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INTERVIEW Getting to know CDS Tom Lawson

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Orporal Stuart Langridge, a veteran of both the Afghanistan and Bosnian conflicts, committed suicide in a barracks room at Canadian Forces Base Edmonton, on March 15, 2008. He was 28 years of age. Following Stuart’s death, there were several investigations led by the Military Police National Investigation Service (NIS), whose actions are being reviewed by the Military Police Complaints Commission (MPCC), under 32 complaints lodged by Stuart’s parents, Shaun and Sheila Fynes.

The evidentiary stage to the MPCC hearing process was completed on January 9, 2013. This four-part series is meant to serve as an overview to highlight some troubling aspects uncovered during these hearings.

Part One of this four part series considered failures of a 2008 sudden death investigation conducted by the NIS. Part Two considered the improper designation of next-of-kin (NOK) status to Stuart’s ex-girlfriend by the Lord Strathcona’s Horse (Royal Canadians) chain of command. This third part examines the failure of the NIS to investigate any of the very serious allegations of criminal wrongdoings. Finally, Part Four will conclude by examining several broader and troubling issues that have come to light through testimony at the MPCC and that are awaiting resolution.

**STUART'S FINAL DAYS**
On March 4, 2008, while being cared for in a civilian hospital in Edmonton, and in spite of Stuart’s urgent pleas to remain committed until his transfer to a rehabilitation and detox clinic in Ontario, he was allegedly ordered out of the hospital and back to his unit, the Lord Strathcona’s Horse (LdSH), to live under close supervision...
within unit lines. Stuart’s behaviour, discipline and sobriety were to be monitored for two weeks before a decision would be made to send him for treatment at a civilian rehabilitation clinic.

We find this assertion a stretch because there was no evidence produced showing that plans were being arranged for Stuart’s admission at any clinic. For an institution like the military that runs on paper, it is unusual, to say the least, that there was no paper trail adduced during the MPCC hearings that demonstrate Stuart was actually being considered for voluntary admission to a drug rehab centre.

After allegedly being ordered back to base, Stuart was made to live in the ‘defaulter’s room,’ under strict disciplinary conditions designed as a sort of ‘probation,’ before the military would agree to send him on to the specialized clinic to treat his addictions.

One thing is certain: as Stuart’s hospital records demonstrate, his compulsory return to base was ordered by the LdSH’s chain of command. Surprisingly, testimony at the MPCC inquiry did not help in determining who gave this order. What we know is that a CF physician, the LdSH adjudant and the LdSH sergeant major, were instrumental in designing Stuart’s close supervision scheme. That said, they were likely not acting alone and, we suspect, not without the knowledge of the LdSH chain of command.

Subject to the Code of Service Discipline, Stuart had no choice but to return to base, or else he may have been charged for failure to follow a lawful command. In hindsight, maybe this would have been best — it might have led to his release from the Canadian Forces, and Stuart could then have sought the medical treatment he so obviously needed.

Stuart’s compulsory return to base begs the question: If Stuart needed treatment for drug use and depression, and the Army agreed to his treatment in the first place, why was he not sent directly from the hospital to treatment? Why was he ordered back to base?

**SUICIDE WATCH?**

The imposed restrictions placed on Stuart on March 4, 2008 have been referred to by many soldiers and officers as “suicide watch” or akin to a suicide watch. However, that’s not the official position — the Canadian Forces will have you believe that there is no such thing as a suicide watch. Ever. In fact, the regimental adjudant testified that he was “allergic” to the term. Yet, contrary to this, in at least five interviews, several CF members testified that Stuart **was** in fact on “suicide watch” and/or “24/7 watch” and/or “had a high risk of suicide.” Go figure.

In denying that there was a formal suicide watch, the unit adjudant stated: “I don’t pretend for a second to say that the regiment knew how to deal with this soldier 100 per cent perfectly; that wouldn’t be the truth.”

This, we believe.

**ALLEGATIONS OF CRIMINAL WRONGDOING**

In 2010, the NIS conducted an investigation into several allegations concerning Stuart’s suicide, *inter alia*, an allegation of criminal negligence causing death, pursuant to section 220 of the Canadian Criminal Code.

Before proceeding, however, we need to consider two concepts: What is negligence? Generally speaking, negligence has four components: (1) A duty of care must exist. (2) There must be a breach of this duty. (3) There is causation between the two. (4) There are damages.
Who would be responsible for discharging a duty of care? A fiduciary, to name but one class. A fiduciary is a person or organization that assumes care of an individual. A fiduciary duty has been said to exist, *prima facie*, in situations where a person or organization holds a position of superiority and influence over another person.

