February 28, 2024

VIA EMAIL

Office of the Chief Coroner
BC Coroners Service
PO Box 9259, Stn Prov Govt
Victoria, BC V8W 9J4

Dear Chief Coroner:

RE: Death of Kendal Campeau

We write on behalf of the family of Kendal Lee Campeau, the BC First Nations Justice Council, the Union of BC Indian Chiefs, the First Nations Summit and Prisoners' Legal Services to request that the BC Coroners Service exercise its authority under s. 18(3) of the *Coroners Act* to call an inquest into Mr. Campeau's death. Mr. Campeau was a member of the Yellow Quill First Nation who passed away while in the custody of Correctional Service Canada ("CSC") on November 14, 2021 at Pacific Institution in Abbotsford, BC due to methadone toxicity.

Deaths in custody call for a higher level of outside scrutiny, given the closed and often abusive nature of prisons. This is especially important when an Indigenous person dies in custody, considering the ever-growing representation of Indigenous people in prisons and the parallels between prisons and residential schools, where so many Indigenous children died due to abuse and neglect.

In Mr. Campeau's case, there are a number of very serious concerns about his treatment in custody, including his experiences in long-term solitary confinement, his allegations that he was brutally raped by prison officers and that an officer gave him a razor blade and encouraged him to kill himself, the multiple physical assaults against him by other incarcerated people, and his significant mental health needs. Further, there is evidence that Mr. Campeau did not receive adequate healthcare, including after the overdose that ultimately led to his death and in relation to substance use and chronic pain, and that CSC failed to properly consider Mr. Campeau's Indigenous identity in making decisions about him. There is also evidence of numerous failures to properly preserve evidence surrounding the circumstances of Mr. Campeau's death, which raises additional concerns about the need for transparency.

The Board of Investigation ("BOI") regarding Mr. Campeau's death, carried out by CSC's Incident Investigations Branch,[1] demonstrates that CSC cannot be left to investigate itself, and that an outside inquiry is required.

Holding an inquest into Mr. Campeau's death would further the goals of *Coroners Act* s. 18(3)(a), since there is a public interest in the circumstances of deaths in custody and a particular interest in the deaths of Indigenous people in custody. An inquest would also further s. 18(3)(b) of the *Coroners Act*; incarceration is in many ways a dangerous practice in and of itself, exposing people to harms like solitary confinement, violence, unsanitary living conditions, punitive enforcement related to substance use, poor medical care and more. Indigenous people are especially likely to be exposed to many of these harms.[2] Further, the treatment and conditions Mr. Campeau endured while in custody exposed him to a risk of death in a number of ways, detailed further below.

Mr. Campeau was only 31 when he passed away. As an Indigenous person, he had been harmed repeatedly by colonial systems – including as a child when he was taken away from his family and placed in group homes, where he was treated abusively. He was also held in youth custody, attacked by a police dog at only 12 years old, and abused in provincial jails in Saskatchewan before coming into CSC custody, where he experienced further abuse. Mr. Campeau's death at Pacific Institution must be understood as part of Canada's history of forcibly separating Indigenous families, the mass incarceration of Indigenous people, and the links between prisons and colonialism.[3]

Mr. Campeau's family and the organizations named below call upon the BC Coroners Service to convene an inquest as soon as possible to publicly scrutinize the conditions Mr. Campeau endured in custody and the treatment he received and how these experiences contributed to his death, and to identify ways to prevent future deaths. Mistreatment in custody too often occurs behind closed doors, without any outside scrutiny, and an inquest is necessary to shine a public light on Mr. Campeau's experiences behind prison walls.

Mr. Campeau's conditions of confinement and abuses in custody

The conditions and abuses Mr. Campeau experienced in CSC custody are detailed in correspondence from Mr. Campeau's sister, Ashley Fontaine, and from Prisoners' Legal Services ("PLS") on behalf of Mr. Campeau's family to Correctional Service Canada (attached).

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[1] Correctional Service Canada, "Board of Investigation into the Death of an Inmate at Pacific Institution (Regional Treatment Centre) On November 14, 2021" ["BOI report"].

[2] See for instance Office of the Correctional Investigator of Canada, "Indigenous People in Federal Custody Surpasses 30%" (Ottawa: 21 January 2020). See also Office of the Correctional Investigator of Canada, *Annual Report 2017-2018* (Ottawa: 2018), *Annual Report 2020-2021* (Ottawa: 2020) and *Annual Report 2021-2022* (Ottawa: 2022). See also Prisoners' Legal Services, *Decarceration through Self-Determination: Ending the mass incarceration of Indigenous people in Canada* (April 2023).

[3] Final Report of the Truth and Reconciliation Commission of Canada.

CSC's BOI report does not meaningfully engage with most of the issues raised in this correspondence. For instance, there is no discussion of Mr. Campeau's experiences of solitary confinement, and how this might have affected his mental state and physical health, despite ample evidence of the numerous harms of isolation.

