C A N A D A

PROVINCE OF QUEBEC
DISTRICT OF MONTREAL

No.: 500-17-120468-221

S U P E R I O R C O U R T
(Civil Division)

KAHENTINETHA

KARENNATHA

KARAKWINE

KWETIIO

OTSITSATAKEN

and

KARONHIATE

Plaintiffs

v.

S O C I É T É Q U É B É C O I S E D E S INFRASTRUCTURES

ROYAL VICTORIA HOSPITAL

MCGILL UNIVERSITY HEALTH CENTRE,

MCGILL UNIVERSITY,

VILLE DE MONTRÉAL,

and

ATTORNEY GENERAL OF CANADA,

Defendants

and

ATTORNEY GENERAL OF QUÉBEC

Impleaded Party

AFFIDAVIT OF PHILIPPE BLOUIN IN SUPPORT OF THE PLAINTIFFS' APPLICATION FOR AN INTERLOCUTORY INJUNCTION

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1. I the undersigned, Philippe Blouin, residing at _____, solemnly affirm the following:
2. I am a witness in the plaintiffs' application for an interlocutory injunction, case no. 500-17-120468-221, at the Superior Court of Quebec.

Introduction

3. I have been asked by the kanien'kehá:ka kahnistensera (Mohawk Mothers) to produce a report sharing the results of the preliminary investigation on potential unmarked graves of Indigenous children on the grounds of the Allan Memorial Institute and ex-Royal Victoria Hospital. The archival materials and literature presented in this report were gathered by a team of researchers, including volunteers Keith Scott and Sarah Hollyer-Carney, since the allegations were first made public, in November 2021. I am a translator and a PhD candidate in anthropology at McGill University, studying the traditional alliance protocols of the Rotinonhsión:ni (Iroquois) Confederacy. I was entrusted with this task because I have been studying both the institutional oppression of Indigenous peoples in Canada, and the pre-colonial constitution of the Rotinonhsión:ni Confederacy, the Kaianere'kó:wa, through fieldwork with Kanien'kehá:ka Elders. In particular, this report examines the landscape of psychiatric research at the Allan Memorial Institute under Dr. Ewen Cameron, from 1943 to 1964, with a focus on the potential use of children and Indigenous people as test subjects.

Limitations

4. This investigation is complicated by the scarcity of archival evidence, which is due to several factors. As explained in the Final Report of the Truth and Reconciliation Commission of Canada, a 1933 Canadian federal government policy stipulated that "school returns" could be destroyed after five years and reports of accidents after ten years, leading to the destruction of fifteen tons of paper (**Exhibit P-17**, p. 9). An estimated 200,000 Indian Affairs files were destroyed between 1936 and 1944, while in 1957 Indian and Northern Health Services were instructed to destroy correspondences and records of medical treatments of First Nations and Inuit people, including transportation, escort services, admissions to hospitals, requests for treatment and medical reports after a retention period of two years (pp. 9-10).

5. In addition to this deliberate destruction of archival evidence concerning the treatment of Indigenous peoples in health care services, the principals of Indian Residential Schools often failed to record the details of the numbers of children

who died in their schools, usually omitting to indicate the causes of deaths. After 1915, Indian Affairs simply stopped publishing principals' reports, and no standard procedure existed to provide information on student deaths (**Exhibit P-17,** p. 8). According to the Truth and Reconciliation Commission of Canada, "it is probable that there are many student deaths that have not been recorded in the register because the record of the death has not yet been located. (...) There also exists the possibility that the death may not have been reported at all" (p.9)

6. Additionally, the MK-Ultra program, which potentially led to the death of Indigenous patients, is certainly one of the most secretive research programs that has existed in the post-war Western world. Even though occasional leaks to the media suggested the existence of this program (for example, **Exhibit p-18**), it is a well-established fact that CIA Director Richard Helms ordered the destruction of all files related to the MK-Ultra program in January 1973 (**Exhibit p-19**, p.3). The MK-Ultra program was only made public because the CIA failed to destroy a number of financial records, the discovery of which led to a *Joint Hearing Before the Select Committee on Intelligence and the Subcommittee on Health and Scientific Research of the Committee on Human Resources* before the United States Senate, in 1977 (**Exhibit p-19**, p.5). In the following years a Class Action Suit was launched by victims of the MK-Ultra program and their family members (**Exhibit p-20**).

7. It must also be mentioned that the Allan Memorial Institute was one of the last health care institutions in Canada to have adopted the national card reporting system of its patients to provincial health authorities. As appears in the correspondence between officials of the Quebec Ministry of Health, the Allan Memorial Institute (AMI) and the Royal Victoria Hospital (**Exhibit p-21**), the Allan Memorial Institute had been invited to adopt the card reporting system as early as in 1952. The AMI's failure to integrate the system elicited criticism of the AMI's secrecy. Dr. Ewen Cameron, director of the AMI, deferred the issue to the administration of the Royal Victoria Hospital, whose policy, he explained, governed the AMI (**Exhibit p-21,** p. 16). The correspondence shows Quebec's Ministry of Health repeatedly insisting on the necessity for the AMI to report its patients to government authorities, at times being puzzled as to its apparent reluctance to join the reporting system adopted throughout the country (p.6). The first set of patient cards were only reported to government health authorities by the AMI in April 1961 (p.22), nine years after the initial request.

8. Even today, it seems that the institutions responsible for Indian Hospitals, Residential Schools, and the MK-Ultra program remain secretive about those issues. Despite Access to Information requests, we have not been able to access a number of restricted documents from Library and Archives Canada concerning governmental grants given to the Allan Memorial Institute, the psychiatric treatment of Indigenous peoples and juvenile delinquents in the 1950s and 1960s, as well as Defense Research Board projects concerning Indigenous populations and the treatment of juvenile delinquency in Indigenous reservations

(**Exhibit p-22**). Similarly, we have not been able to access restricted archival documents concerning the involvement of McGill psychiatrists with Defense Research Board projects, such as McGill's Donald Hebb fonds, which concern the work of AMI psychiatrists with Inuit people in the Canadian Arctic. Our request to access documents concerning the Douglas Institute, a psychiatric ward affiliated with McGill University, and owned by the Centre intégré universitaire de santé et de services sociaux (CIUSSS) de l'Ouest-de-l'Île-de-Montréal, were denied. The reasons given were that ethics board approval and academic researcher status were required to access the files (**Exhibit p-23**). A request for documents about Indigenous people interned in psychiatric wards with Duplessis Orphans was also rejected by the CIUSSS de l'Est-de-l'Île-de-Montréal (**Exhibit p-24**). It was also impossible to access the personal archives of McGill psychologist Clifford Scott, who had worked at the AMI until his resignation in 1958, due to the files being closed to researchers until 2041 (**Exhibit p-25**). Our search for files at the Weredale House, a center for juvenile delinquents in Westmount which was linked to the AMI, also failed due to the necessity of obtaining a signature of the Director of the Youth Horizons Foundation to access files and a form indicating that such requests are rarely granted (**Exhibit p-26**).

9. This lack of material must be considered to understand the prevalence of indirect evidence in this report. One cannot expect to find direct proof of lethal experiments being conducted on test subjects at the AMI without a full disclosure of restricted archives and a thorough forensic investigation on site. Yet this report shares crucial indices suggesting that Indigenous children could have died after being used as test subjects at the AMI and buried in unmarked graves. In the years to come more evidence will certainly help to shed light on these allegations, especially if more archives are opened after the Canadian government and Pope Francis acknowledged that Indigenous peoples were subjected to genocide in Canada. Some crucial investigations are currently under way, notably a lawsuit from victims of Indian Hospitals (**Exhibit p-27**). Most importantly, during the National Inquiry into Missing and Murdered Indigenous Women and Girls, several Indigenous and Inuit families in Quebec testified about children who died or went missing "in circumstances unknown to their families after being evacuated from the community for medical reasons or, more broadly, after being admitted to a health and social services institution" (**Exhibit p-28**, p.1).

10. To date, Indigenous families have reported no less than 88 children who have disappeared after being institutionalized in Quebec since the 1950s, with ongoing investigations using Bill 79, which facilitates access to medical documents for the families of children who disappeared in Quebec (**Exhibit p-141**). Many testimonies report that some families were told that their children had died, while they had actually been institutionalized in psychiatric wards, some being "convinced that the babies were kidnapped to be used in medical experiments or sold to non-Indigenous families" (p.1). We hope that cross-referencing the findings from the current report with such investigations, notably with the help of Bill 79, *The Act to authorize the communication of personal information to the*

families of Indigenous children who went missing or died after being admitted to an institution, adopted by the National Assembly in Quebec, will allow us to understand better the extent of medical experimentation on Indigenous test subjects in the 1950s and 1960s. Our understanding is that the topic of the psychiatric treatment of Indigenous peoples in this period in Canada has rarely been broached in academic research, possibly in part because of the lack of available information. Yet the evidence raised by this report suggests that this topic is in urgent need of investigation before its victims and their memories fade away with time or are buried under tons of concrete due to construction work on the grounds of the ex-Royal Victoria Hospital and Allan Memorial Institute.