We believe that the Canadian Forces, by ordering Stuart out of hospital to return to unit lines and placing him under strict conditions including sign in/sign out requirements, and placing him on watch, not only demonstrates they knew Stuart was at risk of self-harm, but also may indicate that they assumed the duty of a fiduciary over Stuart. In doing so, we believe that the Canadian Forces owed Stuart a ‘duty of care.’ By failing in their duty towards Stuart, allegedly, the LdSH may have acted negligently.

Here, the *allegation* of criminal negligence merited investigation because the Canadian Forces may have owed a fiduciary duty toward Stuart Langridge, the LdSH chain of command knew that Stuart was suicidal, and the LdSH failed to provide care to Stuart Langridge, which led to his suicide.

For these reasons, determination of whether or not Stuart was on a suicide watch and/or whether the CF chain of command assumed fiduciary responsibility over Stuart was paramount. Especially if there had been a suicide watch, there may have been negligence by the chain of command, and the NIS should have considered there to be no choice but to investigate.

Remarkably, the NIS lead investigator concluded an investigation into negligence without interviewing a single witness. This is quite the feat. Indeed, we believe it must be a world record for expeditiously conducting such a complex police investigation! The NIS investigator's conclusion? There was no suicide watch contemplated or instituted by the chain of command.

To this we ask: How could the intentions of the chain of command be inferred without at least interviewing members of the chain of command? Mystifying!

**FAILURE OF THE NIS TO INVESTIGATE**

The 2010 NIS investigative file was closed in April 2011 because the lead investigator concluded, following (allegedly) over five months of work, and allegedly spending approximately 300 hours of personal time, that the legislation referred to in the complaint was inapplicable. Unusually, this conclusion was also reached without the NIS investigator consulting any but one of the hundreds of legal officers employed by the Canadian Forces.

To be charitable, we will describe the NIS investigation as a cursory review of legislation because, under oath, the lead investigator actually stated that he never conducted a review of documents or interviewed any of the witnesses, because he “never got past the analysis of the offence.” Sometimes, life is indeed stranger than fiction.

**THE ROLE OF LEGAL PRECEDENT**

The NIS investigator testified that the primary reason for the 2010 complaint not being investigated and being stalled after a review of documents is because he “was not able to find one reference in the entire body of case law precedent in any jurisdiction in Canada where that particular offence or that particular idea of negligence had been applied by the courts to be an issue of suicide.” The NIS has now interpreted Canadian criminal law and found it wanting. This is, of course, nonsense.

The fact that a section of law had not spoken directly to an issue before is not justification not to apply the law correctly and
fully. Indeed, this is how legal precedent is established. To us, this demonstrates that the lead NIS investigator did not have the know-how, the training, the resources, the capabilities, and/or the ambition or desire to investigate this complaint. One would think that somewhere in all of this, his immediate superiors in the NIS organization would (and should) have intervened to correct the errors of his ways. They did not.

THE EMPLOYER / EMPLOYEE RELATIONSHIP

In any employment situation, the duty of superiors is to protect employees from foreseeable harm. This makes abundant sense. Here, there were specific allegations made that, due to the conditions of employment imposed on Stuart by the chain of command, after ordering him out of hospital, the Canadian Forces had a duty to ensure his safety while he was under their care, and this did not happen.

Despite that the chain of command knowing that Stuart had said he would “rather kill himself than return to base,” the lead NIS investigator did not see fit to investigate why this was overlooked, and ignored. Remarkably, the lead investigator stated his opinion that this fact was irrelevant.

Whether arrogance or ignorance, this probably shows that the lead investigator never had an intention to investigate. Instead, the lead investigator concluded that a negligence charge was unmerited because Stuart was “provided food, shelter, clothing and medical attention during his stay.” How convenient, but absurd. A duty of care, we allege, outside the Third World, extends beyond basic human needs.

CONCLUSION

In our opinion, the 2010 NIS investigation resembled more of an administrative illusive exercise focused on exonerating the chain of command from all liability, than a focused, professional and disciplined approach to an investigative task. Throughout his investigative exercise, the lead investigator was heavily reliant on input from the CF chain of command — from which the NIS claims to be independent.

This and other concerns about the NIS alleged ‘independence’ or ‘freedom of action’ will be considered in our next article. Meanwhile, suffice to say that we have our doubts.

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