

Military Police
Complaints
Commission



Commission d'examen
des plaintes concernant
la police militaire

National Defence Act – Part IV
Section 250.53

FINAL REPORT

Following a Public Interest Hearing
Pursuant to Subsection 250.38(1) of the *National Defence Act*
With Respect to a Complaint Concerning the Conduct of
Sergeant David Mitchell; Petty Officer, 2nd Class Eric McLaughlin;
Sergeant Matthew Ritco; Sergeant Scott Shannon;
Warrant Officer Jon Bigelow; Warrant Officer (Retired) Sean Bonneteau;
Warrant Officer Blair Hart; Master Warrant Officer Ross Tourout;
Chief Warrant Officer (Retired) Barry Watson; Major Daniel Dandurand;
Lieutenant-Colonel Brian Frei; Lieutenant-Colonel (Retired) Bud Garrick; and
Lieutenant-Colonel Gilles Sansterre

File: MPCC 2011-004
Ottawa, March 10, 2015

Mr. Glenn M. Stannard, O.O.M.
Chairperson

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I. OVERVIEW

1.0 OVERVIEW

Introduction

1. There are at least three separate and distinct audiences for this report.
2. The first audience consists of the parties, namely the complainants and the subjects of the complaint. Their focus will be on the findings and conclusions reached by the Commission with respect to each of the 30 allegations making up the complaint.
3. A second audience is the Canadian Forces National Investigation Service (CFNIS) and the Canadian Forces Provost Marshal (CFPM), who is the head of the Military Police, of which the CFNIS is a part. While also obviously a primary audience for the Commission's specific findings on each allegation, the CFPM will also focus on the Commission's recommendations arising from those conclusions.
4. A third audience is the Canadian public at large. The *National Defence Act* (NDA) allows the MPCC to hold a public hearing where warranted. One obvious reason for public hearings is to promote confidence in the Military Police complaints resolution process through open and transparent hearings. Since public hearings also deal with systemic issues of public importance, a report of the proceedings can promote awareness of the issues underlying the particular complaints, explain why they are important and point out the implications of the Commission's conclusions.
5. Each of these interests of the three respective audiences is dealt with in the body of this report. The Commission's conclusions as to each of the allegations are set out in one place in the chapter entitled "Findings", which also provides a short explanation of the reasons for each finding. The Commission's recommendations, aimed at addressing any deficiencies, gaps or other concerns identified in the Findings or the report as a whole, are addressed in the "Recommendations" chapter. That chapter sets out, under topic headings, the Commission's specific recommendations on each subject along with a brief rationale. The necessary facts and other background information to allow for an

understanding of the Findings and the Recommendations is to be found in the body of the report in chapters 2.0 to 4.6, which are organized by topic. In the report, unless otherwise specified, the ranks of individual CF members mentioned are their ranks at the time of the event(s).

6. In recognition of the potential usefulness of a roadmap and explanatory comments, the Commission also offers this Overview, which is intended to orient the general reader to the contents of the report.

7. The status of this Overview as road map and commentary means it is not a substitute for reading the report itself, nor is it an executive summary in the usual sense of a précis of the full contents. Not every issue addressed in the report is set out in this Overview. While the sections of the Overview correspond to a number of the chapter headings of the report, some issues dealt with in several chapters of the report are brought together in one section of the Overview. Some linkages made explicit in the Overview may only seem implicit in the report, and the order in which issues are discussed may be different.

8. In reading this Overview as well as the full report, the reader should bear in mind the jurisdiction of this Commission. The role of the Commission is to investigate specific complaints about Military Police investigations and/or conduct. In the present case, those complaints arise in the context of separate grievances on the part of the complainants, Shaun and Sheila Fynes, about what the Canadian Forces did and did not do in connection with the death by suicide of their son, Cpl Stuart Langridge. The Fynes brought to the attention of the CFNIS a number of complaints against the CF they asked to be investigated. Their complaints about the CFNIS' conduct arise from how those complaints against the CF were dealt with, or not dealt with, by the CFNIS. Their complaints about the CFNIS also deal with a number of matters arising from various contacts, communications and other interactions between the Fynes and the CFNIS over a three-year period following Cpl Langridge's death.

9. It is important to keep in mind the focus of this Commission must at all times be on the complaints about the CFNIS and its members. There is no mandate for the

Commission to investigate the substantive complaints against the Canadian Forces underlying the Fynes' complaints about the CFNIS' conduct. On the other hand, it is inevitable in the course of considering the thoroughness, accuracy and impartiality of the CFNIS investigations, the Commission must have regard for what it was the Fynes were alleging about the CF. Although those underlying issues are of considerable potential public interest and importance, it cannot be the role of this Commission to offer an opinion as to their merits. All this Commission can do is to review and comment on what the CFNIS did in response and how it conducted itself in the course of its interactions with the complainants. Because this Commission has come to the conclusion a number of matters presented by the complainants to the CFNIS were not properly investigated, it must be emphasized and re-emphasized, this conclusion does not extend to any conclusion at all about the likely outcome had a proper investigation been conducted.

The Complaints

10. Cpl Stuart Langridge was found dead, hanging from a ligature fashioned from his military belt, attached to the chin-up bar in an army barracks room. The CFNIS conducted three separate investigations into matters connected with his death. The first, the 2008 Investigation, was intended to investigate the sudden death and to determine whether there were grounds to suspect foul play. The second, the 2009 Investigation, arose from complaints by the Fynes about a decision to give authority over Cpl Langridge's funeral to someone other than them. The third, the 2010 Investigation, arose from their allegations that members of the CF were culpably negligent in connection with this death.

11. The complainants allege deficiencies with respect to each of these investigations. They allege some or all of these deficiencies are related to a lack of independence by the CFNIS and a bias on the part of its members in favour of the military and its chain of command. They also allege the deficiencies are related to a lack of skills, professionalism, competence, experience or training on the part of the CFNIS members involved. In addition, they complain about the CFNIS' failure to disclose their son's suicide note to them, as well as about a number of matters arising from their interactions

with the CFNIS both in their status as the family of a deceased soldier and as the complainants in two of the CFNIS investigations conducted.

The Hearing Process

12. The complaints made by Shaun and Sheila Fynes about the CFNIS investigations following the death of their son, Cpl Stuart Langridge, go to the core of military policing and raise issues of public interest and importance that in the Commission's view required a full Public Interest Hearing (PIH).

13. The PIH was extensive, involving the testimony of some 90 witnesses and the entering into evidence of over 22,000 pages of documentary material.

14. Given the importance of the issues to both the complainants and the subjects, and given the broader implications, it is understandable that from time to time there were disagreements, including differing positions about matters of process and procedure, which led to competing submissions among counsel for the various parties as well as counsel for the Commission. For the most part, differences were resolved on an amicable and principled basis and overall there was good cooperation on most matters.

15. Some of the process issues were specific to the hearing, but some were of much broader importance, touching on the mandate and jurisdiction of the Commission and as such require special mention.

MPCC JURISDICTION

16. The subjects of the complaint made a number of submissions aimed at narrowing the Commission's focus in the hearing and in this report. The subjects asserted the Commission is restricted to dealing with allegations of professional misconduct and cannot review systemic or policy issues. They also submitted the Commission can only look into the matters related to the policing function of the Military Police and not to "administrative" matters, and the Commission may not look into or inquire about the conduct of individuals who are not members of the Military Police.

17. While it is correct the Commission's mandate is focused on the specific complaints made against specific subjects in the context of specific investigations, this does not mean in the process of considering those complaints the Commission is forbidden from considering the broader context in which the matters in question took place, or the impact of policy and systemic issues on the conduct being examined. Further, when a complaint alleges deficiencies in an investigation, it will be necessary for the Commission to consider not only what was done but also what was not done that should have been done. In order to evaluate the thoroughness of an investigation it will be necessary to understand what there was to investigate, including information that could have been available to the Military Police but was not obtained or investigated by them. This might, in the process, raise inferences or questions about the conduct of third parties, but those are, after all, the very matters the CFNIS was asked to investigate.

“SPEAKING WITH ONE VOICE”

18. The right of individuals to be represented by counsel of their own choice is undoubted. Nevertheless, the Government's decision in this case that one set of counsel would represent multiple and disparate individuals and institutions connected with the military and/or government, raises concerns. Department of Justice counsel was put into the position of advocating not only for the interest of its clients the subjects, but also for the interests of government as a whole, the CF and the CFNIS, as well as for the interests of the various CF and CFNIS personnel who were actual or potential witnesses. While there is no necessary conflict amongst all those interests, it seems unsafe to assume at the outset no divergence in interests might subsequently ensue. From the point of view of public perception, there is also a risk of government appearing to use this single representation of multiple interests to enforce conformity of viewpoints where none exists, resulting either in unfairness to the subjects or in unnecessary obstacles to the Commission's fact-finding mandate.

19. In terms of documentary disclosure, the role of government counsel as both an advocate for the subjects and the “gate keeper” for access to documents raises further complexities, if only on the level of appearances.

20. The Commission is far from alleging any actual irregularities or improprieties in the current hearing, but it does consider there to be a real risk of public scepticism where a single counsel team represents such a multiplicity of interests. The current Treasury Board *Policy on Legal Assistance and Indemnification* has the effect of making common representation the default position. It would be preferable to avoid potential problems and any potential appearance of irregularity from the outset by providing independent counsel to the subjects of a complaint.

SOLICITOR-CLIENT PRIVILEGE

21. There is no question solicitor-client privilege occupies a unique place in our legal system. The protection from compelled disclosure of matters discussed between a client and his or her lawyer is nearly absolute. It is also true, however, that the law makes it clear the privilege belongs to the client, not the lawyer, and the client is free to waive the privilege as he or she sees fit.

22. In the context of this hearing, the Government asserted the “client” for any communication between a lawyer and a member of the CF, including a member of the CFNIS, is the Minister of National Defence, and only the Minister can claim the privilege or waive it. The Minister made a blanket claim of privilege over all communications between government lawyers and any member of the CF. The impact of this position is that material made available to the CFNIS and relevant to the way it conducted its investigations is not available to the Commission. This can have a significant impact on the ability of the Commission to exercise its mandate to consider the thoroughness of investigations and to evaluate the validity of conclusions reached in those investigations.

23. Accordingly, the Commission asked the Minister to waive privilege with respect to material made available to the CFNIS as part of its investigations or that would have been available had it been requested by the CFNIS. The Commission did not, and would not, ask for any lawyer/client communications dealing with consultations between the subjects of the complaint and their lawyers in connection with this PIH.

24. The Commission's request for this limited waiver of privilege was turned down by the Minister, who indicated such waivers are extremely rare, and cited jurisprudence affirming solicitor-client privilege is critical to the administration of justice. The Commission is of the view the real question is whether there should be a waiver of privilege where a communication is needed for a full and fair hearing of the evidence and no prejudice will result to a subject of a complaint. It is of the view no legal or policy rationale exists that would prevent disclosure of such material, and urges the Government to reconsider its position with respect to future proceedings.

25. In the current hearing, the refusal to waive privilege did not crucially affect the Commission's ultimate ability to arrive at conclusions about the investigations in issue. On one issue, however, it did lead to unnecessary withholding of information on a key question. In the context of the 2010 Investigation, the evidence discloses the investigators sought legal advice shortly after their meeting with the complainants. No further investigative work was done and the file was closed without any factual investigation of the complainants' allegations. Presumably, the legal advice was in some way relevant to the decision to close the file. It may even be the very fact of obtaining legal advice might have been asserted by the subjects as a full defence against allegations of a deficiency in the handling of that investigation. The subjects did not raise any such defence and any resulting prejudice can only accrue to their interests.

26. The Commission was able to conclude the validity of any legal advice obtained would necessarily depend on the facts made available to the lawyers being consulted. Since the complainants disputed the validity of many of the facts and conclusions in the materials gathered by the CFNIS, and in light of the Commission's own determination there were significant evidentiary gaps in the materials available, absent evidence to the contrary, the Commission was able to conclude the legal opinions obtained could not provide conclusive guidance unless and until the facts upon which that advice was based were corroborated.

27. The fact the Commission was able to conclude, fortunately and somewhat fortuitously, that it was able to deal with the complaints even absent some of the material

that would have been available to the CFNIS investigators, does not in any way diminish the concern with regard to the privilege claims. The subjects of the complaint are entitled to defend their interests by whatever legal arguments are available to them. The Government, on the other hand, ought not to be erecting obstacles to the Commission's fact-finding mandate.

The 2008 Investigation

28. In the aftermath of a sudden death, both the police and the coroner (in Alberta, the Medical Examiner) conduct investigations to determine the cause and manner of death. While this leads to a degree of overlap, the police mandate is to investigate possible offences. A primary question for the police to answer is whether a death is suspicious. In this sense, the lead investigator assigned to the CFNIS investigation of Cpl Langridge's death was accurate in stating the purpose of the investigation was "to rule out foul play."

29. The investigative steps undertaken in the 2008 Sudden Death Investigation, however, did little in terms of answering the questions necessary to conclude the investigation. Instead, it was marked by three months' worth of sporadic activity but little progress towards its ostensible purpose. While the lead investigator was correct in bearing in mind the need to keep an open mind and avoid tunnel vision, this does not justify a reluctance to use the evidence assembled to form hypotheses and then test them against further facts and evidence gathered.

30. The issues with the 2008 Investigation begin with the processing of the death scene.

31. The investigators took their time, methodically compiling a meticulous catalogue of the state of the room and its contents. The time taken to complete this exercise, during the entirety of which Cpl Langridge's body was left hanging in place, became the basis for a complaint by the Fynes that the investigators showed disrespect by unnecessarily leaving the body hanging and exposed to view by passersby rather than promptly cutting it down and/or covering it. Those complaints cannot be sustained. The time taken to process the scene was within normal parameters and expert evidence establishes it would

not have been proper to disturb the body, cut it down or cover it before authorization was given for the body removal service to take it away. The Medical Examiner (ME) had agreed to allow the investigators to complete their work of processing the scene before ordering the body to be removed.

32. Nevertheless, some of the steps taken by the investigators were unnecessary and/or could have been completed after the body was removed. More importantly, the investigators do not appear to have pursued their work with any clear understanding of its purpose. The evidence was processed but not analyzed and no inferences or conclusions were drawn. Seemingly fixated on the instruction to keep an open mind, the investigators dismissed the probative value of the ME's declaration the scene was consistent with a classic suicide by hanging. They also failed to appreciate the implications of the position of the body, the fact Cpl Langridge's feet were at all times in contact with the floor, such that he could have stood up at any time to stop the process, the evidence of lividity on the body and the lack of the petichiae on the face, all of which were strongly suggestive of suicide, as was the lack of evidence of a struggle or of any disturbance of the room's contents.

33. If the investigators were seriously considering the possibility of foul play, they did not conduct any of the expected further investigative procedures to confirm or deny it, including examining the possible entry points for an intruder or looking for fingerprint evidence. Despite elaborate early precautions to preserve the evidentiary integrity of the scene, the lead investigator disturbed possibly relevant evidence and ended by potentially contaminating the scene when he performed a last walkthrough and opened various doors and drawers without wearing gloves.

34. The fate of the suicide note is illustrative. The note was addressed to Cpl Langridge's family and among other things asked for a simple family funeral. It was photographed and video-taped; its contents were recorded and the note itself was carefully put into a plastic bag, with strict attention to the rules for evidentiary continuity. It was then put away as "evidence". It was intentionally not released to the family on the basis the investigation was ongoing, a decision that made it impossible for the family to

carry out the wishes expressed in the note. Nevertheless, literally nothing was ever done with the note, including no fingerprints or handwriting analysis being undertaken. Eventually, the note was forgotten by the investigators, missing from the list of personal possessions sent to the CF, and the family remained in the dark about its existence for 14 months.

35. The lack of focus and seeming uncertainty of purpose of the investigation are also illustrated by the Investigation Plan (IP). An IP should act as a guide to plan the investigative steps to be taken in order to address the questions needing an answer in order to conclude the investigation. In this case, the IP was simply an unranked and unorganized list of issues, observations, tasks, and notes to self that could be of no use either in organizing investigative steps or in clarifying how they related to the goals of the investigation.

36. One of the matters noted in the IP was “possible negligent actions on behalf of the CF resulting in possible involvement in the death.” A subsequent Quality Assurance (QA) Review by the CFNIS of the 2008 Investigation, criticized the investigators for pursuing the topic of negligence, which the QA Review asserted should have been left for administrative review by a CF Board of Inquiry. That criticism was misguided. Negligence can form the basis for a charge under the *Criminal Code* or the Code of Service Discipline. Negligence in connection with a sudden death is a proper subject for police investigation and is well within the mandate and jurisdiction of the CFNIS.

37. The problem with the negligence aspect of the 2008 Investigation was not its subject matter but the way in which it was conducted.

38. The investigators became interested in the issue of possible negligence as a result of hearing Cpl Langridge may have been under a suicide watch at the time of his death. They reasoned if Cpl Langridge killed himself despite being under a suicide watch, the failure of the watch to prevent the suicide might constitute negligence. After the first few days, most of the investigative activity in the 2008 Investigation seems primarily focused on whether there was a suicide watch, to the point where that narrow question replaced

the correct one, which should have been whether there was evidence of culpable negligence in connection with Cpl Langridge's death.

39. The limiting assumption that negligence could only arise if there was a suicide watch, prevented the investigators or their supervisors from pursuing information obtained in their interviews that seemed to point to the possibility of negligence on a different basis. They did not notice information that may have suggested, in the circumstances, the failure to mount a suicide watch might have been evidence of potential negligence just as much as mounting a defective one. Focusing exclusively on whether facts confirmed or denied a suicide watch, they did not notice the restrictive conditions imposed on Cpl Langridge may have had some connection with his subsequent death, regardless of what they indicated about the presence or absence of a suicide watch. Instead, without confirmation of a suicide watch from the interviews, the negligence aspect of the investigation simply petered out.

40. Whether in terms of confirming suicide so as to rule out foul play or in terms of investigating possible negligence, what was not done in the 2008 Investigation was as important as what was done. Puzzling decisions were made not to contact Mrs. Fynes or to interview Ms. A¹, whom the military recognized as Cpl Langridge's common-law spouse. Both had information highly relevant to both the issue of suicide and of potential negligence, which the investigators failed to obtain.

41. No treating physician and no one involved in dealing with Cpl Langridge's addictions issues was contacted. No tests were conducted on any of the items seized from the death scene and no follow up was undertaken with respect to the scene or what was found there. No chronology was compiled of Cpl Langridge's final days.

42. Early on, the investigators conducted warrantless searches of Cpl Langridge's vehicle and storage locker. Nothing came of these searches, but the testimony of the investigators demonstrated an alarming lack of understanding of the law of search and seizure as it applied in the circumstances.

43. The investigators closed the file shortly after receiving the ME's confirmation the death was a suicide.

44. The final version of the Case Summary in the 2008 Investigation file removed references to the investigative steps related to the suicide watch issue. The Concluding Remarks in the file stated Cpl Langridge committed suicide, referred to his mental health issues and stated they were caused by or subsequent to his addictions issues. The final version of the Remarks added that the suicide occurred despite attempts by the military to provide Cpl Langridge with structure and support. It is questionable whether, as it was conducted, the investigation was capable of supporting any of those conclusions, other than the death was suicide. Following strenuous objections by the Fynes, the other conclusions were deleted by the CFNIS, for reasons of "compassion" rather than inaccuracy.

45. The 2008 Investigation was unsatisfactory both as a sudden death investigation and as an investigation of possible negligence in Cpl Langridge's death. While the ultimate conclusion Cpl Langridge's death was a suicide is clearly correct, little if anything of what the investigators did in the sudden death investigation contributed to that conclusion. On the other hand, while the investigators were correct in identifying potential negligence as a live investigative issue, their understanding of the concept was unnecessarily limited and that portion of their investigation led nowhere.

46. The overall deficiencies in the investigation are attributable to general inexperience in the investigation of domestic sudden deaths, as well as to a general failure of oversight and supervision. The inexperience of those conducting the investigation is not surprising since the CFNIS had only started to conduct domestic sudden death investigations in 2005. Given the relative infrequency of suicides on Defence Establishment property, it is likely such inexperience is a continuing issue.

The Suicide Note

47. After a number of false starts, in January 2009 the CF commenced a Board of Inquiry (BOI) into Cpl Langridge's death. Toward the end of the process, the President of

the BOI noticed a notation in a form accompanying the Province of Alberta Death Certificate referring to a suicide note. The General Occurrence (GO) file for the 2008 CFNIS Investigation contains a copy of the suicide note, but the evidence suggests neither it, nor any mention of it, was included with the redacted version of this file provided to the BOI. Six weeks after first asking about it, the BOI President was provided with a copy of the note and after another full month, he was given permission by his chain of command to contact the Fynes and to disclose the existence and copy of the note to them.

48. Even though the note was addressed to the Fynes and contained a specific request with respect to Cpl Langridge's funeral, no one had informed them about its existence or its contents until the BOI President called them on May 22, 2009, some 14 months after Cpl Langridge's death.

49. The Fynes were distraught. Not knowing about the note or its contents, they had been unable to act on Cpl Langridge's request for a family funeral rather than the full military funeral that took place. They believed the note had been concealed from them in a cruel, callous and disrespectful manner. In the aftermath of the Fynes' reaction, the CFNIS and its members provided many different, and often incompatible, explanations to the CF, to the Fynes and to the public, which in some cases bore no relationship at all to the facts of the case. It was suggested at various points it was necessary to withhold the note because of CFNIS policy about evidence; it was done in consideration of the best interests of the family; it was done to protect the integrity of the investigation; it had been intended to release the note but this intention was not carried out expeditiously. There was even a suggestion the Fynes themselves were in some way implicated because they did not ask about a note when they spoke to the lead investigator during the investigation. A year later, the Officer Commanding (OC) of the CFNIS Western Region Detachment (WR) was still telling the Fynes there had been a policy at the time not to disclose suicide notes and was providing them with the rationale that it would have been worse for them had the note been disclosed and it were subsequently to have turned out not to be genuine. This insensitive rationale was also provided by other CFNIS witnesses during their testimony before this Commission.

50. The efforts to formulate explanations appear to have been much more strenuous than any efforts to discover what actually happened. None of the suggested explanations was based on information from the investigators themselves and most, if not all, appear based on nothing beyond conjecture. In particular, there was no policy to prevent disclosure of suicide notes. The testimony of the investigators themselves suggests, while there was an initial decision to withhold the original note because the investigation was at an early stage, there was no consideration given to the question of whether the existence of the note should be disclosed to the family. As time passed, the note was simply forgotten and the failure to disclose it had no other basis. When the investigation was concluded, the original note was not returned to the family because there were no adequate processes in place at the Detachment for the return of seized items. When steps were finally taken to return other items, the suicide note was not included. As it had by then long been forgotten, no one noticed its absence. This simple though disturbing explanation does not seem to have been discovered by the CFNIS Chain of Command before the investigators testified in this Commission's hearing.

51. Very early on, the emphasis in CFNIS communications, both to the Fynes and to the public, shifted from attempts to explain or justify withholding the note to a message there had been a change in CFNIS policy or procedures that would prevent any recurrence. The public was also informed the CFNIS had apologized.

52. The Fynes never accepted the proposition there had been a formal apology made to them for withholding the note. While there may be some semantic issues about what precisely was apologized for, and to whom various apologies were delivered, the evidence reveals there were a number of occasions where the CFNIS and the CF expressed their regret and apologies for what had happened. However, the CFNIS did not apologize immediately, nor take steps to deliver the original note personally to the Fynes once the failure to disclose it was discovered. In fact, when the Fynes first asked for the original note, the Detachment's initial reaction was to suggest the Fynes make an Access to Information request to obtain a copy, and to advise they did not foresee the original being turned over.

53. The status of the second component of the messaging, about a change in CFNIS procedures to prevent any future recurrence, is more equivocal. The evidence reveals statements about changes in procedures having been enacted were being repeatedly communicated from 2009 onward, even though no explicit written policy about disclosure of suicide notes was in fact adopted before July 2011. The evidence does disclose that during this period before the adoption of a written policy, there had been a change in procedure in the form of an oral directive calling for the family to be informed of the existence of a suicide note as soon as possible and for a copy or the original of the note to be provided to the family or Next of Kin (“NOK”) as soon as possible. CFNIS HQ also monitored individual cases to ensure suicide notes were not withheld.

54. The actual written policy adopted calls for the NOK to be advised of the existence of a note “as soon as it is practicable” and for the note to be released to them or to the addressee “upon conclusion of the investigation” or “as soon as it is no longer required for the investigation.” Based on the evidence, this new policy is not fundamentally different from the existing practice at the time of Cpl Langridge’s death. It appears the CFNIS considers the failure to disclose Cpl Langridge’s suicide note to have been a mistake in practice rather than a mistake in policy. Nevertheless, the testimony heard by this Commission reveals there was and continues to be a lack of common understanding as to what is meant by disclosure “as soon as practicable” or “when it is no longer needed for the investigation.” Most of the CFNIS witnesses’ views about the appropriate time for disclosure did not change after the “new” policy was adopted. Different witnesses gave differing and contradictory accounts as to their understanding of when, as a practical matter, a suicide note would be disclosed under both the former practice and the new policy. Based on that testimony, it appears the measures put in place are insufficient to prevent a recurrence of what happened to the Fynes. Notwithstanding the written policy, it is far from certain that future suicide notes will be revealed in time for any instructions in them about the deceased soldier’s requests for his or her funeral to be acted on by the family.

The 2009 Investigation

55. In the immediate aftermath of Cpl Langridge's death, the Fynes assumed they would be planning his funeral. They were soon informed that, in fact, it was Ms. A, as Cpl Langridge's common-law spouse, who would be making those decisions as Cpl Langridge's Primary Next of Kin (PNOK). Their Assisting Officer (AO) described their reaction as being "crushed like a grape." They did, however, acquiesce, believing they had no choice. The actual decisions about the funeral were largely the subject of negotiations between Ms. A and the Fynes.

56. The Fynes subsequently discovered Cpl Langridge had filled out a Personal Emergency Notification (PEN) naming them as Primary and Secondary NOK. This discovery led them to conclude they were unjustly prevented from acting in the capacity Cpl Langridge wished them to act and their anger at the military increased.

57. Through the office of the DND/CF Ombudsman, the Fynes' complaints were brought to the attention of the CFNIS. The OC CFNIS WR undertook to conduct an investigation, naming himself as lead investigator.

58. Like the Fynes, the OC assumed the PNOK named in the PEN form was the proper person to be recognized by the military as PNOK, including for purposes of funeral planning and decision making. The initial file was opened in December 2009 and a decision to conduct a full investigation was made in February 2010, but otherwise little progress was made for a number of months. The initial investigator working with the OC was transferred before any actual investigative work was undertaken. The investigator appointed to replace him conducted three interviews intended to identify who made the decision to recognize Ms. A as PNOK. He too was then transferred.

59. A third investigator (the "Investigator") was appointed and the OC largely withdrew from active participation. This Investigator took a totally different tack. He determined the PEN form was on its face not a document intended to create legal rights or obligations and therefore discounted its relevance to the question of who was properly Cpl Langridge's NOK or PNOK. Based on his own research, he determined there was no

relevant CF regulation or order defining NOK or PNOK and instead relied on the “customs of our society” to conclude that NOK equals spouse and spouse includes common-law spouse. Having determined Ms. A was Cpl Langridge’s common-law spouse based on military policies and regulations, he recommended closing the file without further investigation.

60. The Investigator never interviewed either the complainants or Ms. A, preferring to rely on the documentary record in the file. He also did not feel it necessary to pursue the issue of who in the CF had made the PNOK decision, since he concluded it was Cpl Langridge himself who appointed Ms. A as his PNOK when he entered into a common-law relationship with her.

61. There was initial incredulity on the part of the Investigator’s supervisors, including the OC, who asked for further interviews to be conducted with respect to military policies about NOK. Despite repeated views by the ostensible “subject matter experts” who were interviewed, to the effect that these were legal questions requiring legal input, the Investigator’s views prevailed and the file was closed with no further investigation and without legal advice being sought.

62. Throughout the course of his participation in the investigation, the Investigator assumed the Fynes’ complaint and therefore the subject matter of his investigation were simply based on the question of who was NOK. He did not understand the complaint he was investigating dealt with the decision making in connection with Cpl Langridge’s funeral. He testified he only became aware of this aspect of the complaint from watching a news conference held by Mrs. Fynes. He dealt with this as an additional complaint rather than as the actual nub of the complaint leading to the 2009 Investigation. In his view, this “additional” complaint was answered by the fact the Fynes had input into the decisions about Cpl Langridge’s funeral.

63. The issue of who is entitled to make decisions with respect to a military funeral is a complex legal question. It is inconceivable to this Commission that the Investigator, a non-lawyer, attempted to tackle it on the basis of his own research, with no legal advice,

and that the OC, the Case Manager and the rest of the supervisory team at CFNIS WR agreed with this approach.

64. The Investigator was mistaken in his understanding of the nature of the Fynes' complaint. His review of the law and of applicable military policy was incomplete. Many, if not most, of his legal assumptions were arguably incorrect. His conclusion about who was the decision maker is logically puzzling, and his reliance on his own sense of social custom to decide the legal question of Next of Kin cannot be justified.

65. The Fynes' own understanding of the PEN form as the basis for determining that question may also have been mistaken. However, they were correct in asserting, in focusing on the question of whether Ms. A was Cpl Langridge's common-law spouse, the 2009 Investigation was not addressing the actual complaint they had made. The Fynes were also correct in complaining the time it took to conduct the 2009 Investigation was excessive. That aspect of the 2009 Investigation, along with the failure to keep the Fynes informed in any meaningful way of what was happening, was also unjustifiable.

66. It may well be, in the end, the Fynes' complaint was not capable of being sustained. If such is indeed the case, it would not be for the reasons cited by the Investigator and the actual investigative work done would not justify the conclusions reached.

The 2010 Investigation

67. In May 2010, the Fynes met with the OC CFNIS WR in order to discuss, among other things, a complaint they wished to bring alleging negligence on the part the CF Chain of Command responsible for Cpl Langridge's care. During the course of that extended interview, the Fynes made allegations about the military's role in Cpl Langridge's death essentially along the following lines.

68. At the beginning of March 2008, Cpl Langridge was in a civilian hospital following several suicide attempts. He requested to be sent to a treatment facility to help him deal with his addictions issues and the hospital was willing to have him stay there

until a transfer could be arranged. Instead, the CF ordered Cpl Langridge back to the base, where, despite the CF's knowledge of his instability, he was made the subject of restrictive and humiliating conditions. Cpl Langridge was coerced into agreeing to the conditions on the basis he would only be sent for treatment if he could demonstrate compliance with the conditions, even though the CF had already decided he would not be sent. The purpose of the conditions was to goad Cpl Langridge into acting out, so as to justify the CF's intention to discharge him from the military. Cpl Langridge proved incapable of coping with the conditions and stated he would rather kill himself than return to work under them. Following a brief stay in the hospital, Cpl Langridge was returned to the base. He again asked for the conditions to be relaxed, but was told he must continue to comply with the conditions. Unable to cope, Cpl Langridge committed suicide.

69. The Fynes also alleged the CF was aware of Cpl Langridge's past suicidal episodes and had a duty to keep him safe as a result. Mrs. Fynes alleged she had been assured Cpl Langridge was being monitored on a 24/7 basis. In their view, either Cpl Langridge was under a suicide watch that was defective or, if he was not, he ought to have been under a proper suicide watch. In either case, the military was negligent.

70. The Fynes believed these facts made out the elements of the *Criminal Code* offence of criminal negligence. In a formal complaint letter provided during the interview, Mr. Fynes also alluded to *Criminal Code* offences set out under the rubric of "Failing to Provide the Necessities of Life" and "Duties of Persons Directing Work".

71. The Fynes also told the investigators they believed there were errors and inaccuracies in both the CFNIS 2008 Investigation record and the CF BOI, which they alleged was biased.

72. During the meeting, the OC made representations the CFNIS would conduct an elaborate investigation that would not take previous investigations – including the BOI – at face value, but rather would re-examine all existing evidence and would interview or re-interview all witnesses. Following the interview, the lead investigator assigned to the

file assembled documents, including the BOI report and several items from the 2008 GO file, and requested legal advice.

73. There was no further investigation and as early as mid-August 2010 a decision was made to close the file without further investigation.

74. In order to justify closing the file without conducting any actual investigation, it would have been necessary to determine either the CFNIS had reliable evidence conclusively contradicting the facts necessary to support a criminal or service offence; or, even if the facts were as alleged by the complainants, no offence would be made out. Because of claims of solicitor-client privilege, this Commission is not in a position to know what legal advice was given to the CFNIS or on what such advice was based. Nevertheless, the legal advice could only be as accurate as the facts upon which it was founded and those facts were necessarily limited to the facts in the possession of the CFNIS.

75. In terms of a potential factual basis, the BOI was controversial and its conclusions were questioned even internally in the CF. Quite aside from the OC's representations it would not be taken at face value, the BOI on its own could not have been relied on to test whether an offence could be made out on the facts. The 2008 Investigation only considered negligence to the extent of attempting to determine whether there was a suicide watch in place. Because of the limited investigation conducted, the information gathered and conclusions reached in the 2008 Investigation were not capable of either refuting or supporting the allegations made by the Fynes. Unless the CFNIS investigators or their legal advisors assumed the 2008 Investigation or the BOI refuted the allegations made by the Fynes, there was no basis to conclude those allegations could be dismissed without further investigation. It would appear to be a self-defeating exercise to conduct a fresh investigation that begins by accepting, without further investigative work, the facts and conclusions disputed by the complainants.

76. The investigator who was subsequently asked to produce a PowerPoint presentation to explain the decision to close the file did his own analysis of the elements of the various offences alleged by the Fynes. His substantive legal analysis of those

elements is open to question, but it is in any event unclear what reliable facts were or could have been used to conclude the elements were not capable of being made out on the facts of the case. The presentation itself was limited to the *Criminal Code* offences set out in the Fynes' written complaint. A police investigation cannot be circumscribed by the specific charges a complainant may identify. The question for the CFNIS was whether the Fynes' allegations, if substantiated, were capable of making out either a *Criminal Code* or a service offence. It was for them, rather than for the complainants, to determine what those offences might potentially be.

77. Various CFNIS witnesses stated they did consider or would eventually have considered service offences as well as *Criminal Code* offences. There is no record of any such consideration or analysis taking place. The service offences that might potentially have been relevant are NDA s. 124, "negligent performance of a military duty" or s. 129(1) "conduct to the prejudice of good order and discipline".

78. All of the criminal and service offences potentially applicable, in one way or another include as a foundational element a duty to do or not to do something and conduct in contravention of that duty.

79. The statements made by the Fynes during the May 2010 interview alleged a duty by the CF to keep Cpl Langridge safe, based on its control over him. Additional allegations made during that interview, potentially capable of supporting the existence of a duty or conduct required by law, include the alleged CF knowledge of Cpl Langridge's suicidal tendencies, the alleged decision to remove him from a place of apparent safety in the hospital and the statements allegedly made to Mrs. Fynes reassuring her Cpl Langridge was being kept safe. The facts as claimed by the Fynes also alleged a failure to fulfill the duty to keep Cpl Langridge safe, either by failing to mount an effective suicide watch or by placing him under conditions they knew or ought to have known would destabilize him, and alleged these acts or omissions contributed to his death.

80. If those allegations were substantiated it is by no means certain a criminal or service offence could not be made out. That is not to say a charge would or should have been laid. The facts referred to by the Fynes were no more than allegations and without

substantiation could not be relied on to support a charge. However, until they were investigated, it was not possible to know whether a charge could possibly be warranted.

81. The CFNIS file with respect to the 2010 Investigation should not have been closed without any actual investigation of the allegations made by the Fynes during the May 2010 interview.

82. The Fynes also made allegations during that interview the Commanding Officer in the Regiment had committed an offence by failing to institute a suicide prevention protocol and by failing to convene a Summary Investigation (SI) following each of Cpl Langridge's suicide attempts. The CFNIS did not investigate either allegation. Certainly, in the case of the alleged failure to institute a suicide prevention protocol, there was no basis to dismiss the allegation summarily.

83. In their rush to close the file, the CFNIS members never attempted to do the very thing they promised to do, namely to uncover the truth of what had happened to Cpl Langridge, while apparently doing the very things they promised not to do, notably taking previous investigations at face value and using them to justify dismissing the Fynes' allegations.

84. It is understandable the investigators would want to be cautious with the allegations made by the Fynes. They were by no means ordinary allegations and a decision that criminal or service offence charges relating to negligence could be laid on their basis may well have been without precedent. However, that does not justify dismissing them out of hand without further investigation. Just because a set of facts has never happened before, or has not formed the basis of a charge before, does not mean it cannot meet the elements of an offence. Precedent is not a requirement when a charge is applied to a novel set of facts.

85. While it is not possible to conclude the failure to investigate demonstrates CFNIS bias or lack of independence, that failure may indicate a lack of imagination and an inability to conceive of the possibility the military may have borne some responsibility for Cpl Langridge's death. In that respect, this Commission is in no position to opine

about any potential outcome of a proper investigation into the allegations. It can conclude, however, such an investigation ought to have taken place and the Fynes' allegations that the CFNIS failed to properly investigate potential criminal or service offences alleged to have been committed by the CF Chain of Command in connection with Cpl Langridge's death are substantiated.

CFNIS Interactions with the Fynes

86. From the outset, many of the Fynes' complaints and much of their dissatisfaction can be seen as related to the way the CFNIS interacted and communicated with them.

87. The investigators in the 2008 Investigation appeared to have considered the Fynes extraneous to their investigation. The only contact with the Fynes during that investigation was initiated by the Fynes on another issue. There was certainly no effort to elicit relevant information or to brief the Fynes about the progress or results of the investigation.

88. The shocking failure to inform the Fynes about the existence or contents of the suicide note was, as the CFNIS later recognized, inexcusable. In many ways, it laid the ground work for many of the complaints that led to this Commission's public hearing.

89. The CFNIS response to the discovery of the suicide note was geared more to finding a plausible explanation to convey to the CF and the public, than to providing accurate information or to try to make amends to the Fynes. On this matter as well, the Fynes appeared to have been an afterthought. Immediately upon discovering the suicide note had not been disclosed, the CFNIS ought to have personally delivered the note to the Fynes, provided an immediate official apology and made a concerted effort to find out exactly what happened so as to provide a meaningful explanation to the Fynes. They did none of these things. The apology they did provide a month later was the result of the CFNIS CO accidentally calling the Fynes' number in the mistaken belief he was calling their AO.

90. During the course of the awkward accidental conversation with the Fynes, the CO undertook to ensure the Fynes would be provided with a report about the 2008 Investigation. Whatever improvement ensued in the relations with the Fynes as a result of this commitment was quickly dissipated by the delivery of a heavily censored copy of the GO file, amounting to one-third of its actual size, which deleted all officer notes, witness interviews and documentation about the evidence collected. Although the Fynes eventually were given a less expurgated, though still incomplete, copy of the file, the entire saga managed to make things worse rather than better and led to complaints, substantiated by this Commission, that information was improperly severed without legal or policy justification.

