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Investigating the *modus operandi* of the National Investigation Service

by Michel W. Drapeau & Joshua M. Juneau

On Saturday, March 15, 2008, Corporal Stuart Langridge, age 28, committed suicide in a barracks room at Canadian Forces Base Edmonton. As a member of the Lord Strathcona's Horse (Royal Canadians), Stuart had served previously in the Bosnia and Afghanistan conflicts.

At the time of his death, and since his return from Afghanistan, Stuart suffered from depression and anxiety. This stood in sharp contrast to Stuart's henceforth solid reputation as an exemplary, strong and proud trooper whose performance 'exceeded the standards' and whose potential for advancement was deemed to be 'above average.'

What followed Stuart’s death was a series of errors by inexperienced, unsupervised, and untested National Investigation Service (NIS) investigators, who made careless mistakes, and a unit personnel administration process that was, in our opinion, out of character with the Canadian Army’s century-old credo of “leaving no one behind.” This has left Stuart’s parents, Mr. and Mrs. Fynes, feeling “deceived, misled and intentionally marginalized.”

Over the past four years, six DND/CF investigations took place into the death of Stuart; a Board of Inquiry was convened by the Land Forces Western Area, whose results have yet to be presented to Stuart’s parents; a summary investigation was conducted by the LdSH Regiment and whose results have only been partly disclosed; an investigation by the DND/CF Ombudsman, which has been put on permanent hold; and three successive NIS investigations, each in calendar year 2008, 2009 and 2010. Importantly, none of these investigations has examined the serious failings of the unit personnel administration, or the alleged shortcomings in Stuart’s CF medical care.

In March 2012, the Military Police Complaints Commission (MPCC) commenced a public interest inquiry looking into 32 allegations filed by Stuart’s parents against 13 Military Police (MP) officers, in relation to their conduct during the three NIS investigations. During the course of that inquiry, the MPCC considered testimony from 92 witnesses, through 62 days, which straddled nearly 10 calendar months. Testimony has uncovered unusual...
dramatic and disturbing events, both in the lead up to and in the aftermath of Stuart’s unfortunate passing. We acted as lawyers for Stuart’s parents, Mr. and Mrs. Fynes, throughout these hearings. What follows is a synopsis of our closing submissions.

This article is Part One in a four-part series examining the testimony before the MPCC. Part One will consider failures of a 2008 sudden death NIS investigation, which was meant to determine the cause of Stuart’s death. Part Two will consider the improper designation of next of kin to Stuart’s ex-girlfriend, and the lasting consequences stemming from this error. Part Three will examine the failure of the NIS to investigate allegations of criminal wrongdoings. Finally, Part Four will conclude by examining broader and troubling issues that have come to light through testimony at the MPCC and that have yet to be addressed since they are all outside the jurisdiction of the MPCC.

A SUDDEN DEATH INVESTIGATION INTO STUART’S SUICIDE

A police investigation is conducted to determine the cause of any sudden death of a member of the Canadian Forces. In the context of suspected suicide, the purpose of such an investigation is to rule out whether foul play contributed to that member’s death.

Assigned as lead investigator of Stuart Langridge’s sudden death investigation was a master corporal in the NIS Western Detachment in Edmonton. At the outset of his testimony, the master corporal outlined his belief that the training and coursework he had undergone made him fully qualified for his role in this matter. We disagree, especially given that he had never acted as an investigator, either leading or assisting, on any prior investigation.

CAUSE OF DEATH

In what can only be described as a strict, if not blind, adherence to NIS mandate, the lead NIS investigator testified that, until his signature appeared on his final report, he could not rule out suicide as a cause of death. Instead, he kept an “open mind” to the possibility of any cause of death.

Examples of alternate conclusions offered by the lead NIS investigator include: Stuart may have been murdered, and the suicide note may have been written by a member of Stuart’s immediate family. No evidence was given to support these theories, which, in these circumstances, are very unusual.

Consider that Stuart was found hanging from a noose made from his belt, which was attached to a chin-up bar in the entrance to a barrack room. Other evidence should have made suicide immediately apparent as the cause of death:

- Post-mortem lividity demonstrated that the position of the body hanging in the entrance to the barrack room was as it was when Stuart died;
- There was a suicide note left on the nightstand near Stuart’s body. The suicide note was addressed to his family and provided, among other things, Stuart’s last wishes as to his funeral arrangements;
- There were no signs of forced entry to the windows or the door to the room. The door to the room was locked from the inside;

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The coroner, after pronouncing death, told the lead investigator that he believed this to be a "classic suicide";
The lead investigator learned that Stuart had had several previous suicide attempts within days of his death.

LACK OF PROPER RESPECT FOR HUMAN REMAINS
After being discovered by the base MPs, Stuart's body was left to hang for over four hours in the entrance way to the barracks room with little space for several responders entering and exiting the room, including the lead investigator, to squeeze by his body. During that period, Stuart's body remained totally uncovered.

Before the MPCC, we submitted that common sense dictates that it was inappropriate to leave Stuart hanging for that long before covering him up and cutting him down. By failing to promptly cover Stuart's body, and then delaying his being cut down, we submitted that the CF failed to show respect for his remains.

