crossing

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over between different themes, I'm sorry, but the issue that -- also the issue that comes up here, and particularly in relation to Ranch Ehrlo, is when Thunderheart was -- both times he was discharged, they came up with a great set of -- you know, various recommendations and various things that should be done. Of course, the reality of that was none of those were possible in Labrador based on the services that were -- that were available.

And again, as the representative said, we made those on the basis of best practices, but didn't really realize that they were totally unworkable. So Thunderheart was leaving, and again this becomes a theme of really with a plan, but not a workable plan, so really no plan in place.

The next theme I sort of want to focus on, and again comes up throughout the previous submissions, were communication issues. And this begins with -- again, I would -- I guess it was categorized as the legacy of colonialism and the mistrust of authorities. And this was

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particularly the case for Simeon and Ruby.

Simeon talked a lot about communication at the circle hearing, and he recounted his own time in school and how in school he was forced to speak English. And if he tried to speak his own language, then, he said, there was soap pushed in his mouth or he was beaten. He said -- his words were that was my introduction to communication. That's not communication.

Through their lives in the community, Simeon and Ruby had experience with interacting with authorities. Simeon, at the circle hearing, spoke a number of times as his time as a special constable with the RCMP, and Ruby did community work. And very telling, and these were Ruby's words at the circle hearing, that she described the authorities, and I think, in particular, those working in social services in the community as the monsters. And the monsters were out there, and the monsters were out to destroy everything that we were trying to do.

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So when they encountered the system back in April of 2015 in relation to their own child, you know, this is the background that they are coming with.

Mr. Richard in his report makes a number of observations in this regard, including that the family, in dealing with CSSD, felt alienated and uninvolved. They expressed, as they did at the circle hearing, their dissatisfaction with communication and consultation. Transparency and accountability were in question throughout the whole delivery of the -- of the services. And that, Mr. Richard's words, CSSD were unable to establish effective communications with this family. In fact, I think he said in this case communication was really miscommunication.

Two factors that certainly contributed to this, which is touched on a little bit today, is the fly-in/fly-out model of service delivery, and also the inexperience of many of the staff who were involved in providing services.

I think the way that Simeon and Ruby felt often

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in their interactions with CSSD is they were seen, but they were not heard. There were two incidents or -- yeah, two incidents that were highlighted in the report, which are significant, I think, to the issue of communication. The first of these is an incident that occurred during Thunderheart's second placement at Ranch Ehrlo, which had happened in 2016.

At its worst, this incident can be described as an assault causing bodily harm. At its best, it could be described as a restraint gone wrong. As Mr. Richard notes in his report, the circumstances around this event are murky. But it happened in May of 2016 and related to Thunderheart acting out while at Ranch Ehrlo. And staff were there trying to settle the situation, which included other residents at the time. And in the course of this incident, Thunderheart wanted to go to his room and get his guitar.

Thunderheart loved music. It was one of the consistent things that seemed to ground him

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through these various experiences. And he was restrained from going to his room, and as a result of what happened, Thunderheart felt back -- fell back and hit his head. And he was taken to hospital.

As I said, there's, you know, various -- there's different versions of this -- of this event, but I think what's important to remember or recognize about it is, it is a boy -- it's a boy who sustained an injury to his head and is a boy who was taken to hospital. At its core, that's what happened. There may be different versions of how that happened.

Ranch Ehrlo says that it completed a critical incident report and that this information was communicated to CSSD in Natuashish around approximately, I think, May 16, 2016. The person who received that received that on the day that they were scheduled to fly out of Natuashish. And this report, whatever its nature was, was not seen.

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This report -- so this individual returned 14 days later, on the 30th of May, and saw this report. This was not communicated to Mr. and Mrs. Tshakapesh until at least the 12th of June. So now almost a month after the incident itself has occurred.

And again, there are differing views on what happened -- what happened here. CSSD believes that they told Mr. Tshakapesh about the incident. Mr. Tshakapesh says that CSSD were there at his office that day, but not for that reason, but for another reason. But it does seem, based on an email that he did send a few days later, that he was aware that Thunderheart's head had been pushed into a wall. But there's certainly no indication that he was aware that his child had been -- had been taken to hospital.

