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# How a Labrador youth home failed Wally Rich: Innu inquiry hears details of his last months alive

*Commission told Natuashish teen was isolated by language, bullied by staff, and encouraged to seek mental health care elsewhere*

By [Tara Bradbury](#)

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Wally Rich was 15 years old when he died in a group home in Happy Valley-Goose Bay.

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*Lawyers for the families of six young Innu people from Natuashish who died after spending time in care presented their experiences at the Inquiry Regarding the Treatment, Experiences and Outcomes of Innu in the Child Protection System on Thursday, April 23, 2026. The Telegram will publish a story on each of the submissions.*

**Warning: This story deals with suicide and includes content that some readers may find difficult.**

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Five days before 15-year-old Natuashish youth Wally Rich died while at the Labrador Group Home in Happy Valley-Goose Bay, he made it clear he was struggling, telling a friend he was thinking about suicide.

What followed, a provincial inquiry has heard, were critical breakdowns by a system that was already failing him: safety checks

weren't carried out, his mental health wasn't assessed, and language barriers may have prevented staff — some of whom were not properly trained — from understanding the level of risk he faced.

Wally expressed suicidal ideation online to a friend, who relayed it to his mother back in Natuashish. She, in turn, contacted the group home.

When staff spoke with Wally about it, he repeated those thoughts, saying he felt no one cared about him. He then left the facility.

The police and a social worker were called, and staff left the home to find him. When he returned that evening and was asked if he wanted to go to the hospital, he said he was fine and just wanted to be left alone.

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Staff members were instructed to remove anything from his room that he could use to harm himself and to check on him every hour.

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Those checks, an investigation later revealed, were sporadic and sometimes consisted of workers simply listening through the floor below his room to hear whether he was moving.

By the time Wally was found in his bedroom at the group home on May 22, 2020, he had been dead for hours.

“The tragic death of Wally Rich should not have occurred,” lawyer Will Hiscock said at the provincial inquiry examining the deaths of Innu children and youth involved in child

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protection, presenting a submission on behalf of Wally's parents, Etien and Nympha Rich.

This story is one of six examining the deaths of young Innu people from Natuashish whose cases are now before the inquiry: Wally, Kirby Mistenapeo, James Poker, Faith Rich, Thunderheart Tshakapesh and Jacob Collins. Investigators hired by the inquiry have produced private, detailed reports on each case.

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All six young people were involved in the child protection system, and each of their families applied to participate in the inquiry, seeking an investigation into their deaths and the relation to the services they received.

Common issues and systemic failures have emerged: disempowerment, gaps and inappropriateness of services, accountability

failures, communication breakdowns, solvent abuse, and the ongoing effects of colonialism and intergenerational trauma.

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Through their lawyers, the loved ones of six young people from Natuashish who died between 2015 and 2020 – (clockwise from top left) Faith Rich, Kirby Mistenapeo, Jacob Collins, James Poker, Thunderheart Tshakapesh and Wally Rich – presented submissions to the Inquiry Regarding the Treatment, Experiences and Outcomes of Innu in the Child Protection System on Thursday, April 23, 2026. The inquiry's mandate is to examine systematic issues within the provincial child welfare system, conduct investigations into the young people's deaths, and to make recommendations to the government.

## Youth home staff trained in corrections, not social work

In Wally's case, Hiscock said, those systemic issues took on specific forms: a lack of supports in Natuashish, staffing shortages and high caseloads, chronic communication breakdowns, and an environment that left the teen alienated rather than protected.

Wally had been in provincial care for about a decade, despite his parents' participation in years of programming recommended to them by the Department of Children, Seniors and

Social Development (CSSD), with the goal of reuniting the family.

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He was placed in the Labrador Group Home in Goose Bay, hundreds of kilometres from his hometown, in November 2019.

The home had been a youth correctional facility until 2015, and concerns have been raised by Wally's parents, former staff, social workers and investigators that it continued to operate with a custodial approach.

Many staff members were trained in corrections rather than social work, psychology or other fields that would prepare them to work in a Level 4 placement, which is intended to provide specialized programming for youth with complex needs.

Staff showed limited empathy, investigators found. Rules were strict. Etien and Nympha

said Wally's phone calls home were limited, and snacks for the children at the facility were kept under lock and key.

