Looking forward: A springboard for change, or a recipe for recurrence?

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Stuart Langridge, a Canadian Forces veteran, committed suicide by hanging himself in a barracks room at Canadian Forces Base Edmonton on March 15, 2008. The administrative aftermath of Stuart’s death was conducted, in our opinion, in a lackadaisical fashion, resulting in several complaints being investigated through a public inquiry by the Military Police Complaints Commission (MPCC) straddling ten (10) calendar months.

Stuart’s parents, Mr. and Mrs. Fynes, continue to hope that lessons may be drawn from the Canadian Forces’ (CF) blundering, so that these errors will never be repeated again.

This article is the final part of a four part series. Part One considered failures of a 2008 Sudden Death investigation conducted by the NIS (National Investigation Service). 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) (LdSH) chain of command. Part Three examined the failure of the NIS to investigate serious allegations of criminal wrongdoings.

We continue to be hopeful that the findings and recommendations by the MPCC will be the first step in correcting systemic wrongs, so that never again will a family have to endure the hardships that Mr. and Mrs. Fynes have been forced to endure. However, lessons to be learned from the death of Stuart Langridge extend far beyond the reach of the MPCC. This part will present such commentary which looks forward, so that the pain and suffering endured by Mr. and Mrs. Fynes may be used as a catalyst for changes to occur.

CF MEDICAL CARE

One of the allegations of the 2010 NIS investigation concerned Stuart Langridge’s medical care during the last year of his life, and concomitant failure of the CF to provide a safe work environment.

“In a truly professional armed forces … concern for image ought to be subordinate to concern for professional integrity. In the long run, of course, these two desiderata may be found happily to coincide. In the short run, however, they may often appear to be adversary.”

~Arthur Shafer, 1997

ABOVE: This photograph of Cpl. Stuart Langridge was taken in Afghanistan, during his deployment on Operation ATHENA. (SHEILA FYNES)
for him. After all, the deficient health care provided to Stuart Langridge, who was assessed as having PTSD, and sent for more testing to confirm this diagnosis, in the end, did not allow him to survive his oft-demonstrated suicidal ideation. However, at present, the CF Health Care system has escaped from having to explain their actions, and escaped from any form of accountability. We raised concerns that this may have occurred because of the comments made by former Chief of Defence Staff (CDS) Walt Natynczyk in a 2010 letter to the editor, which appeared in the Ottawa Citizen while the 2010 NIS investigation was still open. The CDS stated: “Langridge received sound medical care from the best that our provincial and military medical systems can provide. Sadly, despite the efforts of many assisting health care professionals, his close friends and the leaders of his regiment, it was not enough.”

In giving the CF health care system a triple-A rating, CDS (Ret’d) Natynczyk made it difficult for anyone to conduct a critical review of the CF medical care provided to Stuart Langridge, a PTSD sufferer. In the process, Natynczyk may have removed the potential to draw lessons to avert another tragedy.

UBIQUITOUS CF PUBLIC AFFAIRS
Several witnesses at the MPCC hearings stated that the Army, and its commanders, are considered and treated as a “brand” that needs protecting. As a result, if there are allegations of wrongdoing by the chain of command, and it becomes public knowledge, there is an entire team of CF public affairs officers committed to ensuring that the outcomes are projected in a way that best protects the CF brand.

Yet, one of the values detailed in the CF Code of Values and Ethics is that CF members act, at all times, in the public interest, and in a manner that will bear the most public scrutiny. During the course of the MPCC inquiry, it became clear that, at all material times, the CF leadership relied heavily on the wide-scale use of sizeable CF public affairs resources to protect the brand. In so doing, in our opinion, the CF leadership likely placed their own interest ahead of the public interest contrary to the notions of CF leadership and accountability; perhaps, eroding the credibility of the nation’s armed forces in times of crisis.