And this is an issue that is of great significance to Mr. and Mrs. Tshakapesh, because although they knew there were -- by Mr. Tshakapesh's email in June, they knew that there was some type of an incident, but certainly

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it does not appear that they knew that their child was hospitalized. And not even now any -- and not even now, the -- any detail as to the extent of what that involved.

And this, it certainly seems to be, and it was identified by Mr. Richard, as, you know, a clear communication breakdown on something that was clearly needed to be communicated to parents. There was a total reliance on CSSD who had a fly-in/fly-out model with not the necessary continuity to convey this. But as any of us can imagine as parents, you know, your child goes to the hospital, wherever they are, you want to know.

Mr. Tshakapesh -- Mr. Tshakapesh and Mrs. Tshakapesh did not, you know, find out, I think, the true extent of this incident until 2021 when they were contacted by another resident of Ranch Ehrlo who was there at the time who provided them with a very vivid description of what happened. And that triggered Mr. Tshakapesh requesting a police investigation. And none of this has ever

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been resolved to his -- to his satisfaction.

And so for -- it has led to great regret on their part. They feel that if they had known in May of 2016 that Thunderheart had had a head injury, that they would have sought more investigation because it is relevant because they commented that when he returned from his -- that placement at Ranch Ehrlo, he was not the same boy. He did not have the same interest in his music. He did not have the same interest in other activities that he had previously enjoyed.

It is also significant that the Hope Valley employee who was at the circle hearing, where Thunderheart went following his Ranch -- his second Ranch Ehrlo placement, so his second Hope Valley placement, she also recognized that Thunderheart was a changed boy. So all this information together, certainly the Tshakapeshes feel that if they had known that something happened... And it's a fear, a concern that they live with and still haunts them today.

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The other aspect of communication which was very significant in the report was the use of medication and communication around that. At various times throughout his placements, particularly at Ranch Ehrlo, Thunderheart was on and off medication. Sometimes wanting to take it, sometimes not wanting to take it, sometimes disappointed because his parents didn't want him to take it.

And there -- again, there is a lot of mixed or miscommunication around the use of medication. And again, Simeon and Ruby bring their own experience to this. They've had some personal experience, particularly of antidepressant medication. They have had anecdotal experience of others on anecdotal antidepressant medication. They had communications with Thunderheart while he was there and on medication that caused them concern.

They certainly communicated that they do not feel, and Mr. Richard reflects this in his report, that these concerns that they expressed

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were heard. Mr and Mrs. Tshakapesh also expressed concern with respect to explanations they were given about these medications. And that has been echoed by others today.

And also, this is all happening for them thousands of kilometres away. They have sporadic contact with their child, and they are being fed information, but not necessarily given the opportunity to understand and digest that information. And these are just, you know, two examples of issues that arose throughout Thunderheart's time in care, of how information was being transferred, filtered through Ranch Ehrlo, filtered through CSSD, and it clearly was a model that was not working.

They also expressed concerns about reports of Thunderheart being absent, AWOL. In fact, that was the cause of his second discharge from Hope Valley, and on one occasion caused Simeon Tshakapesh, you know, to drive to Saskatchewan to get him.

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The -- another part of the communication piece that's identified in Mr. Richard's report is Simeon's position as a community leader. This has been described, I think Mr. Richard called it at the circle hearing, a hot potato.

It suggested that Mr. Tshakapesh's community position as a leader, as he said at the circle hearing himself, as a person -- I'll amend slightly, with a big voice but a big heart, and who wasn't afraid to speak out and that somehow this caused confusion on the part of CSSD. And certainly I suggest that that is not Mr. Tshakapesh's failure or failing on his part -- as a failure on the part of CSSD.

He was a known -- he was a known quantity in the community for sure. But there should have been no confusion between Mr. Tshakapesh as deputy grand chief or Mr. Tshakapesh as Thunderheart's father. I think, any of us, we found ourselves in Mr. Tshakapesh's position and we had big voices, that we would be using the tools that we had to get the help not only for our own child

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but for our community. I mean, that's all he wanted. He wanted a healthy child living in a healthy community.

