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

IN THE MATTER OF the Investigation into the Treatment, Experience and Outcome in the Child Protection System of WALLY RICH (deceased on May 22, 2020)

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

Submissions on Behalf of Etien Rich and Nympha Rich Re Investigation into the Death of Their Son Wally Rich

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I. *Overview*

1. 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 Etien Rich and Nympha Rich, continue to deal with this profound loss.

2. On April 27, 2022, the *Inquiry Respecting the Treatment, Experiences and Outcomes of Innu in the Child Protection System Order* ("the Order") established an inquiry ("the Inquiry"). Per s 4(2) of the Order, the Inquiry was established to, among other things,

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

3. On December 23, 2022, Etien Rich, Wally's father, and Nympha Rich, Wally's mother, were granted standing to participate in the Inquiry, including full rights of participation in the formal hearing relating to the investigation of Wally Rich's death.

4. Following consultations with Etien and Nympha, on August 19, 2025, a Nature and Scope Order was issued by the Inquiry, which defined the parameters of the investigation:

i. The availability [of] services for parents and children in Natuashish;

ii. The effects of the approach taken by the group home placement;

iii. Mental health services (or lack of) provided to Wally while at the group home placement;

iv. Support and resources provided to the group home placement by CSSD;

v. Appropriateness of the skills, training and supervision of group home placement staff; and

vi. Communication between group home placement, CSSD and the parents while Wally was at the group home placement.

5. On January 15, 2026, an Investigator's Report was completed by Tara Petti, MSW, RSW with assistance from Kenn Richard, MSW, MSC, which investigated systemic issues that contributed to Wally's death ("the Wally Rich Investigator's Report"). Ms. Petti and Mr. Richard ("the investigators") reviewed documents and interviewed witnesses, including Etien and Nympha. The report identified 17 systemic issues:

    1. Absence of reunification-focused family supports

    2. Poor coordination of services and family connection

    3. Custodial, institutional model misaligned with child welfare

    4. Lack of individualized programming and cultural safety

    5. Structural constraints and unresolved operational deficiencies

    6. Absence of proactive, embedded mental health care

    7. Inadequate crisis response and policy non-compliance

    8. Fragmented monitoring, documentation, and continuity of care

    9. Ineffective oversight, licensing, and accountability

10. Insufficient clinical and multidisciplinary support

11. Reactive rather than preventive system response

12. Inadequate training for high-risk, complex care

13. Weak Governance, Accountability, and Executive Oversight

14. Weak Clinical Governance, Oversight, and Supervision

15. Normalization of Non-Compliance and Regulatory Drift

16. Pandemic conditions exposed system fragility rather than causing failure

17. Chronic communication breakdown and information loss

The report also identified three contextual systemic issues:

1. The Legacy of Colonialism

2. Structural prevention service scarcity and geographic (remote) inequity

3. Cultural Connection Recognized in Principle but Not Implemented in Practice

The findings of the investigators on these issues should be accepted as an accurate description of many of the systemic failures within the child protection system during the time Wally was in care.

6. On March 2, 2026 through March 6, 2026, Etien and Nympha participated in a Healing Circle in relation to the investigation into Wally's death.

7. On March 31, 2026, the investigators gave further testimony. They reviewed and expanded on systemic issues that they identified in their final report ("the Final Investigator's Report"), a report which synthesized and elaborated on the

findings of the investigators' reports on the six deaths that were investigated through the Inquiry, including the Wally Rich Investigator's Report.

8. These submissions review the findings of the Wally Rich Investigator's Report in relation to the six parameters of the investigation, with specific attention to how the various systemic issues affected Wally, as well as how they affected Etien and Nympha as the parents of a child who was placed at the Labrador Group Home ("LGH") by the Department of Children, Seniors and Social Development ("CSSD"). These submissions also indicate further systemic issues suggested by the Wally Rich Investigator's Report, the Final Investigator's Report, the Report on Innu Services, and other sources, and provide recommendations from Etien and Nympha regarding changes they would like to see going forward.