It begs the questions: Do the Armed Forces need upward of 150 CF public affairs officers? Aren’t CF Commanders, not public affairs staff, to be entrusted with keeping the Canadian public properly informed?

BOARDS OF INQUIRY VS. CORONER’S INQUEST
Parallel to the three NIS investigations, a Board of Inquiry (BOI) was conducted by general duty officers to investigate the circumstances of Stuart Langridge’s death (its findings were published in the late in 2011, but have yet to be officially served on Mr. and Mrs. Fynes). The BOI provided a venue for the collection of “army” agencies in the LFWA to circle the wagons and, in the process, openly share their findings with the NIS. These two allegedly “independent” investigative bodies shared each other’s files and accessed the same pool of witnesses.

The symbiotic relationship between the BOI and the NIS during the NIS investigation raises serious concerns regarding
the lack of independence between these two bodies. It begs the question: Under what premise would a BOI and an NIS criminal investigation need to be coordinated? If, as they allege, the NIS operates in complete independence of the chain of command, we allege that there is no perceivable reason why they should have coordinated their efforts as they did.

Perhaps the time has come to examine why independent civil institutions, such as a coroner’s inquest, should not be relied upon to investigate the sudden death of CF members on Canadian soil, instead of convening an ad hoc military BOI. This tried and proven process, where a five-person jury publicly reviews the circumstances of the sudden death, and where the presiding coroner is responsible to ensure that the jury maintains the goal of fact-finding, not fault-finding, would be beneficial to grieving families in bringing proper and timely closure. It would also prevent the military from investigating its own.

A CIVILIAN FEDERAL POLICE FORCE SHOULD BE CREATED FOR DND/CF

The NIS is, in reality, an internal affairs police force, under the exclusive control of the CDS through his delegate, the VCDS (Vice Chief Staff of Defence). The day-to-day public face of the Military Police is as a satellite organization of the VCDS, a fact that is emphasized by the email suffix appellation used by each member of the “CF MP” staff. The NIS is constituted entirely of military members, and it exercises jurisdiction over CF members, DND employees, CF Personnel and Family Support Services (CF PFSS) employees and dependants of CF members subject to the Code of Service Discipline.

To preserve independence, in the United Kingdom, military criminal law operates under a highly specialized Ministry of Defence Police Force (MDPF), made up of civilian police officers and civilian staff, which investigates all major crimes by military personnel. The MDPF also has responsibility for crime prevention and detection, investigation of serious offences on military establishments (i.e. fraud or deaths), the physical protection of the defence establishment, as well as defence research establishments and critical national infrastructure assets, as well as the security of Crown property. Offences committed by civilians relating to the military are dealt by the MDPF, while only service offences by military personnel are left to the jurisdiction of the military police. Canada should emulate this, as it provides the required independence from the chain of command.

In our opinion, the jurisdiction of any complex or serious crimes which occur on a Canadian base would be more skillfully investigated by such a police force, and would ensure that a victim (and family) of a serious crime benefit from the conduct of an independent criminal police investigation, handled by a trained and experienced body of civilian investigators, who possess the required expertise and experience.

CONCLUSION

This article brings to a close the four-part series examining the failures of the NIS, in particular, towards the safety and dignity of Stuart Langridge, a veteran of both the Bosnian and Afghanistan conflicts. Mr. and Mrs. Fynes have devoted over five years of their lives to correct the negative legacy of their son’s death, which was imposed by Langridge’s Regiment in order to, allegedly, absolve the LdSH of any responsibility in his tragic and untimely passing.

We continue to be hopeful that the MPCC hearings will be the first step in correcting obvious systemic wrongs, so that never again will a family have to endure the hardships that Mr and Mrs Fynes have been forced to endure.

Lessons to be learned from the death of Stuart Langridge, however, extend far beyond the reach of the MPCC. If there is no admission a system is broken, then there is little hope that it will be fixed. Unless the NIS and CF shortcomings are acknowledged, this is a sure recipe for recurrence.