And it almost begs the question, given Mr. Tshakapesh's profile, given his personality, you know, if he couldn't get help -- if he couldn't get help for his child, then those without voices, what hope did they have?

Finally, I just want to touch on the last item of post-care planning and support. And this really takes me back to where I began in giving the brief description of Thunderheart's journey through the child welfare system.

That on September 30th of 2015, he was discharged from the Hope Valley Treatment Centre. There was really no discharge plan. Follow-up with his physician. Did he have one? And he returned to the community. There seemed to be little, if any, activity at that time with CSSD. There seemed to be some contact, but here you had a young boy with complex mental health issues

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approaching his 15th birthday. And it just seemed that nothing was happening.

So as I said before, on the 18th of January 2001, he turned 16. Again, nothing happens. There was no plan, no services, no support. His file is closed and, tragically, he takes his own life. He aged out.

Now, his testimony that he gave before this commission, Mr. Richard certainly had some comments about that. You know, this is an arbitrary construct, this aging out. You know, those of us who are parents, you know, our children don't age out of our lives. I think Mr. -- I think Mr. Richard stated this very bluntly in Thunderheart's report, and it's a very sad comment, that all parties gave up the first chance they had to do so.

In terms of recommendations, we don't have anything specific. Mr. Tshakapesh has been -- has been clear that whatever comes out of this Inquiry, whatever the model that is suggested,

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that it has to be firmly Innu-based, that it has to embrace Innu culture. It has to embrace Innu language, Innu spirituality. And very important for Simeon and Ruby, the new attachment to the land and the land as a healer has to be incorporated.

Simeon and Ruby are also realistic, and it's stated in my submission and they recognize it, that as challenging as this Inquiry has been, this is only the beginning and the hard part is yet to come, and that is implement whatever model and hopefully it's one that gives the Innu the degree of self-determination that they desire. That there is a lot of work to do and that they will need help. And they hope that it recognizes that the way this has been working is not a system that is familiar to the Innu people historically and that it needs to build on the values of the Innu people.

Simeon and Ruby also have a fear. They have a fear that the Inquiry will do its part, it will make the appropriate recommendations but that the

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Government of Canada, the Government of Newfoundland and Labrador and the political leaders of both will not have the courage to do what needs to be done. That they will not provide the resources to do what needs to be done.

In closing, at the circle hearing, Simeon explained that in January 2001, when his son was born, he went to his grandmother and said, Grandma, how should I -- what should I name my child? And she said, you have heard the thunder and the lightning. You have heard the power of that noise. That noise is Thunderheart. And Simeon and Ruby ask you and the governments to not lose the power of Thunderheart and the power of Thunderheart's spirit and to do the right thing. Thank you.

COMMISSIONER IGLOLIORTE:

James, thank you very much. This is Jim Igloliorte.

JAMES MAHER, K.C.:

It's been a long time, Commissioner.

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COMMISSIONER IGLOLIORTE:

Yeah. I was reflecting on the year 1985, when you -- when I first met you. You were skillful, dedicated, and a smart lawyer then. Of course, that has never changed.

JAMES MAHER, K.C.:

Thank you, Commissioner.

COMMISSIONER IGLOLIORTE:

I want to say to you that -- I want to say to you that it's quite telling that your client is the emphatic exclamation point to these hearings on the death investigations. We all know that without the effort that Ruby and Simeon put in, very likely this Inquiry either would not be happening now or it may have taken a very different form. So to hear your advocacy on their behalf and on the behalf of the Thunderheart's memory is quite compelling to us as Inquiry commissioners.

So I want to assure you and your clients that we are listening and we have heard from many people that this Inquiry is called the Innu Inquiry, and clearly it is because of the voice that you talk

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about, that we are listening to.
JAMES MAHER, K.C.:
Thank you, Commissioner.
COMMISSIONER IGLOLIORTE:
Thank you. I simply want to say that your presence is appreciated and the work that you do is also appreciated.