II. Systemic Issues

i. The Availability of Services for Parents and Children in Natuashish

9. The Wally Rich Investigator's Report identified two systemic issues regarding the availability of services in Natuashish for parents and children:

    a) Absence of reunification-focused family supports

    b) Poor coordination of services and family connection

10. The first systemic issue—the absence of reunification-focused family supports—was clear in the situation of Wally and his parents. As Etien and Nympha have noted, they undertook years of treatment and programming which had been recommended to them by CSSD in the interests of family reunification, 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. Further, on page 11 of the Wally Rich Investigator's Report, the investigators highlight "chronic staffing shortages, high caseloads, and limited-service [*sic*] options in Natuashish. These conditions constrained social workers' ability to provide sustained engagement with families, reducing opportunities for prevention, stabilization, and reunification planning."

11. The second systemic issue—the poor coordination of services and family connection—was also evident, and was particularly acute after March 18, 2020, when travel restrictions prevented in-person access between Wally and his parents. As noted on page 11 of the Wally Rich Investigator's Report, "[t]he file 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 and poorly integrated into overall care planning."

12. The Wally Rich Investigator's Report also identifies the failure to operationalize cultural and land-based supports. While Wally was a resident at LGH, a Cultural Connection Plan was developed with input from his parents to support Wally's connection to his family, his community, and Innu culture and language. However, Wally signed the plan on May 19, 2020, three days before his death, and as such the plan's recommendations were not implemented.

13. Beyond the two systemic issues identified above, the details in the Wally Rich Investigator's Report suggest an additional systemic issue regarding the availability of services in Natuashish for parents and children: an absence of early, preventive family supports to keep families together. Per the Wally Rich Investigator's Report at pages 10–11, "Etien 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 following his death." Further, as noted above, opportunities for prevention were reduced by "chronic staffing shortages, high caseloads, and limited-service [*sic*] options in Natuashish."

14. This absence of early, preventive family supports to keep families together was also emphasized in the Final Investigator's Report. As the investigators note at page 7 when describing the availability of services in Natuashish and Labrador more broadly,

> Mental health, addictions, developmental screening, early intervention, and family support services were either minimal, inconsistent, or entirely unavailable. Where services did exist, they were crisis-driven, reactive, and poorly coordinated. Early indicators of distress frequently emerged without corresponding preventative support capable of stabilizing youth and families prior to crisis escalation. Service responses were predominantly activated at crisis points, with child removal and residential placement functioning as primary interventions. Investigations documented missed opportunities for early intervention, including

> unacted clinical recommendations and unresolved educational or therapeutic planning needs.

15. The Report on Innu Services underlines the 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: an absence of long-term placement facilities. As noted on page 7 of the report, "before 2017, there were no Innu services, no funding, and no program staff in Innu child & family services." It is only very recently that Innu-led staffed residential facilities have been developed. The first such facility was opened in Sheshatshiu in August 2018. As noted on page 36 of the report,

> All of the placement homes are Innu-managed and operated, with oversight by two independent boards, [Shushepeshipan Ishpitentamun Mitshuap] and [Mushuau Innu Emergency Placement and Group Home], established by [Sheshatshiu Innu First Nation] and [Mushuau Innu First Nation] respectively. The homes offer 24/7 residential care and are run primarily by Innu staff, based on the Innu Care Approach.

16. In Natuashish, a facility that can accept long-term placements does not yet exist. In April 2019, an emergency placement home for short-term placements was opened in Natuashish. In April 2025, a hybrid home capable of accepting short-term and long-term placements was opened in Goose Bay. There are plans to transition the operation of this facility to Natuashish in 2027, though this depends on the planned construction of the facility in 2026. The emergency placement home can currently accommodate up for five children and youth in Natuashish, and as noted on page 40 of the report, the facility "has prevented the potential removals of 51 Innu children and youth as of June 2025."

17. It bears mentioning that both of these additional systemic issues are symptoms of one of the contextual systemic issues identified in the Wally Rich Investigator's

Report: structural prevention service scarcity and geographic (remote) inequity. As the investigators note at page 30,

> Across multiple interviews, Natuashish and the broader Labrador region were described as having significantly fewer services than other jurisdictions. Geographic isolation, limited health infrastructure, and reliance on fly in fly out services meant that parents and children faced substantial barriers in accessing mental health, addiction, educational, and crisis supports. Several witnesses acknowledged that services available in Labrador were not comparable to those available elsewhere in Canada.