The Montreal Experiments and MK ULTRA

11. The Allan Memorial Institute of Psychiatry (AMI) opened in September 1943. McGill University's Board of Governors appointed Scottish psychiatrist Donald Ewen Cameron as its founding Director and Chairman of McGill University's Department of Psychiatry (**Exhibit p-20**, p. 26). The institute was housed in Ravenscrag, a luxurious mansion that Sir Hugh Allan, a Scottish-Canadian shipping magnate, donated to the Royal Victoria Hospital in 1940 (**Exhibit p-29**). As the Allan Memorial institute was co-administered by the Royal Victoria Hospital and McGill (**Exhibit p-20**, p. 4), Ewen Cameron was also the psychiatrist-in-chief of the Royal Victoria Hospital, and had previously worked in various hospitals, including the John Hopkins Hospital, the Worcester State Hospital, the Albany Hospital, and the Provincial Mental Hospital in Brandon, Manitoba, as appears in his curriculum vitae (**Exhibit p-31,** p.2). In the years to come, Cameron would become president of the Canadian Psychiatric Association, the American Psychiatric Association, and the World Psychiatric Association.

12. After opening a "Behavioral Laboratory" in the stables next to the main building of the Allan Memorial Institute (**Exhibit p-20**, p. 26), Cameron was hired by the U.S. Army to conduct a psychiatric examination on nazi war criminal Rudolf Hess during the Nuremberg Trials (**Exhibit p-31**, p.3). From the outset, in 1943, the Canadian Army expressed interest to Dr. Cameron in the establishment of a Department of Psychiatry at McGill University to train its own army psychiatrists (**Exhibit p-30**). In the early years of the AMI, military bodies (the U.S. Army, the Canadian Army's Defence Research Board and the Royal Canadian Air Force) provided much of the AMI's funding, including almost half in 1949, with significant funds also received from the Rockefeller Foundation (**Exhibit p-32**).

13. Between 1950 and 1964, $221,673.95 (approximately $2,695,675.98 in 2022) in public funds from the American and Canadian governments were granted to psychiatric research at the AMI (**Exhibit p-20**, p. 8). Three Government of Canada agencies were involved: the Defence Research Board (DRB); the National Research Council (NRC), which became the Medical Research Council; and the Department of National Health and Welfare (H&W) (**Exhibit p-33**, p. 29). Between 1950 and 1964 the AMI received at least $495,444.41 in funding for ten experimental research projects (p. 42). Five grants were awarded under

Canada's federal "Mental Health Grant" program between 1948 and 1964, for a total funding amount of $166,403.41: Project no. 290, "Behavioral Laboratory (1950-1951, $4,197.00); Project no. 604-5-13, “Research Studies on E.E.G. and Electrophysiology” (1950-1957, $60,353.33); Project no. 604-5-14, “Support of a Behavioural Laboratory” (1950-1954, $17,875.00); Project no. 604-5-74, “Study of Ultraconceptual Communication” (1959-1961, $26,228.08); and Project no. 604-5-432, “A Study of Factors Which Promote or Retard Personality Change in Individuals Exposed to Prolonged Repetition of Verbal Signals” i (1961-1964, $57,750.00) (**Exhibit p-20**, pp.5-6). Other grants included Project no. 604-5-433, "The Influence of Psychotropic Drugs upon Cerebral Responses to Peripheral Stimulation in Man"; Project no. 604-5-76, "A Study of the Effects of Nucleic Acid Upon Memory Impairment in the Aged"; and Project no.604-5-432 (**Exhibit p-33**, pp. 42-50).

14. Dr. Cameron's work had spiked the interest of the Central Intelligence Agency, which used three private medical research foundations, including the Society for the investigation of Human Ecology, also known as the Human Ecology Fund, to funnel grants to the AMI for a total funding of $59,467.54 for the period covering March 18, 1957 to June 30, 1960, as part of the “MK ULTRA" program's “Subproject 68” (**Exhibit p-20**, p.35). MK ULTRA was the "principal CIA program involving the research and development of chemical and biological agents,” as well as "radiological materials capable of employment in clandestine operations to control human behavior" (**Exhibit p-18**, p.69). It was launched in 1953 and involved an extensive network of "physicians, toxicologists, and other specialists in mental, narcotics, and general hospitals, and in prisons" (p.71), across no less than eighty-six universities and institutions (p.3). MK ULTRA was divided into 149 subprojects, "many of which appear to have some connection with research into behavioral modification, drug acquisition and testing or administering drugs surreptitiously" on both animal and human subjects, many of which were unwitting.(p.5). MK ULTRA was initially established "to counter the perceived threat of Soviet, Chinese, Korea, and other Communist bloc country advances in brainwashing and interrogation techniques,” thought to be able to thoroughly "brainwash" individuals into embracing their ideology, and as it concerned foreign intelligence, it was removed from congressional oversight through the July 1947 National Security Act in the United States (**Exhibit p-20**, pp.9-10). Trying to gain a strategic advantage over the communist bloc, the CIA set out "to perfect techniques...for the abstraction of information from individuals whether willing or not” and “develop means for the control of the activities and mental capacities of individuals whether willing or not” (p. 11). As research on the manipulation of human behavior using "radiation, electroshock, various fields of psychology, psychiatry, sociology, and anthropology, graphology, harassment substances, and paramilitary devices and materials,” MK ULTRA "was considered by many to be professionally unethical, legally questionable, and risky to the rights and interests of humans" (p. 12).

15. The Allan Memorial Institute in Montreal was one of the most important hubs for the MK ULTRA program. Through Subproject 68, with Dr. Ewen Cameron as its principal investigator, the CIA commissioned the AMI to "study the effect upon human behavior of the repetition of verbal signals," using drugs such as LSD-25 to "break down on-going patterns of behavior" before subjecting patients to prearranged verbal signals for up to 16 hours a day for six or seven days while in sensory isolation, and then continuous sleep for up to 10 days, as explained in declassified CIA documents (**Exhibit p-34**, p.3). Conducted from 1948, before the CIA came into play, to 1964, when Dr. Cameron left the AMI (**Exhibit p-20**, p.21), the "Montreal Experiments" were deeply marked by his theories on how the mind and society work. Influenced by eugenics, Cameron believed that society was divided between "the strong" and "the weak," the latter including people who felt anxious or insecure with the state of the world, and who had to be isolated from society by "the strong." Society had to be protected from the weakness of mentally ill people by letting "the strong"—i.e. experts such as psychiatrists—decide who can parent and prevent the spread of weakness into society (p.28). Having difficulties recruiting volunteers for his experiments and unable to obtain their cooperation (p.31), Cameron used the general patient population of the AMI, often sent there for minor ailments such as postpartum depression and who were "completely absurd candidates for anything more than psychotherapy or over the counter pain medication" (p.23). Cameron subjected them against their will and knowledge to some of the most horrific scientific experiments on human beings in history.

16. Following Dr. Cameron's theories, the minds of patients could be thoroughly reprogrammed in two steps: "depatterning" (i.e. erasing past memories and behaviors) and "psychic driving" (implanting new behavioral patterns). Depatterning typically involved several psychiatric treatments:

    1) Electroconvulsive therapy (ECT) using much higher voltage than normal and multiple treatments every day for extended periods of time instead of the usual use of 2 to 3 ECT treatments per week. Dr. Cameron purposefully used ECT as an "electrical lobotomy" capable of destroying the mind of his patients, using it "despite the manifestation of convulsive fits, which were generally considered to be contraindications to normal and safe ECT procedure within the industry" (**Exhibit p-20**, p.23). The ECT treatment was deemed complete and successful when patients lost track of their basic memories, self-awareness and sense of space and time, being reduced to a vegetable or "childlike state" and unable to control their bladders and bowels (p. 2-3). A "satisfactory level of depatterning" was attained when patients regressed to the level of 4-year-old children, needing spoon or tube feeding (**Exhibit p-36**, p.66)

    2) Sensory deprivation of the patients by immobilizing their bodies, depriving them of food, water and oxygen, and covering their eyes, ears, and skin. The Defence Research Board funded McGill psychiatrist Dr. Donald

Hebb's investigations on sensory deprivation, which he performed on both humans and animals (rats and dogs in the AMI's animal lab), were particularly instrumental in elaborating this phase of the depatterning procedure (**Exhibit p-35**, p. 200). In 1960, Cameron lectured to the Brooks Air Force Base, enthusiastically reporting the discovery that sensory deprivation could produce hallucinations that amounted to momentary schizophrenia (**Exhibit p-37**). However, Defence Research Board Chief of Division Nelson Whitman Morton asked Dr. Hebb not to disclose part of his work on sensory deprivation (under contract no. 38, **Exhibit p-38**, p.2), but instead to work with the Defense Research Board to "speak positively about other aspects of the work which might serve to drain off the attention of the curious" (p.5).