So I'll ask now Nastash Qupee and also Professor Mike Devine if they have any closing comments. Nastash?
COMMISSIONER QUPEE:
I want to thank you for the presentation and I think it just reinforces that the foundation that we're building here, it's built on Innu values. And I think about their circle here, in Ruby and Simeon's, and it's never far from my mind of the things that they have spoken about and the importance of the Inquiry to make sure that we keep those recommendations close and moving forward that they're not on the shelf.

So again, thank you for your presentation.

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JAMES MAHER, K.C.:
Thank you.
COMMISSIONER DEVINE:
Yes, Mr. Maher, Mike Devine. I also want to thank you for your presentation. Quite a powerful ending, actually, I found.
COMMISSIONER QUPEE:
Yeah.
COMMISSIONER DEVINE:
So I appreciate that. I do want to say also though, to -- I guess the whole thing about the fear of what may not happen and is certainly something that the Commissioners have -- you know, have thought about and talked about, and we're putting our minds to how we can do this in a way that government really feels the impetus to move forward with it or maybe even feel pushed, I don't know. I don't know if anybody can push government, but we'll give it our best try for sure.

And certainly, the kind of change that we see would be transformational change so that the Innu take over their own child welfare and -- because

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it's not just about the child welfare system, as you well know, but about the community too. So we do have a broad focus on what needs to happen to actually bring about the change to repair some of -- a lot of the damages that have been done over the years, and hopefully a kind of reconciliation approach that can come from this, should government decide to do it. So thank you very much.
JAMES MAHER, K.C.:
Thank you.
KELSIE LOCKYER:
Thank you, Commissioners, and thank you, Mr. Maher, for your submissions. So that will conclude today's submissions.

I just have a few quick words before turning it over to the Commissioners to close the day and close this week of hearings. This week we heard from investigators, researchers, and counsel on behalf of the six families. And I want to thank everybody for the work and dedication required to get here today.

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Tuesday was our first day of hearings this week. It was also my third anniversary of my call to the bar. So I've been working on this Inquiry for half my career as a lawyer, and I cannot overstating what an honour -- it has been such an honour, particularly this early in my career. The work has been heavy, but the weight is an honour to carry, and it is nothing in comparison to the weight of the grief and anguish that the families and the communities have had to suffer.

So to everybody who participated this week, to everybody who put in work to get here, thank you. To Kenn and Tara for their compassion and humanity in conducting their investigation. The researchers for granting that work.

Thank you to all the other counsel, particularly counsel for each of the six families for lending their voices, support and knowledge for the system.

Thank you to the Inquiry staff behind the scenes and to the Innu people for opening yourselves to

this process. Thank you all.

It's been an honour to work alongside you, to learn from you, and to get to know everybody involved.

So with that, I'll turn it over to the Commissioners.

COMMISSIONER IGLOLIORTE:

Thank you very much again, Kelsie. We really appreciate the work that you've done this week, and, of course, with all of the staff of the Inquiry behind the scenes.

Just to prove to you how experienced and adept we are, I'm going to call on Professor Mike Devine to do the closing prayer for us. As you know, in the last four years that we've been speaking to Innu we're struck by how devoted they are in their present religion, but how close they are tied to all of their spirituality from the past.

So it's very fitting that Mike offer a closing prayer today.

COMMISSIONER DEVINE:

Thank you, Jim.

So greater God, we thank you for the hearings this week. We thank you for all the people who attended, who participated. And we put our minds and our hearts and souls to the Innu people in particular, as this is what all of this is about, to improve the lives of the Innu.

We ask this through Christ our Lord. Amen.

COMMISSIONER IGLOLIORTE:

Amen. Thank you very much.

COMMISSIONER QUPEE:

Thank you.

KELSIE LOCKYER:

Thank you. The hearings are now closed.

(Conclusion of Submissions of Family Counsel.)

C E R T I F I C A T E

I, Beverly Guest, of Elite Transcription, of St. John's, in the Province of Newfoundland and Labrador, hereby certify that the foregoing pages, numbered 1 to 234, dated April 23, 2026, are a true and correct transcript of the proceedings which has been transcribed by me to the best of my knowledge, skill and ability.

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