91. In late November 2009, the CFNIS finally did provide an in-person briefing to the Fynes about the 2008 Investigation. The briefing was conducted by the OC CFNIS WR, who had no personal involvement in the 2008 Investigation, though he did play an important role in the discussions surrounding the discovery of the suicide note. During the briefing, the Fynes raised many of the issues about the 2008 Investigation that later came to form one of the bases for their complaint to this Commission. Though there is no evidence of any intention to mislead, the OC did not provide any specifics about the investigation and some of the explanations and answers given to the Fynes in response to their questions were inaccurate or unrelated to the facts of the case.

92. Although the *National Defence Act* establishes a mandatory process for the Military Police to report any complaint they receive to the CFPM and to this Commission, the OC treated the Fynes' concerns as requests for information rather than as complaints to be acted upon. Although he undertook to provide answers to all unanswered questions, less than half of the questions raised and left unanswered during the course of the briefing were in fact dealt with in follow-up. In his testimony before this Commission, the OC cited his own assessment as to the merits (or lack of merit) of the Fynes' complaints to justify not having reported or referred them, notwithstanding the Fynes' expressed dissatisfaction with the explanations provided. This circular reasoning, by which a failure to investigate is justified by a prejudgment of the merits of what is

sought to be investigated, is a recurring and unjustifiable theme in the CFNIS approach to complaints made by the Fynes.

93. Many of the questions left unanswered by the November 2009 briefing and some that were answered, but not to the Fynes' satisfaction, were raised again over a year later in a letter addressed to the officer designated by the CF to coordinate contacts with them. Many of the responses then provided by the CFNIS were similar to those given in the course of the November 2009 briefing, focusing on general information unrelated to the facts of the case. Some were factually inaccurate. The answers appeared aimed at justifying the CFNIS' handling of the case rather than providing factual information on what was done. While the failure to provide accurate information was not intentional, the underlying continued failure to make appropriate efforts to gather responsive information was unacceptable.

94. Shortly after the November 2009 briefing, the CFNIS opened an investigative file with respect to the Fynes' complaints about the Regiment designating Ms. A to make decisions about Cpl Langridge's funeral. The OC and a second investigator met with the Fynes in March 2010 to discuss the investigation. In May 2010, another interview was held. The Fynes presented additional complaints, which led to the opening of a separate investigative file into their allegations of CF negligence in connection with Cpl Langridge's death.

95. During the course of the two interviews the OC made numerous representations about how the respective investigations would be conducted and gave specific undertakings to update the Fynes about the investigations through regular contact and to provide them justifications for any conclusions reached. The actual investigations were not conducted in accordance with the representations made, and no substantive updates or explanations were provided to the Fynes. The Fynes were not contacted at all for lengthy periods.

96. Representations about how an investigation will unfold are generally not advisable. When such representations are made, they cannot be treated as unbreakable commitments. Circumstances change, new information is uncovered, preliminary

conclusions are revisited and necessary adjustments will be made. Decisions about the conduct of police investigations should be dictated by the needs of the investigation rather than by any prior commitments made to complainants. However, when such commitments are made and changes subsequently occur, the complainants should be notified and provided with an explanation.

97. In this case, contrary to the OC's representations, both the 2009 and 2010 Investigations were largely based on existing documents rather than, as promised, on interviewing or re-interviewing of witnesses to establish the facts. Despite previous explanations the focus of the 2009 Investigation would be to establish who made the decision to recognize Ms. A as PNOK and on what basis, the 2009 Investigation veered off into a confirmation that Ms. A was Cpl Langridge's common-law spouse. Despite assurances that previous conclusions would be revisited and statements made in previous witness interviews would be tested by direct questioning, the BOI, SI and 2008 Investigation reports and documents appear to have been taken at face value with no further testing or probing. Despite descriptions of elaborate investigative techniques and considerable human resources to be applied to the 2010 Investigation, no actual investigation at all was conducted.

98. There is good reason to question the substantive merits of each of these decisions, but none of them was prohibited simply because of the OC's representations to the contrary. What was not permissible in the circumstances, however, was the utter abandonment of the undertaking to keep the Fynes updated and informed. Based on the testimony of the OC, the failure to honour these commitments was not deliberate but rather the result of inattention and occurred, at least for part of the time frame involved, in the context of serious issues affecting his family. While that may to some extent explain the failure to honour the explicit commitment to provide meaningful updates, it does not excuse it. The Fynes, justifiably, concluded they were once again being ignored and abandoned.

99. A separate unjustifiable departure from the commitments given involves the failure to provide a coherent and comprehensible explanation for the conclusions

ultimately reached in each investigation. In the May 2010 interview, the OC gave a clear and unqualified promise if he were to conclude a charge was not warranted, “I will have the justification for that statement.” The original plan for informing the Fynes of the outcome of the two investigations was to provide them with an oral briefing based on a PowerPoint presentation. Although the decision to close the 2010 file without conducting any further investigation was made as early as mid-August 2010, the Fynes were given no indication of that decision and the final oral briefing for both investigations was scheduled for February 2011. Because the Fynes requested the briefing to be conducted at their lawyer’s office and in his presence, the oral briefing was cancelled and instead, the Fynes were provided in May 2011 with a three-page letter informing them of the decision no charges were warranted with respect to the subject matter of either investigation.

100. The letter itself provides no justification for those conclusions other than to state they were reached as a result of “two detailed and comprehensive investigations.” With respect to the 2009 Investigation, the letter does state the investigation determined Ms. A was Cpl Langridge’s common-law spouse, but offers no further explanation as to how this answered the Fynes’ allegations she was wrongly appointed as PNOK for purposes of making decisions about Cpl Langridge’s funeral. With respect to the 2010 Investigation, the letter provides no explanation at all.

101. The Fynes’ request to have the briefing in the presence of their lawyer may have caused understandable discomfort for the CFNIS, but it did not relieve the OC of compliance with his promise to provide a justification for a decision that charges were not warranted. The statements in the three-page letter do not constitute a meaningful explanation, let alone justification, of that conclusion. Not only does the letter fail to provide any explanation of the investigative steps taken and how they led to the conclusions reached, it does not provide even a hint that the steps taken were entirely inconsistent with the representations previously made to the Fynes. Worse still, the reference to “two detailed and comprehensive investigations” is, at least with respect to the 2010 Investigation, potentially misleading given it involved no actual investigation of the facts whatsoever.

102. Even without the promise to provide justification for any decision that charges were not warranted, the Fynes should have been provided with a proper explanation of what was done in the investigations, including the radical departure from the previous representations. The promise to provide a justification only makes this failure worse, as does the entirely unnecessary length of time to complete each investigation as compared with the actual steps taken, including specifically the unexplained delay in providing a final briefing.

103. From the beginning of the 2008 Investigation right through to the written briefing three years later, the Fynes were not treated by the CFNIS with the respect and consideration they were entitled to receive. They were often ignored and the information provided to them was at best inadequate and at worst potentially misleading. While the CFNIS members involved did not intentionally seek to deceive the Fynes, their interactions with them made it impossible to establish a relationship of confidence and trust.

CFNIS Independence and Impartiality

104. The most serious group of allegations made in the Fynes' complaint challenges the ability of the CFNIS to conduct independent and impartial investigations. This Commission has found each of the investigations conducted by the CFNIS was flawed in a number of respects. The Fynes go one step further and allege the reason the investigations were defective was that the CFNIS, lacking independence from the CF, was biased in favour of the military and its interests. They claim actual influence was exerted through various interactions and coordinated activities between the CF and the CFNIS, and also allege individual members were motivated by a desire to "protect the uniform". If sustained, these claims would go to the heart of the ability of the CFNIS to discharge its mandate to investigate serious and sensitive offences alleged to have been committed in the CF.

105. The importance of police independence is clear and obvious. Without independence from external interference, a danger arises of a "police state" in which

political or government actors can direct police to investigate enemies or refrain from investigating friends. On the other hand, structures must exist to hold police accountable so as to avoid the danger of a different sort of “police state” in which the police exercise arbitrary and unconstrainable powers. The dangers of improper influence from above are heightened for internal police forces, like the CFNIS, who do not have a separate structure or corporate identity and ultimately answer to the CF chain of command. The potential for sensitive issues of independence to arise is especially present when the CFNIS is called on to investigate allegations of wrongdoing related to actions or decisions made or supported by the CF chain of command as opposed to isolated acts of wrong-doing by an individual CF member. The allegations of wrongdoing leveled against the CF and its members in the 2009 and 2010 Investigations, as well as the allegations of cover up with respect to the handling of the 2008 Investigation file, fall precisely into this category.

106. Many of the complainants’ allegations of bias and lack of independence appear to assume the very fact an investigation was defective or its conclusions were unsound is itself proof of an improper purpose. In so doing, the complainants mistake outcome for intent. The Commission found no evidence of any improper purpose or of any outside CF influence in the way the investigations were conducted. The vast majority of the problems with the investigations are the result of inexperience, inadequate supervision, faulty assumptions and human error, with no demonstrated relationship to bias or lack of independence.

107. As a factual matter, none of the complainants’ allegations of bias and lack of independence can be substantiated. Indeed some of the events complained of did not occur as they allege. Nevertheless, police independence and freedom from bias are not only important in terms of actual independence and actual freedom from bias. Because of the importance of maintaining public confidence in the police, appearances do matter. While the evidence does not substantiate the existence of any actual bias or lack of police independence, there are a number of instances and issues that put in question the appearance of independence.

108. With respect to independence, a particularly important issue is the relationship between CFNIS investigations, particularly the 2009 and 2010 Investigations, and internal administrative investigations conducted by the CF into many of the same issues.

109. The CFNIS 2009 Investigation addressed many of the same issues as the SI convened by the CF to look into the administration of Cpl Langridge's estate. The SI was explicitly stated to have been convened "in anticipation of litigation" and could be understood to be intended to help the CF defend its interest against a threatened lawsuit by the Fynes. The OC of the Detachment, who was also lead investigator for the 2009 Investigation, recognized a potential for the overlap in subject matter and in witness list to have a negative impact on the CFNIS investigation and asked for the SI to be deferred. It is unknown why the CF declined to allow the CFNIS investigation to go first, but there is no evidence of any wrongdoing or improper intent in that decision. Nevertheless, the failure to stop the SI could create an impression the CF investigation was considered more important, regardless of its impact on the CFNIS investigation into alleged service offences. Furthermore, once the SI was complete, the CFNIS did access its report. It was the unanimous testimony of all CFNIS personnel involved that the SI had no impact on the 2009 Investigation. Nevertheless, especially in light of the failure to conduct interviews with key fact witnesses, it is not clear the CFNIS investigation was sufficiently robust to refute an unfortunate possible impression the CFNIS deferred to the CF, not only in terms of timing but also in terms of conclusions.

110. The CF also conducted a BOI into the circumstances of Cpl Langridge's death. The Fynes were especially critical of the BOI and how it was conducted, and requested a separate police investigation be conducted into their allegations of CF negligence in connection with their son's death. This became the basis of the 2010 Investigation. In this case as well, CFNIS investigators accessed the BOI report, which contains a number of controversial conclusions and findings of fact. They did not obtain its annexes containing the evidence on which the BOI relied. The testimony is clear it would not have been proper for the 2010 investigators to base their own conclusions on those of the BOI without conducting their own assessment of the evidence. The decision to close the 2010 file was made on the basis of an investigative assessment that did not involve the CFNIS

conducting any new interviews or factual investigations. There is no positive evidence the CFNIS relied on the BOI's factual findings. However, not all CFNIS witnesses seemed to have a clear understanding such reliance would be problematic and, in the context of the limited investigative activity in the 2010 Investigation, at least an appearance might be created that would not bolster public confidence in CFNIS independence.

111. There is no evidence to support the Fynes' contention of improper discussions or information exchanges between the CF and CFNIS. Nevertheless, the CFNIS decision to communicate with the Fynes through a CF officer designated to coordinate the CF relationship with them was not helpful in bolstering the appearance of independence, nor was the CFNIS' participation in media briefings and in Media Response Lines coordinated by the CF. Special care needs to be taken to avoid any impression the CFNIS and DND are "speaking with one voice" or the military is in control of information being provided to the public about CFNIS investigations.

112. The CFNIS decision to cancel a planned verbal briefing for the Fynes, when they requested it be conducted in the presence of the lawyer representing them in a potential lawsuit against the CF, raises concerns. The evidence is equivocal as to whether, as the Fynes believed, the cancellation was motivated by a CFNIS desire to protect the CF's litigation interests, with one member involved testifying his concerns related to his role as a CF member rather than as a CFNIS investigator. CFNIS members should not be wearing their CF hats in their interactions with complainants.

113. There is no evidence the redactions to the 2008 CFNIS GO file originally produced to the Fynes were made with an intent to cover up deficiencies in that investigation. However, it is concerning that many of the ultimate redaction decisions were not made by the CFNIS, but rather by a separate DND department. That process, still in existence today, needs to be reviewed and amended.

114. Ultimately the evidence revealed, whatever the deficiencies in any of the investigations, the CFNIS members involved all sought to complete their tasks to best of their ability and with no intention to cover anything up or to protect the CF.

115. CFNIS members receive strong indoctrination and training on the need to conduct robust investigations into individual behaviour by CF members, regardless of rank. It is not as clear that the importance of vigorous investigations into allegations attacking CF institutional conduct and decisions is equally deeply engrained. In order to ensure allegations are brought forward with confidence, it is necessary to demonstrate any such allegations will be fully investigated and CF conduct will be critically examined. In the present case, the investigations may not have been sufficiently robust or rigorous to avoid fueling suspicions and concerns about police independence and impartiality such as those raised by the Fynes.

The Notice of Action

“NOTICE OF ACTION” AS AN ASPECT OF THE COMPLAINTS RESOLUTION PROCESS

116. A “Notice of Action” is a distinctive and integral aspect of the process set out by statute for dealing with complaints made to the MPCC, never the more importantly than when the Commission decides to hold a Public Interest Hearing.

117. Following completion of a Public Interest Hearing, the Commission prepares an Interim Report, including its Findings and Recommendations. This Interim Report is sent to the Minister of National Defence, the Chief of the Defence Staff, the Judge Advocate General and the Canadian Forces Provost Marshal (CFPM). The *National Defence Act* then requires the CFPM to prepare a Notice of Action setting out the Military Police responses to the Commission’s Findings and Recommendations. The CFPM is to set out any actions taken or planned with respect to the complaint. Where the Military Police declines to act on a Finding or Recommendation, reasons must be set out.

118. Once it has received the Notice of Action, the Commission prepares its Final Report, including a discussion of and responses to the Notice of Action.

119. The importance of the Notice of Action is manifest. The purpose of the independent oversight established by the *National Defence Act* in the form of the MPCC complaints resolution process is to identify deficiencies in practices and procedures; to

promote remediation of such deficiencies; to ensure police accountability; and, in light of the extraordinary powers granted to the police, to safeguard public confidence that the conduct of the Military Police is being properly regulated and overseen. These values, and especially the value of promoting public confidence, require to the maximum extent possible, transparency in the oversight regime. That is the rationale for the availability in appropriate cases, of the MPCC Public Interest Hearing process.

120. The Commission believes that this transparency must extend to the entire Public Interest Hearing process from its inception through to the publication of the Commission's Final Report.

121. In the Commission's view, requiring the Military Police to prepare a Notice of Action before the Commission produces its Final Report is intended to ensure that the Commission, the parties and the public at large may be aware not only of the deficiencies pointed out by the Commission and what the Commission believes should be done about them, but also, and crucially, whether the Military Police accepts these Findings and how, if at all, it proposes to implement the Recommendations. Without such information and the Commission's ability to publicize and comment on it, the principle of accountability is compromised and so is the transparency that is a prerequisite for public confidence in the process.

THE NOTICE OF ACTION IN THIS MATTER

122. In the current case, a Notice of Action was delivered to the Commission some seven months after the Commission provided the Military Police with its Interim Report.

123. The Commission has serious concerns regarding the content of this Notice of Action.

124. There is no requirement that the Military Police accept all – or indeed any – of the Findings and Recommendations set out in an Interim Report prepared by the Commission. What is required is for the Military Police to identify which Findings and Recommendations it will act on, which it rejects or will not implement, and the reasons for any rejections. The Commission can then respond with its final evaluation and

readers of the Final Report, including government, the parties and the public, can reach their own conclusions as to the sufficiency of the proposed responses. If concerns remain, there can then be informed debate and discussion within the democratic process.

125. In the current Notice of Action, with only one exception, the recommendations explicitly accepted relate to relatively minor and technical matters, and even there, steps identified to implement the recommendations are at times vague.

126. There is a slightly larger number of recommendations directly rejected by the Military Police. These include some of what the Commission views as the most important of its recommendations, including recommendations related to:

- ensuring sufficient experience and expertise in the conduct and direction of sudden death investigations;
- ensuring that both the fact and the appearance of police independence is safeguarded in Military Police interactions with the media;
- ensuring all relevant information is before the Commission at Public Interest Hearings;
- preventing the appearance of conflict of interest by ensuring funding for separate legal representation for subjects of a complaint.

127. The Commission is not satisfied that the reasons set out in the Notice of Action justify rejecting these recommendations.

Non-committal responses

128. There is a troubling third category of response in the Notice of Action. This category consists of non-committal responses that do not explicitly reject Findings and Recommendations but also do not accept them either explicitly or by necessary implication.

129. In terms of responses to the Commission's Recommendations, the number receiving such non-committal responses exceeds the combined number of Recommendations either explicitly accepted or explicitly rejected. When it comes to

responses to the Commission's Findings, every response in the Notice of Action but one falls into this category.

130. As responses to the Commission's Recommendations, these non-committal comments most often involve vague references to future policy reviews in which the Recommendations in question will be considered. As responses to the Commission's Findings, the non-committal comments acknowledge that the Findings have been made but contain no indication of whether the deficiencies set out by the Commission are acknowledged and accepted. Sometimes the responses take the form of statements essentially indicating an intention to seek a second opinion, presumably in confidence, from another police force.

131. In the Commission's estimation, all of these non-committal responses amount to rejections of the Findings and Recommendations in question. If they were to be seen otherwise, the Military Police would in effect be entitled to ignore any Finding or Recommendation it chose to address in non-committal terms and neither the Commission nor the public would ever know what if anything was done about the identified deficiencies. The entire issue would be removed from public view. This would fly in the face of transparency, could potentially avoid accountability and would essentially nullify the process of independent oversight.

132. Properly categorizing these non-committal responses as rejections underlines the fact that no reasons are given for not accepting the Findings and Recommendations in question.

Attempt to prevent publication of the Notice of Action

133. The Commission has prepared a more detailed and substantive review of the responses in the Notice of Action in this matter. In the ordinary course, the Commission would publish this analysis as a chapter in its Final Report and would attach the Notice of Action as an appendix to the Report.

134. In the present case, however, four weeks after transmitting the Notice of Action, the Military Police delivered a letter to the Commission instructing the Commission not

to publish the Notice of Action, something the Commission had invariably done without issue in past Public Interest cases. This new policy initiative was implemented by refusing to remove the designation “Protected B” that had been marked on the Notice of Action.

135. “Protected B” is an internal Government of Canada designation intended to prevent the publication of sensitive personal, private or business information whose publication could result in “grave injury”. The Military Police also marked the letter containing the instruction not to publish the Notice of Action, as itself “Protected B.”

136. In the letter setting out the new policy initiative, the Military Police suggested an approach for the Commission to deal with the Notice of Action in light of its “Protected B” designation. The Commission considered the suggested approach to be self-contradictory, inconsistent in principle with transparency and with accountability, and unworkable in practice. In response to the Commission’s objections, the Military Police subsequently offered to remove the “Protected B” designation from the Notice of Action on condition that the Commission agree not to append the Notice of Action to its Final Report. This condition is unacceptable. The Commission cannot agree to suppress publication of a document it considers a central part of the Public Interest Hearing process. Because the Commission could not agree to the self-censorship being proposed, the “Protected B” designations on the Notice of Action and related correspondence remain in place.

137. The Commission believes the parties and the public are entitled to see the Notice of Action. It also believes the use of the “Protected B” designation by means of which the Military Police has sought to censor the Commission’s Final Report is wrong in law. However, much as it disagrees with this use of the “Protected B” designation, the Commission does not intend to flout it by publishing the Notice of Action or referring to the specific information it contains.

138. The Commission has therefore launched an Application requesting the Federal Court to declare that the Military Police cannot prohibit the Commission from publishing

the Notice of Action and that the designation “Protected B” has been improperly applied to the Notice of Action and related correspondence in this case.

139. Pending the Court’s decision on the Application, the Commission has blacked out the chapter in this Final Report containing substantive analysis of the Notice of Action as well as the appendix containing the text of the Notice of Action and the related correspondence. Instead, the Commission has added a brief chapter containing a high level discussion of the Notice of Action, without specific reference to its wording. Once the Court delivers its final decision, the Commission will lift the redactions in a manner and to an extent consistent with the Court’s reasons.

140. The Commission considers the attempt to prevent publication of the Notice of Action to be as inconsistent with the principles of accountability and transparency as the non-committal responses in the Notice of Action, if not more so.

Conclusion

141. The Commission, the parties and the public have a right to know whether the Military Police acknowledges the deficiencies set out by the Commission in its Findings and to know whether and how the Military Police is committed to implement the Commission’s remedial recommendations, or the reasons why it is declining to do so. The Commission’s Findings and Recommendations are not transient expressions of opinion that the Military Police is entitled to peruse and at its option ignore. They cannot simply be dismissed with a non-committal shrug. The Notice of Action is not an element in a private confidential conversation between the Commission and the Military Police. It is a statutorily mandated requirement. The Commission understands it to be an essential part of the information to which the public, not to mention the parties, are entitled in the context of the Public Interest Hearing process. There is no functional reason why the Notice of Action should be cloaked in secrecy or removed from public scrutiny.

142. The purpose of independent oversight of the police is to ensure accountability, encourage remediation of identified deficiencies and promote public confidence in the

effectiveness, objectivity and transparency of the oversight regime. The effective refusals in the Notice of Action to engage with the Commission's Findings and Recommendations and the attempt by the Military Police to prevent its publication, are difficult to square with those purposes. They raise troubling questions as to the willingness of the Military Police to submit to effective independent oversight.

¹ In order to protect the privacy of a non-military witness testifying in a personal rather than professional capacity, the Commission has anonymized the identity of this witness as 'Ms. A'.

II. THE HEARING PROCESS

2.0 THE HEARING PROCESS

History and Outline of Proceedings

1. On January 18, 2011, the Commission received a complaint from Mr. Shaun Fynes on behalf of himself and his wife, Mrs. Sheila Fynes, seeking a review of the investigations conducted by the CFNIS following the suicide of their son, Cpl Stuart Langridge.¹ Mr. Fynes alleged the CFNIS lacked sufficient independence and the investigation of Cpl Langridge's death was biased. He also complained about alleged errors and deficiencies in connection with the CFNIS investigations conducted following the death, including alleged suppression of Cpl Langridge's suicide note for over a year.
2. Mr. Fynes expressed concern that an investigation opened in 2009 to look into allegations members of Cpl Langridge's Regiment did not properly designate his "primary next of kin" remained incomplete more than a year later. He further complained that in 2010, he had requested the CFNIS investigate the possibility of criminal negligence in connection with Cpl Langridge's death, but to date there had been little progress beyond a legal review of the request and a seeking of direction from superiors. Mr. Fynes also pointed to an alleged failure of the CFNIS to communicate with him and his wife about the investigations.
3. On April 29, 2011, the Chair issued a decision to conduct a public interest investigation into the Fynes' complaint.² The decision was made in recognition of the serious allegations about, among other things, the independence and objectivity of the CFNIS in conducting the 2008 investigation and forming conclusions about the death of Cpl Langridge, and about the CFNIS' ability to adequately and independently conduct the 2009 and 2010 investigations.
4. These allegations go to the core of military policing. Such issues could raise questions about the ability of CFNIS members to fulfill their duties and potentially erode public confidence in their investigations. It was also important for the Commission to

conduct an investigation to contribute to a restored confidence in the process for the complainants, as the Fynes indicated they felt marginalized and misled.

5. The complainants had not specifically identified the subjects of the complaint, so it became necessary for the Commission to do so after reviewing the investigative files and interviewing the complainants. Additionally, the complainants indicated they did not believe their initial complaint and subsequent correspondence and conversations captured the totality of their allegations about the 2008 investigation, and noted they might also have further allegations once they were advised of the results of the 2009 and 2010 investigations. As such, an interview with the complainants also allowed for clarification of the allegations.³

6. Based on the information gathered during the public interest investigation, the Commission identified 13 subjects of the complaint and disclosed to them a list of formal allegations.⁴

7. On September 6, 2011, the Chair issued a decision to hold a public interest hearing.⁵ The Commission made it clear from the outset the public interest hearing would require an investigation into systemic matters such as the policies, practices and organization of the Military Police.⁶ The allegations in the complaint put into question the very ability of the CFNIS to conduct independent investigations into the behaviour of members of the CF, particularly where members within the chain of command might be involved.

8. If there were conscious or unconscious biases preventing the CFNIS from uncovering and exposing information potentially detrimental to the CF, or if there was insufficient independence from the CF and its interests preventing CFNIS members from making adequate decisions concerning the issues to be investigated or appropriately working with complainants, this would cast doubt on the ability of the CFNIS ever to carry out its core functions. The allegations went beyond bias to raise specific concerns about incompetence and/or a lack of requisite experience on the part of the CFNIS investigators. An open, public hearing to address the allegations in a transparent manner

and hear what would necessarily be extensive evidence and submissions was deemed necessary and in the public's interest.

9. The Fynes Public Interest Hearing commenced on October 19, 2011, with an initial case conference.⁷ The case conference was called to identify counsel for the parties, set a hearing schedule, and hear a motion from the complainants seeking that the Commission recommend the Government of Canada provide public funding for their legal representation.

10. On September 26, 2011, Col (Ret'd) Michel W. Drapeau, counsel for the complainants, filed a written motion formally requesting that the Commission make a recommendation to the Treasury Board of Canada to grant public funding to the complainants in order for them to retain legal representation for the PIH.⁸ Col (Ret'd) Drapeau argued legal representation was necessary for the complainants to participate fully as parties in the PIH, noting they did not have the financial resources to afford representation without incurring severe hardship.⁹ Col (Ret'd) Drapeau proposed to act at a reduced rate. An accompanying affidavit from the complainants set out their circumstances and means.¹⁰

11. The complainants' request for public funding was opposed by the Government through submissions made in writing by the Department of Justice (DOJ) counsel to the Government of Canada.¹¹ This position was surprising. Understandably, Government resources are not unlimited and public funding for counsel for complainants at MPCC public interest hearings should be considered exceptional rather than the norm. However, the fact Government's legal advisor took a position on whether or not funding was warranted may seem incongruous in circumstances where Government counsel were also representing the subjects of the complaint before the Commission, and where the Government would have to make the ultimate decision about whether to accept a funding recommendation from the Commission, if one was issued.

12. On October 26, 2011, the Commission issued a recommendation to the Government of Canada to grant funding for the complainants' legal representation, at the reduced hourly rates proposed by Col (Ret'd) Drapeau.¹² Pursuant to section 250.44 of

the *National Defence Act*, the complainants are parties to a PIH held by the Commission.¹³ Pursuant to the *Act* and the *Rules of Procedure for Hearings before the Military Police Complaints Commission*¹⁴ they are entitled, as much as the subjects of the complaint, to participate fully in the hearing including cross-examining witnesses, presenting evidence and making submissions, including final submissions. The Commission found that, in order for the status of parties to be meaningful, it is inevitable in some complex cases such as this one, the complainants will need some form of representation at the hearing.

13. The Minister of National Defence issued a decision to grant public funding for the complainants' legal representation on March 16, 2012.¹⁵ The decision may have been delayed to some extent by confusion regarding the responsible agency. The Commission's funding recommendation was issued to The Honourable Tony Clement, President of the Treasury Board of Canada. In January 2012, Mr. Clement advised the Commission he had forwarded the recommendation to the Minister of National Defence as he felt it was more appropriate for it to be dealt with by the Minister under his powers and discretion.¹⁶ The interval between the Commission's recommendation and the Minister's funding decision had the unfortunate result of forcing Col (Ret'd) Drapeau to remove himself, for the time being, as solicitor of record and preventing him from preparing for the imminent commencement of the hearing.

14. Following the October 2011 case conference, the Commission received evidentiary materials and disclosed that evidence to the parties in preparation for witness testimony. Although document production did not always proceed smoothly or without incident, ultimately sufficient documentation was identified and made available to the Commission to allow it to conduct the PIH and carry out its mandate. On March 27, 2012, the Commission entered into evidence six collections of documents containing a large volume of material provided to the Commission by the complainants and by the Government, and which had previously been disclosed accordingly.¹⁷ As further documents were identified and redactions reassessed, new documents and revised versions of existing documents were added to the evidentiary record. By the conclusion

of the hearing, the Commission had entered a total of 1699 documents into evidence, adding up to over 22,000 pages of material.

15. The PIH heard the testimony of its first witness on March 27, 2012. The Fynes Public Interest Hearing heard evidence from 90 witnesses over 60 days of testimony, generating over 12,500 transcript pages. The last witness testified on October 10, 2012.

16. Closing submissions and reply submissions from the parties were filed on January 2 and January 8, 2013 respectively, and oral submissions were heard January 9, 2013.

17. On October 12, 2012, Col (Ret'd) Drapeau formally requested supplemental funding in anticipation of the extensive work required to prepare written closing submissions, make oral submissions at the hearing, and prepare written reply submissions.¹⁸ The Commission issued a funding recommendation on October 30, 2012, to grant supplemental legal funding at the reduced hourly rates again proposed by Col (Ret'd) Drapeau.¹⁹ On February 14, 2013, the Minister of National Defence issued a decision to grant supplemental funding for the complainants' legal representation in recognition of the increased length of the hearing, the increased number of witnesses, and the extensive documentary evidence filed.²⁰

18. In keeping with the Commission's commitment to conduct open and fair hearings in the public view, no part of the hearing was held *in camera*. In only one instance was a publication ban imposed on the contents of the hearing, and this concerned graphic video recordings produced by the CFNIS investigators depicting the scene of Cpl Langridge's suicide and their initial work at the scene, as well as that of the ME Investigator.²¹ The video was viewed at the request of the complainants. Members of the media were permitted to be present during this evidence but were not permitted to record or broadcast images or audio of its contents. The publication ban is permanent.

19. In addition to the critical importance of full and timely disclosure from the Government and the parties of all materials relevant to the matters under investigation, the Commission's ability to meet its mandate also greatly benefits when the Government takes a cooperative approach to information-gathering functions like witness interviews.

Similarly, when a flexible approach is taken with complex legal issues, significant impasses can be resolved. All those who were involved in the PIH faced significant challenges and all, including Commission counsel, at times made errors in their sincere but unrealistic attempt to meet ambitious deadlines intended to give the public, and especially the parties, the timely answers they deserved.

20. Although a number of obstacles and process issues arose in the course of this complex and extensive public interest hearing, in many cases these were ultimately overcome through cooperation between the Commission, the parties, and their counsel. The procedural challenges encountered often – but not always – resulted from positions taken by the Government institutions involved, especially with respect to legal privilege and other impediments to disclosure.

21. This by no means implies any bad faith or misconduct on the part of the Government counsel who appeared before this PIH. All counsel clearly sought to carry out their instructions in a manner that recognized their ethical and professional obligations. Wherever responsibility for some of the problems outlined in this chapter might lie, it should not be seen to rest with counsel who represented their clients diligently under often difficult circumstances.

22. Ultimately, and despite the difficulties and setbacks, the most important objectives of the Commission were accomplished with the cooperation of all parties and counsel involved. In the end, it was possible to hold the public interest hearing in the open and provide meaningful findings and recommendations, which can be openly shared with the complainants, the subjects, the Government of Canada, and the Canadian public.

THE INTERIM REPORT AND THE NOTICE OF ACTION

23. On May 1, 2014, the Commission delivered the Interim Report to the Minister of National Defence, the Chief of the Defence Staff, the Judge Advocate General, and the Canadian Forces Provost Marshal (CFPM).²² Four months later, on September 5, 2014, the Commission wrote to the CFPM to inquire as to when the Commission could expect to receive the Notice of Action.²³ On September 16, 2014, the Chief of Staff of the

Canadian Forces Military Police Group (CF MP Gp) replied that the Notice of Action was ready, but that a delay of about one month was anticipated before it could be sent to the Commission, because the CFPM wished to brief the Senior Chain of Command regarding the Notice of Action before its distribution.²⁴ The Commission was advised that the Notice of Action would be forwarded following the briefing of the senior leadership.

24. On November 4, 2014, the Commission received an e-mail message from the CF MP Gp advising that it would be approximately six more weeks before the Notice of Action would be ready to be sent to the Commission, as the briefing to the Senior Chain of Command had been rescheduled to the last week of November 2014.²⁵

25. On December 10, 2014, the Commission was advised of still another delay in the delivery of the Notice of Action, meaning that the Notice of Action would not be delivered in mid-December as expected.²⁶ In an e-mail message, the CF MP Gp advised the Commission that further to the briefing already provided to the Chief of the Defence Staff about the Interim Report and the Notice of Action, the Minister also wished to be briefed. The message explained that as the Commission provides its Interim Report to these statutory recipients, it was to be expected they would wish to be briefed as to the status of the file before the Notice of Action was provided to the Commission. The CF MP Gp did not provide additional information as to when the Commission could now expect to receive the Notice of Action, but indicated that once the briefing to the Minister was scheduled, the Commission would be advised.²⁷

26. On December 11, 2014, the Commission responded, expressing concern about the unacceptable delay in providing the Notice of Action.²⁸ At this point, more than seven months had passed since the delivery of the Interim Report.

27. Shortly after, the CFPM provided the Commission with a Notice of Action. The Notice of Action was received on December 16, 2014 and was dated December 3, 2014.

28. The Notice of Action was marked “Protected B,” a level of an internal government designation intended to protect sensitive personal, private, or business information that could result in grave or severe injury if compromised or released.²⁹

29. On December 22, 2014, the Commission wrote to the CFPM to acknowledge receipt of the Notice of Action. At that time, the Commission requested that the “Protected B” designation be removed so that the Notice of Action could be included in the Commission’s Final Report, as had been done in previous cases.³⁰

30. On January 15, 2015, the Commission received a letter from the CF MP Gp indicating that the Notice of Action could not be included in the Commission’s Final Report or otherwise published and that it would remain designated “Protected B”. The letter itself was also marked “Protected B”. In this correspondence, the Military Police suggested an approach to deal with the Notice of Action in light of this designation, but the Commission considered this approach to be both unacceptable in principle and unworkable in practice.

31. Over the course of the following weeks, the Commission exchanged correspondence with the Military Police to express its strong objection to the attempt to prevent the publication of the Notice of Action, and to seek clarification of the reasons for this unprecedented position. As most of the correspondence received about this matter was marked “Protected B”, the details of the exchanges are not discussed here.

32. On February 11, 2015, the Military Police transmitted its final decision on the matter to the Commission, maintaining its refusal to permit the publication of the Notice of Action.³¹ In this correspondence, the CFPM agreed to provide an undesignated version of the Notice of Action to the Commission, but only on the condition that the Commission provide assurances the Notice of Action would not be appended to the Commission’s Final Report. The Commission could not agree to these conditions, and advised the CFPM on February 12, 2015, that it would not provide the requested assurances.³²

33. The Commission has launched legal proceedings requesting the Federal Court to declare that the Military Police cannot prevent the Commission from publishing the Notice of Action and that the designation “Protected B” has been improperly applied to the Notice of Action and related correspondence in this case. Pending the Court’s decision in this matter, the Commission is prevented from publishing the Notice of Action and correspondence related to its designation, or from referring to the specific information they contain. The Commission has therefore redacted the chapter in this report containing a substantive analysis of the Notice of Action and the appendix attaching the text of the Notice of Action and related correspondence. Once a final decision is rendered by the Court, the Commission will lift these redactions in a manner and to an extent consistent with the Court’s reasons.

The Commission’s Mandate

34. The Commission provides independent civilian oversight to the Military Police. The Commission is mandated to review conduct complaints (meaning a complaint about the conduct of a member of the military police), and interference complaints (meaning a complaint about interference with a military police investigation), which have been referred to it.³³ Conduct complaints refer to complaints about the conduct of MP members in the performance of their policing duties or functions. These include the conduct of an investigation, the handling of evidence, responding to a complaint, the enforcement of laws, and the arrest or custody of a person.³⁴

35. Created by statute, the Commission has had a number of powers conferred upon it to enable it to carry out its functions efficiently, fairly, and independently. The Chair can decide to commence a public interest investigation or hearing if it is “advisable in the public interest” to do so.³⁵ This decision is discretionary. The Commission can commence an investigation even if the originating complaint has been withdrawn. The Chair has the ability to set rules for the conduct of investigations and hearings and for the performance of the Commission’s other duties and functions.³⁶ The Commission has the power to summon witnesses and compel them to provide sworn evidence, as well as to

produce any documents or things under their control, which the Commission considers necessary for its investigation.³⁷

36. Subject to certain exceptions, the Commission operates under relaxed rules of evidence (like many administrative bodies) and can receive and accept evidence and information even if it would not be admissible in a court of law (for example, because of rules against hearsay).³⁸ The Commission also has a legislated duty to “[...] deal with all matters before it as informally and expeditiously as the circumstances and the considerations of fairness permit.”³⁹

37. The Commission’s conclusions are non-binding and its reports are not legally enforceable, but the Military Police leadership must provide written reasons for declining to act on the Commission’s findings and recommendations. As such, the nature of the Commission’s work is akin to a public inquiry, with its influence “[...] being a matter of moral or political suasion through transparency and public accountability, rather than executive or adjudicative authority.”⁴⁰ The Commission is legally and administratively separate from the CF and the Department of National Defence and is not subject to direction from the Minister in respect of its operational mandate. The Commission operates at arms’ length from the Government and does not form part of the Crown. The Commission’s legal counsel is staffed independently of the DOJ, whose lawyers provide the bulk of legal services to Government agencies.⁴¹

Submissions about MPCC Jurisdiction

38. In their final submissions, the subjects of the complaint made a number of assertions concerning the MPCC’s jurisdiction. Notably, the subjects submit that: the MPCC can only make findings about allegations of professional misconduct; it should not review systems or policy issues; and:

[...] Nor did Parliament contemplate that this Commission would become a vehicle by which the conduct of the CF generally, or anyone within the CF aside from the MP, would be investigated. The mandate of this Commission cannot be used as a springboard to investigate or criticize the conduct of non-MP members of the CF or the Government of Canada [...]⁴²

39. The Commission accepts the general principle that its oversight mandate is focussed on the specific complaints made against specific subjects. However, when the complaint alleges deficiencies in an investigation, that mandate requires it to examine whether or not investigators were diligent, thorough, objective, and competent during their investigation(s). This means the Commission's mandated function, as envisaged by Parliament, to monitor and assess the day-to-day decisions of the Military Police, requires it to examine what the Military Police members examined or ought to have examined.