18. With respect to Natuashish specifically, they note at pages 30–31 that

> Parents and children in Natuashish faced chronic, systemic shortages in mental health, family support, addiction, educational, and crisis services. These gaps were rooted in geographic isolation, underinvestment, and inequitable service delivery models, resulting in reliance on fly in fly out services or off-coast supports that were difficult to access.

19. These issues with fly-in-fly-out services in Natuashish are described in more details in the Final Investigator's Report. The investigators note at page 8 that CSSD

> implemented a distinctive system whereby professional staff were assigned to the community on a rotational basis, with each rotation lasting two weeks. This was to manage chronic staff turnover issues and resulting service gaps. While this approach may have solved one problem, it created another. Lack of service continuity worked against the formation of trusting relationships between Innu clients and their non-Innu helpers and without trust actions associated with problem amelioration become most difficult. This is especially true when previous relations were traumatic, which for Innu people, was most often the case.

20. 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 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 in 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 in Natuashish.

ii. The Effects of the Approach Taken by the Group Home Placement

21. The Wally Rich Investigator's Report identified three systemic issues regarding the effects of the approach taken by LGH:

    a) Custodial, institutional model misaligned with child welfare

    b) Lack of individualized programming and cultural safety

    c) Structural constraints and unresolved operational deficiencies

22. The first systemic issue—the misalignment of the custodial, institutional model with child welfare—was a glaring issue, and one that both Etien and Nympha raised as a concern. As the investigators noted at pages 13–14 of the Wally Rich Investigator's Report:

> Multiple witnesses, including Wally's parents, raised concerns about the LGH's historical origins as a youth corrections 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, rigid rule enforcement, and limited empathy.

Some examples of this lingering corrections mentality identified by Etien and Nympha include the fact that whenever Wally called them, the length of the calls would be restricted by the LGH staff, and the fact that snacks for the children were locked up.

23. At LGH, residents including Wally were supervised, but at page 13 the investigators characterize this supervision as "custodial, reactive, and focused on maintaining routine rather than addressing underlying emotional or psychological needs." They note at page 12 that

> the approach taken by the Labrador Group Home (LGH) 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 vulnerability, and emerging mental health risk.

24. This issue had a particular personal importance for Etien. In his youth, Etien had resided at LGH when it was a youth corrections facility, and the idea that decades later his son Wally was now residing in that same place, exposed to a similar corrections mentality and environment, was very painful to him.

25. The second systemic issue—the lack of individualized programming and the lack of cultural safety—was clear in general at LGH and specifically in relation to Wally. Regarding the lack of individualized programming, the Wally Rich Investigator's Report notes at page 13 that "[p]rogramming 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 was a resident of LGH, the LGH logs indicated signs of Wally's declining mental health, yet as the investigators note at page 13, these changes "were not followed by meaningful clinical response or adaptation of care."

26. The lack of cultural safety was emphasized by Etien and Nympha. As noted at page 14 of the Wally Rich Investigator's Report,

> Etien and Nympha Rich described staff as predominantly non-Innu and not speaking Innu-aimun, and expressed concern that language restrictions and lack of cultural understanding contributed to Wally's sense of alienation. Etien further alleged differential treatment of Innu children compared to non-Innu children, framing the LGH approach as discriminatory and inequitable.

27. There is no indication that Wally's cultural safety was a priority at LGH. As a resident there, he could speak Innu-aimun with his brother Donny, who was also a resident of LGH, but English was the dominant language of the facility. One of the few intentional uses of Innu-aimun by LGH staff was after the onset of the COVID-19 pandemic, when the group home coordinator obtained a video in Innu-aimun explaining the COVID-19 pandemic. The video was presented at LGH, and although the group home coordinator noted that both Wally and his brother Donny were very responsive to this video, Wally was offered no further programming or activities in Innu-aimun. Overall, as noted at page 14 of the Wally Rich Investigator's Report, concerns were raised in interviews with members of the LGH staff regarding LGH's "limited cultural responsiveness and inability to create a sense of belonging for Indigenous youth placed far from their communities."