Several NIS witnesses testified that Stuart was left to hang because all scenes of death are treated as homicide until determined otherwise, and it is policy to wait until the medical examiner's arrival before cutting any hanging victim down. In consideration of the facts outlined above, we find this explanation unreasonable.

Even if we are wrong about when a body should be cut down, there certainly was no reason to leave his body uncovered, hanging in the doorway to the room while the lead NIS investigator conducted an excruciatingly detailed photo and video inventory of the few personal effects that were in that temporary room in the barracks. To document the scene, the investigator took over 150 photographs, and a 40-minute video. We view this as excessive and unnecessary.

FAILURE TO DISCLOSE THE EXISTENCE OF A SUICIDE NOTE
Stuart left a suicide note addressed to members of his family. The existence of this note was not made known to his parents until over 14 months after his passing. This created unnecessary and lasting pain and anguish for his parents.

The NIS lead investigator testified that Stuart's suicide note was not released because it was considered 'evidence.' In the context of a sudden death investigation — which is limited to determining whether or not a victim died at their own hand or whether foul play was involved — we fail to understand what a suicide note could be evidence of. It also begs the question: With a belief that Stuart's suicide note was evidence, why then was the note not sent by the NIS for forensic evaluation, such as fingerprint or handwriting analysis, to confirm it was indeed Stuart's note? This was not done.

NEW NIS POLICY REGARDING SUICIDE NOTES?
On March 15, 2008, there was no written policy for the handling of suicide notes by the NIS. Be that as it may, in 2011 a new NIS policy was created that is summarized in CF media lines. It reads as follows: "A copy of the note should have been released to the family right away, with the original released to them after the completion of the investigation."

When pressed, during testimonies, on what is meant by "right away," even with this revised policy there appears to be confusion within the NIS as to the ordinary, everyday meaning of this term:

- The lead NIS investigator testified that, if the new NIS policy had applied, Stuart's suicide note would have been released after the medical examiner's final report, in May 2008.
- Another NIS member testified that a copy of Stuart’s suicide note should have been provided to the Fynes "right away" — meaning "immediately, without delay, transferred to the person to which it's addressed, or to the executor of the estate." This would necessarily have been in March 2008.
- Another opinion was offered by an NIS member that the actual suicide note would have been released after foul play was
ruled out. This point in time was identified as April 2008, when the medical examiner had confirmed 10 of 11 indici of suicide because there were no lingering red flags, and the investigator could be confident that this was a suicide.

Thus, even with the benefit of hindsight and what is called a “clear” policy, none of the NIS investigators that were called as witnesses before the MPCC could be certain about the interpretation or application of this “new” policy about suicide notes, and the universally accepted, common meaning of the term right away.

FAILURE TO RETURN STUART'S ESTATE IN A TIMELY MANNER

The lead NIS investigator testified that Stuart’s sudden death investigation was closed within three months after his death. However, the NIS continued to hold on to exhibits, which included items of personal property, for many months beyond that. Stuart’s personal effects were not returned until 15 months after his death. Some of these materials originally retained were unconnected to the investigation; for example, Stuart’s bible and get-well cards from family and friends.

Disturbingly, at least three inventories were made of Stuart’s estate, all different and all incorrect. Some items appear on one inventory list and disappear afterwards. Some items, such as Stuart’s treasured chair and footstool, were not “found” until nine months after the first inventory was taken, and only after Stuart’s father threatened to report the matter to the local police. Tragically, some items, such as Stuart’s samurai sword, a family heirloom that was bequeathed to him by his grandfather, went missing while allegedly under the care of the regiment. It is still missing.

LESSONS LEARNED

By not having proper protocol in place, the NIS, we allege, let Stuart down, and also let down his family. The consequences of these oversights and mistakes have proven both devastating and lasting.

Ultimately, the issue of suggested improvements to the NIS investigative scheme, to help ensure such scarring occurrences never happen again, is the job of the MPCC. But perhaps the time has come to have an honest, independent review as to the raison d’être for the CF’s internal police force to conduct these types of sensitive sudden death investigations. Rhetorically, we ask, why couldn’t the RCMP or provincial specialized and independent major crime units not be trusted with the investigation of all sudden deaths that occur on Canadian soil — a situation that existed prior to the large-scale 1998 amendment to the National Defence Act.

Most obviously, Stuart’s tragic death and its aftermath will result, we hope, in a host of changes — not only as to how and who conducts sudden investigations but, equally important, the role, functions, composition, jurisdiction and oversight of administrative investigations conducted by and for the Canadian Forces. The key issue would be whether investigations such as a board of inquiry should continue to supplant say, a coroner’s inquest, when a soldier’s death occurs on Canadian soil. We think not.

We hold the strong belief that in life and death, CF members (and their surviving families) are fully entitled to all their rights under Canadian law, which includes provincial legislation. We also believe that investigations of all deaths that are unnatural, unexpected, unexplained or unattended should be investigated by a coroner’s inquest, held to publicly review the circumstances of a death by a five-person jury. The goal of such an independent inquest would be one of fact-finding, not fault-finding, and to draw awareness so as to hopefully prevent future deaths.

Next month, Part Two of this four-part series will consider the improper designation of next of kin to Stuart’s ex-girlfriend, and the lasting consequences stemming from this error.

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