3) ECT and sensory deprivation were typically combined with enormous doses of various mixtures of experimental drugs, including LSD-25, PCP (sernyl), chlorpromazine (largactil/thorazine), desoxyn, nitrous oxide, sparine, equanil, tuinal, insulin, pentothal, sernyl, seconal, pentobarbital, phenobarbital, amobarbital, nembutal, sodium amytal (truth serum), curare, and artane (**Exhibit p-25**, p. 25).

17. Following the depatterning procedure and the ensuing loss of their cognitive capabilities and sense of space-time, the next step for many patients was to undergo “psychic driving.” This process aimed to “repattern” the patients' minds by playing them audio messages, including many disparaging sentences (“you are selfish”) in loops repeated between 250,000 and 500,000 times. The tapes were played after the patients were placed in drug-induced comas, using chlorpromazine (Largactil/Thorazine) and barbiturates such as secobarbital (Seconal), pentobarbital (Nembutal) and phenobarbital (Veronal), as well as globin-zinc insulin, for 20 to 22 hours a day for up three months. This was interspersed with the administration of hallucinogenic drugs and electric shocks (**Exhibit p-20**, p. 2; **Exhibit p-39**, p. 92). Perfected by the research of AMI psychiatrist Hassan Azima, these prolonged sessions of psychic drama happened in the "Sleep Room," which patients feared so strongly that they would walk with their back to the wall when passing the door to the sleep room (**Exhibit p-20**, p. 2). Dr. Robert A. Cleghorn, who worked with Cameron and replaced him as Director of the AMI in 1964, admitted that in reality these methods "effected little beneficial change,” although they were less damaging than the "cutting of their brains by leucotomy" (**Exhibit p-96**, p. 63).

<u>Other fields of research at the AMI</u>

18. Cameron, however, did also use leucotomy, more commonly known as lobotomy, although perhaps not performing them himself but rather in collaboration with neurosurgeons. Recent research (**Exhibit p-40**) revealed how in the 1940s Cameron had collaborated on lobotomies with McGill neurosurgeon Wilder Graves Penfield, who had become the first director of the Montreal Neurological Institute (MNI) at the Royal Victoria Hospital, which opened in 1934 thanks to a

$1.2 million grant from the Rockefeller Foundation (**Exhibit p-41**). Penfield, who had been performing lobotomies since the 1920s, including on a 12 year-old child (**Exhibit p-40**, p.260), had helped select Cameron to direct the AMI (p.254) and was eager to build a partnership between AMI psychiatrists and MNI neurosurgeons. Starting in 1944, Cameron selected seven patients on whom Penfield performed experimental psychosurgeries, called "gyrectomies" (p.271). The questionable results of these operations, as two gyrectomized women were finally given standard lobotomies as their state worsened (pp.272-273), pushed Penfield to abandon this procedure and become an anti-lobotomy advocate (p. 276). Cameron, on the other hand, concluded in a paper that although gyrectomy "has no greater value than the lobotomy. . . . However, we may just as clearly state that it is reasonable to explore this new field of surgery and psychiatry through further modifications of this and other operations" (p.275).

19. It must be noted that Donald Hebb had also been part of the MNI in 1937, before joining the AMI, studying "the remarkable effects of electrical stimulation of the cortex during Penfield's operations and to investigate the long-term effects of the operations on his patients" (p.266). In 1939, Hebb analyzed the case of a 15-year-old boy with a speech defect being lobotomized (**Exhibit p-42**, pp.74-75). A number of Hebb's students sought to extend his findings by observing the effects of brain damage on a large number of experimental animals.

20. One of Hebb's students, Ruth Hoyt-Cameron, worked on the effects of electroconvulsive shock in rats before studying the effects of lobotomy on the behavior and intelligence of adult humans (**Exhibit p-35**, p. 201)—in her case, on veterans operated on as part of a lobotomy research program launched in 1948 at the Ste. Anne de Bellevue Veterans' Hospital (**Exhibit p-43**, p.44). It appears that Hebb's interest in the ablation of specific parts of the brain was related to his research on sensory restriction, as another means to achieve such a restriction (**Exhibit p-35**, p. 201). As appears in the McGill Department of Psychiatry's report to the Rockefeller Foundation covering its work from 1949 to 1954, lobotomy continued to be a point of interest at the AMI well into the 1950s: "Together with Dr. Penfield's staff we are extending our attempts to work out more adequate forms of brain operations for the relief of tensional anxiety states." (**Exhibit p-44**, p.74). "Frontal lobe therapy" is listed as part of "a number of experimental projects" (p.69). It is also indicated that "in the Veterans Hospitals, a research program on lobotomy has been carried on over several years" under the direction of Dr. Hebb (p.26). It must be noted that the plural "Veterans Hospitals" also includes the Queen Mary Veterans Hospital, whose psychiatric ward had a bed capacity of 70 (p.14), under Project Study of Lobotomy in schizophrenia (**Exhibit p-120**). In addition, psychosurgery was employed at the Verdun Protestant hospital, also managed by McGill (p.101).

21. Another potentially lethal therapy Cameron used was insulin shock therapy, where patients were plunged into a coma and then awakened by the administration of glucose. Cameron had pioneered insulin coma therapy as a

research psychiatrist in the Worcester State Hospital between 1936 and 1938 (**Exhibit p-46**, p. 3; **Exhibit p-31**, p.2). Robert A. Cleghorn, Cameron's colleague and successor as head of the AMI, explained that coma therapy was then known to have a mortality rate of 1%, but that in reality this depended on the procedures and care of the patient (**Exhibit p-46**, p. 3). In Manitoba, two deaths from insulin shock therapy were recorded in 1938 (**Exhibit p-45**, pp. 76-77). Cleghorn also indicates that Cameron was keen on exploring dangerous uncharted territories of psychiatric experimentation. When Cleghorn indicated that Cameron's experiments with administering adrenalin to patients with chronic anxiety activated the anterior pituitary ACTH system, Cameron dismissed his comment, saying "you never know what will happen Doc." According to Cleghorn, Cameron "was not concerned with the physiological principles involved in what he was doing. This represented a lack of that fundamental curiosity which is an important force in research" (**Exhibit p-46**, p.4).

22. In addition to lobotomies, insulin coma therapy and the administration of massive doses of electroshocks and experimental drugs, the records show that Cameron conducted unethical, unscientific and blatantly cruel experiments from an early date. When he was at the Brandon Mental Hospital in Manitoba between 1929 and 1936, Cameron treated schizophrenics with

> "red light produced by filtering light from fifteen 200-watt lamps through an inch of running water and a layer of sodium salt of ditolyldisazo-bis-napthylanine sulphuric acid impregnated into cellophane. The color red was chosen because it is the colour of blood. In the experiments, schizophrenic patients were forced to lie naked in red light for eight hours a day for periods as long as eight months. Another experiment involved overheating patients in an electric cage until their body temperatures reached 102 degrees F" (**Exhibit p-20**, p.26).

23. At the Allan Memorial Institute, many of Cameron's experiments took place in the "Behavioral Laboratory," which was set up in the stables next to the main building and used for experiments on "sensory deprivation, psychic driving, electroshock and the use of the male hormone testosterone on women patients" (p. 31). While the use of magnetic tapes and movies was already mentioned as early as in 1955 (**Exhibit p-44**, p. 26), substantial renovations of the stables to host movie photography installations were proposed in 1959 (**Exhibit p-47**). Yet the list of staff active in the Laboratory for Experimental Therapeutics in 1957 indicated that its 2,300 square feet of space were largely insufficient for eighteen full-time people working there (**Exhibit p-48**). The same report contains a request for extra space for larger animal quarters. Other cutting-edge installations at the AMI included electrically-shielded electromyographic laboratories (**Exhibit p-44**, p. 26) and Canada's first isotope laboratory for research on the thyroid gland on elderly people (p.29).

24. Thanks to substantial funding from the Rockefeller Foundation, the Department of Veterans Affairs, the Department of National Health and Welfare, the Defense

Research Board, the National Research Council, the U.S. Army and the Royal Canadian Air Force (**Exhibit p-44**, p. 20), the Allan Memorial Institute had undergone a massive expansion, with its staff growing to 231 people in its 10 first years of activity (p. 16). Lack of space brought Cameron to rent out extra space in downtown buildings (**Exhibit p-49**). However, in addition to its space at the Allan Memorial Institute, McGill's psychiatric department also had access to several partner institutions for its research: the Psychiatric Division of the Children's Memorial Hospital, the Psychiatric Division of the Queen Mary Road Veterans Hospital, the Verdun Protestant Hospital (Douglas Institute), the Montreal General Hospital, the Ste. Anne de Bellevue Psychiatric Division of the Department of Veterans Affairs, and the Mental Hygiene Institute (**Exhibit p-44**, pp. 10-14).