28. The third systemic issue—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 a child's contact with LGH, with the child's placement at LGH. As noted at page 14 of the Wally Rich Investigator's Report,

> The service agreement governing the LGH 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 LGH often had complex and competing needs, yet the home lacked the flexibility or resources to adapt its approach accordingly.

As a result, children might end up being placed at LGH even if LGH was not a suitable environment for their care.

29. LGH's unresolved operational deficiencies were continual and well documented. As noted at page 14 of the Wally Rich Investigator's Report, "[m]onthly reviews identified persistent deficiencies in areas such as safety, programming, crisis intervention, and record keeping." According to the monthly reviews of LGH during the time Wally was a resident there (November 2019 through May 2020), in any given month LGH failed to adequately meet between five and eight of the standards required for placement resources, including five standards that were never met during the entirety of Wally's placement at LGH.

iii. Mental Health Services (or Lack of) Provided to Wally While at the Group Home Placement

30. The Wally Rich Investigator's Report identified three systemic issues regarding the mental health services provided to Wally while he was at LGH:

    a) Absence of proactive, embedded mental health care

    b) Inadequate crisis response and policy non-compliance

    c) Fragmented monitoring, documentation, and continuity of care

31. The first systemic issue—the absence of proactive, embedded mental health care—was a significant issue for the entirety of Wally's placement at LGH. Before he arrived at LGH, Wally had a number of documented cognitive and psychological issues. As noted at page 17 of the Wally Rich Investigator's Report, these included a "history of trauma, substance use, emotional dysregulation, and involvement in high-risk behaviours." However, despite these known issues, the investigators note at pages 16–17 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 LGH, at no point was Wally assessed by a psychologist or a psychiatrist.

32. The general approach of LGH to mental health access for its residents is aptly summarized by the investigators on page 17: access to mental health services was "dependent on youth initiation or consent, rather than proactively offered as part of a comprehensive service plan," and "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 LGH, but was rather expected to shoulder the burden of 1. Identifying himself as in need of mental health services; and 2. Navigating the process of accessing services for himself. This seems like an unreasonably heavy burden for any child, much less a child dealing with a number of cognitive and psychological issues.

33. The lack of proactivity of LGH's approach is evident in the few documented situations where the possibility of mental health services for Wally was contemplated, but not achieved. As the investigators note at page 17, "[i]n December 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." As the investigators note on pages 17–18, a few months later,

> On May 14, 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 this refusal, nor that Wally's decision was contextualized within his developmental stage or known difficulties with emotional regulation.

34. The second systemic issue— inadequate crisis response and policy non-compliance—was a general issue at LGH. Per the Wally Rich Investigator's Report at page 19,

> Mental health response within the LGH was consistently framed through ineffective crisis management protocols rather than therapeutic care. Protocols were frequently not followed, partially followed or completed in an ineffective manner. RCMP involvement was described as common and appropriate during critical incidents, highlighting the lack of accessible clinical alternatives. Several CSSD witnesses acknowledged gaps in formal mental health intervention and the absence of internal clinical oversight within the group home.

35. This issue of inadequate crisis response and policy non-compliance was acutely evident in LGH's response to Wally's suicidal ideation, which he expressed on May 17, 2020. As noted at page 8 of the Wally Rich Investigator's Report, "[i]t was Nympha who informed the LGH on May 17, 2020, that Wally had expressed suicidal ideation," to a friend online. As noted in interviews with LGH staff members and the LGH incident report, this prompted two members of the LGH 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 LGH, after which LGH staff called the RCMP and the CSSD on-call social worker. LGH staff members left the placement to search for Wally, and he eventually returned to LGH around 5:30 that evening.