While the BOI report does mention Mr. Campeau's allegations of rape by officers, the report appears to dismiss his allegations as delusional – with no further investigation by CSC's Incident Investigations Branch, despite evidence that the assault was at the front of Mr. Campeau's mind in the days and weeks leading up to his death. (The version of the BOI report released to Mr. Campeau's family is partially redacted and it seems that several of the redactions relate to these allegations, so these comments are based on the information available to Mr. Campeau's family at this time.)

PLS has represented thousands of incarcerated people over its more than 40-year history, and has heard numerous stories from clients about prison officers committing assaults (including sexual assaults) against incarcerated people and/or facilitating or encouraging assaults by incarcerated people against one another. Further, Mr. Campeau's mental health issues would have made him an especially vulnerable target, since any attempts to report abuse could have been dismissed as delusional. As Mr. Campeau's sister explained in her letter, he talked to his family about being raped and assaulted, but CSC did not consult or seek more detail from them.

The Correctional Investigator of Canada (the ombudsperson for federal prisons) and others have identified the ways in which prison staff facilitate a violent culture within federal prisons, including sexual violence. An assessment of the workplace culture at Edmonton Institution in Alberta revealed widespread violence and harassment between and among prison staff, with some staff reporting being sexually assaulted by co-workers.[4] In 2022, a prison officer from Nova Institution in Nova Scotia pleaded guilty to sexually assaulting three incarcerated women,[5] and another officer from Grand Valley Institution in Ontario has also been charged with sexual assault for having a sexual relationship with a prisoner.[6] The Canadian Association of Elizabeth Fry Societies has documented additional instances of CSC employees engaging in sexual coercion or violence against people incarcerated at federal institutions designated for women.[7]

In his 2017-2018 annual report, the Correctional Investigator wrote:

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[4] Hawryluk, H. & Popik, J. Families First: Supports for Occupational Stress Inc. "Edmonton Institution Needs Assessment & Analysis – Report on Needs Assessment (January 2019).

[5] Jane Sponagle, *CBC News*, "Former prison guard jailed for sexually assaulting inmates in Truro" (Aug 23, 2022). Online: https://www.cbc.ca/news/canada/nova-scotia/former-correctional-officer-sentenced-three-years-sexual-assault-1.6559727.

[6] Gordon Paul, *Waterloo Region Record*, "Case of Grand Valley correctional officer charged with sexual assault returns to court in April. Online: https://www.therecord.com/news/waterloo-region/case-of-grand-valley-correctional-officer-charged-with-sexual-assault-returns-to-court-in-april/article_fe563160-2b0b-55de-9037-d1607d7062df.html.

[7] Canadian Association of Elizabeth Fry Societies, "Sexual Coercion and Violence in Prisons Designated for Women" (April 14, 2021). Online: https://ac935091-bf76-4969-8249-ae3a107fca23.filesusr.com/ugd/d2d30e_b783e9490a454f78b3a47d0e226fa152.pdf.

> Corrections is not just about prisoners or prisons; careful attention and consideration must also be paid to staff. The lesson to emerge from maximum security Edmonton Institution this past year is that staff practices that undermine or degrade human dignity — sexual harassment, bullying, discrimination — can lead to a toxic work culture…if staff disrespect, humiliate or disabuse each other one can only imagine how they might treat prisoners.[8]

Mr. Campeau's allegations should have been taken seriously, and the fact that they were not meaningfully investigated by CSC demonstrates the need for outside scrutiny, including by the Coroner.

Inadequate healthcare

CSC's BOI report identified multiple concerns regarding the healthcare that Mr. Campeau received prior to his death. For instance, the report found that Mr. Campeau applied to participate in CSC's Opiate Agonist Treatment ("OAT") program nearly one month before he died, but CSC failed to take the steps required by policy to initiate treatment. Mr. Campeau's death was due to methadone toxicity, presumably from methadone he obtained from the unauthorized prison market. If Mr. Campeau had been prescribed OAT, he would not have had to seek out methadone on his own. Despite this failing, the BOI did not make any recommendations to CSC to address this.

The BOI report also criticized CSC for only checking on Mr. Campeau every four hours after he returned from outside hospital following an overdose on the morning of his death, noting that "more frequent monitoring…for symptoms such as decreased respiration would have been prudent especially as he had been placed in a camera cell in the [CSC] Medical Hospital". The BOI report also criticized CSC for failing to have a policy regarding the monitoring of patients who have overdosed on methadone. This led to the BOI's lone recommendation to CSC – that CSC "*consider* reinstating the Methadone-Opiate Overdose directive/protocol" (emphasis added).

The BOI also identified issues with the discharge information provided by Abbotsford Regional Hospital on the morning of Mr. Campeau's death, including a lack of "treatment modalities or follow up monitoring", and noted that "lack of detailed information from the community hospital was an ongoing issue". A Coroner's inquest could also examine whether the care provided by the hospital was adequate and issues of communication between community hospitals and CSC.