40. This does not constitute an attempt to expand or exceed its jurisdiction, as claimed by counsel for the subjects. To the contrary, in order to discharge its mandate, the Commission must be able to understand the information available to the Military Police and – most importantly – information which could have been available to the Military Police *but was not obtained or investigated* by them. To contend the Commission is precluded in these circumstances from examining what the Military Police members uncovered or ought to have uncovered in their investigation of a death, a potential crime, or a service offence would be an artificial and inappropriate constraint.

41. The final submissions of the subjects also warn the Commission against investigating, making findings, or making recommendations relating to the administration of the Military Police. The subjects note that sections 2(1) and 2(2) of the *Complaints about the Conduct of Members of the Military Police Regulations*, provide a definition of the military police duties and functions that may be the subject of a complaint.⁴³ Under section 2(2) of the regulations, when an MP member performs a duty or function relating to “administration, training or military operations that result from established military custom or practice,” these are not *policing* duties or functions. The closing submissions of the subjects describe such administrative matters as:

Duties or functions related to administration are those unrelated to core policing and that a MP officer performs in his capacity as a member of the CF. They are, therefore, excluded from the “policing duties and functions” that may be subject of a complaint and more properly considered matters of “administration” based on common sense and interpretation of analogous case law.⁴⁴

42. For this reason, counsel for the subjects submit, matters such as the development of media lines and communications strategies and “establishing reporting priorities; development of policies and procedures as well as application of ATIP legislation in relation to disclosure” are excluded from the Commission’s oversight jurisdiction.⁴⁵

43. The Commission accepts, as a general principle, there are matters related to what the Military Police do that are not connected with their policing function but rather arise in the context of their status as an administrative unit within the CF. However, this does not mean, as submitted by counsel for the subjects, certain Military Police duties and functions are categorically prohibited from consideration. A CFNIS member simply performing an administrative duty may not be subject to a conduct complaint, but a CFNIS member whose conduct in relation to an investigation or other core policing function is alleged to be *deficient* will be subject to a complaint to the MPCC even if part of the complaint pertains to how administrative matters impacted the investigation. Investigating and making findings and recommendations with respect to MP conduct in relation to an investigation is explicitly within the Commission’s jurisdiction.

44. While the subjects’ final submissions strenuously maintain the topic of media releases and communications strategies are outside of the Commission’s jurisdiction to investigate, one of the Fynes’ central complaints is that the CFNIS lacked independence in its approach to the investigations it undertook. In so far as the content of media releases or the interaction between CF and CFNIS communication strategies either confirms or rebuts these allegations, these topics are well within the Commission’s jurisdiction to investigate and to make findings and recommendations as appropriate.

45. Further, the interactions of the CFNIS members with the complainants form part of their policing function to be reviewed by the Commission and were directly raised in the Fynes’ complaint. To the extent the complainants sought to obtain Cpl Langridge’s file from the CFNIS, it is within the Commission’s mandate to address the issues that arose in the disclosure of the file to the complainants.

46. Similarly, if the evidence demonstrates a shortcoming in an investigative step or other procedure related to a gap or deficiency in Military Police policy or training, it is

also clearly within the Commission's jurisdiction to point out the deficiency and recommend corrective measures.

47. To draw a line between what Military Police and CFNIS members do in the course of an occurrence or investigation and the many interconnected activities capable of impacting on what they do and how they do it, is to propose an artificial and unrealistic distinction. Sections 2(1) and 2(2) of the *Complaints about the Conduct of Members of the Military Police Regulations* are not "watertight compartments."⁴⁶

48. With specific respect to allegations about CFNIS independence, the subjects submit, "[t]his Commission has no free standing jurisdiction to conduct a review of the structure and means by which the CF has chosen to provide police oversight for the force."⁴⁷ The Commission does not accept the terms in which this argument is framed. Systemic issues touching upon CF oversight and Military Police independence can affect the competence of investigations and may lead to improperly conducted investigations. As such, these issues are *directly* within the Commission's mandate. Where specific allegations are made about improperly conducted investigations, including allegations that the investigators in question are biased or lack sufficient independence, it is incumbent upon the Commission to examine the conduct of the investigation wherever it leads. The concepts of police bias and tunnel vision are well-understood phenomena. Even an unconscious bias or a perceived lack of independence can seriously undermine the outcome of a police investigation and the public's trust in the institution.

49. The subjects further submit:

[T]his Commission must be equally careful to ensure that its process is not subverted or its mandate exceeded by the broad and sweeping complaints against the CF at large which permeated this hearing. The vast majority of the witnesses who appeared before this Commission were not Subjects of this complaint, nor were they MPs. Many of them are the target of very serious accusations by the complainants, including accusations that they have made professional errors and or committed criminal offences. **It is not the role of this Commission to investigate, pursue or comment on the behaviour of other government actors.**⁴⁸ [Emphasis added]

50. This description of the Commission's role is inaccurate. The focus of the Commission's examination is to consider the thoroughness of the police investigations. If

the Commission is presented with complaints about misconduct and/or inadequacies in connection with the thoroughness of an investigation or the adequacy of its conclusions, these complaints must be examined. It cannot be known whether an investigation was thorough and comprehensive unless one looks into what there was to investigate. Conclusions reached might, in the process, raise inferences or questions about the conduct of third parties, *but these were, after all, the very questions the CFNIS was tasked to investigate*. The Commission's ability to determine for itself what the subjects knew or had the means of knowing, and to summon witnesses from the CF, the DND, or even other government departments in the course of its investigation into a complaint, should be beyond dispute.⁴⁹

51. Finally, the subjects submit:

This Commission has no jurisdiction to make findings or recommendations regarding the means by which the CF has chosen, as an institution, to provide legal advice to the NIS. Nor does this Commission have the jurisdiction to make findings about the conduct of individual JAG lawyers who have been subpoenaed to appear as witnesses before this Commission and have been the subject of serious professional allegations by the Fynes and their counsel.⁵⁰

52. The Commission reiterates the view its oversight of Military Police investigations requires an examination of the facts and information available to investigators. Where investigators rely upon legal advice provided to them, or on legal advice provided to other members regarding the conduct being investigated, it is appropriate for the Commission to attempt to understand the circumstances of these communications. Where a deficiency in the advice (such as a mistake of law) impacts the conduct or findings of an investigation based on that legal advice, the finding may be relevant to an assessment of the reasonableness of the police investigation and may explain the reason for the outcome of investigations subject to a complaint. It should be noted this report has made no such findings on the facts as revealed by testimony and by documents made available to the Commission. This result in no way diminishes the legitimacy of the inquiry.

Speaking with One Voice

53. The Commission acknowledges the high standards of professionalism demonstrated by counsel for the complainants and the subjects throughout a lengthy, complex, and occasionally contentious hearing process.

54. In particular, the comments here are not intended to reflect on the personal conduct of the individual lawyers in the Department of Justice and the CF acting on behalf of the subjects and the Government in the PIH. The Commission stresses that counsel conducted themselves throughout the proceedings with integrity in often stressful circumstances to discharge what, to the Commission, appears to be an almost impossible assignment given the disparate interests of their “unified” client.

55. It should nevertheless be noted, the Government’s decision that one set of counsel would represent multiple and disparate individuals and institutions connected with the Military and/or Government raises a number of potential concerns.

56. Professor Kent Roach testified about the representation of Military Police at public inquiries and considered the topic in a related paper submitted to the Commission. He discussed the possibility a conflict of interest may arguably arise where interference with Military Police independence has been alleged, and yet those complained about are represented by lawyers who also represent the CF and the Government.⁵¹ The independence problem is compounded by a Government policy sometimes referred to as “speaking with one voice,” about which the Hon. John Major remarked critically in the Final Report of the Commission of Inquiry into the Investigation of the Bombing of Air India Flight 182:

There is no doubt that agencies, no less than individuals, are entitled to representation by counsel who will present their actions and represent their interests in their best light. Where one set of counsel is appointed to do this for a variety of agencies with historically divergent perspectives and understandings, the task becomes unmanageable and risks trivializing the real differences that separate the agencies and compromising the benefits that might be expected from the separate representation of competing viewpoints.⁵²

57. In these proceedings, the “one voice” approach meant, as a practical matter, a single legal team composed of DOJ and other Government or Military counsel represented throughout the PIH the interests of:

- The thirteen individual CFNIS subjects, who were a party to the proceedings and whose reputational interests were directly at stake;
- The dozens of witnesses currently or formerly employed by the CF or the Department of National Defence (and who were thus entitled to legal representation by DOJ counsel under the Treasury Board’s *Policy on Legal Assistance and Indemnification*);⁵³
- The Canadian Forces Provost Marshal;
- The Canadian Forces;
- The Department of National Defence and the Minister; and
- The Government of Canada.

58. The DOJ played a central role in acting for the MP, the CF, and the DND in responding to requests for documentary disclosure. This meant the DOJ was responsible for directing searches for documents in the possession of its various clients and making decisions about redactions and privilege claims prior to disclosure. The DOJ disclosed these documents in coordination with the CFPM Legal Advisor. This arrangement effectively puts the DOJ in the position of acting both as an advocate for its clients and as “gatekeeper” on behalf of the Government as a whole in the process of disclosing documents.

59. While it is possible all these interests align and all these parties share a common perspective on the facts and issues raised during the hearing, the apparent decision, as a matter of policy, to proceed on the assumption all these separate voices will be harmonized into a single consistent perspective carries a risk. This unified representation risks creating an impression of unfairness, whether to the complainants or to the subjects themselves, and appearing to raise unnecessary obstacles in the Commission’s fact-finding mandate.

60. Early in the proceedings, Commission counsel voiced concerns to members of the DOJ legal team about the potential impact on fairness, or at least the appearance of fairness, in these proceedings.⁵⁴ One practical concern arose from the possibility, in the context of its representation of one set of interests, the legal team might obtain information from sources like pre-hearing interviews, which would otherwise not be available to other interests being represented if not for the joint representation. Given the legal presumption that facts within the knowledge of one member of a law firm - let alone one member of a legal team - become facts within the knowledge of all members, and given the ethical obligation of counsel to share potentially relevant information with their client, a perception of unfairness might well arise. It was therefore suggested consideration be given to establishing ethical screens designed to insulate the different working groups of Government counsel from one another. This would have allowed all parties and interests to be represented by DOJ or other Government counsel with no possible appearance that otherwise unavailable information was being shared. These concerns were acknowledged but dismissed by Government counsel, who noted the Treasury Board's *Policy on Legal Assistance and Indemnification*⁵⁵ did not contemplate such undertakings or ethical walls for Government counsel, and maintained such measures did not appear necessary or appropriate in this case.⁵⁶

61. The Government's decision to speak with a single voice runs the risk of appearing to enforce conformity of viewpoints where such conformity might not otherwise be expected to exist. Concerns could arise about the possibility that a particular interpretation of evidence or a theory of the case reflecting the perspective of one or more institutional interests might be advanced in preference to an approach more directly reflective of the interests or views of one or more of the subjects.

62. To be clear, it is not being suggested any such circumstance actually did arise in the present hearing. Neither the Commission nor the public has any right to inquire about conversations between any persons or institutions being collectively represented and the lawyers who represent them, so all that is left are possibilities and appearances. What matters is that the *possibility* of such circumstances is inherent in the policy of having Government institutions, fact witnesses and all the subjects of a complaint being

represented by a single counsel team. This possibility can lead to an appearance of irregularity, which is damaging to the process even when, in factual terms, there may be absolutely no impropriety.

63. Public confidence in the integrity of the complaints process depends on the fairness, transparency and legitimacy of the Public Interest Hearing process. To stress again, while the Commission has no reason to believe anyone acted in any way other than appropriately, appearances and perceptions count. There is a real risk of public scepticism in circumstances where a single counsel team represents such a multiplicity of interests. Such scepticism can be particularly unfortunate where it may raise doubts about the ability or willingness of a subject of a complaint to raise defences and explanations which could reflect negatively on Government institutions like the Military or other witnesses being represented by the same legal team.

64. To be sure, clients must be free to select counsel of their choice to represent them, and nothing in these comments should be understood as seeking to deny that right. The difficulty is, the Treasury Board *Policy on Legal Assistance and Indemnification* – cited by the counsel team as a reason for declining to establish ethical screens that would clarify who was speaking for which client – also has the appearance of acting as a constraint on the subjects’ and witnesses’ actual ability to retain counsel of choice.

65. As a practical matter, this policy places the subjects in a difficult position. They are forced to choose between accepting representation by DOJ counsel paid for by the Government, or objecting to such an arrangement and going through the long and arduous process of obtaining independent representation (or opting to retain private and independent counsel at their own expense). It would be preferable to avoid the potential problems completely from the outset by providing independent counsel to the subjects to protect their interests with no possibility of a perception of potential divided loyalty. In the past, the DOJ’s Canadian Forces Legal Advisor appears to have recognized this problem by appointing independent counsel for the subjects of PIHs.⁵⁷ On a going forward basis, it would be preferable to follow that process by providing the subjects with independent counsel at the outset of a PIH.

Fact-finding and Effective Oversight

66. To conduct effective oversight of the Military Police in accordance with its mandate, the Commission requires access to facts potentially relevant to a complaint. Those facts may be found in documents or in the oral testimony of witnesses. For hearings to be conducted effectively, it is necessary for the potentially relevant information to be available to Commission counsel and the parties sufficiently in advance of the actual testimony to allow for meaningful preparation both by Commission counsel and the parties, including the complainants. In the PIH process, potential relevance is determined by reference to the issues arising from the complaint submitted to the Commission. The qualifier “potential” relevance is significant because it is not possible to determine actual relevance before evidence is collected and examined. Sometimes, when witnesses or subjects decline pre-hearing interviews, actual relevance cannot be determined until actual testimony is heard.

67. Where the complaint includes allegations of errors and inadequacies in investigations conducted by the CFNIS, potentially relevant information includes, at a minimum, the information that was available or could have been available to the investigators, along with the complete record of what was done to gather and draw conclusions from that information.

68. At the outset, it is necessary to acknowledge, in the present case, the information gathering exercise necessary to support meaningful fact-finding was both extensive and intensive. Much of the burden for collecting and processing the information fell on the CFNIS, on various branches of the CF and on their counsel. Given the volume of material, the complexity of some of the evidence, the potential for controversy arising from some of the legal issues and the time pressures inherent in the process, in may have been inevitable some mishaps would occur and there would be occasions of disagreement about what information should or could be made available.

69. Given this context, it is important to acknowledge the efforts of the CF, the CFNIS and their counsel team to comply with the information gathering needs of the Commission and to work with Commission counsel – and where appropriate counsel for

the complainants – in a spirit of cooperative problem-solving, which ultimately led to most issues finding a reasonable resolution.

70. Nevertheless, the process was not always a smooth one.

DOCUMENTARY DISCLOSURE

71. The Commission appreciates the extensive and notable cooperation of all involved in the massive undertaking of responding to document requests for a large and complex PIH. Assembly of the immense collection of documents forming the evidentiary record was only possible because of the cooperation and hard work of the parties and their counsel, as well as of the Commission's own counsel and staff.

72. The Commission understands the enormity of the task and the fact mistakes are inevitable, but disclosure issues, when they do arise, prejudice the ability of the Commission to do its work. The emergence of a number of disclosure issues on the one hand highlights problem areas in the hearing process, and on the other hand illustrates the possibility to resolve such issues with open discussions and concerted efforts. The hope is the incidents discussed below will be used as lessons to prevent, or at least to minimize, the impact of disclosure problems for future hearings.

73. When the Commission conducts a hearing, the *NDA* confers on it the power to compel witnesses to appear and give evidence and also to produce any documents under their control the Commission considers necessary to the full investigation and consideration of the matters before it.⁵⁸ Quite properly and helpfully, the Government legal team responsible for disclosure also was instructed to disclose to the Commission, upon request, all the records it would be entitled to receive as if the Commission had actually issued a summons.⁵⁹

74. Shortly after the decision to conduct a PIH was issued, Commission counsel requested from the CFPM a number of documents identified as being relevant to the complaint, in addition to the GO files for the three investigations already produced earlier.⁶⁰ The initial request covered documents at CFNIS WR and CFNIS HQ relating to Cpl Langridge's death, interactions with the complainants, the 2008, 2009, and 2010

investigations, or the issues raised by the complainants. The initial request also sought documents relating to any meetings where the complainants' case was discussed and any Military Police member was present, as well as information concerning the investigative training of CFNIS members in general, and the training specifically received by the 13 subjects in particular.

75. As Commission counsel reviewed documents and began to conduct pre-hearing interviews, follow-up disclosure requests were issued. In February 2012, Commission counsel wrote to the CFPM Legal Advisor requesting that potential witnesses represented by DOJ counsel search their records to identify relevant documents in their possession not already provided to the Commission.⁶¹ This request was made upon the realization witnesses at pre-hearing interviews referred to and acknowledged the existence of relevant documents the Commission had not seen previously, putting Commission counsel in the position of having to review them only after the interviews or, in a few cases, shortly beforehand.

76. The pace of document production and the completeness of disclosure were not always problem-free. In particular, there were instances of last-minute disclosure of large collections of documents sent on the eve of testimony, and also late disclosure of documents that would have been exceptionally relevant for witnesses who had already testified. At the commencement of the hearing, for example, the Commission received a very large production of documents from the Government. Commission counsel raised concerns at that time about the difficulty such last-minute productions would impose.

77. In another instance, just prior to the testimony of Dr. Mohr, a psychologist employed by the CF, and Mr. Perkins, a Base Addictions Counsellor, roughly 100 pages of new documents relevant to that testimony were produced at the last moment.⁶² This belated production occurred despite numerous specific requests for these documents and repeated confirmation all relevant documents had been produced. On this occasion, DOJ counsel stressed the late disclosure had not been intentional. The story of these documents requires some explanation, notably because their eventual production was preceded by numerous requests and by repeated confirmations all relevant documents had

been produced. This raises serious concerns about the adequacy of document searches conducted.

78. Commission counsel requested disclosure of Cpl Langridge's complete medical file in January 2012 following the pre-hearing interview with Dr. Mohr when Commission counsel realized the records might not be complete.⁶³ A first version of the file was produced in early February.⁶⁴ On February 23, 2012, Commission counsel made a specific request for any notes about a CFB Edmonton Garrison Clinic or Mental Health Clinic case conference about Cpl Langridge held on or about March 7, 2008.⁶⁵ Commission counsel were subsequently told no such notes were found.⁶⁶

79. On March 16, 2012, Commission counsel made a specific request for Cpl Langridge's complete mental health file and records because it appeared the records in the Commission's possession were still incomplete. Further mental health records were provided on March 29, and the Commission made a request for confirmation the records were now complete and included records for Cpl Langridge's addictions counselling.⁶⁷ However, late in the afternoon on the day before Dr. Mohr and Mr. Perkins were scheduled to testify, new BAC records were received by the Commission – including the previously requested note specifically referring to a March 13, 2008 Base Clinic case conference about Cpl Langridge. This was the first record received of a conference held two days before Cpl Langridge's death. These documents were highly relevant to the evidence of Mr. Perkins, one of the BACs in question, and to that of Dr. Mohr. Furthermore, one of the documents previously produced with respect to Dr. Mohr's testimony turned out to be the wrong document, and the correct document was only produced the morning of her testimony. This document was several hundred pages in length.⁶⁸

80. These documents would also have been highly relevant to witnesses who had already testified. Commission counsel reserved the right to bring some witnesses back to testify about the documents,⁶⁹ although, fortunately, this did not prove necessary.

81. DOJ lead counsel acknowledged it was neither desirable nor acceptable that documents were being provided on such a late basis. She noted the legal team for the

Government had made a number of inquiries to ensure the complete medical records were produced.⁷⁰ The team believed the complete medical records had been produced to the Commission as of March 30, but through an oversight, additional documents existed, which were not produced to the Commission. This was only discovered days before the scheduled testimony.⁷¹ Further, the lengthy document was identified by the witness as incorrect and in need of replacement only the night before her testimony, and this was corrected as soon as DOJ counsel became aware of it. DOJ lead counsel made it clear she believed a thorough search had been made, and the appropriate priority had been given to the document requests. She promised to personally make the necessary queries to ensure all search efforts were made and do everything within her power to ensure this did not happen again.⁷²

82. The Commission accepts DOJ counsel's *bona fides* in this matter. However, this does not diminish the frustration and inconvenience caused to the Commission and all parties by the inadequate research conducted on behalf of the CF.

83. On another occasion, the Commission received 200 additional pages of CFNIS materials on June 8, 2012, just two business days before the testimony of Maj Bolduc, the DCO CFNIS during the relevant investigations. The materials included communications from Sgt Mitchell to Maj Dandurand and were clearly captured by the Commission's September 2011 request for disclosure "of all notes, memorandums and correspondence (including internal)" at CFNIS HQ and Western Region concerning interactions with the complainants or related to Cpl Langridge's death.⁷³ The late disclosure was made more vexing in view of a February 2012 letter from Government counsel, which made assurances all documents responding to this request had already been provided in December 2011.⁷⁴

84. In yet another instance, in February 2012, Commission counsel requested any documents or information concerning all changes or revisions made following the Fynes case to Military Police policies and procedures with respect to the disclosure of suicide notes.⁷⁵ Two documents were received in reply: an October 2010 revision to a CFNIS SOP, and a July 2011 revision to that policy.⁷⁶ Following a witness interview in April

2012, Commission counsel sent a further disclosure request seeking confirmation of the date when changes relating to the procedures for the disclosure of suicide notes were made, as well as any and all records of interim policies or directives prior to those changes taking effect.⁷⁷ On April 23, 2012, DOJ counsel advised that LCol Sansterre changed the policy by means of quarterly OC conferences and monthly conference calls in and around July 2009. Commission counsel were advised, “[t]here are no additional written documents related to these communications.”⁷⁸ However, on the day of LCol Sansterre’s testimony to discuss the policy, additional written records of the OC conferences and conference calls were provided to the Commission.⁷⁹ Then, in the June 8, 2012, document production, and after LCol Sansterre had already testified on these issues, further records directly relevant to this request were delivered.⁸⁰

85. These incidents suggest a flaw in the means by which documents are searched and identified, and possibly a deficiency in the understanding of the relevance of these documents on the part of those in possession of them.⁸¹ The frustrating disclosure problems were discussed on the record at the hearing on June 11, 2012.

86. A further instance of late disclosure involves the production of the subjects’ documents in the summer of 2012.⁸² Many of these documents were clearly covered by the initial September 2011 request,⁸³ and they were directly relevant to the conduct of the CFNIS investigations and related activities. The documents included such basic information as the status reports for the investigations and should have been produced well before August 2012. The documents also included Sgt Bigelow’s notebook, which was never scanned into SAMPIS and would have been invaluable to the Commission and to the parties during the testimony of the fact witnesses heard between March and June 2012.

87. The delay is particularly remarkable considering subjects’ counsel were initially insistent on having all testimony completed in the spring of 2012,⁸⁴ which it turns out was a time prior to when these documents were ultimately produced.

88. These incidents provide just a few snapshots of an occasionally troubled disclosure process throughout the PIH. While there is no suggestion any individual acted

improperly or any of the disclosure delays were intentional, the Commission was and remains concerned, since late production of documents has a serious impact on its ability, and the parties' abilities, to prepare for witness testimony.⁸⁵

89. Whether there is a strict legal right to receive documents in advance of a witness' testimony, receiving documents on the eve or the morning of such testimony means a scramble to assimilate new information and the possibility of missing implications or nuances, which only become clear with sufficient time for review or comparison to other evidence. This impact is even greater when a particularly relevant document is produced for witnesses who have already testified. Ultimately, the truth-seeking function of the Commission is impaired when relevant and important information does not come to light in time. It is inevitable errors or oversights will occur during the process of reviewing and producing many thousands of documents, but disclosure problems such as these can raise doubts about the completeness of searches and, in particular, the reliance which can be placed upon assurances that all relevant documents have been produced.⁸⁶

90. In light of these concerns, the Commission urges the greatest diligence be exercised in responding to document disclosure requests, so complete and comprehensive searches are undertaken in a timely manner. The Commission urges Government counsel to obtain the necessary assurances to confirm these searches have been completed before advising the Commission all requested documents have been produced or no such documents exist.

91. Beyond the timing and thoroughness of disclosure, the Commission, at times, also met with resistance to its disclosure requests. This merits attention because of the potential this sort of reaction has to impact negatively on the Commission's ability to function. In one instance, counsel for the CFPM and counsel for the DND/CF legal advisor challenged the relevance of the materials being requested and the Commission's jurisdiction to request them.⁸⁷ As such, the Commission was asked to provide further information "[...] regarding the relevance of the following information to the conduct of the military police subjects at issue in this matter [...]".⁸⁸ To name a few, the documents said to be of doubtful relevance included the mental health file materials requested from

Dr. Mohr, documents concerning a possible suicide watch for Cpl Langridge in December 2007, records of suicide prevention training, March 2008 Base Clinic case conference records, and documents related to the personnel file review of Cpl Langridge.⁸⁹

92. The Commission agrees with the position taken by Commission counsel these comments appear to suggest it is the role of the DOJ and/or its clients to pass judgment on what is and is not relevant to the Commission's investigation in responding to document requests.⁹⁰

93. For the reasons explained above in discussing the Commission's jurisdiction, the issue of whether or not materials requested by the MPCC were reviewed by the MP is irrelevant to whether or not those documents should be produced to the Commission. Similarly, the topics the Military Police chose to investigate cannot constrain the topics relevant to the Commission: the Commission's role is to determine the topics and materials the members *should* have investigated. It should be noted a similar position was previously advanced by the DOJ in *Garrick et al. v. Amnesty International Canada* before the Federal Court of Canada, where it was decidedly rejected by de Montigny J., who wrote:

[...] it is for the Commission, not the Government, to determine ultimately what documents are relevant to its inquiry. If it were otherwise, the Commission would be at the mercy of the body it is supposed to investigate. This was clearly not the intent of Parliament.⁹¹

94. In this instance, the relevance of materials did not appear to be understood by those in charge of gathering and producing them. Because the Commission must rely on the searches conducted by those from whom it requests materials, this disconnect between their understanding of relevance and Commission counsel's understanding is of obvious concern.

95. The Commission was also advised there were three boxes of documents concerning Cpl Langridge obtained from searches throughout DND and the CF, and

while the view was expressed it was unlikely these documents were relevant, Commission counsel were invited to attend in person to review the documents.⁹²

96. Despite the initial opinion by the CFPM Legal Advisor and the CF/DND Legal Advisor as to the dubious relevance of the documents, the in-person review by Commission legal counsel of the three boxes of material generated a request for over 1600 pages of material. Some of the documents were likely duplicates of items already in the Commission's possession, but the materials also yielded significant new evidence. The large volume of materials ultimately produced as a result of the review made it clear there are good reasons for the Commission and its counsel to be the judge of what is relevant to a hearing.

WITNESS INTERVIEWS

97. When the Commission decides to hold a PIH to investigate a complaint, the information available through documents is supplemented by oral witness testimony.

98. The Commission has the power to compel the appearance of witnesses by summons but also sought the cooperation of witnesses in advance of their testimony by inviting them to participate in pre-hearing interviews. Such interviews are of great assistance to the Commission in gathering new information and gaining insight into witnesses' knowledge and recollections prior to their testimony. The interviews are also helpful to the Commission in determining whether or not calling a witness to appear at a hearing is, in fact, necessary. The names of people may appear on documents, which thereby suggest they have relevant information, but an interview may establish they have scant involvement in the matter or their evidence would not add materially relevant information. Pre-hearing interviews also can contribute to efficient use of time and resources by enabling Commission counsel to focus the witness' examination-in-chief at the hearing on the most relevant topics about which the witness can assist the Commission. In addition, conducting pre-hearing interviews allows Commission counsel to provide more disclosure to the parties, at least about the expected areas to be covered with the witnesses, which in turn assists the parties in preparing for the hearing.

99. In order to facilitate cooperation and gain information from as many witnesses as possible, the Commission agreed with a DOJ proposal⁹³ that the pre-hearing interviews with witnesses who were represented by Department of Justice counsel (such as CF members and Crown employees) would be conducted on a confidential “off-the-record” basis.⁹⁴ The agreement meant witness interviews would not be recorded or transcribed (apart from notes taken by Commission counsel), and the content of the interviews would not be used to cross-examine or impeach the witnesses during their testimony. For each witness who participated in a pre-hearing interview, a “will-say” statement outlining the general topics anticipated during a witness’ testimony was disclosed to the parties. These terms were also applied to unrepresented witnesses and witnesses represented by other counsel.

100. While perhaps not ideal in terms of efficiency, the confidential pre-hearing interview format agreed to may be an inevitable cost of securing witness interviews in advance of their testimony and encouraging candour in those interviews. The trade-off is, the closed nature of the interviews does not necessarily engender public confidence in the transparency of the process.

101. Despite the Commission’s agreement to confidential off-the-record interviews to facilitate witness cooperation, not all witnesses agreed to participate in pre-hearing interviews. The Commission proposed that the subjects of the complaint be interviewed under similar terms as the non-subject pre-hearing interviews. As was their undoubted right, the subjects of the complaint did not agree to be interviewed in advance of the hearing.⁹⁵ In addition, several MP and JAG witnesses also declined to participate in pre-hearing interviews. PO2 Gazzellone and Maj Bolduc, both non-subject CFNIS witnesses, refused to participate in a pre-hearing interview,⁹⁶ as did LCdr Thomson, LCol King, Maj Fowler, LCol MacGregor and Maj Reichert, from the Office of the Judge Advocate General. DOJ counsel requested the identity of witnesses who refused to be interviewed be kept confidential. The Commission did not agree with this request.⁹⁷

REDACTIONS

102. Redactions are portions of documents expurgated by Government on the basis they are not producible to the public as a result of either a common law privilege or a statutory provision.

103. Documents may be redacted by Government agencies to remove personal information, to sever information protected by national security concerns (such as those enumerated by section 38 of the *Canada Evidence Act*),⁹⁸ or to prevent the disclosure of confidential communications afforded special protection by legal privileges (like solicitor-client privilege). When redactions are made carefully and judiciously, an appropriate balance can be struck between protecting sensitive information where disclosure could cause harm, and respecting the public's right to be informed and hold the Government accountable.

104. The Commission urges the exercise of great diligence to ensure any and all redactions applied by the Government legal team to documents prior to disclosure are well-founded and appropriately confined in order to guarantee the broadest disclosure possible.⁹⁹ In this case, while there were a few instances in which redactions seemed excessive, the majority of the redaction issues encountered during the PIH were resolved through discussions between counsel and through the cooperation of counsel in reconsidering redaction decisions.

105. It should also be noted that a major portion of the redactions, which were imposed because of litigation privilege, were correspondingly lifted when the complainants discontinued their civil litigation claim against the Government.¹⁰⁰ Other redaction issues were resolved through creative compromises. Others still were never resolved.

106. The most vexing redaction problems occurred in the context of the ongoing issue of claims for solicitor-client privilege, which were made on a blanket basis. Because this issue took on a special importance and involved not just the redaction of documents but also extended to oral testimony as well, it is dealt with separately.

SOLICITOR-CLIENT PRIVILEGE

107. A sporadically recurring issue creating significant friction involved the reflexive and absolutist invocation on the part of DOJ counsel of solicitor-client privilege on behalf of the Minister of National Defence with respect to information which, at the time, appeared centrally relevant to the mandate of the Commission.

108. At the outset, it is important to acknowledge the central importance of the doctrine of solicitor-client privilege. Solicitor-client privilege applies to any confidential communications between a client and his or her lawyer made with respect to seeking or providing legal advice.¹⁰¹ The privilege is a class privilege, meaning it presumptively applies in every case of such communications, and anyone seeking to have privileged information admitted has the burden of demonstrating why the communication should not be privileged.¹⁰² There are only a few limited exceptions where the privilege will not apply or will be overridden by a court, such as in the case of legal advice intended to facilitate the commission of a crime or fraud or where the privilege would block evidence that might be the only way for an accused person to establish innocence.¹⁰³

109. The validity of the privilege and its special place in the legal system are not in issue. The functional reason for the extraordinary protection of solicitor-client privilege in our legal system is rooted in the need to protect client confidences in the context of the administration of justice in an adversarial system.

110. A client whose confidential communications to counsel could be exposed and disclosed against his or her will would be reluctant to seek legal advice or to be represented by legal counsel. The privilege promotes candour between clients and their legal advisors, enables individuals and institutions in need of advice to make fully informed decisions about how to conduct their affairs and facilitates access to the justice system. Although the protection of solicitor-client communications from disclosure is nearly absolute, the privilege belongs to the client (not the lawyer) and the client is free to waive that privilege if he or she sees fit regardless of anyone's wishes, including those of the lawyer.¹⁰⁴

111. There are three principal issues comprising the Commission's critical concerns with the solicitor-client privilege claims raised in this hearing.

112. The first issue pertains to advice received by the CFNIS subjects about the investigations. This would include, most importantly, advice potentially underlying the decision to conclude the 2010 investigation without conducting any witness interviews.

113. In the context of these hearings, it is important to bear in mind no suggestion has been made that the subjects ought to be required to waive privilege over any communication seeking legal advice regarding their own interests or their legal rights and certainly not with respect to any advice sought or received in connection with their status as subjects of the complaint. The ability of the subjects to rely on solicitor-client privilege in protecting their interests should not be second-guessed and, in any case, it would be difficult to justify overriding the claim or asking the subjects themselves to waive the privilege.

114. However, the subjects may themselves, in some cases, wish to waive privilege claims in order to explain their actions. It must be said here, should the subjects have wished to rely on legal advice received in order to explain or justify their actions, DOJ counsel would have been placed in a difficult position, considering their CF and DND clients' position against any such waiver of privilege.

115. Treating the Minister as the sole client for the purpose of solicitor-client privilege could create significant problems for the individuals who actually sought or benefitted from the legal advice and whose interests are directly at stake in a PIH. The subjects appear to be effectively bound to insist upon such solicitor-client privilege claims advanced by their DOJ counsel because their counsel jointly represents the Minister and other Government clients. Because the Commission is properly not entitled to inquire as to any conversations between the subjects and their counsel, it – like the public – can only go on appearances. Because it cannot be known precisely whose interests are being advanced as among the many represented by DOJ counsel, when privilege claims are made, uncertainty may remain about the possibility, in some instances, the subjects' ability to answer the allegations made against them might have been prejudiced.

116. Given the fact it is absolutely clear this type of information will often be central to the Commission's mandate during a public interest hearing, consideration may need to be given to the development of a solution to allow the Commission to review the information without making it public and to fully and fairly assess the subjects' conduct in the proper context.

117. The second issue of concern relates to solicitor-client privilege claims over advice received by CF members during the course of the events under investigation and which was known to CFNIS members, or should have become known, in the course of a thorough investigation. What was sought in this hearing was access to information about a number of CF decisions relevant to the Fynes' complaints that may have involved legal considerations. Among these decisions were the CF decision not to mount a suicide watch and its decision to recognize Ms. A as Cpl Langridge's Primary Next of Kin ("PNOK"). Each of these decisions was clearly and centrally relevant to the police investigations being complained about, and any legal considerations would be similarly relevant to the Commission's assessment of the reasonableness of the investigations themselves. Most of the information being sought was either before the investigators in the course of their investigation or could have been available to them.

118. In the present case, the Minister claimed a broad and categorical privilege with respect to any legal information whatsoever either in the documents – where it was redacted – or in the oral evidence.

119. The Commission acknowledges and appreciates the general argument that, if solicitor-client privilege was routinely waived or pierced, this could have a negative impact on the Government's ability to have candid discussions with its advisors.¹⁰⁵ However, the Commission sought limited waiver from the CF and the Government of Canada exclusively, and it is the position taken by the CF and the Government that causes concern. Some of the privileged materials were provided directly to CFNIS investigators by counsel as legal advice, while others were disclosed as documents containing legal advice previously obtained by members of the Regiment. In both cases, a

perverse outcome seems likely when the Commission is categorically denied the same documents and communications as were freely disclosed to CFNIS members.

120. The third issue involves questionable privilege claims made during the testimony of counsel working for the office of the JAG when asked for their individual views about what the law was. The breadth of the objection is illustrated in the testimony of Maj Rodney Fowler in relation to the Commission's efforts to understand the CF perspective on the legal principles governing the administration of deceased soldiers' estates – a question at the heart of the Fynes' complaints about the 2009 investigation. Here, the position of DOJ counsel appeared to be that even asking the witness the meaning of "next of kin," as understood at the time by the CF in connection with the administration CF members' service estates, would violate solicitor-client privilege.

121. DOJ Counsel went further and also contended that even asking the witness to provide basic factual information about whether or not Assisting Officers were entitled to approach his office for legal advice constituted an improper "indirect" attempt to adduce privileged information concerning what advice was given and to whom.¹⁰⁶ The DOJ and JAG view appeared to be that answering these questions would run the risk of improperly disclosing any legal advice *that had ever been given* on the topic within the JAG branch. This was exemplified by Maj Fowler's repeated assertion that answering questions about legal matters within his expertise would cause him to "have to opine" on a legal issue, which fell within the JAG mandate to advise the CF,¹⁰⁷ and thus he could not answer "because it would disclose a solicitor-client confidence."¹⁰⁸

122. On May 23, 2012, the Commission heard submissions on the issue of whether it had jurisdiction to make rulings on questions of solicitor-client privilege. DOJ counsel made extensive submissions on this point but, given the scope of the motion being argued, was not in a position to make submissions on the validity of the objections she made during Maj Fowler's testimony. She requested, in the event the Commission determined it did have jurisdiction to make rulings on solicitor-client privilege, submissions then be heard on the propriety of the objections.¹⁰⁹

123. The Commission ultimately did not make any determinations on this question and, accordingly, has not heard submissions on the validity of the claims themselves. As such, there may be good reasons justifying invoking solicitor-client privilege claims in this matter, of which the Commission is unaware. However, the Commission continues to have great difficulty with these claims at face value. Surely, solicitor-client privilege cannot apply to the CF's understanding of the law it was applying. It cannot be the case the CF was entitled to administer military estates on the basis of legal interpretations, which were or could be kept from the public, thereby creating the impression the CF was entitled to administer a "secret law" concerning military estates touching real lives and real families.

124. In the Commission's opinion, there is no genuine conflict between a lawyer's duty to maintain the privilege over confidential communications with clients concerning legal advice and the lawyer's freedom to make a general public statement about his or her view of the state of the law. However, even if such a conflict did exist, this is precisely the sort of information that should be waived because it goes to the heart of the decisions made and conclusions reached by the CFNIS investigators. In cases where CFNIS investigators rely in good faith on legal information during the conduct of their investigations, they ought to be able to rely on this legal information in presenting their response to allegations made against them before this Commission. Whether or not such reliance did occur in the course of the various CFNIS investigations in this matter, the principle is an important one.