36. Upon Wally's return to LGH, one of the LGH staff members called the CSSD on-call social worker, to update her on the situation. Per the LGH incident report, the CSSD on-call social worker gave direction that LGH staff should "check on Wally and see if he wanted to go to the hospital, call the Mental Health 1800 number or see anyone for further help" and "check his room to ensure that there wasn't anything he could use to hurt himself and to check on him periodically." When LGH 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 on page 18 of the Wally Rich Investigator's Report,

> CSSD and LGH 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 intervention between May 17 and Wally's death on May 22, 2020.

37. The manner in which LGH staff checked on Wally after his suicidal ideation intersects with the third systemic issue: fragmented monitoring, documentation, and continuity of care. As noted on page 18 of the Wally Rich Investigator's Report, "suicide prevention was reduced to visual checks, which were inconsistently carried out and poorly documented." Interviews with LGH staff make it clear that in some cases, these checks were not even visual, and simply involved LGH staff members listening from a different room to determine if Wally was making any sounds in his room. The lack of proper monitoring of Wally was of great concern to Etien and Nympha, and for good reason, given its clear inadequacy.

38. Issues at LGH with documentation and continuity of care were particularly glaring in the crucial period between Wally's suicidal ideation on May 17 and his death on May 22. As noted on page 19 of the Wally Rich Investigator's Report, "[m]ental health documentation was described as poor, unclear, and inconsistent. Reliance on shift notes without structured handover or shared situational awareness contributed to gaps in continuity of care." Since Wally never received a clinical assessment following his suicidal ideation, and since the LGH staff in general lacked training and expertise in mental health (a point expanded on below in section v (Appropriateness of the Skills, Training, and Supervision of Group Home Placement Staff)), 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 a structured clinical assessment that could inform a proper course of care for Wally.

iv. Support and Resources Provided to the Group Home Placement by CSSD

39. The Wally Rich Investigator's Report identified three systemic issues regarding the support and resources provided to LGH by CSSD:

    a) Ineffective oversight, licensing, and accountability

    b) Insufficient clinical and multidisciplinary support

    c) Reactive rather than preventive system response

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

41. Issues with ineffective oversight and accountability were apparent and well documented during the entirety of Wally's placement at LGH. As noted at page 21 of the Wally Rich Investigator's Report, "[m]onthly reviews and compliance reports repeatedly identified deficiencies in critical areas, including safety, programming, crisis intervention, record keeping, and residential planning. These deficits persisted over time without evidence of meaningful corrective action or enforcement by CSSD." As noted above, five standards were consistently identified as unmet in each of the monthly reports issued during Wally's placement at LGH. From the continued pattern of problems being identified, but not solved, the investigators conclude at page 21 "that oversight

mechanisms existed in form but were ineffective in practice, allowing chronic non-compliance to become normalized."

42. The second systemic issue—insufficient clinical and multidisciplinary support—is evident in part from how little evidence there was of robust support. As noted at pages 21–22 of the Wally Rich Investigator's Report,

> CSSD support to the LGH was largely administrative rather than clinical. There is little evidence that CSSD provided sustained clinical guidance, therapeutic oversight, or multidisciplinary support to assist the LGH in caring for high-risk youth. 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.

The investigators characterise the net effect of this insufficient support at page 23: "Roles and responsibilities for service coordination were unclear, contributing to gaps in mental health, education, and crisis response."

43. The third systemic issue—reactive rather than preventive system response—is evidenced by the changes and improvements that occurred at LGH in the wake of Wally's death, rather than in the years that preceded the tragedy. As the investigators note at page 22,

> Several witnesses described improvements implemented after Wally's death, including enhanced training, reduced bed capacity, and 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 a fatal outcome.

v. Appropriateness of the Skills, Training, and Supervision of Group Home Placement Staff

44. The Wally Rich Investigator's Report identified four systemic issues regarding the appropriateness of the skills, training, and supervision of the LGH staff:

a) Inadequate training for high-risk, complex care

b) Weak governance, accountability, and executive oversight

c) Weak clinical governance, oversight, and supervision

d) Normalization of non-compliance and regulatory drift

45. The first systemic issue—inadequate training for high-risk, complex care—was abundantly clear. Although LGH was a Level 4 placement, and its service agreement with CSSD specified that LGH would provide "services including specialized individual and group programming to children and youth with complex social, emotional, behavioral, and developmental needs," LGH staff were not hired for expertise in providing such services, and they were not provided with training sufficient to develop this expertise. As noted at pages 23–24 of the Wally Rich Investigator's Report,

> LGH staff were not qualified social workers, psychologists, or counsellors, and … formal training prior to assuming duties was limited. Orientation was described as brief and primarily operational in nature, with staff relying heavily on on-the-job learning and personal judgment. Training in trauma-informed care, suicide prevention, FASD, and crisis intervention was inconsistent or absent during Wally's placement.