Juvenile Delinquency

25. The biggest project for expanding the AMI's infrastructure came around the end of Cameron's career there, as a culmination of previous work in the field of "juvenile delinquency" involving the Mental Hygiene Institute. This field of research is the main lead of our investigation supporting the allegations of unmarked graves of Indigenous children on the grounds of the Allan Memorial Institute. In 1963, Ewen Cameron partnered with Bruno Cormier, psychiatrist at the federal Saint-Vincent-de-Paul Penitentiary, to write a "Proposal for the Establishment of a Pilot Centre for Juvenile Delinquency." The plan was to open a 50-bed pilot unit operated by McGill to remedy the lack of a "centre serving to co-ordinate the efforts made by many community facilities and their attack upon juvenile delinquency" (**Exhibit p-50**, p.3). Pursuant to the theory considering delinquency as a hereditary problem, the new unit would include a research center "for work in genetics, for endocrinological investigations," as well as psychological and sociological studies (p.4). Its total planned surface was 75,000 sq. ft., divided in sub-units each containing 16 children, at the estimated cost of between $2.25 and $2.5 million, and with a staff of more than fifty people, including 12 psychiatrists (p.5).

26. A similar project had already been outlined in 1957, as Cameron and Cormier sought to establish forensic psychiatry research facilities, partly to study "the psychodynamic effects of deprivation of liberty," that is sensory deprivation (**Exhibit p-51**, p. 3). The two men also discussed facilities for "the disturbed adolescent" (p.9). In addition to the Saint-Vincent-de-Paul Penitentiary, the Kingston Penitentiary was also mentioned in their scientific meetings (**Exhibit p-52**). It was recently revealed that at least 23 women inmates at the Kingston penitentiary were given LSD at that time, and there are reports of electroshocks and pain tolerance tests (**Exhibit p-53**, p. 287). In Saint-Vincent-de-Paul, the inauguration of the psychiatric ward in 1958 under the direction of Cormier in collaboration with McGill psychiatrists led to the use of electroshock on prisoners (**Exhibit p-54**, p. 99). Note that the number of juvenile inmates (those under 21 years of age) incarcerated in federal penitentiaries increased more than two-fold in seven years, going from 312 in 1951 to 696 in 1958, including 325 juveniles in

Saint-Vincent-de-Paul alone (p.18), where juveniles accounted for 23.8% of total admissions (p.214).

27. A first hint at Indigenous peoples appears in Cameron and Cormier's proposal, for a 1962 Services Conference, to make a presentation on "Ethno-criminology - changing patterns of criminality from primitive to modern society" (**Exhibit p-55**). This topic had already been mentioned as a center of interest at the AMI, notably in the proposal for a “World Mental Health Research Institute,” where “the effects of rapid cultural change on mental health” was explained to be a focus of study (**Exhibit p-56**, p. 13). This also included socio-anthropological research on “social factors leading to increase in community hostility,” the study of “means of modifying damaging cultural beliefs” and the “social factors governing sexual patterns of behavior” (p.9). Interestingly, the proposal presented Canada as "a laboratory state, in which the major stresses to which people everywhere are currently subjected may be studied" (p.2).

28. The 1954 *Report to the Rockefeller Foundation* stated that "In the Mental Hygiene Institute, investigations are going forward on delinquent children living in a residential home, and efforts have been made to evolve methods of group treatment of emotionally disturbed children" (**Exhibit p-44**, p. 26). Directed by Baruch Silverman, the Mental Hygiene Institute had opened in 1929 as the outpatient clinic at the Royal Victoria Hospital, reverting to its "primary purpose of encouraging mental health in the population at large" when the AMI was inaugurated, in 1943 (**Exhibit p-35**, p. 47). It worked in close collaboration with McGill's Department of Psychiatry as well as social agencies such as the YWCA (**Exhibit p-57**). As early as in 1951, Baruch Silverman had publicly argued for the creation of an institution for mentally disabled children, with Ewen Cameron on its board (**Exhibit p-58**). In 1953, Ewen Cameron asked for funding for research on children to detect the first traces of mental illness (**Exhibit p-59**). Newspaper articles from 1955 (**Exhibits p-60 and p-61**) announced a $10,000 grant from Canadian minister of Health Paul Martin to study the mental hygiene of teenagers at the Allan Memorial Institute, suggesting that it would last three years and lead to further research. Finally, in 1956 short articles in the press announced that no less than 120 children considered as unruly had been brought to the Mental Hygiene Institute, where they were given "special tranquilizers,” and had to be closely monitored for their potentially dangerous after-effects (**Exhibits p-62 and p-63**).

29. The record does not mention the type of drugs that were used on these children. It must be noted that in 1961, psychiatrist Heinz Lehmann, known for his pioneering work on psychotropic drugs, reported using experimental drugs such as Sernyl, LSD 25, Mescaline Sulfate, Sodium Amytal and Desoxyn HC1 on patients as young as 18 years at the Douglas Institute, also part of the McGill network (**Exhibit p-64**). During the same period, Dr. Lauretta Bender, who had connexions with McGill (**Exhibit p-65**), had been treating autistic and schizophrenic children using LSD-25, UML-491, metrazol, electric convulsions,

subshock insulin, a variety of psychopharmaceutical agents, antihistamines, amphetamines, anticonvulsants, muscle tone stimulants, meprobamates, phenothiazines, reserpines, antidepressants and tranquilizers (**Exhibit p-66**). In one of his articles, Cameron mentions treating at least one patient aged 17 (**Exhibit p-39**, p. 92).

30. It is not known where the children that were brought to the Mental Hygiene Institute came from. As part of the Red Feather network, Montreal's Mental Hygiene Institute was linked to an extensive network of social agencies, including the Y.W.C.A, the Canadian National Institute for the Blind, and "facilities for orphans, delinquent children, unwed mothers, and the homeless at such institutions as the Protestant Orphan Asylum, the Old Brewery Mission, Weredale House and the Sheltering Home" (**Exhibit p-67**, p. viii). The term "Residential homes" used in the Rockefeller Report could indicate correctional centers as much as orphanages or Indian residential schools, as "Archival documents show that psychiatrists in the 'Mental Hygiene' Division of the Canadian Department of National Health and Welfare were in regular dialogue with Indian Affairs during the late 1940s and 1950s regarding the ongoing project of assimilating Indigenous children" (**Exhibit p-68**, p. 182).

31. A 1954 research memorandum requesting a grant from The Commonwealth Fund for research on "Family Health, Adolescent Roles and Mental Health" (**Exhibit p-69)** and sponsored by McGill Principal F. Cyril James reveals an interest in the cross-cultural comparison of juvenile mental health (p. 11). Most importantly, this grant application was jointly prepared by Ewen Cameron, Eric Wittkower—who would establish McGill University's Transcultural Psychiatry Unit in 1955 (**Exhibit p-70**)—and McGill sociologist Oswald Hall, whose connections with ethnographic research will be explained in the next section of this report.

32. The above evidence shows an undeniable interest in juvenile subjects at the McGill Department of Psychiatry and its affiliate Institutions, including the AMI. It is likely some of these young people were treated and potentially experimented on at the AMI.

Transcultural psychiatry

33. According to Raymond Prince, another founding member of McGill's Transcultural Psychiatry Unit, the TransCultural Psychiatry Unit was established in 1955 "on the advice of Chairman D Ewen Cameron" (**Exhibit p-72**, p. 432). Prince was funded by the CIA's Human Ecology Fund to conduct field research on Yoruba shamanism "to collect psychocultural data on cultures and countries of interest to the CIA for psychological warfare purposes" (**Exhibit p-71**, p.205). Along with other fields of research where the Transcultural Psychiatry Unit was doing innovative work, Prince refers specifically to his colleague H.B.M. Murphy's research on "cultural variations in optimum dosage levels of tranquilizing and antidepressant drugs according to culture or race" (**Exhibit p-72,** p.436). The study included observations of different drug tolerance levels according to

ethnicity, including with chlorpromazine (**Exhibit p-73**). H.B.M. Murphy was also interested in youth unrest, as his PhD thesis was titled "Ethnic Variations in Juvenile Delinquency" (**Exhibit p-72**, p. 433), and published a paper on "Theories of Youth Unrest" (**Exhibit p-73**).