The BOI report also identified other gaps in the health and mental health care provided to Mr. Campeau by CSC, including the failure to properly complete certain assessments or

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[8] Office of the Correctional Investigator, *Annual Report 2017-2018* (June 29, 2018). Online: https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx.

documentation, including assessments of mental health need and of wellbeing while held in a Structured Intervention Unit (a form of isolation that has replaced administrative segregation). No recommendations were made to address this problem.

There is a notable gap in CSC's BOI with respect to the impact of solitary confinement on Mr. Campeau's mental and physical wellbeing, and no assessment of whether the care he received responded to the well-known psychological harms of isolation. There is similarly no discussion of the ethical problems with CSC health providers repeatedly signing off on Mr. Campeau's continued placement in isolation, a practice which has recently been questioned by the BC Health Professions Review Board.[9]

Nor is there any engagement with the allegation that a CSC officer gave Mr. Campeau a razor blade and encouraged him to kill himself—which is, appallingly, the kind of allegation that PLS has heard repeatedly from incarcerated clients. Catherine Latimer, the Executive Director of the John Howard Society of Canada, similarly testified to the Standing Senate Committee on Human Rights that if people incarcerated at Millhaven Institution (a CSC facility in Ontario) "'indicated that if they were feeling suicidal and they mentioned it to one of the guards, the guards would say, 'Go ahead and commit suicide; it'll be one less person for us to look after.'"[10]

The BOI also fails to consider the impact of repeated assaults against Mr. Campeau on his emotional and physical health, or whether the care he was receiving was responsive to his experiences of trauma in custody. As Mr. Campeau's sister Ashley wrote in her letter, "The psychological damage and physical abuse that Kendal suffered through, changed him. It had such detrimental impact on his mental well-being, it literally broke him."[11] Although much of the abuse Mr. Campeau suffered in custody may have been historical, there is significant evidence it was on his mind when he died. The BOI report does not engage with this, or consider whether he might have been using methadone to cope with unaddressed physical or psychological pain—including from these experiences.

The BOI also fails to consider whether the healthcare Mr. Campeau received was culturally appropriate or culturally safe for him as an Indigenous person, or whether he would have benefitted from an alternative to prison, such as an Indigenous-run healing lodge. That said, the BOI does indicate that CSC "failed to accurately capture how the oppressive effects of colonization and forced assimilation under the Indian Act…impacted [Mr. Campeau's] actions and behaviours" or to appropriately consider Mr. Campeau's Indigenous identity in decision-making.[12]

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[9] *Complaint v. College of Physicians and Surgeons of BC*, 2019-HPA-141, 31 May 2022. Online: 2022 BCHPRB 39 (CanLII) | Complainant v. College of Physicians and Surgeons of British Columbia (No. 1) | CanLII.

[10] Standing Senate Committee on Human Rights, *Report on The Human Rights of Federally-Sentenced Persons* (June 2021), p. 177. Online: https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf.

[11] Ashley Fontaine letter, p. 4.

[12] BOI report, pp. 21-22.

Punitive and enforcement-oriented approaches to substance use

CSC's BOI report also demonstrates the various punitive approaches by CSC to address substance use, which only drive people to use substances more covertly – in turn making using more dangerous. Indeed, the BOI indicates that, after Mr. Campeau overdosed on the morning of November 14, 2021, he denied taking any substances – likely to avoid being disciplined for having contraband and/or to protect other people who may have shared their medication with him. An inquest is necessary to examine whether CSC's punitive and enforcement-oriented approach to drugs and contraband contributes to people using substances in more secretive and dangerous ways that increase the risk of overdose death.

Failure to preserve evidence

CSC's BOI identified numerous violations of CSC policy on preservation of crime scenes and evidence, as well as violations of the policy on the management of incidents. This included the failure to provide (and possibly to retain) records related to whether Mr. Campeau used his cell alarm before he died, records related to security patrols and counts, and CCTV footage (possibly including footage from inside the cell where Mr. Campeau was being held when he died). This raises questions about *why* this information was not preserved and whether any of it was destroyed or withheld intentionally – questions that it does not appear CSC's Incident Investigations Branch examined.

Conclusion

For all the reasons outlined above, Mr. Campeau's family and the organizations named below call on the BC Coroner to convene an inquest to meaningfully examine the treatment Mr. Campeau endured while in federal custody and examine the links between the abuses he suffered, his mental and physical health, and his death, and to make recommendations to prevent future deaths of incarcerated people.

Yours truly,

On behalf of the BC FIRST NATIONS JUSTICE COUNCIL

Kory Wilson
Chair

On behalf of the UNION OF BC INDIAN CHIEFS

Grand Chief Stewart Phillip
President

Chief Don Tom
Vice-President

Chief Marilyn Slett
Secretary-Treasurer

On behalf of the FIRST NATIONS SUMMIT

Cheryl Casimer
Political Executive

Robert Phillips
Political Executive

Hugh Braker
Political Executive

On behalf of PRISONERS' LEGAL SERVICES

Nicole Kief
Policy Director & Senior Legal Advocate

cc: Ivan Zinger, Correctional Investigator of Canada