Many members of the LGH staff had been working at LGH since it was a youth corrections facility, and without a significant amount of specialized training, it is clear that such staff members were poorly equipped to deliver high-risk, complex care.

46. As a result, the LGH staff were ill-equipped to respond appropriately to Wally's suicidal ideation, a concern that was raised by Etien and Nympha. As the investigators note at page 24 of their report, "[p]arents 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 LGH staff and the skills required to provide adequate care to high-risk children with complex care needs is part of why Etien and Nympha believe that LGH should no longer operate, for fear that a situation like Wally's could recur, with the same tragic results.

47. The second systemic issue—weak governance, accountability, and executive oversight—is apparent in the repeated failures to address persistent, well-documented issues with LGH. As noted at page 25 of the Wally Rich Investigator's Report, describing LGH,

> 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 and 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.

48. Etien and Nympha raised a concern that is further evidence of the weak governance and oversight of LGH: Wally being bullied by a member of the LGH staff. It goes without saying that such behaviour is completely inappropriate for an adult who is meant to be providing care to a child, and the fact that such behaviour not only occurred at LGH, but apparently was not addressed, is indicative of failures of governance and oversight.

49. The third systemic issue—weak clinical governance, oversight, and supervision—was evident in the general absence of clinical guidance at LGH. As noted at page 26 of the Wally Rich Investigator's Report,

> 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 or undocumented. Decisions regarding safety, privacy,

> supervision, and risk were made without clinical guidance and were often inconsistent and ineffective, relying instead on the subjective judgment of individual staff members.

A result of this approach was that high-risk situations like Wally's were not managed therapeutically, and the responses and actions of the LGH 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.

50. Supervision was also inadequate at LGH, which was arguably one of the consequences of the first two systemic issues. At page 24 of the Wally Rich Investigator's Report, the investigators describe supervision at LGH as "primarily custodial and focused on routine compliance rather than reflective practice or clinical decision-making. There is little evidence of regular supervision that included case discussion, risk assessment, or therapeutic planning." Further, as they note at page 26, "[s]taff lacked structured guidance to interpret behavioural changes, escalating mental health risk, or the cumulative impact of trauma and loss. This gap left staff unsupported in managing complex clinical situations and contributed to inconsistent responses during critical periods." Given the inadequate training of the LGH 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 LGH ended up with a deficient approach to supervision.

51. The net effect of this 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 known to be suicidal, suicide prevention ended up being a mix of visual checks and auditory checks from outside of his bedroom. During a period when clinical supervision was most needed, it did not occur.

52. The fourth systemic issue—normalization of non-compliance and regulatory drift—was evident in the repeated pattern of LGH's deficiencies being identified and documented, but not addressed. As noted at pages 26–27 of the Wally Rich Investigator's Report,

> Despite repeated identification of deficiencies through monthly reports, compliance reviews, and investigations, systemic non-compliance persisted at the Labrador Group Home. Deficits 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 emphasize at page 27, with non-compliance normalized, "unsafe practices became routine rather than exceptional."

53. A fifth systemic issue is also evident from Wally's case, connected to the lack of cultural safety identified above in section ii, and the third contextual systemic issue identified by the investigators (i.e., cultural connection recognized in principle but not implemented in practice): inadequate language training of LGH staff in Innu-aimun. 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 LGH staff was not only occurring without clinical guidance, but in his 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 can 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.