34. During the same period, McGill researchers, such as psychologists Wallace E. Lambert, Eva Libman and Ernest G. Poser, also studied cross-cultural differences in tolerance to physical pain using deceptive means and what seemed like torture instruments: "The instrument used for testing pain tolerance consisted of a clinical sphygmomanometer with sharp, hard rubber projections sewn into the pressure cuff" (**Exhibit p-75**, p. 352). Among these researchers, Ernest Poser also studied patients' reactions to hypnotic suggestions during methohexitone-induced sleep, a practice that is very close to Ewen Cameron's research on mind control (**Exhibit p-76**), while Lambert also studied ethnic cleavage among children (**Exhibit p-77**). Although Lambert, Libman and Poser's research on cross-cultural resistance to pain apparently concerned Jewish and Protestant individuals and apparently did not include Indigenous subjects, similar studies done at that time focussed on Indigenous subjects, purportedly due to their reputation as being hyposensitive, including Mi'kmaq and Inuk test subjects (**Exhibit p-78**).

35. Most importantly, in 1963 H.B.M. Murphy supervised a study of the intelligence levels of no less than 92 children aged 9 to 11 from the Kanien'kehá:ka (Mohawk) territory of Kahnawake (spelled Caughnawaga at the time), conducted at the Allan Memorial Institute by Barbara Wainrib and Joan Rothman (**Exhibit p-79**). The study of Kahnawake children conducted at McGill used intermediaries such as the Quebec Society for Retarded Children and the Montreal Children's Hospital, who had previously evaluated the mental capacities of 44 Kahnawake children, finding that "they constituted a social problem" (p.2). Wainrib and Rothman studied the children's sense of verbal meaning, perception of space, sense of identity and reasoning capacities, comparing the data with White and African Americans from other tests. They claimed that their results showed a decrease in mental capacities between the youngest and oldest children they studied, concluding that Caughnawaga children were "more childish and less ready to identify with human society" (p.9) because of their "relative immaturity" (p.13). This was seen as a social risk that had to be addressed by psychiatrists.

<u>Research on Indigenous and Inuit peoples by the Defense Research Board</u>

36. In fact, this intelligence test on Caughnawaga children had already been planned more than a decade earlier by a group dubbed "Panel on Indian Research", an initiative of the Defense Research Board (DRB) and chaired by Nelson Whitman Morton (**Exhibit p-80**, p. 2), McGill University's first PdD graduate in psychology, who had worked with Chester Kellog on intelligence tests and the classification of pupils in the 1920s before joining the DRB (**Exhibit p-81**, pp. 147-148). Other panelists included University of Toronto anthropologist T.F McIlwraith (who would later become the Panel's Chairman), officials from the Indian Affairs Branch, the Dominion Bureau of Statistics, majors and colonels from the Canadian Armed

Forces, and McGill sociologist Oswald Hall (**Exhibit p-80**), who, as explained above, would later partner with Ewen Cameron on the project “Family Health, Adolescent Roles and Mental Health.” The mandate of the Panel on Indian Research was to assist "in the many problems encountered in bringing Canada's Indians into the national stream" (p.2). According to R.A. Hoey, the director of Indian Affairs, psychology and sociology were particularly important to secure “information relating to the temperament of the Indian, his innate inertia, his nomadic instincts, lack of frugality, etc. It is perhaps well that we should have thorough understanding of these before we undertake a program aimed at the legitimate exploitation of the resources to which the Indian claims ownership” **Exhibit p-82**, p. 3).

37. At the first meeting of the Panel of Indian Research, on November 18, 1949, Morton insisted that one of its main priorities was to investigate “the educability of the Indian child.” The first project they sponsored was a study by G.H. Turner and D.J. Penfold comparing the intelligence levels of Indigenous children at the “Caradoc reserve,” now called Oneida of the Thames, in Ontario, with that of White children, to determine if the difference between them was hereditary (**Exhibit p-80**, p. 3, **Exhibit p-83**). The Superintendent of Education Colonel Bernard F. Neary proposed in 1949 to extend the Turner-Penfold study to no less than eighteen Indigenous reservations throughout Canada, including Kahnawake/ Caughnawaga (p. 13).

38. With a disproportionate focus on Rotinonhson:ni (Iroquois) territories, to which the Oneidas and the Mohawks belong, the Panel on Indian Research also planned to integrate the results of the Caradoc intelligence tests with other anthropological and sociological studies of the Iroquois, starting with the study of "Socialization Processes Among the Iroquois" done by Marcel Rioux in the Kanien’kehá:ka (Mohawk) territory of Six Nations of the Grand River (p. 6). Rioux’s study sought to understand "child-rearing practices and family reactions to newborns" in this reserve through a questionnaire containing 94 questions, “many of them highly sensitive and intrusive in nature,” such as “Does the couple continue to have intercourse?”; “At what time does the exposure of sex cease?”; and “Is there any curb to self-manipulation?” (**Exhibit p-84**, pp. 151-152). These invasive questions on childhood sexuality elicited criticism from the Mohawks’ local Women’s Council, who wrote to Ross MacDonald, speaker at the House of Commons, to protest this “highly improper ... infringement on their private life.” Rioux was a member of the Panel on Indian Research (**Exhibit p-80**, p. 16) and his questionnaire had been reviewed by its other members prior to the study (p.6).

39. Documentation from the Panel on Indian Research also mentioned two other studies of Kahnawake/Caughnawaga by two of its regular members, who also happened to be professors at McGill: 1) anthropologist Fred W. Voget's study of "Acculturation at Caughnawaga: a Note on the Native-Modified Group," which investigated separatist movements and sub-cultures in Kahnawake who were opposed to the Church and the Indian Act (**Exhibit p-80**, p-18, and **Exhibit p-85**);

2) McGill sociologist Oswald Hall's study of "The Industrialized Indians of Caughnawaga," which focussed on the unruly behaviors of Caughnawaga people. Hall stated that "In the first instance the reservation seems to be organized around hostility toward the federal government" and that "the reserve displays a volcanic uneasiness. It is marked by recurrent disturbances of a minor riot character" (**Exhibit p-87**, p. 10). Although it was not mentioned in the minutes of the Panel on Indian Research, it must also be noted that, in addition to these studies, a Masters' dissertation was produced at McGill in 1958 concerning "Educational Retardation Among Non-Roman Catholic Indians at Oka," which is the Mohawk community of Kanehsatake (**Exhibit p-88**).

40. Research on nutrition, where children on reserves across Canada were deprived, without consent, of important dietary nutrients so that scientists could observe the deleterious effects (**Exhibit p-89**), was also a focus of the Panel on Indian Research. The Panel stated that these experiments led to the psychological discovery that "Indian children seemed more amenable to suggestion than white children" (**Exhibit p-80**, p. 18). "Delinquency" was also mentioned as a field of interest by the Panel on Indian research and referred to "an expert" known to its chairman without further explanation, which likely referred to Cameron (p. 23).

41. Although AMI psychiatrists apparently did not participate directly in the Panel on Indian Research, despite the preponderant role played by colleagues such as Oswald Hall, the record nonetheless shows their close collaboration with the DRB in the Canadian Arctic. The potential inclusion of research on "Eskimo problems" had been mentioned by the Panel on Indian Research (**Exhibit p-80**, p.7), but this research was finally taken over, along with the Psychological Research Panel, by the Operational Research Group from the Biological Research Division, also chaired by McGill psychologist N.W. Morton (**Exhibit p-90**, p. 94). Ewen Cameron, who was already funded by the DRB for work on community responses to disasters, and James Tyhurst, also a psychiatrist at the AMI, were selected for research on "Behavioural problems in the adaptation of white men to the Arctic" (p. 98). Acclimatization to the sensory deprivation of the North was also a point of interest, as their colleague Hebb had already served on the Psychological Research Panel of the DRB, a panel that had endorsed, like Morton, hiring Cameron. In 1951, Cameron was removed from his work on community disasters for reasons unknown (*ibid.*), and the former chairman of the DRB, Omond Solandt, would later make the following statement during a court investigation: "It was my view at the time and continues to be that Cameron was not possessed of the necessary humanity to be regarded as a good doctor" (**Exhibit p-91**, p. 136). James Tyhurst, on the other hand, would later be convicted of sexual abuse of his patients in "master/slave" sessions involving rape and whipping, in a case the B.C. Court of Appeal called "deplorable and [defying] all norms of civilized conduct between individuals" (**Exhibit p-92**). AMI psychiatrist Robert Cleghorn was also involved in work in the Arctic concerning flight fatigue (**Exhibit p-96**, p. 58), working with an assistant from the Royal Canadian Air Force, Gofton, who curiously published many on Indigenous blood groups and genetics (**Exhibit**

p-97). AMI psychiatrists were closely connected with the research the DRB was doing on Indigenous people or using Indigenous subjects. These close collaborations increase the likelihood that Indigenous subjects were also experimented on at the AMI.