They were also concerned that a staff member was bullying their son. The allegation was raised earlier this year at a hearing into his death, and Hiscock said he was shocked it wasn't denied or questioned by social workers and group home staff.

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"Rather, it was enforced that they had seen activities themselves that gave them concerns about staff bullying children there," he told the commission.

"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."

Despite having a service agreement with the provincial government, the group home wasn't even licensed during the six months Wally lived there, as it was unable to meet most required standards.

## **Youth encouraged to seek their own mental health services**

Investigators said the facility met residents' basic needs for food, shelter and supervision, but found no evidence of individualized care planning or structured therapeutic programming.

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They also discovered deficiencies in crisis intervention, programming, record keeping and other areas that had been flagged in monitoring reviews and compliance reviews, but there was no substantial guidance, correction or enforcement by CSSD.

Records show Wally's mental health was declining, but no meaningful intervention was followed. When he declined counselling, no alternative efforts were taken to try to engage him.

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At no point during his time at the Labrador Group Home was Wally assessed by a psychiatrist or psychologist, despite a documented history of trauma, substance abuse, emotional dysregulation and other challenges.

Youth at the facility were often encouraged to seek help on their own through external services such as wellness lines or help centres.

“(Wally was) expected to shoulder the burden of, one, identifying himself in need of mental health services, and two, navigating the process of accessing services for himself,” Hiscock said.

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“This seems like an entirely unreasonably heavy burden for a child, much less a child dealing with a number of cognitive and psychological issues.”

## **Nobody spoke his language**

No one working at the home was Innu or spoke Innu-aimun. In a situation where a child is expressing thoughts of suicide, Hiscock said, the lack of cultural and linguistic connection was especially inadequate.

“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. Surely at that moment, we need as clear communication as possible, and that could not occur in this case, because nobody spoke his language,” he said.

“The role that played in his sense of alienation is something we will never know, but it does seem a very natural link.”

A cultural connection plan was eventually developed for Wally with input from his mom and dad. He signed it three days before his death, but none of its recommendations had yet been implemented.

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Wally's parents were given information suggesting he was fine, Hiscock said, and their insight into his emotional state wasn't taken into account.

Communication breakdowns worsened during COVID-19 and were worse again after Wally's death. Etien and Nympha received conflicting details of the circumstances from different sources, leaving them confused and wondering who was not telling the truth, and why.

## **Parents want change for other youth and families**

Wally's parents offered several recommendations to the commission, hoping to improve outcomes for other Innu children and families.

They want to see the Labrador Group Home shut down and demolished, taking its history as a youth correctional facility with it. In its place, they envision a new facility with a

home-like environment, staffed by properly-trained workers.

They'd also like to see Wally memorialized in the new facility, perhaps through its name or a piece of artwork, as a reminder to staff of their responsibilities to the children in their care.

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They say placements for Innu children must include workers who are familiar with Innu culture and speak the language, and children in care should have meaningful access to both.

They also call for Innu language supports for families, so they can communicate effectively with those responsible for their children

“If Wally’s legacy can save lives, that is what Etien and Nympha want,” Hiscock said.

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 Inquiry Chief Commissioner Judge James Igloliorte and inquiry commissioners Anastasia Qupee and Mike Devine attend the inquiry launch at Confederation Building in April 2022. -SaltWire file photo

Inquiry Chief Commissioner Judge James Igloliorte and inquiry commissioners Anastasia Qupee and Mike Devine attend the inquiry launch at Confederation Building in April 2022. – Telegram file photo PHOTO BY GLEN WHIFFEN /Glen Whiffen

## **About the inquiry**

The Inquiry Respecting the Treatment, Experiences and Outcomes of Innu in the Child Protection System was officially launched in 2022. It will review and analyze Innu involvement with child welfare, identify systemic gaps and barriers to avoiding involvement, and examine the broader cultural and community impacts, before delivering a final report with recommendations to the province in October 2026.

The commissioners — retired provincial court judge James Igloliorte, former Innu Nation Grand Chief Anastacia Qupee, and retired Memorial University social work professor Mike Devine — have heard from investigators, researchers, other experts, and the families of six young Innu people who

died between 2015 and 2020; four of suicide and two of hypothermia.

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