125. The positions taken in support of the broad privilege claims being asserted seem far removed from the generally understood purposes thought to underlie the privilege. Most importantly, insofar as they block access to information, which was or arguably should have been looked into during the course of the investigations being complained about, these sweeping claims seem in direct conflict with the Commission's oversight mandate. If the Commission is to evaluate the thoroughness and technical competence of the investigations, it ought to have access to the information that was or should have been before the investigators.

126. In keeping with the spirit of public comments made by the Minister of National Defence reiterating the Government's commitment to full cooperation with the Commission, the Commission sent a letter to the Minister on June 18, 2012, seeking a pragmatic compromise to the impasse.¹¹⁰ The Commission recognized the law authorizes the Minister, as the ultimate "client" and holder of the privilege on behalf of the Government of Canada, to waive the privilege either on a blanket basis or with respect to specifically identified communications. Rather than contending with the legal framework for the privilege claims, which involved certain very broad claims and could result in protracted adversarial proceedings, the Commission instead wrote to the Minister of National Defence requesting he exercise his discretion to waive the solicitor-client privilege claims on a limited basis.¹¹¹

127. In the past, the Minister has recognized the utility of this doctrine, and indeed granted a waiver in respect of a legal opinion related to a case before the Commission in order to facilitate the Commission's exercise of its mandate in a public interest investigation.¹¹²

128. The waiver sought for the current PIH would have applied only to specific communications going to the heart of the subject matter the PIH was meant to investigate. Because of potential prejudice to the subjects possibly arising from their inability to discuss the legal advice they reviewed or relied upon, the Commission also specifically requested the Minister consider waiving any claim of privilege with respect to information that might be helpful for the subjects of the complaint to explain their actions.¹¹³

129. On June 21, 2012, the Commission received the reply from The Honourable Peter MacKay, then Minister of National Defence. The Minister declined to waive any of the claims of solicitor-client privilege and explained, the state of the law made any such waiver extremely rare. He based this conclusion on jurisprudence affirming solicitor-client privilege as critical to the administration of justice in Canada, citing a Supreme Court of Canada decision declaring that solicitor-client privilege must remain "[...] as close to absolute as possible"¹¹⁴ as supporting stringent norms to ensure its protection.

The Minister concluded the Commission's request that he waive the claims of solicitor-client privilege

[...] is neither warranted nor advisable in this case. Such a waiver would not accord with the state of the law in Canada or with the nearly absolute practice in maintaining confidentiality over communications between clients and legal advisors.¹¹⁵

130. While the Commission remains of the view that there was clearly no legal impediment preventing the Minister, who claims the sole status of “client”, from waiving the privilege, as a client may do so at any time and for any reason, the Commission also recognizes it was within the Minister's discretion to decide to refuse the limited waiver request. However, where it is the Minister who claims the sole status of “client” for purposes of waiver, the real question in connection with any given communication that may be capable of attracting solicitor-client privilege is: *should there be a waiver of the privilege if it is needed for a full and fair hearing of the evidence and no prejudice will result?* A refusal to waive solicitor-client privilege can deprive the Commission and the parties of extensive information central to the mandate of the MPCC.

131. In the event of an impasse such as arose in this hearing, the recourse, whether directly or by way of judicial review, would be to refer questions about the Commission's jurisdiction and about the propriety of solicitor-client privilege claims to the Federal Court of Canada. Any such recourse would significantly delay the progress of a PIH – likely for many months – and would incur great cost to the Commission, to the parties, and to the Government to resolve. Such a detour inevitably would impede the Commission from being able to discharge its statutory mandate, which includes a requirement to “deal with all matters before it as informally and expeditiously as the circumstances and considerations of fairness permit.”¹¹⁶

132. As it turns out, subsequent testimony put the importance of some of the legal information being sought into a somewhat different perspective. Sgt Shannon testified he did not seek legal advice in connection with the 2009 investigation and conducted his own legal research about the Next of Kin issue.¹¹⁷ In terms of the briefing he prepared for the chain of command concerning the conclusions of 2010 investigation, it is not known whether Sgt Shannon relied on the existing legal opinion obtained by MCpl Mitchell with

respect to the potential offences involved. To the extent any external legal analysis or external opinion played any role in the earlier decision to close the file without conducting any investigation, such opinion could only have been based on the information that had been gathered for the file. The Commission has found this information was incomplete and contained many factual errors.¹¹⁸ With respect to the 2008 investigation, the evidence indicates the investigators who did look or could have looked into the evidence never turned their minds to the issue of the authority of the CF to conduct a suicide watch or to any legalities that would have been relevant to such a decision. As well, they never interviewed any of the individuals who might have directly received legal advice on these matters.¹¹⁹

133. All these factors reduced, although they did not eliminate, the importance of the content of any legal information received by the CF or by the CFNIS, in assessing the three CFNIS investigations.

134. In the final analysis, the Commission was able to discharge its oversight function with the Fynes' complaints adequately, even without the legal information originally sought. That is a fortunate and somewhat fortuitous outcome, though it does not in any way diminish the concern with regard to the privilege claims. It would still have been preferable for a more complete examination of the issues, particularly in respect to the 2010 investigation, for the Commission to have the information. The information requested was relevant and material to the Commission's mandate and remains so. In future cases, a similar blanket refusal by the Minister to waive privilege could have an even more serious impact on the Commission's work.

135. The Commission continues to believe the Minister ought to consider waiver requests on a case-by-case basis and, unless there is actual prejudice, privilege ought to be waived so as to allow the Commission to discharge its oversight mandate. Where, as may sometimes be the case, the perceived risks associated with a waiver are too great, the possibility of allowing the Commission to receive the information without disclosing it publicly in order to discharge its mandate should not be discounted. The "limited waiver" of privilege is certainly well understood in Canadian law, in that disclosure of a

privileged communication for one purpose does not mean it can then be used for any other purpose.¹²⁰ Similarly, it is possible to disclose a privileged document under strict conditions and preserve the intention not to waive privilege.

136. Recent legislative developments make it clear that a limited waiver regime is entirely consistent with the great value placed on protecting solicitor-client privilege on the one hand, and police oversight functions on the other. This Commission, which was created by the *National Defence Act*, is modeled after the Commission for Public Complaints Against the RCMP, which was created by the *Royal Canadian Mounted Police Act*.¹²¹ The Commission notes that the *RCMP Act* has recently been amended by Bill C-42¹²² to permit the Commission for Public Complaints Against the RCMP to access information covered by solicitor-client privilege as well as other privilege claims.¹²³ When the amendments come into force, ss. 45.4(2) and (3) will provide that:

(2) Despite any privilege that exists and may be claimed, the Commission is entitled to have access to privileged information under the control, or in the possession, of the Force if that information is relevant and necessary to the matter before the Commission when it is conducting a review under section 45.34 or 45.35 or is conducting an investigation, review or hearing under Part VII.

(3) The entitlement to **access includes the right to examine all or any part of a record** and, subject to the Commissioner's approval, **to be given a copy of all or any part of a record**.¹²⁴ [Emphasis added]

137. Pursuant to s. 45.41 of the amended *RCMP Act*, should the Commissioner of the RCMP refuse to grant the Commission for Public Complaints Against the RCMP access to the privileged information, a conciliation mechanism can be employed under which, at the Commission's request, the Minister will appoint a conciliator (such as a former judge of the superior court of a province or of the Federal Court).¹²⁵ The conciliator will then review the privileged information and provide observations regarding the information and its relevance and necessity to the matter before the Commission. If after these observations are received an agreement concerning the privileged information cannot be reached, the parties may apply for judicial review.

138. The Commission for Public Complaints Against the RCMP will not have unfettered access to privileged information, nor is the privilege waived by virtue of

accessing the privileged information. Pursuant to s. 45.43 of the amended *RCMP Act*, the Commission for Public Complaints Against the RCMP may not use the privileged information for any other purpose than the matter for which the access was granted, and under s. 45.47(2) may not disclose that information to anyone other than certain persons (such as the Minister, or the Attorney General if the information is required for criminal proceedings).¹²⁶ Additionally, the new s. 45.44(2) provides that whenever the Commission for Public Complaints Against the RCMP prepares a document or report for distribution, this document must first be reviewed by the Commissioner to ensure it does not contain privileged information before it can be published or distributed. Although this is a somewhat complicated and even convoluted system for reviewing solicitor-client privileged information, the amendments are an explicit recognition that a functional and pragmatic mechanism of limited waiver that facilitates the work of a police oversight body is at least possible.

BOI & SI STATEMENTS AND ANSWERS

139. It should be self-evident by now that the Commission's oversight mandate requires it to be able to receive and review whatever information was available to investigators in any matter the Commission has been charged with investigating. For this reason, another evidentiary hurdle for the PIH was the strict, letter-of-the-law insistence by Government counsel on the absolute inadmissibility of statements and answers given by witnesses during a BOI or SI even though this information was provided to the CFNIS investigators.

140. In the course of the 2009 Investigation, MCpl Mitchell obtained from LFWA a draft report of the BOI examining the circumstances of Cpl Langridge's death, which included extensive findings based on the evidence heard at the BOI.¹²⁷ The findings and supporting facts were expressly tied to the testimony of particular witnesses. MCpl Mitchell also received from LFWA the report and annexes to the SI conducted concerning the administrative actions taken by the Unit after Cpl Langridge's death.¹²⁸ These materials comprised over 575 pages and, among other things, contained the

questions Maj Chenette (who conducted the SI) provided to a large number of LDSH witnesses concerning the events following the death and the answers they provided.¹²⁹

141. The documents obtained by the CFNIS were of clear relevance to the 2009 and 2010 investigations, given they provided a wealth of information on the subjects of those very cases. The documents were scanned into SAMPIS and investigators assigned to these files reviewed them. Accordingly, the BOI report and SI report and annexes were clearly relevant and important to the Commission's work.

142. Section 250.41(2) of the *National Defence Act* prohibits the Commission from receiving or accepting certain evidence:

(a) any evidence or other information that would be inadmissible in a court of law by reason of any privilege under the law of evidence;

(b) any answer given or statement made before a board of inquiry or summary investigation;

(c) any answer or statement that tends to criminate the witness or subject the witness to any proceeding or penalty and that was in response to a question at a hearing under this Division into another complaint;

(d) any answer given or statement made before a court of law or tribunal; or

(e) any answer given or statement made while attempting to resolve a conduct complaint informally under subsection 250.27(1).¹³⁰ [Emphasis added]

143. The DOJ took the position none of the information provided by witnesses in the BOI or SI was admissible because of section 250.41(2) of the *NDA*. All such information was redacted, meaning large portions of the 2009 GO file were essentially just blacked-out pages. Commission counsel argued the *NDA* provision did not prohibit admitting the information for the limited purpose of demonstrating what information was available to the CFNIS members during their investigations, even if the statements themselves could not be used as evidence of what a witness actually said for the purpose of making findings. For a time, the matter came to an impasse.

144. A compromise was ultimately reached to admit some of the information in question through the use of agreed-upon summaries. One document included a list of the questions asked to witnesses during the SI.¹³¹ DOJ counsel agreed with Commission

counsel these should not be redacted, as they were not inadmissible under any *NDA* provision. The questions were admitted verbatim except where the question could identify the answers provided by a specific witness. The questions were important because of the possibility the conduct of the SI, which took place before any CFNIS investigation into the same issues, may have contaminated certain witnesses by the nature of those questions.¹³² The second document contained a general summary of the information the SI witnesses provided.¹³³ Any information capable of identifying which witness provided what information was reworded or omitted. Neither Commission counsel nor the DOJ regarded the compromise as derogating from or contradicting their respective conflicting positions about the appropriate interpretation of section 250.41(2) of the *National Defence Act*.

145. Significant compromises were made in connection with this global summary. However, while the resulting documents did not wholly satisfy anyone, the compromise prevented delays and allowed important and relevant information to be received.

146. The reading of the restriction in *NDA* section 250.41(2)(b) proposed by the DOJ once again has the effect of depriving the Commission of the ability to examine the very materials the CFNIS had access to during the investigations. More specifically, the Commission is prevented even from examining the documents for the purpose of assessing what information the CFNIS had in its possession (rather than for the truth of its contents). Here, too, the Commission's mandate to informally and expeditiously deal with the matters before it is relevant,¹³⁴ since the proposed interpretation of the section can add significant length, complexity and expense to a PIH (for example, by operating as a de facto "best evidence rule" requiring the expense of hearing testimony from witnesses even when their evidence is uncontroversial). The prohibitions also mean a significant tool for testing the reliability and credibility of a witness is impeded, to the detriment of the Commission's ability and duty to uncover the truth.

147. Notwithstanding these problematic aspects of the prohibitions in the *NDA*, the compromise reached in this hearing demonstrates the benefits of a collaborative problem solving approach, which mitigates some of the potentially detrimental impact of the

provision. The Commission is hopeful compromise will be employed more often and, in future hearings, the Government can adopt a more relaxed approach to recognize the distinction between accepting statements for the truth of their contents and the fact the statements were made.

SPECIFIC DOCUMENT MANAGEMENT PROBLEMS ARISING FROM SAMPIS

148. The Commission faced a number of document management problems specifically related to the uniqueness and idiosyncrasies of SAMPIS, the electronic military police information database into which investigative materials are compiled and stored.¹³⁵ SAMPIS is a police records management system developed by the firm Versaterm, and is a customized version of a commercial system licensed to police services across North America.¹³⁶

149. These problems related to SAMPIS are distinct from the issues of production discussed earlier in this chapter. They may recur in future PIH proceedings unless dealt with specifically. A significant amount of time and attention was spent at the hearing in an attempt to understand the problems and, in some instances, answers were still lacking despite best efforts by all involved to get to the root of the issues.

Multiple versions of GO files

150. On June 26, 2012, the Commission heard evidence from a panel of witnesses called to testify about SAMPIS and the management and disclosure of GO files (the “GO files panel”).¹³⁷ Although the opinion of members of the GO files panel was that the SAMPIS system is “very reliable,”¹³⁸ problems undoubtedly remain. The evidence of the GO files panel made it clear, between the quirks of SAMPIS and simple human error, (which, despite the clear diligence of the CFPM liaison officer to the MPCC and all those responsible for ATIP severances and disclosure, may be inevitable) SAMPIS may produce unpredictable results. Due to the systemic nature of this issue, it can be expected the disclosure of potentially incomplete and/or inconsistent versions of GO files is likely to reoccur in future complaints. Unless dealt with, this problem will continue to make it difficult for the Commission to have confidence in the completeness of disclosure and for

the Commission and the parties to adequately apprehend and assess the facts within an investigation.

151. The fundamental problem is the fact there are a number of scenarios in which pages may not print when disclosing a GO file, and there is no guarantee these omissions will be caught by those reviewing the files prior to disclosing them to the Commission. At least some of these scenarios impacted the documents provided to the Commission. Throughout the proceedings, the Commission received multiple versions of the General Occurrence Files for the investigations in question. It became apparent there were differences in the page count between the redacted and unredacted versions of the GO files, and these differences were not explainable simply because redactions were made.¹³⁹ The issues were eventually remedied through follow-up disclosure.¹⁴⁰

152. The Commission sought explanations for the different versions of the GO files for the three investigations produced to the Commission and to the complainants.¹⁴¹ The issue was not that pages were consciously withheld, but rather that they were unaccountably missing in the disclosure.

153. The Commission's concern is to ensure the hearing record fully reflects all of the documents included in the electronic system and available to the Military Police members involved in the investigation.¹⁴² Consequently, the Commission sought evidence regarding the workings of SAMPIS, as well as explanations concerning the discrepancies and information about any measures put into place by the Military Police to ensure the problem of incomplete disclosure or missing pages did not reoccur.

154. According to the process in place for disclosure, when a request for a GO file is received, the CFPM liaison officer to the MPCC first contacts the relevant Military Police Unit to ensure all records connected to that file have been scanned.¹⁴³ A "release" is then generated in the system. For MPCC disclosure, everything but information protected by solicitor-client privilege is to be included. Because the SAMPIS release function for disclosure automatically selects all items in the GO file for the release, privileged materials must be visually identified and manually de-selected by the operator.¹⁴⁴ This

means that in the ordinary course, the expectation is all the materials that can be disclosed to the Commission should be included in the disclosure release.¹⁴⁵

155. There are, nevertheless, some problems created by the process with respect to privileged materials. Where information is marked as solicitor-client privileged by the individual who created an entry, but in actuality contains a mixture of privileged and non-privileged material, the Commission is concerned that entire entry may, inadvertently, not be printed. The evidence of the panel is that a whole text box would be de-selected if the entire content pertained to a legal assessment.¹⁴⁶ This gives rise to the possibility of errors in judgment resulting in entire entries not being produced, even though only portions should in fact have been removed. Additionally, when text boxes or other documents containing a legal opinion are redacted manually, it is clear something has been severed,¹⁴⁷ but in other cases, entries marked as privileged are de-selected for printing, meaning there will be no indication in the disclosed file that a document exists but was not included.¹⁴⁸

156. Although each entry marked as privileged is examined by the liaison officer to determine whether something has been identified improperly – or has not been identified as being privileged when it should have been – each entry is not necessarily examined by legally trained individuals to determine whether privilege claims can or should be made.¹⁴⁹

157. Many of the other problems with GO file production are the result of SAMPIS idiosyncrasies. Entries in a GO file often include documents scanned or added into the file.¹⁵⁰ This is where the system's quirks arise. In many cases, the scanned or added documents will be missing from the final printout or PDF file disclosed.¹⁵¹ Generally, the printout will include a notation indicating the pages are missing, and the operator can then print them manually.¹⁵² However, in some cases, depending on how the document was initially attached to the file, there will be *no indication* in the printout the missing document existed.¹⁵³

158. What this means is, depending on a number of factors, printouts of the GO file are often incomplete, at least initially. There seems to be no easy way to ensure the integrity

of the contents of the disclosed file. Discovering and restoring any missing documents involves additional steps, including a review of the entire GO file for references to files or recordings that are missing.¹⁵⁴ The GO files panel testified many of the discrepancies in the different versions of the GO files provided to the Commission were likely a consequence of these issues, combined with a possible failure to manually incorporate some of the missing images.¹⁵⁵ Nevertheless, some of the discrepancies simply could not be explained.¹⁵⁶

159. It is difficult to reconcile differences between GO file releases because of the way SAMPIS organizes the output. When generating a release, SAMPIS determines the order in which the documents will be printed and assigns page numbers.¹⁵⁷ However, the page numbers are only set out in relative terms based on the pages sent to the printer and *not* based on the total number of pages in the GO file. This means a given document could appear on a different page in each release and, if for any reason a folder is not selected for printing or pages do not print, there will be no skipping of page numbers to indicate any portion of the file is missing.

160. In the end, the inquiries made mean the Commission is, overall, now satisfied all of the GO file materials for the three investigations at issue in this case have been produced. The oversights that led to the failure to produce all pages initially are not surprising, given the large number of pages involved and a page reconciliation process vulnerable to human error. However, they emphasize the discouraging prospect that these problems are likely to be recurring, if not systemic. Through no fault of the individuals involved, the evidence of the GO file panel has revealed the unfortunate reality that the disclosure process is inefficient and error-prone.

161. It is of great concern there are so many opportunities for entire pages not to be disclosed despite the good faith efforts and diligence of the individuals involved. In this vein, although it is clear the SAMPIS problems were not the product of bad faith or any intent to hide information, the weaknesses in the system left the complainants with the impression the CFNIS was keeping a “double set of files”¹⁵⁸ because there were such large and unexplainable discrepancies between what was found on the same pages of the

different versions of the GO files they received.¹⁵⁹ Efforts to resolve these issues would help to prevent any future impression by victims, complainants or families that the CFNIS is trying to hide information.

SAMPIS and “related dates”

162. A further SAMPIS issue, which can influence the integrity of the evidence received by the Commission, involves the dates reflected in GO file entries. The evidence of the GO file panel is a SAMPIS entry generally has more than one date assigned to it.¹⁶⁰ For example, an investigator may take a statement from a witness but not enter the statement into SAMPIS until several weeks later. The SAMPIS entry itself would be internally date-stamped with the current date, but the user might also assign to the entry the date the statement was originally taken. However, when the GO file is printed, *only* the user-assigned date is displayed.¹⁶¹ It appears at the top of the GO File entry, below the author’s name, under the heading “Related date.”¹⁶²

163. The problem that arises is the entry gives no indication to anyone reviewing the GO file of the date when the entry was made. Only the assigned “related date” is known. This means, from the perspective of an individual reading a disclosed GO file, an entry may appear to be more contemporaneous than it is. During the testimony of MS McLaughlin, for example, he was asked to look at his typed “Investigative activity” entry concerning a meeting with the DND and CF Ombudsman Investigator, Mr. Patrick Martel. The “related date” field for this entry reads Friday, December 18, 2009, the date when the meeting took place.¹⁶³ MS McLaughlin could no longer recall when this entry was typed.¹⁶⁴ From SAMPIS metadata provided to the Commission, it was learned the entry was created on January 15, 2010.¹⁶⁵ This was nearly a month after the meeting.

164. MS McLaughlin prepared this entry from memory and without the benefit of notes.¹⁶⁶ The significance of this span of time is the fact his recollection of the meeting differs from Mr. Martel on some significant points – in particular, MS McLaughlin’s entry specifically stated Mr. Martel identified Capt Lubiniecki as negligent in appointing the wrong next of kin,¹⁶⁷ while Mr. Martel adamantly denies this.¹⁶⁸ The fact it is impossible to know simply by looking at the GO file entry when this synopsis was

written means one might mistakenly assume the individual creating the document had done so nearly immediately after the events described, and thus with a fresh recollection of what transpired.

165. If it were necessary to resolve competing versions of evidence, it is possible greater weight would be assigned to the documentary evidence (or the testimony derived from it if used to refresh a witness' recollection) based on this mistaken assumption, as compared to the weight that might be assigned if one learned an entry was written some time after the events discussed and without the assistance of notes or a recording. To be clear, there is no suggestion MS McLaughlin acted improperly in any way. The point is the Commission, as a review body, (or a trial judge in the case of a criminal prosecution) might inadvertently be misled when such entries are disclosed and the police member has no personal recollection of when the entry was typed.

166. Similarly, MS McLaughlin prepared a complaint synopsis for the 2009 GO file after he and Maj Dandurand met with the complainants. MS McLaughlin believed he created this entry “[...] almost immediately after or the following day”¹⁶⁹ after the meeting, which was held November 28, 2009. The entry also has the “related date” heading of November 28, 2009. However, based on the SAMPIS metadata information provided to the Commission in an affidavit from Mr. Beaulieu (the Military Police National Records Centre Manager, SAMPIS administrator, and a participant in the GO files panel), the complaint synopsis was actually created on January 12, 2010, a month and a half after the meeting with the Fynes.¹⁷⁰

167. In assessing the reliability or weight to be assigned to an entry made into the GO file, it is very relevant for the Commission to know how long after the events the entry was made and what materials were used to prepare it. Because of the way the system prints the entries, the Commission is not in a position to easily know whether entries are contemporaneous or whether more questions need to be asked about what materials were used to refresh memory. A Military Police witness could seek to refresh his or her memory of events based on a document he or she sincerely (but mistakenly) believes had

been written contemporaneously, and, without making onerous additional enquiries, there would be no indication of the true date it was created.

168. The idiosyncrasies in the design and functioning of SAMPIS raise serious concerns about the integrity and accuracy of SAMPIS files being disclosed to the courts, this Commission or other third parties. Consideration should be given to working with the designer of the underlying software in order to address these concerns.

¹ Complaint from Shaun Fynes to MPCC Chair Glenn Stannard (18 January 2011).

² *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to conduct a public interest investigation pursuant to s. 250.38(3) of the *National Defence Act* (29 April 2011), online: MPCC <<http://www.mpcc-cppm.gc.ca/03/303/2011-004a-eng.aspx>>.

³ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to conduct a public interest investigation pursuant to s. 250.38(3) of the *National Defence Act* (29 April 2011), online: MPCC <<http://www.mpcc-cppm.gc.ca/03/303/2011-004a-eng.aspx>>; Letter from Julianne Dunbar, General Counsel, MPCC, to Col T.D. Grubb, Canadian Forces Provost Marshal (9 May 2011).

⁴ *Re MPCC File no. MPCC-2011-004 (Fynes)*, List of Allegations, online: MPCC <<http://www.mpcc-cppm.gc.ca/03/303/2011-004c-eng.aspx>>

⁵ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to conduct a public interest hearing pursuant to s. 250.4(1)(b) of the *National Defence Act* (6 September 2011), online: MPCC <<http://www.mpcc-cppm.gc.ca/03/303/2011-004b-eng.aspx>>.

⁶ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to conduct a public interest hearing pursuant to s. 250.4(1)(b) of the *National Defence Act* (6 September 2011), online: MPCC <<http://www.mpcc-cppm.gc.ca/03/303/2011-004b-eng.aspx>>.

⁷ Transcript of Proceedings, vol. 1, 19 Oct 2011, p. 1.

⁸ Letter from Col (Ret'd) Michel W. Drapeau, Counsel for the Complainants, to Geneviève Coutlée, Legal Counsel, MPCC (26 September 2011).

⁹ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Complainants' motion to issue a recommendation for public funding for legal representation, (26 September 2011), pp. 2-4.

¹⁰ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Affidavit of Sheila Fynes, (28 September, 2011); *Re MPCC File no. MPCC-2011-004 (Fynes)*, Affidavit of Shaun Fynes, (28 September 2011).

¹¹ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Submissions of the Government of Canada on the Request for Funding (5 October 2011).

¹² *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to recommend funding for legal representation for the complainants, Mr. Shaun Fynes and Mrs. Sheila Fynes (26 October 2011), p. 10.

¹³ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.44(a).

¹⁴ SOR/2002-41. See Rules 12, 17, 29, 33 and 39.

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- ¹⁵ Letter from The Honourable Peter MacKay, Minister of National Defence, to Glenn Stannard, Chairperson of the Military Police Complaints Commission (16 March 2012).
- ¹⁶ Letter from The Honourable Tony Clement, President of the Treasury Board, to Glenn Stannard, Chairperson of the Military Police Complaints Commission (12 January 2012).
- ¹⁷ Transcript of Proceedings, vol. 3, 27 March, 2012, pp. 139-141; Exhibit P-1, Collection A, vols. 1-2; Exhibit P-2, Collection B, vols. 1-2; Exhibit P-3, Collection C, vol. 1; Exhibit P-4, Collection D, vols. 1-14; Exhibit P-5, Collection E, vols. 1-3; Exhibit P-6, Collection F, vol. 1.
- ¹⁸ Letter from Col (Ret'd) Michel W. Drapeau, Counsel for the Complainants, to Mark J. Freiman, Commission Counsel, MPCC (12 October 2012).
- ¹⁹ *Re MPCC File no. MPCC-2011-004 (Fynes)*, Decision to recommend funding for legal counsel to prepare closing submissions for the complainants, Mr. Shaun Fynes and Mrs. Sheila Fynes (30 October 2012).
- ²⁰ Letter from The Honourable Peter MacKay, Minister of National Defence, to Glenn Stannard, Chairperson of the Military Police Complaints Commission (14 February 2013).
- ²¹ Transcript of Proceedings, vol. 13, 19 April 2012, pp. 1-15.
- ²² Letter from Glenn M. Stannard, Chairperson, MPCC, to Col R.P. Delaney, Canadian Forces Provost Marshal (30 April 2014).
- ²³ Letter from Glenn M. Stannard, Chairperson, MPCC, to Col R.P. Delaney, Canadian Forces Provost Marshal (5 September 2014).
- ²⁴ Letter from LCol D.W. Shuster, Chief of Staff, CF MP Gp, to Glenn M. Stannard, Chair, MPCC (16 September 2014).
- ²⁵ Email from Monique Larouche, MPCC Liaison Officer, CF MP Gp, to Julianne Dunbar, General Counsel, MPCC (4 November, 2014 at 0921 hrs) subject: MPCC-2011-004 (Fynes) – CFPM Notice of Action.
- ²⁶ Email from Monique Larouche, MPCC Liaison Officer, CF MP Gp, to Jennifer Hohmann Wood, Registrar, MPCC (10 December, 2014 at 1057 hrs) subject: Update as to NOA – Fynes PIH.
- ²⁷ Email from Monique Larouche, MPCC Liaison Officer, CF MP Gp, to Jennifer Hohmann Wood, Registrar, MPCC (10 December, 2014 at 1057 hrs) subject: Update as to NOA – Fynes PIH.
- ²⁸ Letter from Glenn M. Stannard, Chairperson, MPCC, to Col R.P. Delaney, Canadian Forces Provost Marshal (11 December 2014).
- ²⁹ Treasury Board of Canada Secretariat, *A Guideline for Employees of the Government of Canada: Information Management (IM) Basics*, online: <http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=16557§ion=HTML> (accessed January 15, 2015); Government of Canada GCpedia, Classification: Designated Information, online: http://www.gcpedia.gc.ca/wiki/Classification#Designated_information (Accessed January 15, 2015). See also, Treasury Board of Canada Secretariat, *Security Organization and Administration Standard*, online: <http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=12333> (accessed February 9, 2015).
- ³⁰ Letter from Glenn M. Stannard, Chairperson, MPCC, to Col R.P. Delaney, Canadian Forces Provost Marshal (22 December 2014).
- ³¹ Letter from Col R.P. Delaney, CFPM to Glenn M. Stannard, Chair, MPCC (11 February 2015).
- ³² Letter from Glenn M. Stannard, Chairperson, MPCC, to Col R.P. Delaney, CFPM (12 February 2015).
- ³³ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250 (Definitions) (“NDA”); s. 250.18(1); s. 250.19(1).

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- ³⁴ *Complaints about the Conduct of Members of the Military Police Regulations*, P.C. 1999-2065.
- ³⁵ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.38.
- ³⁶ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.15.
- ³⁷ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.41(1).
- ³⁸ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.41(1)(c) and s. 250.41(2).
- ³⁹ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.14.
- ⁴⁰ *Re Second Review of Amendments to the National Defence Act Pursuant to S.C. 1998, c. 35, s. 96, Military Police Complaints Commission Submissions to the Independent Review Authority*, (June 23 2011), p. 1.
- ⁴¹ *Re Second Review of Amendments to the National Defence Act Pursuant to S.C. 1998, c. 35, s. 96, Military Police Complaints Commission Submissions to the Independent Review Authority*, (June 23 2011), pp. 1-2.
- ⁴² Final submissions of the subjects, pp. 29-30.
- ⁴³ *Complaints about the Conduct of Members of the Military Police Regulations*, P.C. 1999-2065 [“*Complaint regulations*”].
- ⁴⁴ Final submissions of the subjects, p. 32.
- ⁴⁵ Final submissions of the subjects, pp. 30 and 33.
- ⁴⁶ *Canada (Attorney General) v. Amnesty International Canada*, 2009 FC 918, [2010] 4 FCR 182, at para. 72; Final submissions of the subjects, pp. 31-32.
- ⁴⁷ Final submissions of the subjects, p. 34.
- ⁴⁸ Final submissions of the subjects, pp. 34-35.
- ⁴⁹ *Garrick et al. v. Amnesty International Canada*, 2011 FC 1099, paras. 87-88.
- ⁵⁰ Final submissions of the subjects, p. 35.
- ⁵¹ Exhibit P-176, doc. 1435, pp. 52-53.
- ⁵² Commission of Inquiry into the Investigation of the Bombing of Air India Flight 182, *Air India: A Canadian Tragedy* (2010) vol. 1, Chapter 2, p. 79. <online: http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/air_india/2010-07-23/www.majorcomm.ca/en/reports/finalreport/volume1/default.htm >.
- ⁵³ Treasury Board of Canada, *Policy on Legal Assistance and Indemnification* <online: <http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?section=text&id=13937> >.
- ⁵⁴ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Mr. Gérard Normand, General Counsel, DND/CFLA, (5 January 2012); Letter from Mark J. Freiman, Commission Counsel, MPCC, to Mr. Gérard Normand, General Counsel, DND/CFLA, (16 January 2012); Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (15 February 2012).
- ⁵⁵ Treasury Board of Canada, *Policy on Legal Assistance and Indemnification* <online: <http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?section=text&id=13937> >.
- ⁵⁶ Letter from Mr. Gérard Normand, General Counsel, DND/CFLA, to Mark J. Freiman, Commission Counsel, MPCC (12 January 2012); Letter from Elizabeth Richards, Counsel for the Subjects, DOJ, to Mark J. Freiman, Commission Counsel, MPCC, (3 February 2012).

⁵⁷ See MPCC 2005-024, *Chairperson's Final Report Concerning the Conduct of Military Police Members of CFNIS, Western Region* (19 December 2007), 1.3: The Hearing Process <online: <http://www.mpcc-cppm.gc.ca/01/1400/3700/2005-024/index-eng.aspx>>.

⁵⁸ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.41(1)(a).

⁵⁹ Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (28 February 2012).

⁶⁰ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Col T.D. Grubb, CFPM (7 September 2011). The Commission also issued a summons to the CFPM OiC for the production of the GO files for public disclosure in order to satisfy ATIP requirements; Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (7 November 2011).

⁶¹ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (14 February 2012).

⁶² Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 1-2.

⁶³ Statement by Ms. Coutlée, Commission counsel, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 3-4.

⁶⁴ Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (8 February 2012), p. 2.

⁶⁵ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (23 February 2012).

⁶⁶ Statement by Ms. Coutlée, Commission counsel, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 3-4.

⁶⁷ Statement by Ms. Coutlée, Commission counsel, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 3-4.

⁶⁸ Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 4-5.

⁶⁹ Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 14-15.

⁷⁰ Statement by Ms. Richards, counsel for the Subjects, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 6-14.

⁷¹ Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 6-14.

⁷² Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 6-14.

⁷³ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Col T.D. Grubb, CFPM (7 September 2011); Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (14 June 2012).

⁷⁴ Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (8 February 2012).

⁷⁵ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (23 February 2012).

⁷⁶ Exhibit P-5, Collection E, vol. 6, tab 47, doc. 1280; Exhibit P-5, Collection E, vol. 6, tab 48, doc. 1281.

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- ⁷⁷ Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 13-14.
- ⁷⁸ Letter from Elizabeth Richards, Counsel for the Subjects, DOJ, to Geneviève Coutlée, Commission legal counsel, MPCC, (23 April 2012).
- ⁷⁹ Transcript of Proceedings, vol. 16, 26 April 2012, pp. 1-2; Exhibit P-57, doc. 1354; Exhibit P-58, doc. 1355; Exhibit P-59, doc. 1356.
- ⁸⁰ Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 13-15; Exhibit P-119, doc. 1396.
- ⁸¹ Statement by Mr. Freiman, Commission counsel, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 16-17.
- ⁸² Letter from Elizabeth Richards, Counsel for the Subjects, DOJ, to Geneviève Coutlée, Commission legal counsel, MPCC, (3 August 2012); Letter from Judith Bedard, Paralegal, DOJ, to Geneviève Coutlée, Commission legal counsel, MPCC, (15 August 2012); Letter from Judith Bedard, Paralegal, DOJ, to Geneviève Coutlée, Commission legal counsel, MPCC, (20 August 2012); Letter from Judith Bedard, Paralegal, DOJ, to Geneviève Coutlée, Commission legal counsel, MPCC, (30 August 2012).
- ⁸³ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Col T.D. Grubb, CFPM (7 September 2011).
- ⁸⁴ Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 19, 14 May 2012, pp. 149-150.
- ⁸⁵ Transcript of Proceedings, vol. 12, 18 April 2012, pp. 1-2.
- ⁸⁶ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (14 June 2012), p. 2.
- ⁸⁷ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (14 February 2012); Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (23 February 2012); Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (28 February 2012).
- ⁸⁸ Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (28 February 2012), pp. 2-3.
- ⁸⁹ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (14 February 2012); Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (23 February 2012).
- ⁹⁰ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (2 March 2012).
- ⁹¹ *Garrick et al. v. Amnesty International Canada*, 2011 FC 1099, para. 97.
- ⁹² Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (28 February 2012), pp. 2-3.
- ⁹³ Letter from Mr. Gérard Normand, General Counsel, DND/CFLA, to Mark J. Freiman, Commission Counsel, MPCC, (18 November 2011), pp. 2-3.
- ⁹⁴ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Mr. Gérard Normand, General Counsel, DND/CFLA, (23 November 2011), pp. 2-3.

⁹⁵ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (18 November 2011), p. 1; Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (6 December 2011).

⁹⁶ Email from Mr. Gérard Normand, General Counsel, DND/CFLA, to Mark J. Freiman, Commission Counsel (15 February 2012 at 1622 hrs) subject: MPCC; Email from Mr. Gérard Normand, General Counsel, DND/CFLA to Geneviève Coutlée, Legal Counsel, MPCC, (27 March 2012 at 1319 hrs) subject: MPCC- Major Bolduc.

⁹⁷ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Mr. Gérard Normand, General Counsel, DND/CFLA, (23 November 2011), pp. 2-3.

⁹⁸ *Canada Evidence Act*, R.S.C., 1985, c. C-5, s. 38.

⁹⁹ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (14 June 2012), p. 2.

¹⁰⁰ Letter from Col (Ret'd) Michel W. Drapeau, Counsel for the Complainants, to Mark J. Freiman, Commission Counsel, MPCC (27 April 2012); Letter from Dominique Babin, Legal Counsel, DND/CF LA, to Mark J. Freiman, Commission Counsel, MPCC (4 May 2012).

¹⁰¹ J.H. Wigmore, *Evidence in Trials at Common Law*, 3d ed. Rev. By J.T. McNaughton, vol. 8 (Boston: Little, Brown, 1961) at s. 2292, cited in David M. Paciocco and Lee Stuesser, *The Law of Evidence*, (Toronto: Irwin Law Inc., 2008) (5th ed.) at p. 224.

¹⁰² David M. Paciocco and Lee Stuesser, *The Law of Evidence*, (Toronto: Irwin Law Inc., 2008) (5th ed.) at p. 219.

¹⁰³ David M. Paciocco and Lee Stuesser, *The Law of Evidence*, (Toronto: Irwin Law Inc., 2008) (5th ed.) at pp. 227-235.

¹⁰⁴ Robert Hubbard, Susan Magotiaux, and Suzanne Duncan, *The Law of Privilege in Canada* (Vol. 2), (Toronto: Canada Law Book, 2011) at ch. 11, pp. 64-65; David M. Paciocco and Lee Stuesser, *The Law of Evidence*, (Toronto: Irwin Law Inc., 2008) (5th ed.) at p. 220.

¹⁰⁵ Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 70-73; Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 26, 23 May 2012, pp. 32-35.

¹⁰⁶ Testimony of Maj Fowler, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 29-31.

¹⁰⁷ Testimony of Maj Fowler, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 75-79.

¹⁰⁸ Testimony of Maj Fowler, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 85-86.