42. It is not known what boundaries were trespassed by Cameron and his colleagues in their research in the Arctic and whether they used Inuit test patients there, but the Defense Research Board's research initiatives in the Arctic also included controversial studies on the effect of cold. These experiments seeking to unlock the secret of the Inuit body's capacity for acclimation to cold were conducted on no fewer than 288 unwitting Inuit test subjects, including at least 16 children aged 1 to 16 years old. Samples of their blood, urine, skin and liver were extracted for biochemical analysis, while others were subjected to acute short-term exposure tests, with their body parts being immersed in water at temperatures ranging between 5 and 45 degrees Celsius (**Exhibit p-93**). At the same time in Alaska, the Arctic Aeromedical Laboratory also studied acclimatization and cold survival, investigating a potential connection between hyperthyroidism and cold tolerance, measuring thyroid activity in "19 Caucasians, 84 Eskimos, and 17 Indians" by injecting radioactive iodine in their body (**Exhibit p-94**, p.3). Similar to Cameron's description of Canada as a "laboratory state" (**Exhibit p-56**, p.2), these researchers considered the Arctic as "the natural laboratory in which the subjects were set." In the late 1960s, unwitting Inuit test subjects were also subjected to skin grafts as part of the International Biological Program in the Canadian Arctic (**Exhibit p-95**). At any rate, the language elaborated at the AMI continued to be used by Indian Affairs officials in the Arctic, as a 1967 letter from the Regional General of Medical Services stated that its team is gradually building an epidemiology of mental disorders specific to the North, including "sensory deprivation" (**Exhibit p-98**).

Indigenous mental health in the 1950s and 1960s.

43. In the absence of patient records and the restrictions on archival documents about Indian Hospitals, one cannot hope to find direct evidence of transfers of Indigenous patients to the AMI. Library and Archives Canada's School File Series do however contain a reference to a child at the Indian Residential School at Brandon, Manitoba, being treated by psychiatrists from the nearby Brandon mental hospital for what was deemed "a violent temper, abnormal sex urge," in 1938, two years after Ewen Cameron's passage there (**Exhibit p-99**). In the 1940s, a psychiatrist also performed Extra Sensorial Perception studies on Indigenous children at the Brandon Indian Residential School, testing their ability to guess playing cards. (**Exhibit p-100**). The nearby Brandon Indian Hospital (aka the Brandon Sanatorium) was later named in a lawsuit for "widespread mistreatment and abuse" of Indigenous patients from 1947 to 1958 (**Exhibit p-101**). In 1953, for instance, an Ojibway girl being treated for tuberculosis was experimented on at the Brandon Sanatorium, where she says, "doctors bound her

to a gurney, pumped her body with electric currents and then took notes as her fingers curled, her arms shook and her neck strained backwards" (**Exhibit p-102**).

44. As there was no specific mental hospital for Indigenous people in Canada, the policy for institutionalizing Indigenous and Inuit patients in provincial mental hospitals stated that the Department of National Health and Welfare was responsible for paying their board, care and expenditures on a per diem basis (**Exhibits p-103 and p-104**). The Department of National Health and Welfare (H&W) was the same department in which Indian Health Services (IHS) was housed. In collaboration with the Department of Indian Affairs (DIA), both IHS and the larger H&W department were responsible for the transfer of Indigenous children from residential schools to other institutions, including provincially managed hospitals, juvenile detention centers, and psychiatric institutions. Statistical records of Indigenous and Inuit people in mental health institutions show a constant increase from the 1930s to the 1950s. In 1936, 138 Indigenous individuals were in mental hospitals, including 21 in Quebec (**Exhibit p-105**). According to the 1946 Health Reference Book, there were 194 Indigenous patients treated in 22 mental hospitals in 1945 (**Exhibit p-106**, p. 5); and in 1947-48, 296 Indigenous patients treated in 35 provincial institutions according to the Director of Indian Health Services P.E. Moore (p. 4). In 1955, 365 Indigenous patients were reported to be in mental hospitals in Canada, and 21 deaths were recorded, in a letter from P.E. Moore (**Exhibit p-107**). Yet the Annual Report of the Department of National Health and Welfare indicated significantly higher numbers, with 409 Indigenous and Inuit patients in mental institutions in 1954, 483 in 1955, and 522 in 1956, including 209 in the Eastern region alone (**Exhibit p-108**, p. 90).

45. As for the specific institutions where these Indigenous and Inuit patients were sent, the lack of archival records makes this search complicated. However, a 1955 letter from John S. Willis to the Regional Superintendent of the Eastern Region mentions the Verdun Protestant Hospital, later called the Douglas Institute – a large psychiatric ward that is part of the McGill network and thus closely connected to the AMI – as one of the locations where "mentally ill Eskimo patients" were sent (**Exhibit p-109**, p.1). The letter suggests centralizing mentally ill patients in one hospital in the Eastern region, and regrets that neither the Verdun Protestant Hospital nor the Nova Scotia Hospital at Dartmouth wish to look after Inuit patients. However, a handwritten note indicated that although it is difficult to obtain beds for them in any institution, "Verdun will take them if they come from Quebec (Ungava) (p.2). The letter mentions the appalling case of an Inuit child who was at the Mountain Sanatorium in Hamilton, Ontario, after having "a partial lobectomy in Montreal last year," without indicating the cause of this operation nor the Montreal hospital where it was conducted (p.2). That beds were missing for "mentally ill" Indigenous and Inuit people in provincial mental hospitals makes it even more likely that they would have been sent to the Allan Memorial Institute, a research and training center that had difficulty obtaining test subjects for its well-funded experiments (**Exhibit p-20**, p.31).

46. In the fifth meeting of the Committee on Eskimo Affairs held on November 29th, 1954, the Eastern Arctic was explained to be divided into two areas: 1) the east coast of Hudson and James Bays, served by the Moose Factory Indian Hospital in Ontario; 2) the other region included all Inuit people in “northern Quebec and the Arctic islands north of the Hudson Strait, which are served at present by Parc Savard Hospital in Quebec, Sacred Heart Hospital at Caughnawaga, and Mountain Sanatorium in Hamilton.” The report also suggested the possibility of concentrating most Inuit patients at the Mountain Sanatorium (**Exhibit p-110**, p. 5). However, another document (**Exhibit p-111**) also includes the Verdun Protestant Hospital and the Royal Victoria Hospital as partners of the Administrator of the Arctic for the Department of Northern Affairs & National Resources. A 1955 letter from the minister of National Health and Welfare, Paul Martin, written in response to allegations from Anglican Bishop of the Arctic Donald B. Marsh concerning the disappearance of Inuit patients who were sent in the South, gives more detailed information on the hospitals they were sent to (**Exhibit p-112**, p.7). Inuit patients from the Eastern region were sent to the R.C.A.F hospital in Goose Bay, Labrador, and then to a Montreal hospital if they needed special treatment (p.2). The only Montreal hospital mentioned by Martin was the Royal Victoria Hospital, where “occasionally patients must be sent ... for treatment not available elsewhere” (p.5). Martin mentioned 450 Inuit patients currently kept in southern hospitals (p.5). Also note that McGill University researchers played a prominent role in the massive campaign for X-Ray screenings of James Bay Indigenous and Inuit people at the end of the 1940s (**Exhibit p-113**).

47. A 1952 letter from Indian Health Services officer Leroux to a social worker suggests that if Indigenous children in Quebec would be evaluated by medical officers from Indian Health Services before being referred to psychiatrists from the local provincial mental hospitals, they would be considered “social welfare cases" and referred to a psychiatrist from the province if they are “on the border line or are delinquents” (**Exhibit p-114**). In 1951, while the DRB’s Panel on Indian Research was discussing juvenile delinquency (**Exhibit p-80**, p. 18) and while the Mental Hygiene Institute and Ewen Cameron were requesting funding to study “mentally imbalanced” (*mentalement déséquilibrés*) children (**Exhibit p-58**), important amendments were made to the Indian Act concerning juvenile delinquency. The Truth and Reconciliation Committee indicates that the 1951 Indian Act “was the first major revision to the Act in decades.” Opening the door to “shifting the responsibility for First Nations education to provincial governments” and affirming the rights of the Churches, it contained a new provision stating that “a student who was suspended or expelled from school or who did not attend school regularly ‘shall be deemed to be a juvenile delinquent within the meaning of the Juvenile Delinquents Act, 1929’” (**Exhibit p-17**, p. 40, and **Exhibit p-115**, p. 352, Section 119). Their attendance was to be enforced by “Truant officers,” who “shall have the powers of a peace officer” for these tasks, entering “any place where he believes, on reasonable grounds, that there are Indian children who are between the ages of seven and sixteen years of age” (**Exhibit p-115**, p. 351,

section 118). Children who failed to attend school after a 3-day notice would be immediately considered “guilty of an offense and ... liable on summary conviction” to pay a fine or be sent to jail for up to ten days; and the same with their parents if they failed to send their child to school after one year (p.352).