54. There is no indication in the records that any of the staff were fluent in the first language of at least two of LGH's residents, Wally and Donny. Having even one

member of staff 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 could help develop stronger bonds of trust of between the child and the staff member who shares their language. This bond could prove helpful during a time of crisis, as the child would know that there is an adult in the placement with whom they can speak openly and comfortably. For children like Wally, whose suicidal ideation included a stated belief that no one cared about him, having a staff member fluent in their language who the child feels comfortable talking to might even avert certain crises before they happen.

vi. Communication Between Group Home Placement, CSSD, and the Parents While Wally Was at the Group Home Placement

55. The Wally Rich Investigator's Report identified two systemic issues regarding communication between LGH, CSSD, and Wally's parents while he was at LGH:

    a) Pandemic conditions exposed system fragility rather than causing failure

    b) Chronic communication breakdown and information loss

56. The first systemic issue—pandemic conditions exposed system fragility rather than causing failure—is apparent when one examines the regular communication failures to be examined in more detail below. As noted at page 29 of the Wally Rich Investigator's Report,

> While COVID-19 exacerbated service limitations and communication challenges, the investigation finds that core systemic failures predated the pandemic. Pandemic conditions exposed and intensified existing weaknesses rather than creating them. The system lacked contingency planning to protect vulnerable children during crises, and pandemic

> restrictions were frequently cited to justify inaction rather than to prompt adaptive safeguards.

57. The second systemic issue—chronic communication breakdown and information loss—is clear not just between LGH, CSSD, and Wally's parents, but within LGH itself. As noted at page 28 of the Wally Rich Investigator's Report,

> Several witnesses described reliance on shift notes and informal communication within the LGH, contributing to poor continuity between staff and across 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 of his mental health status.

58. Communication between LGH and CSSD was also poor. As the investigators noted at page 27,

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

Further, as they note at page 28, "[i]ncident reporting 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. As the investigators note at page 27, "[s]everal CSSD witnesses acknowledged that they were unaware of key incidents until after Wally's death."

59. Etien and Nympha have been clear that their communication with LGH was inadequate. As the investigators noted at page 28,

> Etien and Nympha Rich reported that they were not consistently informed about Wally's mental health status or the level of concern following his suicidal ideation. They described being reassured that monitoring would occur 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 insight into his emotional state.

Etien and Nympha thus found themselves in a situation where they were not consistently receiving information from LGH that was very important to them concerning Wally, and it was unclear to them whether the information that they were providing to LGH was being used to best care for their son.

60. Etien emphasized that the communication he received from both LGH and CSSD concerning Wally was poor. The information he received seemed to indicate that everything was fine with Wally, when in fact it was not.

61. The breakdown in communication between LGH and Wally's parents was particularly acute for Etien 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 his closet. The contradicting accounts were the source of much confusion and anguish for Etien and Nympha, the incompatible accounts suggesting to them that someone was lying to them about Wally's death, or that someone was attempting to cover something up. This destroyed their trust in LGH and added an unnecessary additional layer of pain and fear when they were already dealing with the loss of their son.

62. A third systemic issue is suggested by this situation, akin to the fifth systemic issue identified in section v: inadequate language supports for Innu parents. Innu-aimun is the first language of both Etien and Nympha. Etien can

understand when some people speak English, but he himself cannot speak English well. Nympha has become increasingly fluent in English, but Innu-aimun remains the language she feels most comfortable understanding and speaking. Having all of their contact with LGH and CSSD occur in English created barriers to mutual understanding, and arguably exacerbated a situation in which the exchange of information was already poor.

vii. Summary of Additional Systemic Issues

63. As noted above, in addition to the 17 systemic issues identified by the investigators, Etien and Nympha submit that 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:

1. An absence of early, preventive family supports to keep families together
2. An absence of long-term placement facilities

Regarding the appropriateness of the skills, training and supervision of group home placement staff:

3. Inadequate language training of LGH staff in Innu-aimun

Regarding communication between group home placement, CSSD and the parents while Wally was at the group home placement:

4. Inadequate language supports for Innu parents

III. Recommendations from Etien Rich and Nympha Rich

64. In light of their tragic experiences with LGH, Etien and Nympha offer four recommendations that they hope will lead to better outcomes for children and parents, and prevent the occurrence of future tragedies.