¹⁰⁹ Statement by Ms. Richards, Counsel for the Subjects, Transcript of Proceedings, vol. 26, 23 May 2012, pp. 126-132.

¹¹⁰ *House of Commons Debates*, Vol. 146, No. 093, (9 March 2012) at 1140 hrs (Hon. Peter MacKay, Minister of National Defence); *House of Commons Debates*, Vol. 146, No. 140, (13 June 2012) at 1455 hrs (Hon. Peter MacKay, Minister of National Defence).

¹¹¹ Letter from Glenn Stannard, Chairperson of the Military Police Complaints Commission, to The Honourable Peter MacKay, Minister of National Defence (18 June 2012), p. 2.

¹¹² Notice of Action from Col D.A. Cooper, Canadian Forces Provost Marshal, to Madame Louise Cobetto, Chairperson of the Military Police Complaints Commission (8 October 2002), Annex D to MPCC 2001-003 and MPCC 2000-055, *Chairperson's final report following a Public Interest Investigation pursuant to subsection 250.38(1) of the National Defence Act with respect to the complaints of Lt-Col Tony Battista and Maj Gordon D. Wight* (12 December 2002).

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- ¹¹³ Letter from Glenn Stannard, Chairperson of the Military Police Complaints Commission, to The Honourable Peter MacKay, Minister of National Defence (18 June 2012), p. 3.
- ¹¹⁴ *Lavallee, Rackel & Heintz v. Canada (Attorney General)*, [2002] 3 S.C.R. 209 at para. 36.
- ¹¹⁵ Letter from The Honourable Peter MacKay, Minister of National Defence, to Glenn Stannard, Chairperson of the Military Police Complaints Commission (21 June 2012).
- ¹¹⁶ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.14.
- ¹¹⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 284-288.
- ¹¹⁸ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹¹⁹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 109-112.
- ¹²⁰ See for example *Rekken Estate v. Health Region No. 1*, [2012] S.J. No. 393, 2012 SKQB 248 (Sask. Q.B.). There, the court held that reports provided to the RCMP by complainants in order to assist in the investigation of potential negligence in the death of their son were found to have been provided to the RCMP by limited waiver of solicitor-client privilege and were still protected by solicitor-client privilege with respect to the defendant health region. This meant the court would not order the disclosure of these reports. See also *Interprovincial Pipe Line Inc. v. Minister of National Revenue* (1995), [1996] 1 F.C. 367 (T.D.), *Caterpillar Tractor Co., Caterpillar Americas Co. and Caterpillar of Canada Ltd. v. Ed Miller Sales and Rental Ltd. (sub nom. Miller (Ed) Sales & Rentals Ltd. v. Caterpillar Tractor Co.* (No. 1)), 1988 CarswellAlta 148, 61 Alta. L.R. (2d) 319, 22 C.P.R. (3d) 290 (Alta. C.A.), *Nova Scotia (Attorney General) v. Royal & Sun Alliance Insurance Co. of Canada*, 2000 CanLII 1080 (N.S.S.C.), 189 NSR (2d) 290, *Phillip Services Corp. (Receiver) v. Ontario (Securities Commission)*, 2005 CarswellOnt 3934, 28 O.S.C.B. 9673, 16 C.P.C. (6th) 193, 77 O.R. (3d) 209, 202 O.A.C. 201, 13 B.L.R. (4th) 69 (Ont. Div. Ct.).
- ¹²¹ *Royal Canadian Mounted Police Act*, R.S.C. 1985, c. R-10, ss. 45.29 – 45.47 (“RCMP Act”).
- ¹²² Bill C-42, *An Act to Amend the Royal Canadian Mounted Police Act and to Make Related and Consequential Amendments to Other Acts*, 1st Sess., 41st Parliament, 2013 (assented to 19 June, 2013).
- ¹²³ Bill C-42, *An Act to Amend the Royal Canadian Mounted Police Act and to Make Related and Consequential Amendments to Other Acts*, 1st Sess., 41st Parliament, 2013 (assented to 19 June, 2013), s. 35.
- ¹²⁴ Bill C-42, *An Act to Amend the Royal Canadian Mounted Police Act and to Make Related and Consequential Amendments to Other Acts*, 1st Sess., 41st Parliament, 2013 (assented to 19 June, 2013), s. 35 (new ss. 45.4(2) and (3)).
- ¹²⁵ Bill C-42, *An Act to Amend the Royal Canadian Mounted Police Act and to Make Related and Consequential Amendments to Other Acts*, 1st Sess., 41st Parliament, 2013 (assented to 19 June, 2013), s. 35 (new s. 45.41).
- ¹²⁶ Bill C-42, *An Act to Amend the Royal Canadian Mounted Police Act and to Make Related and Consequential Amendments to Other Acts*, 1st Sess., 41st Parliament, 2013 (assented to 19 June, 2013), s. 35 (new ss. 45.43 and 45.47(2)).
- ¹²⁷ Exhibit P-2, Collection B, vol. 1, doc.1087, pp. 301-406; p. 1105.
- ¹²⁸ Exhibit P-2, Collection B, vol. 1, doc.1087, pp. 426-428 and 1143.
- ¹²⁹ Exhibit P-70, doc. 1358, p. 3
- ¹³⁰ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.41(2) (“NDA”).
- ¹³¹ Exhibit P-103.
- ¹³² See Section 4.6, CFNIS Independence and Impartiality.

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- ¹³³ Exhibit P-104.
- ¹³⁴ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.14.
- ¹³⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 10-11; Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 114-117.
- ¹³⁶ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 114-115 and 182.
- ¹³⁷ Transcript of Proceedings, vol. 40, 26 June 2012, pp. 112-185.
- ¹³⁸ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 171-172.
- ¹³⁹ Letter from Mark J. Freiman, Commission Counsel, MPCC, to Maj Tim Langlois, CFPM Legal Advisor (9 January 2012); Letter from Geneviève Coutlée, Legal counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (22 May 2012), pp. 2-4.
- ¹⁴⁰ Letter from Dominique Babin, Legal Counsel, DND/CF LA, and Maj Tim Langlois, CFPM Legal Advisor, to Mark J. Freiman, Commission Counsel, MPCC (8 February 2012).
- ¹⁴¹ Letter from Geneviève Coutlée, Legal counsel, MPCC, to Elizabeth Richards, Counsel for the Subjects, DOJ (22 May 2012).
- ¹⁴² Transcript of Proceedings, vol. 20, 10 May 2012, pp. 10-14.
- ¹⁴³ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 126-129.
- ¹⁴⁴ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 144-146.
- ¹⁴⁵ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 126-129. Although the GO file is disclosed as a PDF file rather than printing, the term “print” is used to refer to a SAMPIS release provided to the Commission for simplicity.
- ¹⁴⁶ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 145-146.
- ¹⁴⁷ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, p. 129.
- ¹⁴⁸ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 144-145.
- ¹⁴⁹ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 145-146.
- ¹⁵⁰ See for example Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 47-117.
- ¹⁵¹ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 136-137.
- ¹⁵² Testimony of Mr. Beaulieu and Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 123-125; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 2-8.
- ¹⁵³ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 122-126.
- ¹⁵⁴ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 122-126.
- ¹⁵⁵ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 135-137 and 141-143.
- ¹⁵⁶ Testimony of Ms. Larouche, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 137-139.
- ¹⁵⁷ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 121-122.
- ¹⁵⁸ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 88-89.
- ¹⁵⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 198.
- ¹⁶⁰ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 117-118.
- ¹⁶¹ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 117-118.

¹⁶² Exhibit P-177, doc. 1457, p. 1.

¹⁶³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221.

¹⁶⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 210-211.

¹⁶⁵ Exhibit P-150, tab 2, doc. 1430, p. 1.

¹⁶⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 211-213.

¹⁶⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221.

¹⁶⁸ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, pp. 2-3; Testimony of Mr. Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 18-21.

¹⁶⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 152-153.

¹⁷⁰ Exhibit P-177, doc. 1457, p. 3.

III. NARRATIVE

3.0 NARRATIVE

Early Years and History of Career in Military

1. Stuart Langridge was born in Surrey, British Columbia on March 26, 1979.¹ His mother and biological father were divorced when Stuart was five years old. His mother, Sheila, met Shaun Fynes when Stuart was six, and they subsequently married. Mr. Fynes was continuously in Stuart's life from then on, so he had the benefit of a two-parent family for most of his life. He also had two brothers with whom he was close as a child.²

2. Stuart's early childhood was described by Mr. and Mrs. Fynes as happy. He was an energetic little boy with an infectious laugh.³ He was fond of the outdoors, playing soccer and learned to ski at an early age.⁴ He also took part in karate, football and Scouts.

3. Stuart's involvement with the military began early in his life.⁵ He had always wanted to be in the military⁶ and, on his twelfth birthday, Mr. Fynes took Stuart to the local armoury where he joined the Irish Fusiliers Army Cadets.⁷ Mrs. Fynes said, "From that point on, Stuart was in a green uniform more often than not."⁸ Mr. Fynes encouraged him to join the reserves as soon as he was able⁹ and he enrolled on February 4, 1997.¹⁰ When he was 21, he transferred directly from the reserves to become a full time member in the army. He was posted to the Lord Strathcona's Horse (Royal Canadians) in Edmonton on June 1, 2000.¹¹

4. During his employment in the regular force, Cpl Langridge's occupation was as a crewman.¹² A crewman is an armoured soldier who operates and maintains armoured fighting vehicles including their weapon systems and communications equipment.¹³ Cpl Langridge deployed overseas twice. From October 1, 2002, until April 1, 2003, he was deployed on Operation Palladium in the former Yugoslavia where he was a Coyote (armoured reconnaissance vehicle) driver in an infantry battle group.¹⁴ From August 9, 2004, to February 10, 2005, Cpl Langridge was deployed on Operation Athena in Kabul, Afghanistan.¹⁵ On that mission, he worked as a Coyote gunner on a reconnaissance squadron.¹⁶ He was also deployed from August 14 to November 1, 2003, as part of

Operation Peregrine assisting the British Columbia government in its efforts to fight forest fires.¹⁷

5. Cpl Langridge did very well as a soldier. At the time of his re-engagement with the military in December 2005, Cpl Langridge was described by his troop leader as having “performed extremely well” in his prior employment with the CF, as being “dedicated, loyal and motivated” and a “definite asset to the CF.”¹⁸ In his last personnel evaluation report for the period ending March 31, 2007, Cpl Langridge’s supervisor wrote he was “a very reliable soldier who completed all tasks given to him on time and to a high standard” and he “consistently approached his duties with a vigour and professionalism that sets an example for junior soldiers.”¹⁹ In the last training course he took in March 2007, even though he did not complete it due to medical concerns, the course officer described Cpl Langridge as “demonstrat[ing] above average leadership potential,” “having an extremely positive attitude” and stated, “his overall performance was excellent.”²⁰

March 2007 to June 2007: Cpl Langridge’s Declining Health and Its Consequences

6. Prior to March 2007, Cpl Langridge was generally a fit and healthy young man.²¹ He was described in his personnel evaluation for the period ending March 31, 2006, as “a physically fit soldier, [who] has a warrior’s attitude and continuously places in the top of the Sqn during [the] Sqn fitness competitions and attempted the gruelling Ex MOUNTAIN MAN competition.”²²

7. In terms of pre-existing medical concerns, he did have a history of complaints regarding chest discomfort since at least 2001.²³ Also, he attended an appointment at the Base Mental Health Clinic in December 2003, following his deployment to the former Yugoslavia, after he received less than optimal ratings on his enhanced post-deployment screening report.²⁴ In particular, he had medium risk scores on psychosocial stressors and alcohol problems in addition to a high risk score on the somatization index.²⁵

Somatization is the conversion of anxiety into physical symptoms. However, Cpl Langridge did not complete the assessment process at the clinic and no diagnosis was made.²⁶ In July 2005, following his deployment to Afghanistan, Cpl Langridge was assessed once again and found to be at low risk of problem drinking and to be experiencing no depression, suicidality, panic attacks or generalized anxiety.²⁷ However, it was noted he was experiencing major sleep disturbance.²⁸ No follow-up appointments were made.²⁹

8. In the latter months of 2006, and prior to the onset of his serious medical issues, Cpl Langridge was employed by the Headquarters Squadron.³⁰ The role of Headquarters Squadron is to provide support, both in the field and in garrison, to the other squadrons who are the tactical troops that operate the combat vehicles.³¹ Headquarters Squadron employs CF members who, for example, are cooks, or clerks or maintain the military vehicles.³² Cpl Langridge worked in the regimental kit shop, a store where soldiers could purchase equipment (e.g., boots, gloves, knives) and sundries such as cigarettes and snack food.³³ His work in the kit shop appears to have been intended to give him a break from the tour schedule.³⁴

9. At this time, Cpl Langridge was also in a stable, long-term relationship with Ms. A. They had met in October 2005³⁵ and, by May of the following year, she had moved in with him.³⁶ Ms. A described the early stages of their relationship as “fantastic,” and Cpl Langridge as being someone who “loved to have fun,” “a happy guy” and he “loved being in the military.”³⁷

10. The onset of Cpl Langridge’s serious medical problems seems to have coincided with the Primary Leadership Qualification (PLQ) Course he attended in March 2007. Successful completion of the course would have led to a promotion for Cpl Langridge, as the aim of the PLQ course is “to qualify personnel to perform the duties of a MCpl within the Land Environment.”³⁸

11. Cpl Langridge left on the fourth day of the 34-day PLQ course due to “medical reasons”³⁹ which included “sharp pains in the chest.”⁴⁰ When he visited the Base Clinic upon his return from the PLQ, Cpl Langridge complained of, among other things, chest

pain which he said he had been experiencing for over a year.⁴¹ On subsequent visits to the clinic over the following weeks, Cpl Langridge's doctor, Dr. Sivaprakash Rajoo, determined the pain was likely caused by anxiety – Cpl Langridge complained he had been “under alot [*sic*] of stress lately” – and placed him on medication for anxiety and later, also on antidepressants.⁴² Cpl Langridge's health began to deteriorate rapidly as he complained of insomnia and night sweats as well as decreased energy and concentration.⁴³ Cpl Langridge also revealed he had been binge drinking because it decreased his pain and anxiety and it made him happy.⁴⁴ By May 30, 2007, Dr. Rajoo had written in the clinical notes, “may need to consider PTSD.”⁴⁵

12. On June 12, 2007, Cpl Langridge received a referral to a psychiatrist to be assessed for PTSD versus major depressive disorder.⁴⁶ Dr. Rajoo wrote in his referral that Cpl Langridge suffered from depression and anxiety and failed to improve on medication. He also mentioned Cpl Langridge's underlying alcohol and substance abuse disorder.⁴⁷ As described in testimony, Dr. Rajoo, and later, Cpl Langridge's psychiatrist, Dr. Leo Elwell, considered his two illnesses to be co-morbid and to require concurrent treatment.⁴⁸

13. Sometime in May 2007, Cpl Langridge was transferred from the kit shop to B Squadron (a tank squadron) to prepare for deployment to Afghanistan.⁴⁹ It is standard procedure for any soldier deploying to an operational theatre to undergo safety-sensitive drug screening⁵⁰ and Cpl Langridge was given a safety-sensitive drug test.⁵¹ On June 8, 2007, the Regiment was notified Cpl Langridge's test was positive for cocaine.⁵²

14. As a consequence of the positive test, Cpl Langridge was no longer able to deploy overseas.⁵³ He was transferred back to the kit shop⁵⁴ because, at the time, Headquarters Squadron did not deploy overseas.⁵⁵ There was some suggestion by Cpl Jon Rohmer, a good friend of Cpl Langridge, that Cpl Langridge had purposely failed the test to avoid going on tour.⁵⁶

15. In general, soldiers within the Regiment preferred to be employed within a squadron operating armoured vehicles than within Headquarters Squadron.⁵⁷ From at least one of his own comments, it appears Cpl Langridge felt assignment to Headquarters

Squadron carried a stigma. He told staff at a hospital, where he was later admitted, he was humiliated to have to work in the kit shop because he had been deemed unfit for the field.⁵⁸ Cpl Langridge's first Base Addictions Counselor (BAC), Mr. Don Perkins, confirmed other soldiers looked "very dimly" at those who had to be taken off tour because of a failed drug test, and soldiers not able to go on tour are "the black sheep of the family because you are not holding up your end. [...] If you get dropped out, other people are going to have to pick up your slack."⁵⁹

16. The failed drug test also led the Commanding Officer of LDSH, LCol Pascal Demers, to recommend Cpl Langridge complete counselling and probation.⁶⁰ As explained in testimony by Capt Mark Lubiniecki, the Unit Adjutant, it was common practice if a soldier tested positive for drugs prior to deploying overseas to give that individual an opportunity for rehabilitation, referred to as counselling and probation. The rehabilitation would take place over a 12-month period during which the soldier would seek medical treatment and be tested randomly for drug use. If, at any time during the 12-month period, the soldier failed a drug test, a recommendation would be made for release from the CF.⁶¹

17. Cpl Langridge formally denied the use of cocaine on October 17, 2007.⁶² There was a limited internal review of the test results completed on January 4, 2008, which confirmed the initial positive finding for cocaine.⁶³ On January 14, 2008, Cpl Langridge requested the sample be re-tested by an independent civilian lab,⁶⁴ which delayed the start of the counselling and probation period.⁶⁵ At the time of his death, there is no evidence the secondary testing had been completed, and Cpl Langridge had not yet been placed on counseling and probation.⁶⁶

18. Cpl Langridge was first referred to the BAC in his May 28 and 29, 2007, appointments with Dr. Rajoo.⁶⁷ He met with Don Perkins, an addictions counsellor, over three sessions and, in his June 13, 2007 assessment, Mr. Perkins wrote there was a high probability Cpl Langridge suffered from substance dependence.⁶⁸ Mr. Perkins testified it was his recollection he presented Cpl Langridge with the option of attending residential treatment but, at that point, Cpl Langridge was not interested.⁶⁹ Instead, Cpl Langridge agreed to attend a week-long Secondary Substance Intervention Workshop.⁷⁰

19. Cpl Langridge had not yet been seen by anyone at the Base Mental Health Clinic⁷¹ when he attempted suicide for the first time on June 22, 2007. He tried to overdose on his prescription medication as well as other medications.⁷² He took the pills following an argument with Ms. A when she found cocaine in their home. When Ms. A returned home the next day, she testified Cpl Langridge told her he had not been feeling well, so he took extra pills. She testified she found pills all over the house but was not certain whether he had actually taken all the pills or had just made a mess and the attempt demonstrated he was trying to ask for help.⁷³

20. Following this apparent suicide attempt, Cpl Langridge attended the first day of the substance intervention workshop on June 25, 2007.⁷⁴ The aim of the program was to educate the attendees on their alcohol and drug use and where it might lead.⁷⁵ Cpl Langridge refused to return after the first day because he was “uncomfortable with the ‘huggy feely’ stuff and did not wish to disclose any information to the other participants.”⁷⁶

21. That evening, Cpl Langridge attempted suicide for the second time in three days. He drove to a field, began to drink heavily, and ran flexible piping from the exhaust of his vehicle into the passenger compartment. He was found by friends after he sent text messages asking them to comfort Ms. A.⁷⁷

22. As a result of this second suicide attempt, Cpl Langridge was admitted to a civilian hospital for a short-term stay. His diagnosis upon discharge two days later was he suffered from an alcohol induced mood disorder and severe stress.⁷⁸

July 2007 to November 2007: Medical and Mental Health Evaluations

23. Following his second suicide attempt, Cpl Langridge took a period of sick leave and then summer vacation leave.⁷⁹ Cpl Langridge followed up with members of Mental Health Services and the Base Medical Clinic.⁸⁰ He also agreed to try one-on-one addictions counselling although he attended only three more meetings with Mr. Perkins.⁸¹

24. In mid-July 2007,⁸² Cpl Langridge was transferred from working in the kit shop to working for the Stables NCO, MCpl William Fitzpatrick.⁸³ The job involved taking care of the computer lab and other tasks assigned as part of the RSM's detail such as polishing brass, collecting garbage, changing oil pans and cleaning the mess.⁸⁴ Cpl Langridge described his work as "not a good job," "boring," "sucks," and "nothing to do."⁸⁵ MCpl Fitzpatrick confirmed in his testimony there was not a lot of work for Cpl Langridge and he wasn't busy.⁸⁶

25. On August 7, 2007, Cpl Langridge had an appointment with Dr. Rajoo, at which he was assessed for the appropriateness of being placed on a TCAT or "temporary category."⁸⁷ A TCAT is for soldiers not able to perform to the minimum set of standards for their military trade because of a medical condition.⁸⁸ When the medical condition is resolved, the soldier is removed from the temporary category and can return to their trade and full duties.⁸⁹ In Cpl Langridge's case, Dr. Rajoo placed him on a TCAT for six months.⁹⁰ Among other things, the TCAT alerted the Unit the CF member would be given extra appointments and seen more frequently by physicians.⁹¹ A TCAT is also a step in the process for getting a medical release from the military.⁹² There is evidence Cpl Langridge intermittently expressed interest in pursuing a medical release throughout the last year of his life.⁹³

26. Dr. Rajoo also imposed medical employment limitations (MEL) on Cpl Langridge. MELs describe particular limitations on how a member can be employed by the unit because of a medical concern. They have to be honoured by the military Chain of Command without alteration.⁹⁴ The MELs for Cpl Langridge indicated he was "unfit [for] military operational environment," he was not permitted to use weapons or practice at ranges and he needed regular specialist follow-up.⁹⁵ In practice, this meant he could be at the base working half days or full days doing routine jobs, but could not go out into the field.⁹⁶

27. In August 2007, Cpl Langridge was assessed by a base psychologist, Dr. William Lai, who conducted a clinical interview, administered psychometric testing and reviewed Cpl Langridge's medical file.⁹⁷ During the clinical interview, Cpl Langridge complained of feeling depressed most of the time and, when he was stressed, having difficulties

breathing, blurred vision, dizziness, light-headedness, and chest and intestinal discomfort. He also said he was having “horrifying” nightmares, two or three times a week, though he did not believe they were related to his tours of duty.⁹⁸ Dr. Lai made the following provisional diagnosis in his draft psychological assessment report:⁹⁹

DSM IV DIAGNOSES

Axis I: [...] **Major Depressive Disorder, Single Episode, Severe without psychotic features.** [...] **Posttraumatic Stress Disorder – chronic, moderate** [...] **Alcohol abuse.**

Axis II: Deferred

Axis III: Chest pains; gastrointestinal problems; knee problems

Axis IV: Potential conflicts with common-law and coworkers; concerns regarding health of mother and brother

Axis V: Current GAF 45: **some self-harm ideation, serious impairment in social and occupational functioning.**¹⁰⁰ [Emphasis added]

28. In a case conference note dated August 23, 2007, Dr. Lai observed the psychometric testing results pointed to PTSD, but no specific traumatic incident or event had been identified and identification of such an event was required for a diagnosis of PTSD.¹⁰¹ Dr. Lai testified it was “likely” Cpl Langridge had PTSD¹⁰² based on the information he had at this point, but further exploration was necessary to determine if a full PTSD diagnosis was justified.¹⁰³ Several follow-up appointments were made with Cpl Langridge in an attempt to complete the psychological assessment, but, in the end, the assessment was never finalized.¹⁰⁴

29. Cpl Langridge’s relationship with Ms. A had also been deteriorating since the onset of his health and addiction issues. According to Ms. A, Cpl Langridge began to change in 2006, with more pronounced changes occurring in 2007.¹⁰⁵ Over time, the state of their relationship became more volatile, marked by good days and bad days, as Cpl Langridge’s health and substance abuse issues became increasingly serious.¹⁰⁶ Cpl Langridge told his health care providers in the spring of 2007 he had numerous arguments with Ms. A because of his drinking,¹⁰⁷ and in October 2007, he told them he was having problems at home.¹⁰⁸ In his interviews with Dr. Lai, Cpl Langridge stated Ms. A was someone who was easily “worked up,” had “lots of anxiety” and had given him an “ultimatum,” demanding he stop drinking. However, Cpl Langridge also said he was

determined to keep and improve the relationship with Ms. A, and he wanted to marry her at some point.¹⁰⁹

30. Cpl Langridge attempted suicide for a third time on October 29, 2007. He took an unknown quantity of prescription medication at home and was taken to emergency.¹¹⁰ On his discharge the following day, he was diagnosed as suffering from an alcohol-induced mood disorder as well as alcohol abuse.¹¹¹

31. Following his discharge, Cpl Langridge again met with members of Mental Health Services and members of the Base Clinic.¹¹² His symptoms continued unabated with clinical notes stating he had nervous pains in his chest, was stressed out, tired, confused and would wake up screaming and drenched in sweat.¹¹³

32. On November 15, 2007, Cpl Langridge had an appointment with Dr. Elwell.¹¹⁴ During the appointment, Dr. Elwell conducted a clinical interview.¹¹⁵ His diagnosis was Cpl Langridge suffered from generalized anxiety disorder, major depressive disorder and alcohol abuse but most likely not PTSD. He also identified quite strong personality traits and moderate to severe stressors in Cpl Langridge's life.¹¹⁶ He treated Cpl Langridge by adjusting his medications¹¹⁷ and suggesting individual therapy sessions.¹¹⁸ Dr. Elwell scheduled a follow-up appointment with Cpl Langridge on February 19, 2008, but Cpl Langridge was in Alberta Hospital Edmonton at the time of the appointment.¹¹⁹ The appointment was not rescheduled.¹²⁰

December 2007 to January 2008: Common-law Declaration and Residential Treatment Program

33. Cpl Langridge continued to visit the Base Clinic regularly and also attended individual counselling sessions with a mental health nurse three times through November and December 2007.¹²¹ During his meeting with Mr. Perkins on November 21, 2007, Cpl Langridge requested to attend a residential treatment program.¹²² Because of his deteriorating condition, Mrs. Fynes and Ms. A had staged an intervention that same month aimed at getting him to reduce or stop his substance abuse.¹²³ Cpl Langridge

acknowledged his loss of control to Mr. Perkins, stating, once he started drinking, he was unable to stop.¹²⁴ Arrangements were made for Cpl Langridge to attend a residential treatment program starting early in January 2008.¹²⁵

34. On December 7, 2007, on one of the happier days of their relationship,¹²⁶ Cpl Langridge and Ms. A signed a CF common-law statutory declaration.¹²⁷ Ms. A testified Cpl Langridge had been asking her to sign the declaration since July.¹²⁸ The declaration required they make an appointment and attend at the base, provide identification as well as proof they had lived together for a year and then sign the declaration before a CF officer.¹²⁹ The declaration stated Cpl Langridge and Ms. A “undertake to hold each other out as husband and wife.”¹³⁰ The declaration entitled Ms. A to the benefits the military offered spouses, for example medical insurance and travel assistance.¹³¹ Most importantly, Ms. A agreed to sign the declaration because it would allow her to attend the spousal program at the Edgewood residential treatment centre.¹³² Ms. A testified, “it would allow me to attend treatment at Edgewood with him, something that was really important because Stuart had committed to me that I could be a part of his treatment from start to finish.”¹³³

35. Shortly after Christmas, Cpl Langridge went on a cocaine binge¹³⁴ and, in the opinion of Mr. Perkins, he scared himself. At Cpl Langridge’s request, Mr. Perkins was able to move the residential treatment start date up by a week. Cpl Langridge had given his ID, car keys and credit cards to Ms. A, and Mr. Perkins noted Cpl Langridge was “motivated to get help.”¹³⁵

36. The extent to which Cpl Langridge acknowledged his use of alcohol and drugs varied widely, but when he was admitted to residential treatment, he disclosed he had been bingeing on alcohol two to five times a week for several years. He also stated he had been using approximately two grams of cocaine daily for at least four months. In addition, he acknowledged smoking marijuana daily for twelve years.¹³⁶

37. Cpl Langridge arrived at the Edgewood Treatment Centre in Nanaimo, B.C., on January 4, 2008, but only remained in treatment for six days.¹³⁷ He withdrew from treatment after leaving group therapy sessions.¹³⁸ This led Ms. A to take some of her

belongings, leave their shared townhouse and go to her parents' condominium before Cpl Langridge arrived back in Edmonton.¹³⁹

January 2008 to March 2008: Cpl Langridge's Precipitous Decline

38. Cpl Langridge's substance abuse problems continued following his early departure from Edgewood. Upon his return to the Regiment, Cpl Langridge did not see Mr. Perkins again.¹⁴⁰ A medically ordered drug test on January 22, 2008, returned a positive result for marijuana.¹⁴¹ He tested positive for cocaine and marijuana in hospital on February 2, 2008, after his fourth suicide attempt.¹⁴² He tested positive again for cocaine and marijuana on March 7, 2008.¹⁴³ Though he did at various times in the last weeks of his life attempt to reduce his substance use, and he did seek and desire treatment, Cpl Langridge's struggle with addictions evidently persisted until his death.

39. Cpl Langridge was also undoubtedly upset over the state of his relationship with Ms. A, telling his clinicians he was finding it hard to cope with his girlfriend leaving him, and that he was going through a divorce.¹⁴⁴ However, despite their falling-out, Cpl Langridge and Ms. A continued to have contact. When things were good, Ms. A would return to live in the townhouse with Cpl Langridge, but when things were bad, she would take some clothes and go to her parents' home.¹⁴⁵ In clinical notes from the time, Cpl Langridge described Ms. A as calling him constantly and stated not much had changed except they were not living together.¹⁴⁶ Also, despite Cpl Langridge's early departure from residential treatment and despite the volatile nature of their relationship at the time, Ms. A still attended the spousal program at Edgewood. She testified the program delved into issues of co-dependency and, because of its personal emotional content, was "probably one of the most difficult things I have ever done in my entire life."¹⁴⁷

40. After his return from Edgewood, Cpl Langridge was, at his request, moved to work in a reconnaissance squadron.¹⁴⁸ Cpl Langridge asked for an opportunity to work alongside his peers and demonstrate they could have confidence in him¹⁴⁹ – he wanted to be "an effective soldier of the Strathconas."¹⁵⁰ The move was short lived, lasting less than a week.¹⁵¹ There was conflicting testimony about whether the move did not work out

because the squadron commander did not feel Cpl Langridge was being a productive soldier,¹⁵² or because Cpl Langridge felt mentally he was just not in the right space and the reconnaissance squadron was not the best place for him to be.¹⁵³ Whatever the reason, Cpl Langridge was moved back to Headquarters Squadron working for MCpl Fitzpatrick.¹⁵⁴ Cpl Langridge continued to work in this job until his death.

41. Cpl Langridge's health also deteriorated even further.¹⁵⁵ The clinical notes indicate he told his mental health nurse he "often thinks about hurting himself in the evenings so he won't have to go back to work."¹⁵⁶

42. Cpl Langridge's fourth known suicide attempt was on January 31, 2008, when he tried to hang himself at home.¹⁵⁷ He went to the Base Clinic the next morning where he was observed to be "tearful, curled in a fetal position, no eye contact, active suicidal ideation with plan and means."¹⁵⁸ He was admitted to the RAH for a short-term stay with an admitting diagnosis of "bizarre paranoid behaviour."¹⁵⁹ While in hospital, he attempted suicide for a fifth time on February 3, 2008, by attempting to strangle himself.¹⁶⁰ Cpl Langridge was discharged, apparently against medical advice, the next day.¹⁶¹ His diagnosis was noted as alcohol and cocaine induced mood disorder, alcohol and cocaine abuse, borderline personality disorder and antisocial traits, as well as severe stressors.¹⁶²

43. Mrs. Fynes testified she believed Cpl Langridge would finally be getting proper help after his hospital suicide attempt, and she was therefore astounded to arrive at the RAH on February 4 and find Cpl Langridge ready to leave. She described seeing a red mark on Cpl Langridge's neck from the ligature.¹⁶³ She had a low view of the treatment offered by the RAH, describing it as "a catch and release program" where "people arrive drunk or stoned or whatever and they dry them out and then they kick them out. Three days and you're done."¹⁶⁴ Records from the RAH indicated the discharge was against medical advice because Cpl Langridge wanted to leave but "Mother not willing to take [Cpl Langridge] home [with] her or take responsibility for him."¹⁶⁵ Mrs. Fynes testified she did not want Cpl Langridge to leave the hospital, and felt the hospital was kicking him out.¹⁶⁶ She told the Commission, "[i]f they wanted him to stay, then he wouldn't have been leaving."¹⁶⁷ However, Cpl Langridge insisted on leaving.¹⁶⁸ Mrs. Fynes

testified she then accompanied Cpl Langridge back to the Health Unit and to the Padre's care.¹⁶⁹ The padre and some members of the Base Mental Health Team were concerned that Cpl Langridge was not in fact stable,¹⁷⁰ and Mrs. Fynes recalled they made arrangements to have another soldier stay with Cpl Langridge for his safety.¹⁷¹ On February 5, 2008, just a day after his discharge, Cpl Langridge drove himself to the Alberta Hospital Edmonton and was admitted for a 30-day stay on an involuntary basis.¹⁷²

44. After he was admitted to hospital, Ms. A and his friend, Cpl Rohmer, went to the townhouse where Cpl Langridge had been living. Ms. A described finding pills, drugs, empty beer cans and liquor bottles all over the house. More disturbingly, she also testified she found the bathtub half full of water with "knives everywhere" as well as "between three and five nooses made out of different things that he had obviously attempted to hang himself with" in the basement.¹⁷³

45. In mid-February 2008, this townhouse, which Cpl Langridge and Ms. A had been sharing during their relationship, was given up and the lease was terminated.¹⁷⁴ It was Ms. A's testimony the lease had to be broken because they could no longer afford to pay the rent,¹⁷⁵ while Mrs. Fynes testified Cpl Langridge wanted to move back onto the base.¹⁷⁶ Ms. A removed all of her belongings,¹⁷⁷ and Mrs. Fynes, with the help of the Base Padre and several other soldiers, removed Cpl Langridge's belongings, which were placed in storage at the base.¹⁷⁸

The Military's Knowledge of Cpl Langridge's Condition

46. The Regiment was not privy to the specifics of Cpl Langridge's medical condition as his health deteriorated. The medical authorities share very little with the chain of command.¹⁷⁹ The chain of command received notification of medical employment limitations and medical leave, but the military medical system does not seek approval of the military chain of command to send CF members on treatment.¹⁸⁰

47. The military chain of command would have been aware of Cpl Langridge's reduced work schedule as a result of his deteriorating health. Cpl Langridge was frequently on sick leave or working a reduced schedule. When his health allowed him to work, he was almost always working only half days and, with a few exceptions, only three days a week.¹⁸¹ In his testimony, Dr. Rajoo agreed Cpl Langridge needed to either be off work or on a reduced schedule in order to get better.¹⁸² While the clinical notes are not completely clear, it appears there was no period of time after May 30, 2007 – nine months prior to his eventual suicide – in which Cpl Langridge was healthy enough to be able to work more than four consecutive full days in a row.¹⁸³

48. There was also evidence members of the Regiment chain of command may have been aware of all but the first of Cpl Langridge's suicide attempts.