48. Applied to Indigenous people, the Juvenile Delinquents Act defined a delinquent as someone “liable by reason of any act, to be committed to an industrial school” or, in an amendment targeted specifically at girls, one guilty of “sexual immorality or any similar form of vice”, who could also “be charged under the Indian Act, which prohibited things such as the consumption of alcohol and ‘profligacy’” (**Exhibit p-116**, p. 62). Youth considered unruly could be sent to state-run reformatory training schools and to mental hospitals (p.93). A study of Aboriginal girls sent to the Ontario Training School for Girls (OTSG) by Joan Sangster shows how girls were sent there after doctors and psychologists administered “standardized IQ and personality tests, including the Binet-Simon, Roestch, and Bender-Gestalt.” Deeming children “retarded” by virtue of these tests had dire circumstances and disrespected cultural patterns and differences in ways of knowing (p.116). In addition to the Bender-Gestalt test, the team that tested the intelligence of Kanien’kehá:ka children from Kahnawake/Caughnawaga at the Allan Memorial Institute used the Rorschach test, the Weschler Intelligence scale and a “What are you” enquiry designed by their psychologist colleague Wallace E. Lambert (**Exhibit p-79**, p.4), who also designed pain tolerance tests (**Exhibit p-75**).

49. The recruitment of Indigenous people into mental health institutions occurred in a manner that was arbitrary, culture blind, inhuman, and often political. Mendies and Palys observed that in British Columbia’s psychiatric system between 1879-1950, patients were mostly institutionalized for “breaching social and racial conventions” (**Exhibit p-117**, p. 161). The institutionalization of Indigenous people in psychiatric wards and clinics was often used as a form of punishment, or an attack on traditional segments of Indigenous communities in Canada and in the United States. For example, the Hiawatha Asylum, the American in Canton, South Dakota, incarcerated Indigenous people regardless of their mental health, “because they refused to give up their ceremonial or spiritual ways of life or because they were unwilling to assimilate to the norms of the white settler society.” The “Bureau of Indian Affairs had the power to commit Aboriginal people without any ‘legitimate’ medical reason, and often did so as a means of punishment” (**Exhibit p-118**, p.8).

50. Knowing the extreme treatments that Dr. Ewen Cameron and many of his colleagues administered to White people who had come to the AMI for minor ailments, one can only imagine what they would have done to Indigenous people who did not conform to their model of normalcy. Given that “the ‘Mental Hygiene’ Division of the Canadian Department of National Health and Welfare were in regular dialogue with Indian Affairs during the late 1940s and 1950s regarding the ongoing project of assimilating Indigenous children” (**Exhibit p-68**, p. 182), and

given the evidence that the Royal Victoria Hospital and McGill network were central locations for the treatment of Indigenous and Inuit people, we can confidently and unfortunately say that there high possibility that Indigenous children were funneled to the AMI in the 1950s and 1960s, either through Indian Agents, Juvenile Courts, correctional homes, Indian Hospitals, sanatoria, Residential Schools, Day Schools, Federal Penitentiaries, the Canadian Armed Forces or Hospitals managed by Veterans Affairs. Note that the Annual Report of the Department of National Health and Welfare stated that the Department of Indian Health Services exchanged treatment services "with the Department of Veterans Affairs and the Department of National Defense whenever such arrangements were advantageous" (**Exhibit p-119**, p.66). Also note that the Queen Mary Veterans Hospital in Montreal, where AMI psychiatrists studied lobotomies through "Project 35" (**Exhibit p-120**), did not only have veterans but also Indigenous patients (**Exhibit p-121**).

51. Given the nature of the treatments at the AMI and its affiliated institutions, there is also a high possibility that Indigenous patients could have died from them, whether from lobotomies, coma shock therapy, electroshock, massive doses of experimental drugs or other potentially lethal treatments that were studied at the AMI. Finally, there is sadly a high possibility that test subjects having died from experiments would have been buried on site, as what done in Indian residential schools throughout Canada. That is also what happened with the Duplessis Orphans, whose status Quebec Prime Minister Duplessis had changed from orphans to "idiots and seniles" through Decree 816, ratified by the Lieutenant-Governor in August 1954 (**Exhibit p-122**), to access more funds from the Federal government. They were then considered wards of the state, just like Indigenous children. Once their orphanages were turned into mental hospitals, Duplessis Orphans "were used as guinea pigs for mind control, chemical, radiation, and surgical experiments by psychiatrists and doctors," in addition to being used as slave labour on farms, being molested sexually by their tutors, and being sold to families in the United States in an extensive child trafficking ring (**Exhibit p-123**, p.54). Children who died from psychiatric experiments were "buried anonymously one atop another in cardboard boxes, in the 'Pigsty Cemetery' behind the St. Jean de Dieu hospital" (p.54). The Sisters of Mount Providence sold the lot of the Pigsty Cemetery to the Société des Alcools du Québec in the 1970s, and its fifty unmarked graves were covered by a SAQ depot, without even a plaque or any indication that the bodies of children were underneath it (**Exhibit p-124**, p. 3). We do not wish this to happen for the alleged unmarked graves on the grounds of the Allan Memorial Memorial and ex-Royal Victoria Hospital.

<u>Archeology and architecture of the AMI and RVH</u>

52. As Ewen Cameron himself stated, the Allan Memorial Institute, as McGill's Department of Psychiatry, was administratively dependent on the Royal Victoria Hospital (**Exhibit p-21**, p.16). As appears from a 1957 insurance plan map of the City of Montreal, the AMI also depended on the Royal Victoria Hospital (RVH)

architecturally, as the latter provided its heating (**Exhibit p-125**). In the heritage report produced for the City of Montreal in 2019, the AMI is described as part and parcel of the Royal Victoria Hospital, as its “avant-garde psychiatric institution” (**Exhibit p-126**, p.15). It includes the main building, which Sir Hugh Montagu et Lady Marguerite Ethel transferred to the Royal Victoria Hospital in 1940; the Ravenscrag gardens surrounding it; an annex built in 1952-53 by Barott, Marshall, Montgomery & Merrett; the Irving Ludmer Research and Training Building completed in 1963 by the same architect; the pool built in 1961 over what used to be a garden and donated to the Royal Victoria Hospital by M. and Mrs. Henry Morgan; a garden house; the stables; and a parking lot (p.7). A 1955 Pocket Guide provides detailed maps of the interior design of the Royal Victoria Hospital complex and the Allan Memorial Institute, showing how the AMI’s day hospital was on the western side of the building, that the therapy unit was just east of the entrance, that the wards and doctors’ offices were upstairs, and that research laboratories were on the second floor (**Exhibit p-127**, pp.26-28). Given the intimate connection between the AMI and the RVH, which are also connected by a pathway as shown in this series of drawings (**Exhibit p-128**) it does not seem advisable to rule out the possibility of crucial forensic evidence laying elsewhere in the outside in the grounds of the RVH, outside the perimeter of the AMI. As a matter of fact, the Truth and Reconciliation Commission has reported that Indigenous children were buried directly in the grounds around residential schools because the Department of Indian Affairs considered it “the most cost-effective way”, and “In this, the department conformed to the general practice of the period in the treatment of those who died in institutions. It was not uncommon for hospitals to have cemeteries in which indigent patients were buried, and workhouses for the poor also had cemeteries” (**Exhibit p-17**, p.120). The possible existence of a pauper’s cemetery in the grounds of a health center as old as the Royal Victoria Hospital warrants extreme caution in excavating the land.

53. In addition to the aforementioned drawings, **Exhibit p-129** provides a series of aerial photos and Google Earth snapshots of the AMI and RVH, while **Exhibit p-130** provides photographs taken on the site in the Fall of 2021. Regarding the allegations of unmarked graves in the vicinity of the pool, by viewing these photographs it is clear that the garden behind the Allan Memorial Institute, visible at the left of Figure 1 (1920) in **Exhibit p-129**, at the upper center of Figure 2 (1947-49) and at the left of Figure 3 (1955), was transformed into a pool, seen in Figure 4 (1962) and in photographs from subsequent years. Figure 4, from 1962, also shows a new parking lot between the AMI and the RVH. The pictures around the pool provided in **Exhibit p-130** show a great number of irregularities in the terrain. Utmost care must be taken in examining the ground in these zones to address the allegations that it served as a clandestine cemetary.