A) LGH Should Be Shut Down, Demolished, and Replaced

65. Etien and Nympha emphatically recommend that LGH should be shut down, demolished, and replaced. They are not confident that LGH ever was a safe, adequate placement for children such as Wally, and they are not confident that any reactive changes in the wake of Wally's death have transformed LGH into a safe, adequate placement.

66. Instead, Etien and Nympha recommend building a brand-new group home. By beginning from a fresh start, Etien 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 take a custodial approach to care, will offer better, safer outcomes for any children who should be placed at this new group home.

B) Wally Should Be Memorialized

67. Etien and Nympha want Wally to be memorialized in the group home that replaces LGH. Wally's name and memory would provide a consistent reminder to the placement's staff of the importance of the children who reside in the placement, and the importance of keeping them safe.

68. 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 staff of their sacred duties and responsibilities to the children they care for. If Wally's legacy can save lives, that is what Etien and Nympha want.

C) *Placements that House 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*

69. When Wally resided at LGH, none of the staff members were fluent in Innu-aimun or deeply familiar with Innu culture, and as noted above, Wally's access to Innu-aimun and Innu culture at LGH were practically non-existent. During the six months that Wally lived at LGH, the only exposure he had to Innu-aimun that was officially offered through LGH was a video in Innu-aimun about the COVID-19 pandemic. Although a Cultural Connection Plan was developed for Wally while he was a resident of LGH, the plan's recommendations were not implemented before his death. Wally deserved better, as does any Innu child who finds themselves living in a placement.

70. As noted above, since 2018, Innu-led staffed residential 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 ("IRT") explains in *A Guide to the Innu Care Approach*, Innu-aimun and Innu culture are integral to the Innu Care Approach, Innu culture and language standing as foundations of an Innu child's well-being. Describing this approach at page 3 of the guide, they note that "Parents, Extended Family, Community, Innu Services, Culture & Language, and Elders are like *tshuap* poles building 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 have access to Innu-aimun and Innu culture, Etien and Nympha are concerned that children placed in other residential facilities in the province will lack comparable access, as Wally did.

71. The IRT has been clear that staff in residential facilities outside Sheshatshiu and Natuashish providing services to Innu children should be fluent in Innu-aimun and knowledgeable about Innu culture. As they explain at page 14 of *A Guide to the Innu Care Approach*,

> Innu children and their families need to receive services from trained Innu speaking staff who speak their language and know their culture – in prevention services, in protection services, and in the care homes and support services that they may access. No matter where they live, Innu children have the right to learn and participate in their language and their culture. Access to Innu-aimun and to land-based time in Nutshimit must be ensured, and should be done in a way that is consistent with normal community practices and seasonal activities.

Etien and Nympha echo the IRT's call that 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 children placed in such facilities have access to Innu language and culture that Wally did not during his time at LGH.

D) *Placements that House Innu Children Should Offer Greater Innu-aimun Language Supports for Their Parents*

72. Just as Wally had to communicate with the LGH staff exclusively in English rather than in his first language of Innu-aimun, so too were Etien and Nympha required to communicate with the LGH staff exclusively in English, rather than in their first language. As noted above, Etien can understand English when some people speak it, but he cannot speak English well, and although Nympha has gained increased fluency in English, Innu-aimun is still the language that is most

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

73. Following Etien and Nympha's recommendation C above would certainly help in this regard. Staff members fluent in Innu-aimun would be able to communicate with Innu parents in Innu-aimun, thereby making mutual understanding much easier for all parties. Innu parents would better understand the circumstances of their child in care, and be more confident that any information that they're passing along to staff would be fully understood.

74. 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 that Etien and Nympha faced in their communications with LGH.

IV. Conclusion

75. The tragic death of Wally Rich should not have occurred. It is the sincere hope of Etien Rich and Nympha Rich that by addressing the systemic issues identified by the investigators, by addressing the additional systemic issues identified in these submissions, and by following Etien and Nympha's recommendations set out in these submissions, in the future fewer Innu children will be separated from their parents, and those Innu children that are placed in residential placements 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 a placement is not Innu-led.

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