49. The chain of command was undoubtedly aware of Cpl Langridge's second suicide attempt. Cpl Langridge's friends who received his text message and who found him in his Jeep were CF members and, after receiving the text message, they contacted the MP as well as their supervisor, who in turn contacted the chain of command.¹⁸⁴ The attempt resulted in a military administrative investigation (i.e., a Summary Investigation) into facts and causes. The Summary Investigation contained recommendations regarding how the Regiment could assist in Cpl Langridge's ongoing treatment and recovery.¹⁸⁵

50. With respect to his third suicide attempt, there was military involvement in getting Cpl Langridge to hospital. On the morning of October 29, 2007, Sgt Anick Murrin, who was the sheriff for LDSH,¹⁸⁶ was asked by RSM Douglas Ross to attend at Cpl Langridge's residence.¹⁸⁷ Cpl Langridge had not shown up for work or for a scheduled medical appointment that morning, meaning he was AWOL.¹⁸⁸ Clinical notes state he had phoned the Unit to tell them he would not be going to work because Ms. A had left him.¹⁸⁹ Sgt Murrin found him asleep at his home. After initially being roused, Cpl Langridge seemed unable to wake up, so Sgt Murrin contacted the Base Clinic and was told he should go to a civilian hospital.¹⁹⁰ She called 911 and waited with him until the ambulance came and transported him to hospital.¹⁹¹ She advised the LDSH RSM, CWO Ross, of the situation.¹⁹² In her testimony, Sgt Murrin was adamant she had not been responding to a suicide attempt and did not believe Cpl Langridge was suicidal.¹⁹³

However, Cpl Langridge's military Unit was aware he had been admitted to the RAH psychiatric unit and even advised the Base Clinic.¹⁹⁴

51. Cpl Langridge attempted suicide for a fourth time at the end of January 2008 and again in hospital, a few days later, in early February 2008. Capt William Hubbard, the chaplain for the Regiment, testified Ms. A called him and made him aware of the attempt in January 2008 and, as a result, Cpl Langridge had been taken to hospital.¹⁹⁵ It was Capt Hubbard's evidence he personally spoke to members of the regimental chain of command and made them aware of this attempt.¹⁹⁶ There was conflicting evidence from the members of the chain of command about what (if any) information they received from Capt Hubbard.¹⁹⁷ Capt Lubiniecki did not recall being informed of the January attempt but confirmed having been told of the subsequent attempt made while Cpl Langridge was in hospital.¹⁹⁸

Cpl Langridge's Last Days

52. From February 5 to March 5, 2008, Cpl Langridge was hospitalized as a patient of the Alberta Hospital Edmonton (AHE) in the acute adult psychiatric unit.¹⁹⁹ His admission to hospital was the culmination of several suicide attempts over the course of the prior ten months (including a suicide attempt only days before while at the Royal Alexandra Hospital),²⁰⁰ continuing drug and alcohol abuse, and serious, unresolved mental health issues. While he went to the hospital voluntarily, he was admitted for a 30-day stay on an involuntary basis because his behaviour was unpredictable.²⁰¹ He was admitted in a state of anxiety and suicidal depression.²⁰²

53. While in hospital, Cpl Langridge's progress was mixed. He did join the programming offered by the hospital²⁰³ – for example the Substance Abuse Recovery Group,²⁰⁴ AA²⁰⁵ and Narcotics Anonymous²⁰⁶ – but his attendance at programming was not consistent nor was he particularly engaged.²⁰⁷ He sometimes accessed drugs while in care,²⁰⁸ using his privileges to leave the grounds to visit his drug dealer.²⁰⁹ About halfway through his stay, he confessed to staff he was continuing to use cocaine and, when coming down off the drug, he had increased feelings of suicidality.²¹⁰ In the early hours

of February 19, 2008, Cpl Langridge either contemplated suicide or actually attempted to hang himself with a belt, but then approached hospital staff for help.²¹¹ He stated he wanted to quit drugs, but his addiction made it very difficult.²¹² As a result, he was placed under close observation,²¹³ meaning he could not leave the unit and a nurse had to check on him every 15 minutes.²¹⁴ However, when the restrictions were removed,²¹⁵ there was some suspicion his drug use began again,²¹⁶ and Cpl Langridge was again placed on close supervision until his departure from hospital.²¹⁷ His treating psychiatrist, Dr. Bernard Sowa, testified that while there had been some issues with Cpl Langridge, this was not unexpected in terms of his treatment²¹⁸ and progress was made in terms of his mood and anger settling down.²¹⁹

54. While Cpl Langridge was in hospital, a psychology report was completed on the basis of clinical interviews and psychometric testing. The conclusion of the report stated:

Stuart's history and presentation is consistent with posttraumatic stress disorder with situationally based panic attacks (i.e. going to work for the military). Currently, **he is also struggling with a major depressive disorder and traits of social anxiety.** Stuart also displays traits of borderline and narcissistic personality. At this time, he has very poor coping abilities relying primarily on drug and alcohol abuse with minimal insight into his psychological difficulties.²²⁰ [Emphasis added]

55. Dr. Lori Harper, the clinical psychologist who oversaw the psychology resident who completed the report, said Cpl Langridge presented with symptoms consistent with post-traumatic stress disorder and it could not be ruled out as a diagnosis.²²¹ Similar to the findings of Dr. Lai from August 2007, no traumatic event was identified by Cpl Langridge, though he did allude to one, so no definitive diagnosis of PTSD could be made.²²²

56. Mrs. Fynes was present for the early part of Cpl Langridge's treatment at the AHE. She testified that "Stuart did really well for the first few days and he was starting to make plans about what was going to happen next."²²³ He said he felt safe in the hospital, and expressed interest in moving back to the base. But shortly after that, he seemed almost too happy. Mrs. Fynes felt something was "[o]ut of context, it didn't fit. [...] I remember driving back to the hotel thinking, "There's something wrong here."²²⁴ She phoned the ward and told a nurse she suspected Stuart had accessed some drugs because

his mood and behaviour had changed quickly. Although reluctant to believe this could happen in the AHE, the nurse arranged for testing and cocaine was detected in his system.²²⁵

57. During his stay in hospital, Ms. A and Cpl Langridge continued to have steady contact. Ms. A had assisted him over the phone to get to the AHE and stayed on the phone with him while he waited to be admitted.²²⁶ Ms. A testified she visited Cpl Langridge as much as possible during this hospitalization. However, there were also occasions when Cpl Langridge specifically asked medical staff to not allow Ms. A to visit.²²⁷

58. Towards the end of his hospitalization, Cpl Langridge expressed interest in attending an addiction rehabilitation (rehab) program.²²⁸ This was a course of action supported by Dr. Sowa who stated in testimony, “this is someone who definitely need[ed] treatment for his addictions problems,” and was encouraged by Cpl Langridge’s show of initiative.²²⁹ This was also a course of action endorsed in the psychology report, which recommended, “although Stuart’s insight is somewhat limited, he may benefit from inpatient drug treatment, such as the services available at AADAC or Henwood.”²³⁰ Twice Cpl Langridge contacted Leo Etienne, a CF BAC, to ask if he could remain in hospital voluntarily when his 30-day committal ended, and proceed directly to a residential rehabilitation program.²³¹ Cpl Langridge contacted the base because, as a member of the military, he had certain responsibilities in terms of accounting for his whereabouts with the CF.²³² Furthermore, the CF would be paying the cost of the rehab program.²³³ Mr. Etienne told Cpl Langridge a case conference would be held with the CF treatment team at the base to make recommendations on his continued care.²³⁴

59. The military treatment team wanted Cpl Langridge to come back to base for a period of time prior to attending a rehab program. Cpl Langridge told Dr. Sowa he was required to spend two weeks at the base following his discharge.²³⁵ Dr. Sowa contacted the base and confirmed this was the case.²³⁶ This return to the Unit was referred to in the notes from the Base Clinic as a “**trial of good behaviour**” to see if [he was] capable of going to [an] addiction treatment centre.”²³⁷ According to base medical personnel, the concern was Cpl Langridge had been continuing to access drugs while in hospital and

needed to be stable and “a little bit clean” prior to being sent for addictions treatment.²³⁸ The thinking was Cpl Langridge was suitable for outpatient management and would attend individual and group counselling while at the Base.²³⁹ In testimony, base medical personnel maintained there was no suggestion Cpl Langridge would not be sent for residential rehab eventually, though he first had to be stable, able to follow some routine, and willing to participate in the program.²⁴⁰

60. Cpl Langridge expressed considerable anxiety about returning to the Regiment, telling nursing staff he was scared to leave the hospital.²⁴¹ Dr. Sowa described the events preceding Cpl Langridge’s release from hospital in the discharge summary as follows:

Our plan was to keep him in the hospital until he could be discharged directly to the military. [Cpl Langridge] certainly was not certifiable at the end of the first certificates. **He agreed to stay in hospital as a voluntary patient until arrangements could be made for him to return to a drug rehabilitation program.**

Unfortunately the military called as to inform us [...] that they actually [...] did want him back at the Garrison and that they would make their own arrangements for him to be referred to a drug rehab program. We were rather surprised by this as Stuart had indicated his willingness to stay with us in hospital so that that could be done. However based on that request he was escorted the day after his certificates expired directly to the military Garrison and handed over to his sergeant and this was done on the 5th of March 2008.²⁴² [Emphasis added]

61. While Dr. Sowa had no medical objection to Cpl Langridge leaving the hospital, he did state he did not initiate any return of Cpl Langridge to the base.²⁴³ The plan had been for Cpl Langridge to remain voluntarily in hospital. It was Dr. Sowa’s recollection there was a message from the base saying essentially, “We want him” and “We have our program here.”²⁴⁴ There is also evidence Cpl Langridge believed he had no choice but to leave the hospital and return to the base if he wanted to attend the treatment program he sought.²⁴⁵ Despite Cpl Langridge’s wish to stay in hospital voluntarily and transfer directly to a residential treatment program,²⁴⁶ his clinician’s support for this option²⁴⁷ and his anxiety about leaving the hospital,²⁴⁸ Cpl Langridge returned to the CF base on the morning of Wednesday, March 5, 2008.²⁴⁹

62. Very little is known about the actual arrangements made by the CF for Cpl Langridge upon his return to base, despite the fact Dr. Elwell, Cpl Langridge’s treating psychiatrist on the base, stated in testimony, “we were technically on the hook to watch

after him.”²⁵⁰ There is conflicting evidence as to where he lived upon returning, even though he was assigned a barracks room on the base.²⁵¹ Ms. A testified he had the option of coming to live with her in her parents’ condo, but he instead returned to the base because he had been told he had to by the military.²⁵² It is not known whether Cpl Langridge was required to work, though the clinical notes from the hospital indicate he was told by his BAC he would not be starting work immediately and would instead be attending substance abuse groups.²⁵³

63. Due to Cpl Langridge’s instability, some effort was made to arrange what some CF members referred to as a “suicide watch.”²⁵⁴ This consisted of compiling a list of names of CF members who would be available to “watch” Cpl Langridge on an around the clock basis.²⁵⁵ However, the list and potential watch were never implemented, in part because Cpl Langridge reportedly objected to such supervision.²⁵⁶ It was also called off because Maj Earl Jared, who was the Officer Commanding of Headquarters Squadron where Cpl Langridge worked, did not agree with the measure.²⁵⁷ Despite this, both Mrs. Fynes and Ms. A, stated they received assurances from Cpl Langridge’s BACs that Cpl Langridge would be watched by someone 24 hours a day.²⁵⁸

64. Other details regarding what was expected of Cpl Langridge or the treatment plan put in place to stabilize him are not known. What is known is Cpl Langridge had four scheduled appointments at the Base Mental Health Unit in the two days following his return from the hospital, though he did not show up for three of those appointments.²⁵⁹ There is evidence he did see BAC Dennis Strilchuk between three and five times during the period he was out of the hospital, and was provided individual counseling.²⁶⁰ Cpl Langridge’s last meeting with Mr. Strilchuk was Friday, March 7, 2008, two days following his release from the hospital. Mr. Strilchuk noted Cpl Langridge had been “totally non-compliant” in following restrictions which had been placed on him and Cpl Langridge was “**sent to his unit for close supervision.**”²⁶¹ Cpl Langridge admitted to medical personnel he had been consuming alcohol and using other drugs since he was released.²⁶² In light of these developments, Mr. Strilchuk stated he would no longer work with Cpl Langridge and felt he could no longer help him.²⁶³

65. Following his last meeting with Cpl Langridge, Mr. Strilchuk referred him to the Base Surgeon, Capt Richard Hannah, who met him the same morning. Cpl Langridge was upset. He complained to Capt Hannah about restrictive conditions that had been placed on him.²⁶⁴ There are no details in the documentary record about the conditions Cpl Langridge was complaining about. He told Capt Hannah he wanted to return to the AHE for treatment; Capt Hannah contacted the AHE and learned that the AHE was “full” and not accepting referrals.²⁶⁵ Cpl Langridge refused to go to the RAH instead. Consultation between Capt Hannah, members of the mental health clinic and members of the Regiment, in particular the Regimental Sergeant Major CWO Ross, resulted in a series of medical employment limitations and, in the words of CWO Ross, “control measures” being “imposed” on Cpl Langridge.²⁶⁶ The “control measures” included a requirement to live at the Regimental Duty Centre, to sleep in the defaulters’ room, to keep the door to that room open at all times, a 2100 hrs curfew, a requirement to sign in with the Duty Officer every two hours daily and to provide a phone number where he could be reached if he left the Harvey Building (where the Duty Centre was located).²⁶⁷ Cpl Langridge was also required to attend all medical appointments, abstain from alcohol and drugs, work Monday to Friday from 0800 hrs to 1630 hrs (which was half an hour beyond what other soldiers had to work²⁶⁸) and wear his uniform during the normal duty hours.²⁶⁹

66. According to CWO Ross, the intent behind the conditions was to provide Cpl Langridge with structure and not as punishment, although CWO Ross stated the extra work was “just because I wanted to do that, to be quite honest.”²⁷⁰ If Cpl Langridge failed to comply, he could be charged under military law, as the conditions were considered to be orders.²⁷¹ The defaulters’ room, where Cpl Langridge was required to sleep, was for CF members receiving punishment and, as part of the punishment, they were required to follow a specific and strict work and reporting schedule for a period of time.²⁷² Though Cpl Langridge’s conditions were, in some respects, similar to those imposed on defaulters, Capt Hannah and CWO Ross both stated Cpl Langridge was not a defaulter.²⁷³

67. Both CWO Ross and Capt Hannah stated the conditions were agreed to by Cpl Langridge and were, in fact, welcomed by him.²⁷⁴ The conditions were supposed to provide him with the structure necessary to get back to being a soldier.²⁷⁵ There was no

time limit on how long the conditions would apply. Rather, the conditions were to be in place until Cpl Langridge “showed he could handle himself.”²⁷⁶

68. If Cpl Langridge initially agreed to the conditions, this agreement was short-lived as he very soon came to find them upsetting, onerous and restrictive. On Tuesday, March 11, 2008, less than a week after his return from the AHE, Cpl Langridge visited the Base Clinic complaining he felt like he had been thrown back into the deep end and had no idea where his life was going.²⁷⁷ He stated the conditions placed on him were too hard, and he wanted them changed.²⁷⁸ However, he was advised he “must return to his unit and continue to work and see how he does” and if he was doing okay, there would be consideration of a residential treatment program.²⁷⁹ When faced with returning to his Unit, Cpl Langridge stated to the clinic physician he was suicidal and he “**would rather kill himself than return to his unit.**”²⁸⁰ He was taken to emergency at the Royal Alexandra Hospital where it was noted he was depressed, anxious and suicidal.²⁸¹ In particular, he is quoted as saying he “can’t take army stuff anymore.”²⁸² He complained he had not slept in two days, his anxiety was increased, his mood was low and he had been using drugs more frequently.²⁸³ He was placed under close observation.²⁸⁴ Cpl Langridge told Royal Alexandra staff he wanted to return to Alberta Hospital Edmonton because, during his time there, he benefited from the treatment he received.²⁸⁵ Cpl Langridge remained at the Royal Alexandra for only two days, until Thursday, March 13, 2008, when he signed himself out of hospital against his treating physician’s advice.²⁸⁶

69. In the days preceding his death, there is evidence Cpl Langridge had been giving away his personal belongings.²⁸⁷ There is also evidence he continued to seek to have his “restrictions lessened,”²⁸⁸ in particular to have the two-hour mandatory check-in increased to three hours.²⁸⁹ CWO Ross refused to change the condition, instructing Cpl Langridge he needed to show he could handle himself first.²⁹⁰ Nevertheless, according to CWO Ross, there had been no issues with Cpl Langridge complying with the conditions before March 11, 2008,²⁹¹ and Capt Lubiniecki, the Regimental Adjutant, maintained the chain of command “were happy with [Cpl Langridge’s] performance and the way he was conducting himself up to that point.”²⁹²

70. It remains unknown to what extent Cpl Langridge had actually been complying with the conditions or to what extent he was monitored and supervised. Even though CWO Ross stated the duty staff were fully aware of the conditions,²⁹³ the evidence suggests they were not. According to Sgt Trent Hiscock, who was the Duty Officer on the day of Cpl Langridge's death, the only conditions actually written out and passed on from Duty Officer to Duty Officer were in a handwritten note stating the Duty Driver would drive Cpl Langridge to all his appointments and drop him off.²⁹⁴ The rest of the conditions were passed on verbally and not all the conditions were known by the Duty Staff.²⁹⁵ There was even uncertainty as to whether he had to personally attend every two hours to sign in, or whether it was possible for him merely to check in by telephone.²⁹⁶ In fact, many members believed Cpl Langridge could simply call every two hours.²⁹⁷ By his own admission, Cpl Langridge was not complying with the restrictions on alcohol and drug consumption.²⁹⁸ Since the sign-in sheets for the days preceding his suicide were never found and few other records exist, his behaviour and comings and goings cannot be verified. Although Cpl Langridge's activity was restricted to some extent, Ms. A told the Commission he had managed to visit her at her parents' home and other locations during that time.²⁹⁹ She specifically indicated that Cpl Langridge had, on some of those occasions, seen her by "evading his caretakers."³⁰⁰ She also told the Commission that during his absences Cpl Langridge had been drinking.³⁰¹

71. Throughout this period of time, Cpl Langridge and Ms. A continued to see and call each other. Sometimes Cpl Langridge would show up at places where Ms. A was, other times they would plan to meet.³⁰² However, the relationship continued to be unpredictable, and Ms. A testified Cpl Langridge's mood was very volatile.³⁰³ A few days before Cpl Langridge's death, Ms. A contacted Capt Lubiniecki to discuss whether, as a result of signing the common-law declaration, she would be responsible for the payment of outstanding debts if Cpl Langridge defaulted on payment.³⁰⁴ Capt Lubiniecki testified Ms. A told him she still loved Cpl Langridge but needed a break from him.³⁰⁵ Capt Lubiniecki stated Ms. A had asked if the military was able to place a restraining order on Cpl Langridge, and he had informed her that was not possible, but he did provide her with the name of a lawyer.³⁰⁶ Capt Lubiniecki also testified, following his phone conversation with Ms. A, he spoke to Cpl Langridge, explained Ms. A needed a

break from him, and Cpl Langridge agreed to give her the space she needed.³⁰⁷ In testimony, Ms. A agreed she had discussed separating for a few days from Cpl Langridge, but stated it was not her intention they would separate permanently.³⁰⁸ She also testified she did not recall discussing the issue of a restraining order with anyone around that time.³⁰⁹ There is mention in Cpl Langridge's medical records he had reportedly been harassing her.³¹⁰ Ms. A stated she and Cpl Langridge had continued to discuss plans for the future right up until the day before he died, including plans for Ms. A to visit Cpl Langridge when the CF arranged for him to attend a second residential treatment facility.³¹¹ Cpl Langridge's medical records indicate he attended the Base Clinic and renewed six prescriptions on March 14th. The prescribing physician is noted as Dr. Robin Lamoreux.³¹²

72. On Saturday, March 15, 2008, Cpl Langridge signed in at the Duty Centre at 0700 hrs and again at 0905 hrs.³¹³ It was indicated on the sign-in sheet he was in the room he had been given in the single quarters (colloquially known as the "shacks").³¹⁴ There was conflicting evidence about his activities, but there was evidence Cpl Langridge's mood was bright³¹⁵ and he may have, on his own initiative, shovelled the front walk to the Harvey Building since it was snowing.³¹⁶ At 1100 hrs, he signed in again and had a conversation with the Duty Officer Sgt Hiscock.³¹⁷ Cpl Langridge told Sgt Hiscock there had been a change in his medications. In addition, he said the medications had not taken away his nightmares last night and, as a result, he was very tired.³¹⁸ There also was some conversation about a movie Sgt Hiscock had seen.³¹⁹ Cpl Langridge then went back to his room in the shacks.³²⁰

73. The day of March 15, 2008, many CF members were attending the funeral of Trooper Hayakaze, who had been killed in Afghanistan,³²¹ but Cpl Langridge remained at LDSH and went to the shacks, ostensibly to do laundry.³²² The sign-in sheet records Cpl Langridge signed in again at the Duty Desk at 1235 hrs.³²³ When he did not show up for his next sign in, efforts were made to contact him by phone³²⁴ and by knocking on the door of his room in the shacks.³²⁵ When he did not respond, the master key was obtained, and entry was gained to the room.³²⁶ At 15:20, Cpl Langridge was found dead, hanging

from the chin-up bar in his room.³²⁷ On his desk was a suicide note, which read as follows:

Sorry but I can't take it anymore. I love you Mom, Shaun, James, Mike, Grandma, Aunti, Tom. Please know that I needed to stop the pain.

xoxo Stu

PS I don't deserve any kinda fancy funeral just family. Ty.³²⁸

Stuart Langridge's Death: The Fallout

74. Mr. and Mrs. Fynes were informed of Cpl Langridge's death in a phone call from LCol Demers,³²⁹ on the evening of March 15, 2008. The notification was done in accordance with the Personal Emergency Notification (PEN) form completed by Cpl Langridge and on file at the Regiment.³³⁰ Cpl Langridge had named his parents as his emergency contacts and also as his next of kin.³³¹ A short time after the phone call, the Fynes were notified in person by a CF notification team.³³²

75. Ms. A was also formally advised of the death. Unlike the Fynes, she had not been named by Cpl Langridge as either a contact or as a next of kin on the PEN form at the Regiment.³³³ The Regiment, however, determined she should be contacted.³³⁴ Since she was located in Edmonton, LCol Demers advised her in person after he had contacted the Fynes.³³⁵

76. During the notification, neither the Fynes nor Ms. A were told Cpl Langridge had left a suicide note. The note had been found in Cpl Langridge's room by the CFNIS members who responded at the scene. The Fynes were not advised for another 14 months that a suicide note even existed.³³⁶

77. Shortly after the notification, both the Fynes and Ms. A were assigned Assisting Officers (AO) by the CF. The role of the AO was to provide a link to the military and help the family navigate the military's system of benefits and rules surrounding the death. This included explaining the benefits provided by the CF for the funeral.³³⁷ Mr. and Mrs. Fynes lived in Victoria and their AO was Maj Stewart Parkinson, who was also located in

British Columbia.³³⁸ Ms. A's AO was 2Lt Adam Brown who was located in Edmonton and was part of LDSH.³³⁹

APPOINTMENT OF NEXT OF KIN

78. In making arrangements, the military assumed the "Primary Next of Kin" (PNOK) was entitled to plan Cpl Langridge's funeral.³⁴⁰ (Although legally distinct, the documents and the testimony at the hearings sometimes refer simply to "Next of Kin" (NOK) interchangeably with PNOK.) Initially, the Fynes were identified as Cpl Langridge's PNOK and SNOK ("Secondary Next of Kin") in correspondence sent within the CF³⁴¹ as well as during the initial briefing Maj Parkinson received as the Fynes' AO.³⁴² They were also identified as his PNOK and SNOK on the PEN form at the Regiment. The Fynes began to provide Maj Parkinson with instructions concerning what they wanted for the funeral.³⁴³ However, on March 17, 2008, two days after Cpl Langridge's death, they were informed by Maj Parkinson the Regiment had decided Ms. A was Cpl Langridge's PNOK.³⁴⁴ Mr. and Mrs. Fynes were deeply upset and saddened when confronted with this decision³⁴⁵ as they were told final decision making authority over funeral planning now lay with Ms. A,³⁴⁶ whom they considered simply to be Cpl Langridge's ex-girlfriend.³⁴⁷

79. How the Regiment made the decision to assign PNOK status to Ms. A is not known precisely, though it seems to have been based on the common-law declaration which Cpl Langridge and Ms. A had signed in December 2007. An email from LCol Demers on the morning of March 17, 2008, stated, "**Given the docs on file, it seems [Ms. A] is PNOK, so we need to follow her wishes.**"³⁴⁸ In a casualty coordination meeting held shortly afterwards and attended by senior members of the Regiment and a military lawyer (Assistant Judge Advocate General, or AJAG), further discussions took place about who was PNOK.³⁴⁹ Later that day, Capt Lubiniecki wrote in an email "**[the] AO in Victoria will inform [the] parents that [Ms. A] is the PNOK.**"³⁵⁰ While the Fynes and Ms. A were encouraged to work together,³⁵¹ it was understood from that point forward if there was disagreement about decisions regarding the funeral, the Regiment would accede to Ms. A's wishes.³⁵²

80. In October 2008, many months after the funeral, the Fynes discovered Cpl Langridge had specifically named them as PNOK and SNOK on the PEN form, which was in the possession of the Regiment.³⁵³ This form had been part of Cpl Langridge's file when the PNOK decision was made.³⁵⁴ Based on this revelation, the Fynes were confused and upset over what they believed to be the Regiment deliberately ignoring the explicit written wishes of their son for the Fynes, and specifically Mr. Fynes, to act as his PNOK and therefore plan his funeral.³⁵⁵

THE "FOUND" DOCUMENTS

81. On March 20, 2008, three days following the PNOK decision, four partially completed and previously unknown administrative documents belonging to Cpl Langridge were found³⁵⁶ behind a filing cabinet during some routine house cleaning.³⁵⁷ Each of the "found" documents related to the post-death administration of Cpl Langridge's affairs. The "found" documents were new versions of a PEN form,³⁵⁸ a Designation of Memorial Cross Recipients form,³⁵⁹ a will³⁶⁰ and a Supplementary Death Benefits (SDB) form.³⁶¹ None of the forms was fully completed.

82. Prior to the discovery of these "found" documents, the Regiment was in possession of a series of fully completed and valid forms belonging to Cpl Langridge including the PEN form, an SDB form and a will.³⁶² The "found" documents were significant because Cpl Langridge had changed the executor of his will from his friend David White to Mr. Fynes, changed the beneficiary of his SDB from Ms. A to Mrs. Fynes and again had named his parents as his NOK on his PEN form.³⁶³

83. The "found" documents were turned over to Capt Lubiniecki on March 21, 2008,³⁶⁴ and forwarded to the Office of the Director of Estates in Ottawa on March 26, 2008.³⁶⁵ Capt Lubiniecki was advised by Suzanne Touchette, a Service Estate and Elections Officer for the JAG, the "found" documents were of "no value as they are unsigned."³⁶⁶ Some months later, this initial position was reversed and the "found" will designating Mr. Fynes as executor was deemed by DND to be valid pursuant to the *Alberta Wills Act*.³⁶⁷

84. The Fynes were told about the existence of a second will in an email from Maj Jared on March 26, 2008, but they were only advised that Mrs. Fynes was the beneficiary.³⁶⁸ Mr. Fynes was not advised there was any change in the estate executor until June 17, 2008,³⁶⁹ almost three months after the second will was found. In a letter dated June 19, 2008, Mr. Fynes was formally advised the “found” will was valid, and he, in fact, was the executor of the estate.³⁷⁰

FUNERAL PLANNING

85. With respect to the actual planning of Cpl Langridge’s funeral, Ms. A attended a local funeral home with her AO, 2Lt Brown, and her and Cpl Langridge’s mutual friend, Cpl Rohmer.³⁷¹ The funeral director testified it is the executor who plans the funeral.³⁷² The executor, according to the first will, was Mr. White. In a telephone conversation, he told the funeral director he did not wish to be involved in funeral planning.³⁷³ When the funeral director asked Ms. A about Cpl Langridge’s parents, he was told his father was not involved and his mother lived out of province and would not be coming to make funeral arrangements.³⁷⁴ 2Lt Brown told the funeral director Ms. A was Cpl Langridge’s common-law wife,³⁷⁵ and the funeral director satisfied himself Ms. A and Cpl Langridge had cohabited for two years.³⁷⁶ It was the funeral director’s evidence he was told by 2Lt Brown for funeral arrangements, “It’s [Ms. A] that you will be dealing with.”³⁷⁷

86. The funeral director also received information, possibly from 2Lt Brown,³⁷⁸ possibly from Ms. A,³⁷⁹ which he used to complete the Registration of Death.³⁸⁰ However, the information he received was incorrect. This led to several different versions of the Proof of Death being produced over the course of the next few weeks, each containing slightly different but still legally or factually incorrect information.³⁸¹ Finally, more than a year later, the Fynes had the information on the Registration of Death concerning Cpl Langridge’s marital status, his place of residence and the name of the informant corrected by means of an *ex parte* court order.³⁸²

87. In planning the funeral, Ms. A consulted with the Fynes, seeking their input on some of the decisions.³⁸³ However, the final decisions were ultimately made by Ms. A. In particular, the Fynes acceded to Ms. A’s choice of flag to be draped on the casket so Ms.

A would agree to Cpl Langridge's remains being buried rather than cremated.³⁸⁴ The Fynes also had other requests, including a closed casket, but they ultimately acquiesced to Ms. A having a viewing of the body prior to the funeral.³⁸⁵ It was particularly upsetting for the Fynes because, while they had asked for and were presented with Cpl Langridge's beret and medals,³⁸⁶ it was Ms. A who received the flag from his casket.³⁸⁷

88. The funeral for Cpl Langridge was held on March 26, 2008, at the chapel on the Base.³⁸⁸ Since neither the Fynes nor Ms. A were aware Cpl Langridge had left a suicide note requesting a small, family funeral, there was a large, military funeral.³⁸⁹ The interment for Cpl Langridge was held on March 29, 2008, in Victoria and was attended by, among others, the Fynes and Ms. A.³⁹⁰ Their relationship had been slowly deteriorating, and, by the end of the interment, all communications between Mr. and Mrs. Fynes and Ms. A had irrevocably broken down.³⁹¹

The Fynes' Complaints and CF Responses

89. In the aftermath of Cpl Langridge's death, there were three CFNIS investigations. The first began immediately following Cpl Langridge's death and was tasked to investigate the circumstances of his death.³⁹² The second CFNIS investigation began in late 2009 and was tasked to investigate whether LDSH leadership had been negligent in the performance of their military duty in assigning PNOK status to Ms. A after Cpl Langridge's death.³⁹³ The third investigation began in May 2010 and focused on whether the LDSH chain of command and the medical community were negligent in failing to provide appropriate medical treatment and care to Cpl Langridge, thereby contributing to his death.³⁹⁴

90. There were other administrative proceedings relating to Cpl Langridge's death. It was a requirement, following Cpl Langridge's death, that an internal CF administrative investigation be conducted.³⁹⁵ In this case, both a Board of Inquiry (BOI) and a Summary Investigation (SI) were held. These are internal CF fact-finding processes involving gathering documents and interviewing witnesses and, in the case of the BOI, compelling

testimony from witnesses.³⁹⁶ Generally, a BOI is a more formal process to investigate more significant issues.³⁹⁷

91. The BOI was convened after much delay³⁹⁸ on January 13, 2009,³⁹⁹ almost ten months after Cpl Langridge's death. The mandate of the BOI was "to investigate the cause and contributing factors that may have lead (*sic*) to the death of Cpl Langridge and identify applicable preventative measures."⁴⁰⁰ The Fynes attended the BOI hearing and were of the strong opinion it was tainted by bias in favour of the military and failed to address many of the questions relevant to Cpl Langridge's death.⁴⁰¹ The BOI made findings of fact, as well as recommendations, generally exonerating the CF of any responsibility in connection with Cpl Langridge's death.⁴⁰² While the BOI report was first submitted for the necessary approvals on June 1, 2009,⁴⁰³ the report has yet to receive final approval by the Chief of the Defence Staff.

92. It was as the result of an inquiry by the President of the BOI that the existence of Cpl Langridge's suicide note first came to light.⁴⁰⁴ There was a delay of several weeks between the initial inquiry and the actual disclosure of the existence of the note to the Fynes on May 22, 2009.⁴⁰⁵ The Fynes were informed of the existence of the suicide note by the BOI President and not by the CFNIS, which had stored it as "evidence" and subsequently apparently forgot about its existence.⁴⁰⁶

93. The terms of reference for the SI were issued June 22, 2009.⁴⁰⁷ They state the SI was being conducted "in anticipation of litigation."⁴⁰⁸ By this time, the Fynes had hired legal counsel in an effort to resolve their outstanding claims against the military and had, with their lawyer, met with legal representatives from the CF.⁴⁰⁹

94. The mandate of the SI was focused on investigating the administrative procedures followed by LDSH after Cpl Langridge's death.⁴¹⁰ The report generally concluded there was nothing wrong with the existing CF forms or procedures.⁴¹¹ In his capacity as the reviewing authority for the SI report, BGen K. A. (André) Corbould wrote:

I concur with the findings of the Investigation Officer and that the various possible administrative errors that occurred following the death of Corporal Langridge were not caused through intentional neglect nor that any documentation was mismanaged by a staff member at the Lord Strathcona's Horse (Royal Canadians) (LdSH(RC)), contrary to current regulations.⁴¹²

95. The Fynes had been advised of the possibility of an SI in an email from Maj Lubiniecki on April 29, 2009, indicating that he understood there would be a summary investigation conducted by the Regiment.⁴¹³ They heard nothing further about an SI until their May 5, 2010 CFNIS interview with Maj Dandurand and MCpl Mitchell, when Maj Dandurand suggested that the SI had looked into administrative issues following Cpl Langridge's death. Mr. Fynes stated, "Sorry, and I'll thank you both for sharing it with us, because two years-plus, you can understand our frustration, because nobody ever briefed us or told about that Summary Investigation."⁴¹⁴

96. The SI had been designated solicitor-client privileged and was not to be disclosed or released to any person outside of the CF.⁴¹⁵ Indeed, BGen Corbould wrote, "this topic has been dwelled into enough, and [I] do not believe there to be any benefit of disclosing any of the SI to the Corporal Langridge family, [as] it simply would not provide or console them in any manner."⁴¹⁶ The Fynes did not receive a copy of the SI report until the MPCC public hearing.

97. As time went on, the Fynes grew increasingly frustrated with what they felt was a lack of answers concerning Cpl Langridge's death and the subsequent administrative aftermath. They raised a number of issues including questions about the adequacy of the medical care Cpl Langridge had received and his treatment by the military, the storage and return of Cpl Langridge's personal property, the retention of Cpl Langridge's suicide note, and the mishandling of Cpl Langridge's personal paperwork.⁴¹⁷ They sought, and ultimately received, disclosure of the contents of the 2008 Sudden Death Investigation file, but voiced concerns about its contents and about the redactions made to the copy disclosed to them.⁴¹⁸

98. The Fynes contacted the DND/CF Ombudsman for assistance.⁴¹⁹ They maintained ongoing contact with the Regiment and the Brigade⁴²⁰ and did receive assistance regarding their outstanding concerns from DND Casualty Support,⁴²¹ as well as meeting with the CFNIS as part of their ongoing investigations.⁴²² With the exception of their contact with the Ombudsmen, most, if not all of these interactions were problematic from the Fynes' point of view.

99. On August 31, 2009, the Fynes were successful in having Cpl Langridge's registration of death corrected.⁴²³ They directed their lawyer to attempt to get reimbursement from the CF for the legal fees they paid to achieve this outcome.⁴²⁴ In September 2010, the Fynes' lawyer received a letter from legal counsel for the CF advising the Fynes to no longer "have any further direct contact with members of the Canadian Forces, Department of National Defence or Department of Justice with respect to any matters relating to the claims [Mrs. Fynes] has demanded from the Crown."⁴²⁵ This led to Mrs. Fynes coming to Ottawa and holding a press conference in which she denounced the lack of progress in resolving the outstanding issues related to her son's death.⁴²⁶ The Chief of the Defence Staff responded with a public apology about the delay in releasing the suicide note as well as about the poor communications with the Fynes regarding Cpl Langridge's estate.⁴²⁷ He later clarified he was specifically not apologizing for the medical care Cpl Langridge had received from the CF.⁴²⁸

100. In the fall of 2010, a senior officer, Col Gerard Blais, was appointed by the Minister of National Defence to act as the single point of contact to respond to the Fynes (and other families) who had "expressed concerns for BOI/NIS and other investigations and concerns related to the death of their loved ones."⁴²⁹ Col Blais did attempt to provide information to the Fynes about all of their remaining concerns,⁴³⁰ but, in their opinion, the answers received did not sufficiently address their questions.⁴³¹ The Fynes went on to file a complaint in January 2011 with the MPCC concerning alleged deficiencies in the three CFNIS investigations into the events before and after Cpl Langridge's death.⁴³² That complaint led to the Public Interest Hearing, which forms the basis for this report.

¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 60-61 and 82.

² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 7; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93.

³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93.

⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 7.

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- ⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 7; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93.
- ⁶ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 57.
- ⁷ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 7-8.
- ⁸ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93.
- ⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 93.
- ¹⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2013, p. 8.
- ¹¹ Exhibit P-5, Collection E, vol. 1, tab 9, doc. 1139-E, p. 6; Exhibit P-5, Collection E, vol. 1, tab 10, doc. 1139-F, p. 5.
- ¹² Exhibit P-5, Collection E, vol. 1, tab 9, doc. 1139-E, pp. 4-5; Exhibit P-5, Collection E, vol. 1, tab 10, doc. 1139-F, p. 3; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 6; Exhibit P-5, Collection E, vol. 2, tab 2, doc. 1139-J, p. 36.
- ¹³ See <http://www.forces.ca/en/job/armouredsoldier-1#info-1>; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 28-29.
- ¹⁴ Exhibit P-5, Collection E, vol. 2, tab 10, doc. 1143, p. 290; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 6 and 128.
- ¹⁵ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 6.
- ¹⁶ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 6 and 128.
- ¹⁷ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 128; <http://www.forces.gc.ca/en/news/article.page?doc=canadian-forces-end-firefighting-operations-in-b-c/hnocfjhe>
- ¹⁸ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 128-129.
- ¹⁹ Exhibit P-5, Collection E, vol. 2, tab 6, doc. 1139-N, p. 9.
- ²⁰ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 102.
- ²¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 95; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 9.
- ²² Exhibit P-5, Collection E, vol. 2, tab 6, doc. 1139-N, p. 6; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 107-109 and 130; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 9.
- ²³ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 61.
- ²⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 177.
- ²⁵ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 178; Exhibit P-5, Collection E, vol. 2, tab 10, doc. 1143, pp. 293-294.
- ²⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 176-178.
- ²⁷ Exhibit P-5, Collection E, vol. 2, tab 10, doc. 1143, pp. 227-228.
- ²⁸ Exhibit P-5, Collection E, vol. 2, tab 10, doc. 1143, pp. 227-228.
- ²⁹ Exhibit P-5, Collection E, vol. 2, tab 10, doc. 1143, p. 236.

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- ³⁰ Exhibit P-5, Collection E, vol. 2, tab 6, doc. 1139-N, p. 9; Exhibit P- 22, doc. 1318, pp. 7 and 10-11; Exhibit P-5, Collection E, vol. 1, tab 12, doc. 1139-H, pp. 23-25.
- ³¹ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 61; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 9.
- ³² Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 9.
- ³³ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 200-201.
- ³⁴ Exhibit P- 22, doc. 1318, pp. 10-11; Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 62.
- ³⁵ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 20; Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, p. 50.
- ³⁶ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 21.
- ³⁷ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 21.
- ³⁸ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 113-114.
- ³⁹ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 102-103.
- ⁴⁰ Exhibit P-4, Collection D, vol. 12, tab 100, doc. 1127, p. 48
- ⁴¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 14.
- ⁴² Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June, 2012, p. 3; Exhibit P-132, tab 4, doc. 1399, p. 26.
- ⁴³ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 16 and 18-19; Exhibit P-132, tab 4, doc. 1399, p. 26.
- ⁴⁴ Exhibit P-132, tab 4, doc. 1399, p. 26.
- ⁴⁵ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 21.
- ⁴⁶ Exhibit P-4, Collection D, vol. 12, tab 100, doc. 1127, p. 15; Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 107.
- ⁴⁷ Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June, 2012, p. 17.
- ⁴⁸ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 104; Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June, 2012, p. 48.
- ⁴⁹ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 35; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 21.
- ⁵⁰ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 10; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 31.
- ⁵¹ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 11.
- ⁵² Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 85-87.
- ⁵³ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 83; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 16.
- ⁵⁴ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 83.
- ⁵⁵ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 61.
- ⁵⁶ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 140-144.

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- ⁵⁷ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 62.
- ⁵⁸ Exhibit P-6, Collection F, vol. 2, tab 2, doc. 1294, p. 29.
- ⁵⁹ Testimony of Mr. Perkins, Transcript of Proceedings, vol. 12, 18 April 2012, p. 279.
- ⁶⁰ Exhibit P-5, Collection E, vol. 1, tab 8, doc. 1139-D, pp. 2-3 and 5; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 78.
- ⁶¹ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 12-13.
- ⁶² Exhibit P-5, Collection E, vol. 1, tab 8, doc. 1139-D, p. 4; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 75.
- ⁶³ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 70-71.
- ⁶⁴ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 69.
- ⁶⁵ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 20-21; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 73.
- ⁶⁶ Exhibit P-5, Collection E, vol. 3, tab 17, doc. 1242-P, p. 312; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 30-31.
- ⁶⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 20-21; Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June, 2012, pp. 4-5.
- ⁶⁸ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 175.
- ⁶⁹ Testimony of Mr. Perkins, Transcript of Proceedings, vol. 12, 18 April 2012, pp. 256-257.
- ⁷⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 175; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 77.
- ⁷¹ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 105; Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133.
- ⁷² Exhibit P-6, Collection F, vol. 2, tab 2, doc. 1294, pp. 22 and 45.
- ⁷³ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 26-29.
- ⁷⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 175; Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 77.
- ⁷⁵ Testimony of Mr. Perkins, Transcript of Proceedings, vol. 12, 18 April 2012, p. 245.
- ⁷⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 174.
- ⁷⁷ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 82.
- ⁷⁸ Exhibit P-6, Collection F, vol. 2, tab 2, doc. 1294, p. 2.
- ⁷⁹ Exhibit P-5, Collection E, vol. 3, tab 17, doc. 1242-P, pp. 285-286; Exhibit P-5, Collection E, vol. 1, tab 12, doc. 1139-H, p. 9.
- ⁸⁰ Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 2; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 25 and 28-29.
- ⁸¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 163 and 174.
- ⁸² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 28.
- ⁸³ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 48.