54. Finally, the archeological heritage belonging to ancestors of the Kanien’kehá:ka (Mohawk) Nation on the site of the AMI and the RVH is also at risk of being destroyed by excavation work. It is not known whether the Société québécoise des infrastructures (SQI) and McGill University have the obligation to follow the

recommendations issued by the Arkeos firm, which they contracted to do an archeological assessment of the grounds in 2016 to make sure the zones where it identified archeological potential are protected (**Exhibit p-131**, pp. 68-69). The zones in front of the Hersey pavilion which McGill intends to excavate in the Fall of 2022, before the kahnistensera's first hearing for an interlocutory injunction, are identified as having prehistorical and historical importance in Arkeos's report, which recommends carrying out an archeological inventory there before any land development (p. 69, zones P-03 and H-01). But even if Arkeos's recommendations are followed, its plan is largely insufficient with respect both to the expectations of the Mohawk community regarding the archeological traces of their ancestors and the criminal nature of the medical experiments conducted in the AMI. As historian Donovan King indicates in a letter which he has written for the purpose of the present report, pre-colonial artifacts have been systematically found by construction workers in the vicinity of the AMI and RVH grounds, including on Peel and Sherbrooke Streets as well as further up the mountain, "underneath the Protestant Mount Royal Cemetery on the mountain, which was built over Indigenous graves" (**Exhibit p-132**, p.5). In **Exhibit p-133**, Mathieu Sossoyan, professor of anthropology at Vanier College, provides details on the extensive list of accidental archeological discoveries that have been made in Montreal throughout the years.

55. To conclude this report, I must mention an extensive and insightful critique of Arkeos' archeological assessment that was produced for the purpose of the present report by Karonhia'no:ron, a Kanien'kehá:ka (Mohawk) from Kanehsatake and an anthropology student at McGill University. His letter is filed hereto as **Exhibit p-134**, but I quote its conclusion here extensively, to share with the court Karonhia'no:ron's analysis of how Quebec's *Cultural Heritage Act* is largely insufficient for protecting Indigenous heritage:

> "The report concludes with the statement that six zones with archaeological potential from the prehistoric period have been identified: P-01 to P-06. They are areas that the Arkeos archaeologists identified as being the most consistent with prehistoric human occupation. It's noted, however, that it is entirely plausible that prehistoric burials may be uncovered outside of these six zones. They write that "unless they are located in or near occupied sites, burials are one-off phenomena that are not necessarily heralded by a scattering of artifacts. Their discovery, then, is a matter of chance." (2016:71) Four other zones, H-01 to H-04, are listed as likely containing historic archaeological artifacts. In both cases, it is recommended that an archaeological surveying technique be employed to gain a better understanding of the nature of these deposits. This is important to note. Arkeos and Decasult did not do survey work on the ground. They are recommending that it be done at a later date. This could be as simple of a process as a surface survey, where archaeologists

walk along transects and map the plots, looking for artifacts or signs of inhabitence on the top layer of soil. It could also be more complex, employing aerial surveillance or ground-penetrating radar. Until then, what rests beneath the soil is highly vulnerable to being destroyed by the impending construction…" (**Exhibit p-134,** p.4)

"It is considered a norm in a province like British Columbia for both academic and cultural heritage management archaeologists to consult with Indigenous nations (albeit usually through band council chiefs) before even conceptualizing an archaeological project. However, in Quebec, the situation is very different. This is because cultural heritage management falls under the jurisdiction of the provinces, rather than the federal government, and each province has different legislation governing archaeology. In Quebec, all archaeology projects are subject to the Cultural Heritage Act (2011) which replaced the earlier Cultural Property Act (1972). Under the Cultural Heritage Act, archaeologists are required to consult with and report to the Minister of Culture and Communications.

Cultural heritage is conceptualized as belonging to the state, and almost 80% of funding for preservation comes from the province and its municipalities (Zorzin 2011:123). Cultural heritage "consists of deceased persons of historical importance, historic events and sites, heritage documents, immovables, objects and sites, heritage cultural landscapes and intangible heritage." (Government of Quebec 2011a:5) The issuing of an archaeological permit requires that the archaeologist gain the written consent of "the immovable's owner or of any other interested person." (Government of Quebec 2011b:2) However, there is no particular stipulation calling for a mandatory consultation or collaboration with Indigenous peoples. This is most likely due to the context of archaeology's institutionalization in Quebec during the 1960s and 1970s, with archaeologists Nicolas Zorzin and Christian Gates St-Pierre (2017:414) describing this as a time when politicians looked towards "history and archaeology to rebuild a threatened identity focusing on the French regime." They continue, stating that this resulted in "a slow penetration of the post-processual critical approach [and] a reluctance to acknowledge First Nations' existence in the present." (2017:415) To do so could potentially debase sovereigntist and separatist Quebecois claims to land…" (**Exhibit p-134,** pp.4-5)

"A non-legally binding document, Le code d'éthique et des normes professionnelles, published by the Association des archéologues

professionnels du Québec (AAQ) in 2021, outlines different obligations. The AAQ states their approval and implementation of the United Nations Declaration on the Rights of Indigenous Peoples, as well as the relevant calls to action from the Truth and Reconciliation Commission (2015). Section 2.1.3 states that the archaeologist must ensure that they present themselves directly to representatives of an Indigenous community (not necessarily a band council chief) to outline the archaeological project before they start working. Additionally, Section 2.1.5 states that "the will of the communities directly concerned must take precedence over that of other stakeholders, in compliance with the laws that are in force." (AAQ 2021) The final section I want to note, Section 2.1.7, highlights the importance of incorporating Indigenous peoples and perspectives into the process of doing archaeological work. However, because this is not a legally binding or enforceable document, conformity is a difficult thing to expect or gauge. It is also possible that academics may be more likely to adopt this code of ethics as opposed to corporations like Arkeos and Decasult..." (**Exhibit p-134,** p.5)

"There is an option for Kanien'kehá:ka archaeologists to undertake the responsibility of this investigation, though this would most likely have to be done through the Mohawk Council of Kahnawake. The MCK's portfolio release for the 2021-2024 term lists Ross Kakwirakeron Montour as the head of the Indigenous Rights and Research Portfolio, alongside Barton Skaroniati Goodleaf, John Asenase Rice, Jessica Teiotsistohkwáthe Lazare and Michael Ahríhrhon Delisle Jr (MCK 2021). As stated before, the Council has worked with the City of Montreal on archaeological projects previously. However, if the Kanien'kehá:ka Kanistensera do not want to enlist the help of the band council, this should be respected. The band council represents a colonially-imposed governance system, implemented through the Indian Act and contradicts the authority of traditional Kanien'kehá:ka, Rotinonshonni governance. It is equally as valid of a route to have the Kanien'kehá:ka Kanistensera, other elders and knowledge keepers, as well as community members more broadly, on site to ensure that Kanien'kehá:ka, as well the land and potentially, their ancestors, are being respected. There are many different forms that this project could take. The one that McGill chose to embark upon is one that only adds to the legacy of mistrust between Indigenous peoples, institutions and archaeologists." (**Exhibit p-134,** p.7)

"The New Vic project has been under consideration and in the works for years, but it is only in January 2021 that McGill's

> administration states that they began collaborating with “internal and external Indigenous communities” (McGill 2022) through their Indigenous Initiatives department and with the help of Acosys. Why are the members of these communities unnamed? Who are they? Who are their kin, and who do they claim to represent? The Kanien’kehá:ka Kahnistensera feel that whoever these parties are, they do not represent them nor the people of Kahnawa:ke. That, I think, is the profound issue here. McGill is not willing to listen to and learn from Indigenous peoples, as much as they state this is the case. *Listening* requires listening even when someone does not agree with you, or when someone is hurt by things that you did. *Listening* requires listening to all persons implicated in archaeological research. If someone says that you did not give them a seat at the table when they deserve one, then you should pull up a chair and apologize. McGill University has not done any of this- it has not even taken the first step towards meaningful and ethical partnerships with Indigenous peoples. The words of the university administrating ring hollow.” (**Exhibit p-134**, pp.7-8)

SWORN BEFORE ME at _____,

this ___ day of _____, 20__

_____
COMMISSIONER OF OATHS

Commission no or capacity:

_____

And I have signed at _____,

this ___ day of _____, 20__

_____

No: 500-17-120468-221

SUPERIOR COURT (CIVIL DIVISION)
DISTRICT OF MONTREAL

KAHENTINETHA,
KARENNATHA,
KARAKWINE,
KWETIIO,
OTSITSATAKEN,
KARONHIATE,
Plaintiffs

vs.
SOCIÉTÉ QUÉBÉCOISE DES INFRASTRUCTURES,
ROYAL VICTORIA HOSPITAL,
McGILL UNIVERSITY HEALTH CENTRE,
McGILL UNIVERSITY,
VILLE DE MONTRÉAL,

-and-
ATTORNEY GENERAL OF CANADA
Defendants

-and-
ATTORNEY GENERAL OF QUEBEC
Impleaded Party

AFFIDAVIT OF PHILIPPE BLOUIN IN SUPPORT OF THE PLAINTIFF'S APPLICATION FOR AN INTERLOCUTORY INJUNCTION

ORIGINAL