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- ⁸⁴ Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 180-181; Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 46-47.
- ⁸⁵ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 31.
- ⁸⁶ Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April 2012, p. 118.
- ⁸⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 28.
- ⁸⁸ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 257; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 182.
- ⁸⁹ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 260; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 182.
- ⁹⁰ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 262.
- ⁹¹ Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June 2012, pp. 71 and 73-74.
- ⁹² Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 126; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 181-184.
- ⁹³ Exhibit P-4, Collection D, vol. 12, tab 100, doc. 1127, p. 9; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 151 and 166.
- ⁹⁴ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 260; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 76-77; Exhibit P-15, doc. 1313.
- ⁹⁵ Exhibit P-5, Collection E, vol. 2, tab 4, doc. 1139-L, p. 2; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 11-13; Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, p. 262.
- ⁹⁶ Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June 2012, p. 77.
- ⁹⁷ Testimony of Dr. Lai, Transcript of Proceedings, vol. 45, 11 September 2012, pp. 4, 15 and 17-19; Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 61.
- ⁹⁸ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 62.
- ⁹⁹ Testimony of Dr. Lai, Transcript of Proceedings, vol. 45, 11 September 2012, pp. 5-6 and 19.
- ¹⁰⁰ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 65.
- ¹⁰¹ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 99; Testimony of Dr. Lai, Transcript of Proceedings, vol. 45, 11 September 2012, pp. 23-25.
- ¹⁰² Testimony of Dr. Lai, Transcript of Proceedings, vol. 45, 11 September 2012, p. 32.
- ¹⁰³ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 99; Testimony of Dr. Lai, Transcript of Proceedings, vol. 45, 11 September 2012, pp. 25-28.
- ¹⁰⁴ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, pp. 42 and 53-55; Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 2.
- ¹⁰⁵ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 21-25.
- ¹⁰⁶ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 27-30, 34, 46 and 48-49.
- ¹⁰⁷ Exhibit P-132, tab 4, doc. 1399, p. 26.
- ¹⁰⁸ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 37.
- ¹⁰⁹ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 60.
- ¹¹⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 40-41.

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- ¹¹¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 75.
- ¹¹² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 41 and 166-167.
- ¹¹³ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 166-167.
- ¹¹⁴ Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 2; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 41; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 85-86.
- ¹¹⁵ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, pp. 30-38.
- ¹¹⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 142-143.
- ¹¹⁷ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 92; Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 39.
- ¹¹⁸ Exhibit P-5, Collection E, vol. 7, tab 5, doc. 1307, p. 38; Testimony of Ms. Newing, Transcript of Proceedings, vol. 4, 3 April 2012, p. 190.
- ¹¹⁹ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 99-100; Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 1.
- ¹²⁰ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 100; Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 1.
- ¹²¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 158, 160 and 162; Testimony of Ms. Newing, Transcript of Proceedings, vol. 4, 3 April 2012, p. 190.
- ¹²² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 163.
- ¹²³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 103-105; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 41-42 and 45-46.
- ¹²⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 163.
- ¹²⁵ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 163.
- ¹²⁶ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 43.
- ¹²⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 39-40.
- ¹²⁸ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 43.
- ¹²⁹ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, pp. 79 and 82-83.
- ¹³⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 39-40.
- ¹³¹ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 83.
- ¹³² Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 43-44.
- ¹³³ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 43-44.
- ¹³⁴ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 49.
- ¹³⁵ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 157.
- ¹³⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 3.
- ¹³⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 3.
- ¹³⁸ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 4.
- ¹³⁹ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 51-53; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 118-119.

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- ¹⁴⁰ Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 46-47.
- ¹⁴¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 48 and 152.
- ¹⁴² Exhibit P-6, Collection F, vol. 2, tab 4, doc. 1296, p. 52.
- ¹⁴³ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 72-73.
- ¹⁴⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 45.
- ¹⁴⁵ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 58.
- ¹⁴⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 154.
- ¹⁴⁷ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 44-45 and 56-57.
- ¹⁴⁸ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 79-80; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 89-90.
- ¹⁴⁹ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 80.
- ¹⁵⁰ Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, p. 88.
- ¹⁵¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 45-47 and 154; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 81; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, p. 91.
- ¹⁵² Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 81.
- ¹⁵³ Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 91-92.
- ¹⁵⁴ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 81-82; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, p. 92.
- ¹⁵⁵ Testimony of Ms. Newing, Transcript of Proceedings, vol. 4, 3 April 2012, p. 192.
- ¹⁵⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 151.
- ¹⁵⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 49.
- ¹⁵⁸ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 85.
- ¹⁵⁹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 80.
- ¹⁶⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 50; Exhibit P-4, Collection D, vol. 14, tab 6, doc. 1207.
- ¹⁶¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 477-480; Exhibit P-6, Collection F, vol. 2, tab 4, doc. 1296, p. 46.
- ¹⁶² Exhibit P-4, Collection D, vol. 14, tab 6, doc. 1207.
- ¹⁶³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 126-128.
- ¹⁶⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 126-127.
- ¹⁶⁵ Exhibit P-6, Collection F, vol. 2, tab 4, doc. 1296, p. 46.
- ¹⁶⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 128-129.
- ¹⁶⁷ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 130.
- ¹⁶⁸ Exhibit P-6, Collection F, vol. 2, tab 4, doc. 1296, p. 46.
- ¹⁶⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 131.

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- ¹⁷⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 479-480.
- ¹⁷¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 132.
- ¹⁷² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 69-70.
- ¹⁷³ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 69-71.
- ¹⁷⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 54; Exhibit P-5, Collection B, vol. 2, tab 1, doc. 1139-I, p. 66; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 74; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 133-134.
- ¹⁷⁵ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 74-75.
- ¹⁷⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 133-134.
- ¹⁷⁷ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 74-75.
- ¹⁷⁸ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 133-134; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 63-64.
- ¹⁷⁹ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, p. 71; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 175; Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June 2012, p. 35.
- ¹⁸⁰ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 33; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 175; Exhibit P-15, doc. 1313.
- ¹⁸¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 23, 27-30, 35-39, 42 and 48.
- ¹⁸² Testimony of Dr. Rajoo, Transcript of Proceedings, vol. 38, 21 June 2012, pp. 11-12.
- ¹⁸³ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 21-30, 32, 35-39, 42, 45-48, 51 and 154; Exhibit P-132, tab 4, doc. 1399, p. 27.
- ¹⁸⁴ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, p. 82.
- ¹⁸⁵ Exhibit P-5, Collection E, vol. 2, tab 1, doc. 1139-I, pp. 81-84.
- ¹⁸⁶ Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, p. 183.
- ¹⁸⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, p. 10.
- ¹⁸⁸ Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 188 and 191; Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, p. 13.
- ¹⁸⁹ See Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 40 and 104.
- ¹⁹⁰ Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 191-192; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 40.
- ¹⁹¹ Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 193-194.
- ¹⁹² Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 195-196.
- ¹⁹³ Testimony of Sgt (Ret'd) Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 196-198.
- ¹⁹⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 40; Exhibit P-6, Collection F, vol. 2, tab 1, doc. 1293, p. 32.
- ¹⁹⁵ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, p. 29.
- ¹⁹⁶ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 32-34.

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- ¹⁹⁷ Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, p. 131; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, p. 60.
- ¹⁹⁸ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 83-84.
- ¹⁹⁹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 52 and 69-70; Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 7.
- ²⁰⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 91.
- ²⁰¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 69-70; Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 15-19.
- ²⁰² Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 9.
- ²⁰³ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 131-132 and 138.
- ²⁰⁴ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 133-134.
- ²⁰⁵ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 134.
- ²⁰⁶ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 131.
- ²⁰⁷ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 132, 134, 136 and 139; Exhibit P-4, Collection D, vol. 4, tab 54, doc. 352, p. 2; Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 30.
- ²⁰⁸ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 119 and 163-170.
- ²⁰⁹ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 123 and 132; Exhibit P-4, Collection D, vol. 4, tab 54, doc. 352, p. 2.
- ²¹⁰ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 119.
- ²¹¹ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 119 and 123.
- ²¹² Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 119.
- ²¹³ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 119 and 123-129.
- ²¹⁴ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 32.
- ²¹⁵ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 84 and 130.
- ²¹⁶ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 138-141; Exhibit P-4, Collection D, vol. 4, tab 54, doc. 352, p. 2.
- ²¹⁷ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 140.
- ²¹⁸ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 103-104.
- ²¹⁹ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 39-40.
- ²²⁰ Exhibit P-4, Collection D, vol. 4, tab 48, doc. 346, p. 5.
- ²²¹ Testimony of Dr. Harper, Transcript of Proceedings, vol. 36, 19 June 2012, p. 73.
- ²²² Testimony of Dr. Harper, Transcript of Proceedings, vol. 36, 19 June 2012, pp. 73-75.
- ²²³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 133.
- ²²⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 135.
- ²²⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 135.
- ²²⁶ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 68-69.

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- ²²⁷ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 73-74.
- ²²⁸ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 130, 133-134 and 138.
- ²²⁹ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 48, 50 and 100-101.
- ²³⁰ Exhibit P-4, Collection D, vol. 4, tab 48, doc. 346, p. 5.
- ²³¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, pp. 146-147.
- ²³² Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, p. 285; Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 12-14.
- ²³³ Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, pp. 225; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp.110-111; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ²³⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 146.
- ²³⁵ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 138.
- ²³⁶ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 139.
- ²³⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 52 [Emphasis added].
- ²³⁸ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 124-127; Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, p. 228.
- ²³⁹ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 139 and 142; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp. 133-134 and 190.
- ²⁴⁰ Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, pp. 223-229 and 231; Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, pp.111-112, 125 and 137-138.
- ²⁴¹ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 141-142.
- ²⁴² Exhibit P-4, Collection D, vol. 4, tab 54, doc. 352, p. 2.
- ²⁴³ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 98.
- ²⁴⁴ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, p. 98.
- ²⁴⁵ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, pp. 49-53; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 80-84; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 140-141.
- ²⁴⁶ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 146.
- ²⁴⁷ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 54-56.
- ²⁴⁸ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 141-142; Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 58-59.
- ²⁴⁹ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 143.
- ²⁵⁰ Testimony of Dr. Elwell, Transcript of Proceedings, vol. 5, 4 April 2012, p. 191.
- ²⁵¹ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 93-95; Exhibit P-5, Collection E, vol. 3, tab 1, doc. 1242, p. 1; Exhibit P-5, Collection E, vol. 3, tab 17, doc. 1242-P, p. 289; Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, pp. 181, 195 and 298.
- ²⁵² Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 83-84.
- ²⁵³ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 142; Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 52.

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- ²⁵⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 249; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75-76; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 85-86; Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 53-54.
- ²⁵⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 249, 613 and 615; Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 118; Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, p. 55.
- ²⁵⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 249, 613 and 615.
- ²⁵⁷ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 73-74.
- ²⁵⁸ Testimony of Ms. A, Transcript of Proceedings, vol. 54, 10 May 2012, pp. 103-104; Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 144-146.
- ²⁵⁹ Exhibit P-6, Collection F, vol. 1, tab 2, doc. 1133, p. 1.
- ²⁶⁰ Exhibit P-6, Collection F, vol. 3, tab 1, doc. 1315, p. 3.
- ²⁶¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 145 [Emphasis added].
- ²⁶² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 54.
- ²⁶³ Exhibit P-6, Collection F, vol. 3, tab 1, doc. 1315, p.4.
- ²⁶⁴ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 54.
- ²⁶⁵ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 54.
- ²⁶⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 615, 6-17-618 and 622.
- ²⁶⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 618.
- ²⁶⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p.26.
- ²⁶⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 618.
- ²⁷⁰ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 26-27.
- ²⁷¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 616; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 27-28.
- ²⁷² Testimony of MCpl Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 208-209; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 11 and 39.
- ²⁷³ Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, pp. 161-162 and 312-313; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 616; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 26-27.
- ²⁷⁴ Testimony of Maj Hannah, Transcript of Proceedings, vol. 1, 27 March 2012, pp. 180-183 and 235; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 15-16.
- ²⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193 and 615; Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, p. 45; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 24.
- ²⁷⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 616; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 22.
- ²⁷⁷ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 56.
- ²⁷⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 496 and 616.
- ²⁷⁹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 71.
- ²⁸⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 71 [Emphasis added].

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- ²⁸¹ Exhibit P-4, Collection D, vol. 10, tab 53, doc. 877, p. 1.
- ²⁸² Exhibit P-4, Collection D, vol. 10, tab 53, doc. 877, p. 1.
- ²⁸³ Exhibit P-6, Collection F, vol. 2, tab 3, doc. 1295, p. 31.
- ²⁸⁴ Exhibit P-6, Collection F, vol. 2, tab 3, doc. 1295, pp. 32-33.
- ²⁸⁵ Exhibit P-6, Collection F, vol. 2, tab 3, doc. 1295, p. 32.
- ²⁸⁶ Exhibit P-6, Collection F, vol. 2, tab 3, doc. 1295, p. 32, 36.
- ²⁸⁷ Testimony of WO Hiscock, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 15-17 and 33-34.
- ²⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 194.
- ²⁸⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 616; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 11.
- ²⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 616; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 11.
- ²⁹¹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 17-18.
- ²⁹² Testimony of Maj Lubiniecki, Transcript of Proceedings, vol.6, 5 April 2012, pp. 118-119.
- ²⁹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 615-616.
- ²⁹⁴ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 116-118; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 204.
- ²⁹⁵ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 10-11, 33, 35-36, 41-44 and 116-118; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 29-31 and 46-49; Testimony of MCpl (Ret'd) Hurlburt, Transcript of Proceedings, vol. 45, 11 September 2012, pp. 56-58.
- ²⁹⁶ See: 4.1.1, The 2008 Investigation – Investigating the Sudden Death
- ²⁹⁷ See: 4.1.2, The 2008 Investigation – Investigating Negligence.
- ²⁹⁸ Exhibit P-6, Collection F, vol. 2, tab 3, doc. 1295, p. 31.
- ²⁹⁹ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 85-87.
- ³⁰⁰ Exhibit P-5, Collection E, vol 5, tab 9, doc. 1231, p. 52.
- ³⁰¹ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 87.
- ³⁰² Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 86-87 and 89.
- ³⁰³ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 87-88.
- ³⁰⁴ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 90-91; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 87-88; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 194.
- ³⁰⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 87-88 and 90.
- ³⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 194; Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 181-182.
- ³⁰⁷ Testimony of Maj Lubinecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 91-92 and 183-184.
- ³⁰⁸ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 95-96 and 105.
- ³⁰⁹ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 91.

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- ³¹⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 54.
- ³¹¹ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 95-96; Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, p. 53.
- ³¹² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 63.
- ³¹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 206; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 38-41.
- ³¹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 206; Testimony of WO Hiscock, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 38-39; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April, p. 78; Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 93-95; Exhibit P-5, Collection E, vol. 3, tab 17, doc. 1242-P, p. 289.
- ³¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 249; Exhibit P-1, Collection A, vol.2, tab 2, doc. 001-D, pp. 13, 62-63.
- ³¹⁶ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 12; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 24.
- ³¹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 206; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 11 and 13.
- ³¹⁸ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 13-14 and 61; Testimony of WO Hiscock, Transcript of Proceedings, vol. 7, 10 April 2012, p. 207; Testimony of Capt Dunn, Transcript of Proceedings, vol. 11, 17 April 2012, p. 155.
- ³¹⁹ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 14-15 and 62.
- ³²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 206; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 13-14.
- ³²¹ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, p.123; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 10; Testimony of MCpl (Ret'd) Hurlburt, Transcript of Proceedings, vol. 45, 11 September 2012, p. 71.
- ³²² Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 65-66; Testimony of WO Hiscock, Transcript of Proceedings, vol. 8, 11 April 2012, p. 33; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 20.
- ³²³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 206; Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 15; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 41.
- ³²⁴ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 16 and 70-71.
- ³²⁵ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 16; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 20-21.
- ³²⁶ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 16-17; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 21.
- ³²⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 203; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 21 and 61-63.
- ³²⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 163.
- ³²⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 827 and 830.
- ³³⁰ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol.6, 5 April 2012, p. 124.
- ³³¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 546.
- ³³² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 460-461.

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- ³³³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 546.
- ³³⁴ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 126-127; Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, p. 109.
- ³³⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 462 and 828.
- ³³⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.
- ³³⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 161-163 and 167; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, p. 15; Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 110-111.
- ³³⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 207 and 460; Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, p. 111.
- ³³⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 827; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, p. 33; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, p. 130.
- ³⁴⁰ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 138-139; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 169-170; Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 16-17; Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, p. 114.
- ³⁴¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 114 and 826.
- ³⁴² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 207; Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 16 and 23-24.
- ³⁴³ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 14-15; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 208-209.
- ³⁴⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 209; Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 16.
- ³⁴⁵ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 25-26.
- ³⁴⁶ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 16-17; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 171; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 91-93.
- ³⁴⁷ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 20; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 6 and 61-63.
- ³⁴⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 831 [Emphasis added].
- ³⁴⁹ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 15-16; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 49-53, 65-66, 81 and 87-89; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, p. 143; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 59-60; Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 133 and 136-137; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 167-170.
- ³⁵⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 573 [Emphasis added].
- ³⁵¹ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 55-56 and 67; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 173 and 182-183; Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, p. 139.
- ³⁵² Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 59-60 and 67; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, p. 143; Testimony of LCol Cadieu, Transcript of

Proceedings, vol. 8, 11 April 2012, p. 182; Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 138-139.

³⁵³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 53-54; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 213-214 and 216; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 91.

³⁵⁴ Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 66-67 and 171.

³⁵⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 5, 54; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 214; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 95 and 156.

³⁵⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 558.

³⁵⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 558; Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April 2012, p. 195; Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 108-109.

³⁵⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 68.

³⁵⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 69.

³⁶⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 67.

³⁶¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 70.

³⁶² Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 170-171 and 179-180; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 53-55, 61, 65-66 and 117; Exhibit P-5, Collection E, vol. 1, tab 3, doc. 1135, p. 29.

³⁶³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 550, 571 and 893.

³⁶⁴ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 108; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 558 and 571.

³⁶⁵ Exhibit P-70, doc. 1358, p. 28; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 453.

³⁶⁶ Exhibit P-5, Collection E, vol. 3, tab 17, doc. 1242-P, p. 300.

³⁶⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 869-870.

³⁶⁸ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 119-121; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 887.

³⁶⁹ Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 93 and 103.

³⁷⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 869-870.

³⁷¹ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 26-27 and 74-75; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 151-152; Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 78-79 and 94; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 110.

³⁷² Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 82-83.

³⁷³ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, p. 82.

³⁷⁴ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 80-81.

³⁷⁵ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, p. 80.

³⁷⁶ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 83-84.

³⁷⁷ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 82 and 84-85.

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- ³⁷⁸ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 76-78; Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 86-89; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 111-113.
- ³⁷⁹ Testimony of Mr. Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 86-89; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 153 and 177.
- ³⁸⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 57.
- ³⁸¹ Exhibit P-6, Collection F, vol. 1, tab 4, doc. 1138; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 59-60.
- ³⁸² Exhibit P-4, Collection D, vol. 6, tab 12, doc. 511; Exhibit P-4, Collection D, vol. 4, tab 66, doc. 364, pp. 3-4.
- ³⁸³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 95-96; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 67 and 99-100; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 107-108.
- ³⁸⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 195-196, 208 and 210; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 108; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 172.
- ³⁸⁵ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 117-118; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p.195; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 50.
- ³⁸⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 195 and 209.
- ³⁸⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 40; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 54; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 30.
- ³⁸⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 195 and 201.
- ³⁸⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p.96; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 195-196.
- ³⁹⁰ Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, p. 120; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, p. 162; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 112; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 201.
- ³⁹¹ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 31-32; Testimony of Ms. A, Transcript of Proceedings, vol. 20, 10 May 2012, pp. 120-121.
- ³⁹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ³⁹³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 284.
- ³⁹⁴ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 69-70.
- ³⁹⁵ Exhibit P-6, Collection F, vol. 1, tab 22, doc. 1169, p. 13.
- ³⁹⁶ Exhibit P-70, doc. 1358, p. 2; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 304-305; Exhibit P-132, tab 4, doc. 1399, p. 44.
- ³⁹⁷ Testimony of Col (Ret'd) Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 9.
- ³⁹⁸ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 12; Exhibit P-4, Collection D, vol. 12, tab 65, doc. 1091; Exhibit P-4, Collection D, vol. 8, tab 8, doc. 632, p. 2; Exhibit P-4, Collection D, vol. 2, tab 18, doc. 115, p. 1; Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, p. 53.
- ³⁹⁹ Exhibit P-4, Collection D, vol. 4, tab 25, doc. 323, p. 1.
- ⁴⁰⁰ Exhibit P-4, Collection D, vol. 4, tab 25, doc. 323, p. 2.

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- ⁴⁰¹ Exhibit P-4, Collection D, vol. 8, tab 38, doc. 662, pp. 1-2; Exhibit P-4, Collection D, vol. 1, tab 13, doc. 010-B, p. 3; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 15-23 and 71-72; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 77.
- ⁴⁰² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 305, 307, 359, 364, 374, 378, 383, 385 and 391.
- ⁴⁰³ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, pp. 369-370 and 385-388.
- ⁴⁰⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁴⁰⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁴⁰⁶ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁴⁰⁷ Exhibit P-75, tab 2, doc. 1087-K, p. 3.
- ⁴⁰⁸ Exhibit P-75, tab 2, doc. 1087-K, p. 3.
- ⁴⁰⁹ Exhibit P-4, Collection D, vol. 5, tab 14, doc. 412; Exhibit P-4, Collection D, vol. 5, tab 7, doc. 405.
- ⁴¹⁰ Exhibit P-75, tab 2, doc. 1087-K, pp. 3-5.
- ⁴¹¹ Exhibit P-70, doc. 1358, pp. 28, 30-34.
- ⁴¹² Exhibit P-102, doc. 1390, pp. 28-29.
- ⁴¹³ Exhibit P-4, Collection D, vol. 8, tab 59, doc. 683.
- ⁴¹⁴ Document 1088-B, CFNIS Interview of Mrs. Sheila Fynes and Mr. Shaun Fynes, 5 May, 2010.
- ⁴¹⁵ Exhibit P-102, doc. 1390, p. 17.
- ⁴¹⁶ Exhibit P-102, doc. 1390, p. 29.
- ⁴¹⁷ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032.
- ⁴¹⁸ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.
- ⁴¹⁹ Testimony of Mr. Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 43-44; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 23.
- ⁴²⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 213-216; Exhibit P-5, Collection E, vol. 5, tab 12, doc. 1234; Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 79-82; Exhibit P-4, Collection D, vol. 9, tab 14, doc. 738.
- ⁴²¹ Testimony of Ms. McLeod, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 2-4 and 6-9; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 212-213; Testimony of Mr. Findlay, Transcript of Proceedings, vol. 23 May 2012, pp. 146-179.
- ⁴²² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.
- ⁴²³ Exhibit P-4, Collection D, vol. 6, tab 12, doc. 511.
- ⁴²⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 21-22.
- ⁴²⁵ Exhibit P-4, Collection D, vol. 10, tab 22, doc. 846.
- ⁴²⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 22-23; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 261 and 453-454.
- ⁴²⁷ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1132-I.
- ⁴²⁸ Exhibit P-5, Collection E, vol. 5, tab 10, doc. 1232, pp. 41-42.

⁴²⁹ Exhibit P-5, Collection E, vol. 5, tab 3, doc. 1225, p. 26; Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, p. 52.

⁴³⁰ Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013.

⁴³¹ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032.

⁴³² Exhibit P-4, Collection D, vol. 13, tab 3, doc. 1150.

IV. THE INVESTIGATIONS

4.0 THE SUBJECTS OF THE COMPLAINT: ROLE, INVOLVEMENT AND BACKGROUND

The 2008 Sudden Death Investigation

MASTER CORPORAL MATTHEW RITCO

1. MCpl Matthew Ritco (Sergeant Ritco at the time of his testimony before the MPCC in September 2012) was the lead investigator on the investigation into the sudden death of Cpl Stuart Langridge.¹ He attended at the scene of Cpl Langridge's death with Sgt Jon Bigelow on March 15, 2008.²
2. MCpl Ritco first joined the CF in 1988 and completed boot camp at CFB Cornwallis, Nova Scotia. He was posted to Wainright, Alberta, where he completed his infanteer schooling. MCpl Ritco was then transferred to Winnipeg, Manitoba, where he was stationed with 2 Princess Patricia's Canadian Light Infantry until 1996. At that time, MCpl Ritco left the CF in order to pursue a career in youth corrections.³
3. In the fall of 2001, MCpl Ritco rejoined the CF as an MP member. He completed his six-month MP Qualification Level (QL) 3, or basic training, before being posted to Winnipeg in 2002.⁴ MCpl Ritco completed his corporal-level qualification course (MP QL5A) in 2005. He was promoted to Master Corporal in June, 2006 and transferred to the CFNIS in July, 2006,⁵ when he was posted to Edmonton, Alberta with CFNIS WR.⁶ MCpl Ritco completed his MP Criminal Investigator training – generally considered to be a prerequisite to join the CFNIS⁷ – in November, 2006.⁸
4. During his time with the MP, MCpl Ritco completed three tours of duty – to Croatia, United Arab Emirates, and Cyprus.⁹ He completed a number of police training courses, including a forensic interviewing course run by the RCMP in 2007¹⁰ and Reid's advanced interviewing skills course.¹¹ MCpl Ritco also completed MP training in criminal investigations in 2006 and search and seizure in 2007.¹²

5. On the day of Cpl Langridge's death, MCpl Ritco was on call as the CFNIS duty investigator.¹³ He had no prior experience in conducting sudden death investigations.¹⁴

SERGEANT JON BIGELOW

6. Sergeant Jon S. Bigelow (Warrant Officer Bigelow at the time of his testimony before the MPCC in September 2012) was one of the two CFNIS investigators who attended the scene of Cpl Langridge's suicide on March 15, 2008. He joined the CF in September 1995, and served first as an infanteer, and then a driver (with the 2nd Battalion, Royal Canadian Regiment at CFB Gagetown).¹⁵ He deployed overseas to Bosnia in 1999. It was during this time he applied to join the military police, and he transferred to CFB Borden for his trades training as an MP in January 2000.¹⁶

7. Following his six month training period to become an MP, Sgt Bigelow was posted¹⁷ to CFB Winnipeg between 2000 and 2004. He performed general patrol duties there until late 2001, when he was sent to the United Arab Emirates as part of the first rotation of personnel to serve in the war in Afghanistan. Sgt Bigelow took his forensic evidence collection course online through the Canadian Police Knowledge Network (CPKN) while overseas.¹⁸ Upon his return to Canada in 2002, he was assigned to the position of Court NCO, where he was responsible for ensuring key documents were provided to the courts. Sgt Bigelow also completed a number of MP training programs during the course of this assignment – including taking an investigation course at CFB Borden, and learning how to process crime scenes, document evidence, and conduct basic mobile and on-foot surveillance.¹⁹ He also completed a search warrant training course.²⁰

8. Sgt Bigelow assisted the CFNIS with several investigations during his time as an MP at CFB Winnipeg.²¹ As a consequence of that exposure, he was invited to join the CFNIS in 2004. Sgt Bigelow completed the MP Criminal Investigator course in May 2004 and the Forensic Interviewer course in December 2005.²²

9. When Sgt Bigelow joined the CFNIS, there were no specific training programs, but rather an internship program, which lasted one year.²³ In 2004, he was posted to Edmonton as a member of the CFNIS Western Region, beginning his internship with the

CFNIS. He remained at Western Region as an investigator until July 2008. As a CFNIS investigator, Sgt Bigelow was responsible for investigating serious and sensitive offences – such as sexual assault or fraud. Sgt Bigelow was involved in one suicide investigation while with the CFNIS.²⁴ He was seconded to the RCMP for ten months, where he worked in the General Investigation Section in 2005-2006, during which time he was assigned to work with the RCMP Major Crimes Unit.²⁵ During his work with the RCMP, he gained experience with sudden death investigations, becoming involved in approximately four to six such investigations.²⁶

10. At the conclusion of this ten-month secondment, Sgt Bigelow returned to the CFNIS and was subsequently given a new position as the member in command of the CFNIS WR's National Drug Enforcement Team section.²⁷ He continued to undertake training in investigative techniques including interrogations and interviews, using the Internet as an investigative tool, and conducting drug investigations. Because of his posting with the National Drug Enforcement Team, he was not routinely available to lead death investigations despite being one of the investigators at CFNIS Western Region with experience in the conduct of such investigations.

11. At the time of Cpl Langridge's suicide in March 2008, Sgt Bigelow had not yet obtained his QL6A qualifications, which are the leadership courses necessary for promotion to sergeant.²⁸ While not formally qualified as a sergeant in March 2008, he nevertheless held that title contingent upon the completion of the QL6A.²⁹

12. Sgt Bigelow was not a part of the investigator's cell in the Detachment; he was part of the Drug Enforcement Team whose mandate was to engage in drug investigations.³⁰ From time to time, he was assigned, on a temporary basis, to assist with investigations when manpower was severely limited.³¹

WARRANT OFFICER ROSS TOUROUT

13. WO Ross Tourout (Master Warrant Officer Tourout at the time of his testimony before the MPCC in September 2012) was MCpl Ritco's case manager on the investigation into the sudden death of Cpl Langridge.³² In that capacity, he was generally

responsible for providing direction and oversight on active investigation files,³³ as well as conducting resource and equipment needs assessments and coordinating investigative team members and specialty support.³⁴

14. WO Tourout joined the CF in 1987 as an artilleryman. After completing his basic training, he was posted to the artillery regiment at CFB Shilo, Manitoba,³⁵ where he completed several artillery-related training courses.³⁶ He also completed a tour of duty in Cyprus.³⁷

15. In 1993, WO Tourout was accepted into the MP branch and was sent to CFB Borden for six months where he completed his QL3. He was then posted to CFB Gander, Newfoundland, as a patrolman. In 1997, WO Tourout was posted to CFB Winnipeg, Manitoba, again as a patrolman, holding the rank of Corporal.³⁸

16. While posted to Winnipeg, WO Tourout completed a tour of duty in Kosovo. He transitioned from patrolman to MP investigator. Upon promotion to Master Corporal, he was employed as a shift commander. WO Tourout continued to advance, being placed in command of investigations and then training. Upon his promotion to Sergeant in 2003, WO Tourout was employed as Sergeant in command of police operations, patrols.³⁹

17. In the summer of 2003, WO Tourout was posted back to Gander as the second in command of the MP Detachment. He spent three years in that position. WO Tourout was promoted to Warrant Officer in 2006 and posted to CFNIS WR as a case manager.⁴⁰

18. In the course of his career with the MP and CFNIS, WO Tourout has completed a number of MP training courses, including his QL5A in 1995, QL6A in 2003, and QL6B in 2006.⁴¹ He completed training as an MP criminal investigator in 2001 as well as receiving training in major case management in 2007.⁴² He also completed courses with civilian police forces, including: crime scene investigation, search and seizure with the Winnipeg Police Force; major case management with the Ontario Provincial Police; the RCMP investigator's course; and the Reid's interview and interrogation course.⁴³

19. Prior to supervising MCpl Ritco's investigation, WO Tourout had not conducted or supervised any sudden death investigations.⁴⁴

MASTER WARRANT OFFICER BARRY WATSON

20. Master Warrant Officer Barry Watson (Retired CWO Watson at the time of his testimony before the MPCC in October 2012) was the detachment Master Warrant Officer and Acting OC for the CFNIS Western Region in 2008 and, in that capacity, oversaw the 2008 Sudden Death Investigation. At the time of his testimony, he had 21 years of policing experience.⁴⁵ He joined the CF in 1985 and initially served as a member of the infantry, including an overseas posting in Cyprus in 1988. In 1989, he became a member of the military police.⁴⁶ He was posted as a corporal to CFB Suffield in 1990, where he was engaged in patrol duties. In 1994, he was promoted to Master Corporal and posted to CFB Cold Lake, where he was engaged in both patrol duties and security operations.⁴⁷ In 1997, he was promoted to the rank of Sergeant and was posted to CFB Dundurn as the MP detachment commander. In 2000, he was posted overseas to Bosnia, and in 2002, he was posted to Israel and Syria.⁴⁸

21. In 2004, MWO Watson was posted to the CFNIS WR as the detachment Master Warrant Officer. He was assigned to an overseas posting in Afghanistan in 2007. He then continued in the position of detachment Master Warrant Officer at CFNIS WR, the position he occupied at the time of Cpl Langridge's suicide. His duties included providing oversight of all ongoing CFNIS investigations. He was also responsible for recruiting, discipline, and the day-to-day operations of the detachment.⁴⁹ He was not involved in the day-to-day conduct of investigations, of which there would usually be between 30 and 50 at any given time. Instead, case managers would brief him regarding the status of the investigations, as they would have direct interactions with investigators. He did not review SAMPIS entries on a daily basis and did not attend meetings between the case managers and investigators.⁵⁰ He only became more directly involved with a given investigation if it was necessary.⁵¹ Between March and July 2008, MWO Watson was the Acting OC of the CFNIS WR.

22. In terms of training as an MP and CFNIS investigator, MWO Watson completed basic training for military police, the MP QL3 qualification, in 1989,⁵² and QL5A in 1991. He completed the QL6A, which requires approximately one month, at the time of

his promotion to sergeant,⁵³ as well as the one-month QL6B qualification in 2001, with his promotion to Warrant Officer.⁵⁴ In 2004, he completed the MP Criminal Investigator course, an essential qualification for joining the CFNIS,⁵⁵ which lasts approximately three weeks and covers advanced investigative techniques. MWO Watson's other qualifications at the time of the 2008 Investigation included the Out of Service Training (OST) Major Case Management training course, a three-week course concerning managing major cases across multiple jurisdictions and with multiple forces,⁵⁶ which he completed in 2006.⁵⁷

23. MWO Watson had experience conducting and supervising sudden death investigations, having been involved in approximately 26 sudden death investigations in Afghanistan, generally concerning battlefield deaths, and roughly three sudden death investigations in Canada.⁵⁸ While he had never conducted a suicide investigation as a lead investigator, he had experience supervising suicide investigations as well as accidental deaths and combat deaths.⁵⁹

MAJOR BRIAN FREI

24. Maj Brian Frei (Lieutenant Colonel Frei at the time of his testimony before the MPCC in October 2012) was the Deputy CO CFNIS at the time of the investigation into Cpl Langridge's sudden death.⁶⁰ He reviewed the investigation report and concurred with its findings on July 3, 2008.⁶¹

25. Maj Frei first joined the CF in 1991 and attended the Royal Military College of Canada until his graduation in 1995.⁶² He completed a master's degree in Physics⁶³ at Queen's University before attending MP training at CFB Borden in 1997.⁶⁴ He was posted to CFB Esquimalt in January, 1998, where he acted as Security Operations Officer for approximately a year and a half prior to being appointed Deputy PM for the Pacific area.⁶⁵

26. In 2000, Maj Frei was posted to the CFNIS as an investigator in the Sensitive Investigation Detachment in Ottawa. He remained in Ottawa for approximately two years and completed his posting as the Operations Officer.⁶⁶

27. Maj Frei was deployed to Bosnia as the CFNIS Detachment Commander in 2003. He returned to Canada in the summer of 2003 and was posted to CFNIS Atlantic Region as Detachment Commander. He remained in that position for two years before returning to Ottawa as Executive Assistant to the CFPM, a position he held for the next two years.⁶⁷

28. In the summer of 2007, Maj Frei was posted back to the CFNIS as Deputy CO under LCol Garrick. He held that position until the fall of 2008 when he was selected as CO CF MP Company in Afghanistan; he deployed in October 2009. In June, 2012, Maj Frei was appointed CO CFNIS.⁶⁸

29. Maj Frei had conducted a variety of investigations during his time as an investigator. However, he had never conducted a sudden death investigation.⁶⁹

LIEUTENANT COLONEL BUD GARRICK

30. LCol Bud Garrick (Retired LCol Garrick at the time of his testimony before the MPCC in October 2012) was the CO CFNIS at the time of the investigation into Cpl Langridge's sudden death.⁷⁰ There is no indication LCol Garrick was involved in the investigation in an investigatory, supervisory, or advisory capacity. He does not appear to have been consulted on the file while he was the CO CFNIS.

31. LCol Garrick first joined the MP in 1981 as a private. He was posted to CFB Edmonton following his basic MP training and employed in patrols and criminal investigations. He remained in this position for five years before being posted to Cold Lake, Alberta, as an MP for a further five years. Following that, he was again employed in patrols and criminal investigations.⁷¹

32. LCol Garrick was subsequently accepted into the university training program for NCOs and attended the University of Manitoba, obtaining a degree in Criminology. He then entered the MP Officers course. Following his Officer training, LCol Garrick was posted as the Section Commander for the Special Investigations Unit in Winnipeg.⁷²

33. In 1997, following the creation of the CFNIS, LCol Garrick was transferred to Ottawa as the Operations Officer of CFNIS Central Region, a post he held for two years. He was then posted to the Sensitive Investigations section of CFNIS, where he also remained for two years. He was subsequently deployed to Syria and Bosnia where he led a team of investigators focused on corruption and black market activity.⁷³

34. Upon returning to Canada, LCol Garrick was posted to the Investigations Support Detachment of CFNIS, focusing on surveillance, criminal intelligence, polygraph and computer crime. He held that position for two years before being posted as the Deputy PM, overseeing policy development, records management and ATI requests. He remained in that position for a year and was then posted to Greenwood, Nova Scotia, as OC MP Detachment for two years.⁷⁴

35. In 2005, LCol Garrick returned to Ottawa as Senior Operations Officer for CFNIS. In 2006, he was promoted to Lieutenant Colonel and assumed the position of CO CFNIS. He held that position for two years before taking a position as the Deputy Director General of Criminal Intelligence Service Canada in June 2008. In 2009, he went into private practice as a consultant.⁷⁵

The 2009 and 2010 Investigations: Primary Next of Kin and Criminal Negligence

MASTER SEAMAN ERIC MCLAUGHLIN

36. MS Eric McLaughlin (PO2 McLaughlin at the time of his testimony before the MPCC in September 2012) was one of the initial investigators assigned to the 2009 investigation.⁷⁶ He worked on the investigation with Maj Dandurand between November 2009 and mid-January 2010 when he deployed to Haiti.⁷⁷ He also had some very limited involvement in the 2008 investigation, taking notes during the interview of MCpl Fitzpatrick conducted by MCpl Ritco.⁷⁸

37. MS McLaughlin joined the CF in September 2001.⁷⁹ After completing basic training, he was sent to the Military Police Academy for his QL3 training.⁸⁰ He graduated in February 2003,⁸¹ and for the three years following, he was posted to CFB Edmonton as an MP on the base.⁸² In 2006, he was seconded to the CFNIS WR.⁸³ The secondment lasted for one year and permitted MS McLaughlin to get involved in the work of the CFNIS.⁸⁴ At the end of the year, he returned to his Unit to complete two more months of patrol duties until he was officially posted to the CFNIS in 2007.⁸⁵ He completed his MP criminal investigator course in November 2007.⁸⁶ He remained at CFNIS WR until 2012.⁸⁷ At the time of the hearing, he was posted to the CF Military Police Academy.⁸⁸

38. At the time of his involvement in the 2009 investigation, he had been a member of the CFNIS for a little over two years, not including his period of secondment. He had experience in conducting less than ten negligent-performance-of-duty investigations.⁸⁹ His formal police training up to that point of time, other than his required MP training courses and Criminal Investigator course, consisted of training in use of force, statement admissibility and as a sexual assault investigator.⁹⁰

MASTER CORPORAL DAVID MITCHELL

39. Following the departure of MS McLaughlin, MCpl David Mitchell (Sergeant Mitchell at the time of his testimony before the MPCC in June 2012) assisted Maj Dandurand on the 2009 investigation from mid-February to the end of March 2010.⁹¹ At the end of March, MCpl Mitchell assumed a more central role, in effect, leading the investigation until early September 2010 when he left the detachment for a secondment.⁹² He was designated the lead investigator from the outset of the 2010 investigation in May 2010 until he left in September 2010.⁹³

40. MCpl Mitchell joined the Canadian Forces in 2002 and received his military police credentials in the summer of 2003.⁹⁴ His first posting was to 5 Wing Goose Bay in Northern Labrador where he remained until 2006.⁹⁵ He was then posted to 1 Military Police Platoon in Edmonton where he spent two and half years,⁹⁶ followed by a posting to the Military Police Guardhouse at CFB Edmonton where he spent a short time on patrol before being posted to the CFNIS WR in August of 2009.⁹⁷ He remained at CFNIS

WR until early September 2010 when he was tasked to complete the residency component of his PLQ course and, immediately afterwards, he began a yearlong secondment with the RCMP.⁹⁸ At the time of the hearing, he was posted to Afghanistan in his capacity as a military police officer.⁹⁹

41. MCpl Mitchell began as an intern when he joined the CFNIS in August 2009.¹⁰⁰ During the period of his internship, he worked under the supervision of a qualified member and was not designated as lead investigator on any files.¹⁰¹ Maj Dandurand was formally in charge of the 2009 investigation until the completion of MCpl Mitchell's internship in late March 2010. However, MCpl Mitchell was responsible for most of the legwork on the file.¹⁰² He also demonstrated himself to be ahead of his peer group and his internship was written off ahead of schedule.¹⁰³

42. MCpl Mitchell did not have much experience in conducting serious and sensitive investigations prior to becoming the lead investigator of the 2009 and 2010 investigations. When he began at the CFNIS, a sizable portion of his time was taken up with completing required training courses. He participated in a week-long CFNIS indoctrination course in September and the MP criminal investigation course, which ran from mid-October 2009 to the end of November.¹⁰⁴ This means, prior to his involvement in the 2009 investigation, MCpl Mitchell had, by his own estimation, a little over three full months experience in serious and sensitive investigations.¹⁰⁵ During that three-month period, MCpl Mitchell had been involved in a few serious and sensitive investigations including a forged documents case, several sexual assault investigations and investigations of other military police members, but, because he was an intern, he was not lead investigator.¹⁰⁶ He had not been involved in any negligent-performance-of-duty investigations nor any criminal negligence investigations as a member of the CFNIS prior to his involvement in the 2009 and 2010 investigations.¹⁰⁷ Other than the required MP training, it does not appear MCpl Mitchell had taken any other courses related to police investigations prior to undertaking either the 2009 or 2010 investigations.¹⁰⁸

SERGEANT SCOTT SHANNON

43. Sgt Scott Shannon took over as lead investigator on the 2009 investigation in September 2010 following the departure of MCpl Mitchell.¹⁰⁹ He remained lead investigator until the conclusion of the investigation.¹¹⁰ Though he was never formally assigned to the 2010 investigation, he completed an academic review of the complaint which was included as part of the concluding power point presentation to the command team.¹¹¹

44. Sgt Shannon joined the CF in July 1999.¹¹² Following basic training, he completed his QL3 training at the Military Police Academy in February 2001.¹¹³ He was then posted to 17 Wing Detachment Dundurn in Saskatchewan where he served for the next four and half years, which included his first international deployment to the Persian Gulf where he performed general patrol duties.¹¹⁴ In September 2004, Sgt Shannon completed the MP Criminal Investigator course,¹¹⁵ and in 2005, he became a member of the CFNIS.¹¹⁶ Sgt Shannon served with the CFNIS in Halifax for the next six years,¹¹⁷ transferring to Edmonton and the CFNIS WR detachment in September 2010.¹¹⁸ At the time of the hearing, he was posted to 1 Military Police Regiment in Edmonton where he was the Support Platoon Warrant Officer.¹¹⁹

45. With respect to his training, Sgt Shannon had completed a number of police courses prior to his involvement in the 2009 and 2010 investigations, including an RCMP course on crime scene investigation as well as internal courses on the identification and collection of forensic evidence, cybercrime, sexual assault investigation and electronic crime scene examination.¹²⁰ He had not taken the forensic interviewing course offered by the CF.

46. In addition to completing police courses taken during the course of his employment, Sgt Shannon was awarded a diploma in Law Enforcement, an Honour's degree in Criminal Justice and, at the time of the hearing, was studying for his Master's degree in Public Administration.¹²¹

47. Sgt Shannon conducted 109 criminal investigations as the primary lead investigator in the course of his career.¹²² Prior to becoming involved in the 2009 investigation, he had conducted three different investigations into the negligent performance of a military duty.¹²³ He also had been involved in drafting and reviewing military policy, specifically the CFNIS SOP with respect to sudden deaths,¹²⁴ but did not have any prior experience in investigating a charge of criminal negligence causing death or any charge involving criminal negligence.¹²⁵

WARRANT OFFICER BLAIR HART

48. WO Blair Hart was the Operations Warrant Officer and acted as the Case Manager from the outset of both the 2009 and 2010 investigations until July 2010.¹²⁶ His posting as Operations Warrant Officer coincided with the period of time MS McLaughlin was assigned to work on the 2009 investigation and with MCpl Mitchell's subsequent work on both the 2009 and 2010 investigations. In the summer of 2010, WO Hart assumed the position of Support Operations Warrant Officer.¹²⁷ Despite having significantly less involvement in the day to day management of the investigation files, including the 2009 and 2010 investigations,¹²⁸ he was still a member of the command team and would fill in when WO Bonneteau was unavailable.¹²⁹

49. WO Hart began his military career as a reservist in 1980.¹³⁰ In 1986, he joined the regular force and, following basic training, completed his QL3 training at the Military Police Academy in November 1986.¹³¹ In 1987, he was posted as a trained MP to CFB Shilo in Manitoba,¹³² then subsequently to the Military Security Guard Unit at the Canadian High Commission in New Delhi, India, and to the CF Military Police Academy, first in a security and then in a teaching role.¹³³ In July 2001, he was posted to the CFNIS in Borden, completing his MP Criminal Investigator training in October 2001.¹³⁴ During this posting, he was deployed to Bosnia as a CFNIS investigator.¹³⁵ In 2005, he was posted to CFNIS WR, and, during that posting, he was deployed to Afghanistan.¹³⁶ Upon his return to Canada, he was posted to CFB Edmonton and, in 2009, he returned to CFNIS WR.¹³⁷ He served as the Operations Warrant Officer for approximately 12 to 14 months, after which, he became the Support Operations Warrant

Officer, overseeing criminal intelligence and drug programs.¹³⁸ In 2011, he was posted to Halifax and the CFNIS Atlantic Region office, where he remained at the time of his testimony.¹³⁹

50. WO Hart had been a military police officer for 23 years and with the CFNIS for six of those years when he became involved in the 2009 investigation.¹⁴⁰ He was promoted to acting WO in December 2008, meaning he appears to have had about a year of supervisory experience before he became involved in the 2009 investigation.¹⁴¹

51. WO Hart did have experience investigating a spectrum of cases dealing with allegations of negligent performance of duty.¹⁴² He also acted in a supervisory capacity for an investigation with allegations similar to criminal negligence causing death but with facts in no way similar to the factual background of Cpl Langridge's suicide.¹⁴³ He did not have any experience with the *Criminal Code* offence concerning the duty of persons directing work to prevent bodily harm, nor had he ever heard of it being laid in the context of the CF.¹⁴⁴

WARRANT OFFICER SEAN BONNETEAU

52. WO Sean Bonneteau (Retired Warrant Officer Bonneteau at the time of his testimony before the MPCC in September 2012) was the Operations Warrant Officer on both the 2009 and 2010 investigations from the summer of 2010 until the conclusion of both files.¹⁴⁵ His time as Operations Warrant Officer coincided with Sgt Shannon's role as lead investigator on the 2009 investigation and Sgt Shannon's review of the 2010 investigation.

53. WO Bonneteau joined the CF in July 1987.¹⁴⁶ He began his career in the Air Force as an air weapons technician until he moved in January 2001 to the Military Police Branch.¹⁴⁷ In October 2001, he completed his MP QL3 course and was posted as a patrolman to the MP detachment at CFB Edmonton.¹⁴⁸ He was posted to the CFNIS WR in April 2003 as an investigator.¹⁴⁹ He completed the MP Criminal Investigator course in October 2003.¹⁵⁰ In July 2006, WO Bonneteau was posted to Afghanistan where he ensured security for a team working outside of the CF base and later worked as a CFNIS

investigator.¹⁵¹ In August 2007, he was posted back to CFNIS WR and was selected to become a polygraph examiner, undergoing an intense period of study and training from August 2007 until March 2008 for the polygraph examiner course, following which he became the polygraph examiner for Western Region.¹⁵² During the following years, he also completed three short postings to Afghanistan.¹⁵³ In July 2010, he was assigned as the Operations Warrant Officer for CFNIS WR and named the polygraph co-ordinator for the CFNIS.¹⁵⁴ He retired from the military in May 2011, shortly after the 2009 and 2010 investigations closed.¹⁵⁵

54. WO Bonneteau had been a military police officer for only 17 months when he became a member of the CFNIS.¹⁵⁶ This was a very quick move up from regular MP to what was considered to be the more elite ranks of the CFNIS.¹⁵⁷ While at the CFNIS, WO Bonneteau moved quickly through the ranks to a supervisory position, advancing from the rank of Corporal to Warrant Officer in his five years with the CFNIS.¹⁵⁸ He became a WO in June 2010,¹⁵⁹ only weeks before taking over supervisory duties on both the 2009 and 2010 investigations. His only other supervisory experience prior to his involvement in the 2009 and 2010 investigations appears to have been as team leader on an investigation in Afghanistan over a two-week period.¹⁶⁰

55. In terms of training, WO Bonneteau took an adult/child sexual assault investigator's course, the polygraph course, a forensic interviewing course, a major crime investigator's course and attended numerous seminars on a number of different topics including major case management and informants.¹⁶¹ WO Bonneteau had investigated a wide range of service and *Criminal Code* offences, but was unable to say with certainty whether he had ever investigated allegations of criminal negligence or of negligent performance of a military duty.¹⁶² He had not ever been involved in any investigation regarding the failure to provide the necessities of life or regarding a failure of the employer to ensure a safe work environment for employees.¹⁶³

MAJOR DANIEL DANDURAND

56. Maj Daniel Dandurand was the Officer Commanding of the WR detachment throughout the entire course of both the 2009 and 2010 investigations.¹⁶⁴ He was also the

OC when the failure to disclose Cpl Langridge's suicide note was discovered after the completion of the 2008 investigation and the note was later sent to the Fynes.¹⁶⁵

57. Maj Dandurand joined the CF in 1994 as part of the regular officer training program.¹⁶⁶ He was unsuccessful in becoming a pilot, and, instead, he attended the Military Police Academy at Borden, completing his training in May 2002.¹⁶⁷ He began his career in the MP branch by first completing a year-long provisional employment period for officers.¹⁶⁸ His first six months were spent at CFB Petawawa learning the procedures of a detachment and working on patrols.¹⁶⁹ He then went to the CFNIS in Ottawa for six months where he worked with the Sensitive Investigations cell of the CFNIS, a detachment which dealt with the most sensitive and serious crimes the CFNIS was investigating.¹⁷⁰ He deployed to Afghanistan in 2003 as a multinational MP platoon commander and spent approximately eight months there,¹⁷¹ subsequently returning to Ottawa to work as the executive assistant to the Provost Marshall.¹⁷² In the summer of 2005, he was posted to the United Kingdom as second in command of an MP company. While on this posting, he deployed to Iraq as part of the U.K. involvement in the region.¹⁷³ From the U.K, he came directly to Western Region in July 2008 as the Officer Commanding.¹⁷⁴ He remained in the position until July of 2011.¹⁷⁵ At the time of his testimony, Maj Dandurand was the Commandant of the Military Police Academy.¹⁷⁶

58. Prior to assuming the Officer Commanding position, Maj Dandurand had been an MP for six years, but his experience within the CFNIS came from the six months he spent with the CFNIS during his provisional employment period,¹⁷⁷ five years previous to becoming OC.¹⁷⁸ He did not complete his MP Criminal Investigator course until several months after he became OC, a circumstance he did not consider unusual.¹⁷⁹ He did have some limited exposure to MP investigations during his provisional employment. The rest of his experience was overseas with a significant portion in conflict zones.

59. Maj Dandurand had not done any sudden death investigations, any investigations for failing to provide the necessities of life, nor any investigations related to the duties of an employer to maintain a safe workplace.¹⁸⁰ He had participated in an investigation involving allegations of the negligent performance of duties, which included an allegation

of a poor application and understanding of policy,¹⁸¹ but it was not otherwise similar to the 2009 investigation. Maj Dandurand's training included completing the MP course, the MP criminal investigators course and a course on Major Case Management,¹⁸² as well as professional development seminars. The evidence suggests he did not complete any other specialized investigative training.¹⁸³

LIEUTENANT-COLONEL GILLES SANSTERRE

60. LCol Gilles Sansterre was the CO CFNIS from August 2008 until April 2011.¹⁸⁴ He was the CO during all but the very final weeks of the 2009 and 2010 investigations. He was also the CO when the failure to disclose Cpl Langridge's suicide note was discovered after the completion of the 2008 investigation and the note was later sent to the Fynes.

61. LCol Sansterre joined the military in March 1985¹⁸⁵ and completed his QL3 course in July of that year.¹⁸⁶ He was posted to Halifax as an MP, completed university in 1993 and was then commissioned as an officer in the Military Police branch.¹⁸⁷ From there, he went on to postings in Halifax, Winnipeg, and Borden at the MP Academy.¹⁸⁸ He completed tours in Kosovo and had been to Afghanistan on three separate occasions to conduct investigations.¹⁸⁹ In 2001, he was posted to Ottawa as Deputy Provost Marshal, National Investigation Service.¹⁹⁰ Over the following three years, he commanded two different detachments – the support detachment and central region detachment.¹⁹¹ He was promoted to Lieutenant-Colonel in 2006 and went on to hold the position of Deputy Provost Marshal, Resource Management and Deputy Provost Marshal, Professional Standards.¹⁹² In August 2008, he assumed the position of Commanding Officer of the CFNIS.¹⁹³ At the time of the hearing, he was the Deputy Commander of the newly formed military police group.¹⁹⁴

62. LCol Sansterre did not take the MP Criminal Investigator course but had taken a general investigations techniques course given by the Ottawa Police.¹⁹⁵ On two occasions he had worked on sudden death investigations involving suicide, but only as a first responder.¹⁹⁶ He had not had the occasion to investigate an allegation of criminal

negligence, but he had investigated allegations of negligent performance of a military duty.¹⁹⁷

¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 625.

² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 150-152.

³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 2.

⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 3.

⁵ Exhibit P-134, doc. 1400, p. 2.

⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 3.

⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 13-14; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 9.

⁸ Exhibit P-134, doc. 1400, p. 3.

⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 3.

¹⁰ Exhibit P-134, doc. 1400, p. 3.

¹¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 3-4.

¹² Exhibit P-134, doc. 1400, p. 3.

¹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 6.

¹⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 5.

¹⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 2.

¹⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 3.

¹⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 3.

¹⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 10.

¹⁹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 4-5.

²⁰ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 5.

²¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 5.

²² Exhibit P-135, doc. 1401, p. 3.

²³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 9-10.

²⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 17.

²⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 5-6.

²⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 17.

²⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 6.

²⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 9.

²⁹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 15.

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- ³⁰ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 29.
- ³¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 15-16.
- ³² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 625.
- ³³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 5-6.
- ³⁴ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 7.
- ³⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 2.
- ³⁶ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 21.
- ³⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 2.
- ³⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 2-3.
- ³⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 3.
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- ⁴¹ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 21.
- ⁴² Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 21.
- ⁴³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 4.
- ⁴⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 7.
- ⁴⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 286.
- ⁴⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 6-7.
- ⁴⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 6-7.
- ⁴⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 6-7.
- ⁴⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 11.
- ⁵⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 33-35.
- ⁵¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 12.
- ⁵² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 8.
- ⁵³ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 17.
- ⁵⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 9.
- ⁵⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 9.
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- ⁵⁷ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 17.
- ⁵⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 13-14.
- ⁵⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 14.
- ⁶⁰ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 73.
- ⁶¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 524.
- ⁶² Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 72.
- ⁶³ Exhibit P-178, doc. 1458, p. 1.

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- ⁶⁴ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 72.
- ⁶⁵ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 72.
- ⁶⁶ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 72.
- ⁶⁷ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 73.
- ⁶⁸ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 73-74.
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- ⁷⁰ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 3.
- ⁷¹ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 1-2.
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- ⁷⁴ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 3.
- ⁷⁵ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 3.
- ⁷⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1369.
- ⁷⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 113-114.
- ⁷⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 10-11.
- ⁷⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 3.
- ⁸⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 3; Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 37.
- ⁸¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 3; Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 37.
- ⁸² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 3-4.
- ⁸³ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 4.
- ⁸⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 8.
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- ⁸⁶ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 37.
- ⁸⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 4.
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- ⁹⁰ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 37.
- ⁹¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 13-14; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 55; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 294 and 1369.
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- ⁹³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 56; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 140.

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- ⁹⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 6.
- ⁹⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 6.
- ⁹⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 6.
- ⁹⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 6.
- ⁹⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 201; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 32.
- ⁹⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 104-105.
- ¹⁰⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 13.
- ¹⁰¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 13.
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- ¹⁰⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 101.
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- ¹⁰⁸ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 39.
- ¹⁰⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1370.
- ¹¹⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1101 and 1198.
- ¹¹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115-116; Exhibit P-2, Collection B, vol. 1, tab 1, doc.1087, p. 1058.
- ¹¹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 65.
- ¹¹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 65; Exhibit P-5, Collection E, vol. 2, tab 11, doc. 1144, p. 45.
- ¹¹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 65-66.
- ¹¹⁵ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 45.
- ¹¹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 66.
- ¹¹⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 66.
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- ¹²⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 66; Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 45.
- ¹²¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 66-67.
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- ¹²⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 73-74.
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- ¹²⁶ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 3 and 9; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 6.
- ¹²⁷ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 9.
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- ¹²⁹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 165-167.
- ¹³⁰ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 1.
- ¹³¹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 1-2.
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- ¹³⁴ Exhibit P-115, tab 11, doc. 1388, pp. 2-3.
- ¹³⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 3.
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- ¹³⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 3-4.
- ¹³⁹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 4.
- ¹⁴⁰ Exhibit P-115, tab 11, doc. 1388, pp. 2-3.
- ¹⁴¹ Exhibit P-115, tab 11, doc. 1388, p. 1.
- ¹⁴² Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 12.
- ¹⁴³ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 12-13.
- ¹⁴⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 13.
- ¹⁴⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 9; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 6.
- ¹⁴⁶ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 2; Exhibit P-115, tab 9, doc. 1386, p. 2.
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- ¹⁵⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 197-199.
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- ¹⁶⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 2.
- ¹⁶⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 2; Exhibit P-136, doc. 1402, p. 2.
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- ¹⁷⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 3; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 125.
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¹⁷⁸ Exhibit P-136, doc. 1402, p. 1.

¹⁷⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 4; Exhibit P-136, doc. 1402, p. 2.

¹⁸⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 4-7.

¹⁸¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 5-6; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 8.

¹⁸² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 4; Exhibit P-136, doc. 1402, p. 2.

¹⁸³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 4; Exhibit P-136, doc. 1402, p. 2.

¹⁸⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 6; Exhibit P-115, tab 10, doc. 1387.

¹⁸⁵ Exhibit P-115, tab 10, doc. 1387.

¹⁸⁶ Exhibit P-5, Collection E, vol. 2, tab 24, doc. 1144, p. 11.

¹⁸⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 4-5; Exhibit P-115, tab 10, doc. 1387.

¹⁸⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 5.

¹⁸⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 5.

¹⁹⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 5.

¹⁹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 5.

¹⁹² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 5.

¹⁹³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 6.

¹⁹⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 6.

¹⁹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 3.

¹⁹⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 3-4.

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4.1 THE 2008 INVESTIGATION

4.1.1 Investigating the Sudden Death

ISSUES RAISED BY THE COMPLAINANTS

1. The complainants raise numerous concerns about the way the 2008 investigation into the sudden death of Cpl Stuart Langridge was conducted. They allege the CFNIS investigators tasked with investigating Cpl Langridge's death conducted their investigation with no clearly defined or understood purpose and failed to address the issues to be investigated properly.¹ They allege the investigators failed to define the scope of the investigation appropriately and the CFNIS as a whole failed to provide appropriate direction in this regard. In general, they allege the CFNIS members involved in the investigation lacked the necessary experience and training to conduct it.²

2. In addition to these general allegations, the complainants raise a number of specific issues, many focused on the manner in which the death scene was processed, including allegations of disrespect shown to Cpl Langridge's body.

3. The subjects of the complaint deny the allegations and state they adhered to all relevant policies and procedures for general police investigations in force at the time. They also deny the specific allegations related to processing the death scene and, in particular, they deny Cpl Langridge's body was shown any disrespect.

4. A detailed review of the events surrounding the discovery of Cpl Langridge's body and of the CFNIS investigators' actions at the scene is essential to assess both the general and the specific allegations about this aspect of the 2008 Investigation.

INITIAL RESPONSE TO CPL LANGRIDGE'S DEATH

5. At 1520 hrs on Saturday, March 15, 2008, Cpl Roger Hurlburt unlocked the door to room F314, Barrack Block 164 and discovered the body of Cpl Langridge hanging by

a ligature tied around his neck.³ Cpl Langridge had failed to check in at the duty desk as scheduled (as required by the conditions imposed upon him by the Regiment). When Cpl Langridge did not answer his phone or respond when verbally hailed from outside the locked door of the barracks room in which he spent much of his last 24 hours, Cpl Hurlburt returned to the duty centre to report the situation. Cpl Hurlburt was given a key by Sgt Trent Hiscock, the duty NCO that day, and was ordered to unlock the door and enter the room. When he returned to the barracks and discovered the body, Cpl Hurlburt observed Cpl Langridge's skin was cold and found no pulse.⁴ Cpl Hurlburt drove back to the duty centre and informed Sgt Hiscock of Cpl Langridge's death. Sgt Hiscock ordered Cpl Hurlburt to return to the barracks room and await the arrival of the military police.

6. It is not known precisely when the Regiment alerted emergency personnel to the death but, at 1545 hrs on March 15 2008, Pte Jesse Neill from the CFB Edmonton Garrison Fire Service (EGFS) contacted the 1st Military Police Unit.⁵ He advised Sgt Pierre Rioux base fire personnel were responding to a call reporting a death had occurred in room F314 at 164 Ortona Road. MP members Cpls Scott Broadbent and Tyler James Bruce-Hayes were dispatched. They arrived at approximately 1546 hrs, at the same time as base fire hall personnel.⁶

7. MCpl Ken Munro of the EGFS was let into the room by Cpl Hurlburt, the first to enter after Cpl Langridge's body had been discovered.⁷ Cpl Bruce-Hayes entered at the same time, crossing the threshold into the room but without going past the body.⁸ MCpl Munro checked for vital signs and detected no pulse or respiration. He observed Cpl Langridge's face was pale and exhibited evident cyanosis (the appearance of blue or purple colouration of the skin caused by a lack of oxygen in the blood) around his lips and mouth.⁹ These observations were confirmed by MCpl Bob Bowen of the EGFS.¹⁰ MCpl Munro then moved past Cpl Langridge's body and retrieved his wallet and identification from the desk.

8. The fire personnel then remained outside the room with MP members. Cpl Bruce-Hayes observed the body was suspended from a chin-up bar in the room, and the arms were purple from the elbow down.¹¹ At 1555 hrs, Cpl Bruce-Hayes began to interview

Cpl Hurlburt about what had happened.¹² During this time, Sgt Marty Van Delen of the EGFS contacted the Office of the Chief Medical Examiner (ME) in Edmonton, and was informed an investigator from the ME's office was on his way.¹³

9. At 1556 hrs, eleven minutes after the death was reported to the MP, the 1st MP Unit duty dispatcher contacted WO Ross Tourout of the CFNIS and notified him about the death.¹⁴ At 1602 hrs, paramedics Jacques Coppens and Steve Gillingham of St. Albert Fire Service Ambulance attended the scene. They confirmed there were no vital signs, noting the skin was cold and clammy, and purple in colour, and departed at 1610 hrs.¹⁵

10. At 1605 hrs, Sgt Jon Bigelow of the CFNIS National Drug Enforcement Team received a telephone call from MWO Barry Watson, the detachment MWO and Acting OC for the CFNIS Western Region (WR) in March 2008.¹⁶ MWO Watson informed Sgt Bigelow of the discovery of Cpl Langridge's body at the barracks and requested his assistance in conducting a sudden death investigation under the lead of MCpl Matthew Alan Ritco, who was assigned as the lead investigator because he was the CFNIS duty investigator on call that day.¹⁷ Although Sgt Bigelow was a drug investigator, MWO Watson sought his assistance because the CFNIS WR was experiencing a personnel shortage.¹⁸ Sgt Bigelow readily agreed to assist and was directed to contact MCpl Ritco to advise him of the situation. Sgt Bigelow proceeded to instruct MCpl Ritco to meet him at CFNIS WR.

11. At 1608 hrs, Cpl Bruce-Hayes was informed MWO Watson had dispatched CFNIS investigators to the scene. Cpl Bruce-Hayes was ordered to secure the scene and told not to let anyone into the room.¹⁹ Cpl Bruce-Hayes and Cpl Broadbent kept the door closed, remaining outside the room and ensuring unauthorized personnel did not enter.²⁰ Before the CFNIS investigators arrived, Cpl Bruce-Hayes and Cpl Broadbent recorded their observations of the room and Cpl Langridge's body, noting he was hanging from a combat belt tied around his neck,²¹ also recording the manner in which he was dressed, the fact there was a chair immediately behind the body, and noting some of the contents of the room.²²

CFNIS investigators attend at the scene

12. There was some delay between the report of Cpl Langridge's death to the CFNIS at 1556 hrs and the commencement of the investigation. Prior to attending at CFB Edmonton, MCpl Ritco and Sgt Bigelow had to change into their uniforms, retrieve equipment and travel to the base.²³ The investigators loaded investigative kits (comprised of evidence collection materials, statement forms, cameras, and equipment) into a Unit vehicle.²⁴ Sgt Bigelow testified the work at the detachment took approximately 15 minutes, followed by a five-minute drive to the base MP detachment.²⁵

13. At 1655 hrs, MCpl Ritco and Sgt Bigelow arrived at the CFB Edmonton MP guardhouse. There they spoke with Sgt Rioux and were briefed about what was known at that point about the incident and the identity of the deceased. Sgt Bigelow wrote in his notes the events giving rise to Cpl Langridge's death were still uncertain, but Cpl Langridge had last been seen at 1230 hrs and was possibly on the defaulters' parade.²⁶ MCpl Ritco recorded this information in a SAMPIS entry for the investigation. Sgt Rioux also informed MCpl Ritco the fire department and base MPs were at the scene.²⁷

14. Seeking more information about the deceased before attending the scene, MCpl Ritco and Sgt Bigelow conducted a SAMPIS check on Cpl Langridge while at the MP detachment.²⁸ They were told a representative of the ME's office was on his way, and they waited for him to arrive at the MP detachment.

Arrival of investigator from the Alberta Chief Medical Examiner's office

15. In the province of Alberta, the Chief Medical Examiner is mandated under the provincial *Fatality Inquiries Act*²⁹ to investigate unexpected or unexplained deaths.³⁰ The Chief Medical Examiner must determine, to whatever extent possible, the medical cause of death, the manner of death, the identity of the deceased, the date, time and place of death, and the circumstances under which the death occurred.³¹ Mr. Dennis Caufield, an investigator from the Alberta Office of the Chief Medical Examiner ("ME Investigator"), arrived at the MP detachment at 1712 hrs.³²

16. Mr. Caufield testified he had 27 years of experience with the Office of the Chief Medical Examiner, and 23 years of experience as a senior medical investigator.³³ He testified his duties begin with responding to any incoming calls reporting deaths. He then ascertains whether the death is one that is, in fact, reportable to the ME and requires an investigation under the *Fatality Inquiries Act*.

17. After Mr. Caufield's arrival at the MP detachment, he, MCpl Ritco, and Sgt Bigelow attended the scene of Cpl Langridge's death at 1721 hrs.³⁴ Owing to time differences on their respective watches, MCpl Ritco's notes recorded their arrival at 1724 hrs.³⁵ This caused small discrepancies in the notes and records generated in the course of the investigation.

18. The investigators arrived at the scene approximately one and a half hours after the CFNIS was informed of the death. They met with Cpls Bruce-Hayes and Broadbent and were briefed about fire and ambulance personnel attending, checking vital signs and confirming Cpl Langridge's death. The wallet containing Cpl Langridge's military identification and driver's licence retrieved from the room was turned over to MCpl Ritco at 1728 hrs.

UNDERSTANDING THE ALLEGATIONS: SOME KEY QUESTIONS

What was done and why?

19. The complainants allege MCpl Ritco and Sgt Bigelow conducted the 2008 Sudden Death Investigation with no clearly defined or understood purpose, and lacked the skills, experience and competence necessary to conduct the investigation. The subjects responded that the CFNIS investigators worked thoroughly and with professionalism throughout the investigation, and CFNIS members must handle a sudden death with the same stringency as a homicide. The subjects submit, even if a sudden death looks like a suicide at the scene, the CFNIS will exhaust every avenue and work to avoid tunnel vision.³⁶

20. An initial issue arising from the allegations is the understanding MCpl Ritco and Sgt Bigelow had as to why they were at the death scene and what they did as a

consequence. The CFNIS investigators and the Medical Examiner (ME) investigator had different mandates and differing expertise. Did the CFNIS investigators understand these differences? Did they make use of the expertise of Mr. Caufield, the ME Investigator, and his experience at the scenes of apparent suicides? Did they adjust their approach in any way based on what they found at the scene? Did they take reasonable measures consistent with the investigation of a homicide?

What did the CFNIS members do to analyze the information and evidence available?

21. From the available evidence and information, it should have been apparent early in the 2008 Sudden Death Investigation Cpl Langridge's death was not a suspicious one. Yet, there is no evidence the strong likelihood of suicide was taken into consideration even as a working hypothesis. The absence of ongoing evaluation and analysis of information can have significant consequences for the quality of the initial investigation, as well as the planning and conduct of the ensuing Sudden Death Investigation. To assess the investigation, it is necessary to determine why so many clear indications about the nature of Cpl Langridge's death went unnoticed, as well as to understand the purpose of the meticulous steps taken at the scene before and after his body was removed. It is also necessary to examine what these steps accomplished and whether they were consistent with their stated aim.

Was disrespect shown to Cpl Langridge's body?

22. The allegations of disrespect are of particular concern for the complainants, so the evidence must be examined to determine what in fact happened concerning Cpl Langridge's body and whether there was any element of disrespect.

23. The Fynes allege the CFNIS investigators showed disrespect to Cpl Langridge when they did not immediately lower his body. They also allege his body was not concealed from view during the processing of the scene and the body should have been covered or obscured to prevent it from becoming a spectacle.

24. According to the subjects, Cpl Langridge's body was treated at all times in a respectful manner.³⁷ Their position is the ME Investigator was the individual responsible for deciding when the body could be moved. They also argue it was not appropriate or necessary to cover Cpl Langridge's body during the processing of the scene, and the CFNIS did not have the authority to lower the body.

How was the scene processed following the removal of the body? How should this be done for a sudden death?

25. After Cpl Langridge's body was removed, the CFNIS investigators continued to process the scene and gather evidence. MCpl Ritco and Sgt Bigelow seized what they believed were relevant exhibits and collected all of Cpl Langridge's personal effects. Was the evidence seized helpful? Was important evidence overlooked? What was the value in proceeding as they did, and what were the implications of doing so?

26. Each of these sets of questions will be examined in turn.

PROCESSING THE SCENE: WHAT WAS DONE AND WHY?

27. The CFNIS investigators and the ME Investigator took possession of the scene shortly after they arrived.³⁸ The small, rectangular barracks room was normally intended for a single CF member holding the rank of trooper or corporal.³⁹ The door opened into a narrow hallway spanned by a chin-up bar several feet from the threshold. To the left of the doorway was a wardrobe and cupboards, and to the right was a door to a shared bathroom. Cpl Langridge's body was suspended from the chin-up bar by a military, webbed belt tied into a ligature around his neck. Behind Cpl Langridge was a black chair. The room also had a single bed, a small desk and a vanity and sink. An open window with opened blinds was situated in the middle of the north-facing wall between the bed and the desk. Atop the desk were some books, magazines and papers belonging to Cpl Langridge, along with his suicide note and a pen. Clothes were piled atop a suitcase on the bed. MCpl Ritco prepared a drawing of the room and included it in the GO File.⁴⁰

28. Before the investigators began to process the scene, Mr. Caufield began examining Cpl Langridge's body. Mr. Caufield testified his primary focus is the

examination of the body and making observations about its position and condition to ascertain whether there is any sign the death is the result of a criminal act:

That's really important to us because it changes the nature of the investigation. If we were to see something that suggested that there was some injury or something that might suggest that some other person was involved, we stop that process at that point and we involve other layers of law enforcement, Forensic Identification Section, in this case it would be RCMP Major Crimes, those types of things. So that's one of our functions, when we go there, is to have that look to make sure that we're confident this is not appearing to be a criminal death.⁴¹

29. Mr. Caufield testified he might be called out for two to three similar deaths each day, so he had a mental checklist of information to obtain.⁴² He testified he would have also asked the CFNIS members for information such as the deceased's name, his date of birth, the time when he was found dead, when he was last seen alive, and if they had found a suicide note.⁴³ He quickly formed the view that the death was consistent with a classic suicidal hanging.⁴⁴

30. MCpl Ritco testified, after Mr. Caufield's initial examination of Cpl Langridge's body, he sought Mr. Caufield's permission to take photographs and video of the scene.⁴⁵ At approximately 1733 hrs, MCpl Ritco began to photograph the scene.⁴⁶

31. MCpl Ritco testified the steps differ for processing each scene. He said the first priorities upon arriving at the scene are officer safety and the preservation of life. The next priority is the preservation of evidence.⁴⁷

32. When asked if he formulated a plan of what needed to be done before he entered the room, MCpl Ritco testified his focus was to ensure the continuity of evidence, if there was any, was not compromised.⁴⁸

33. MCpl Ritco testified he would not, at that time, have engaged in a discussion with Mr. Caufield to formulate a preliminary hypothesis as to whether the death was suspicious. He stated, "[i]n my experience, I treat every investigation keeping an open mind. Even though the ME says [...] 'it appears to be a suicide,' that's fine, I take that into consideration, but at the end of the day I conduct my investigation with an open mind."⁴⁹ This need to keep an open mind, even in the face of information and evidence

suggestive of a conclusion of probable suicide, meant that from this point forward the focus would be on completeness of information rather than on drawing any inferences from the information already gathered.

Expert testimony on processing a death scene

34. The Commission heard the testimony of major crimes investigators from the Edmonton Police Service (EPS), the Ontario Provincial Police (OPP), and the Royal Canadian Mounted Police (RCMP). Their approaches to responding to sudden death reports and processing a death scene are not identical. The common thread is each step is purpose-driven and performed without unnecessary delay. It is essential to avoid tunnel vision or unfounded conclusions at the outset of the investigation. They are trained to assess a death scene on the information available and to form opinions as to whether a death is suspicious. This essential step guides the subsequent work at the scene.⁵⁰

35. The EPS has extensive experience conducting death investigations, with its members conducting from one to two per day.⁵¹ Staff Sgt William Clark, who supervises the homicide section of the EPS, described how the approach depends on the information available at the scene. He testified patrol officers who respond to an initial call of a death make a determination, based on available information, whether the death is criminal in nature. Nothing is touched and the scene is kept secure. Regardless of the nature of the death, the individual who reported the death must be interviewed at the scene. The responding officer then consults a sergeant, watch commander or other superior to make a finding about the nature of the death. Where it is decided the death does not appear suspicious, an ME investigator is called in to take charge of the scene and lead the investigation.⁵² If the officers at the scene believe a death is suspicious, a forensic identification team is first sent to gather all evidence. In such cases, homicide detectives are called in to investigate the death, but they will not normally even enter the scene until the Identification team has examined the scene and finished collecting evidence. For a criminal death in the Province of Alberta, only after the police have processed the scene, is the ME normally contacted to remove the victim's body.⁵³

36. S/Sgt Clark stated an officer might consider, when determining whether an apparent hanging was a suicide, whether the scene appears consistent with the manner of death. The position and condition of the body should be assessed for consistency with a death by suicide. For example, suicidal hangings often end with a person hanging relatively low – so, where a person was hanging well off the ground, was there a means for that person to have been suspended on their own and without another's effort? Essentially, the question is, does the scene as a whole make sense and is anything incongruous with the apparent manner of death? The officer investigating will also want to obtain the background of the deceased and gain some perspective as to what may have led the individual to suicide.⁵⁴ The presence or absence of a suicide note *per se* will not be a determining factor when considering whether a death was suspicious.⁵⁵ Where the constable at the scene or a superior considers anything to be suspicious or in question, homicide detectives will be contacted for their opinion; detectives may even be dispatched to the scene for an expert opinion. Often the ME may also be contacted, given the ME's considerable expertise with death scenes.

37. Det. Insp. William Olynyk of the OPP's Criminal Investigation Branch (CIB) testified, if the initial responding officer or a supervisor has any suspicion the death could be criminal in nature, the area crime supervisor (a detective sergeant) will be brought into the discussion.⁵⁶ The detective sergeant will assess the scene and make a determination as to whether it fits the criteria to be assigned to a criminal investigation member – that is, a detective inspector. The detective inspector is then responsible for determining whether a major case manager needs to be involved.

38. Det. Insp. Olynyk testified the initial approach to an apparent suicide is the same as for a known homicide,⁵⁷ and the subsequent investigation is very similar to that of a homicide. Officers wear full biohazard suits to ensure nothing is disturbed, picked up, or left behind.⁵⁸ The scene and the evidence are secured, and no one is permitted in or out.⁵⁹ A decision regarding the nature of the death will be made in consultation with the coroner, bearing in mind the post-mortem examination could change the nature of the investigation. Once the post-mortem is complete and the available evidence has been

assessed to show nothing suspicious, the OPP will be in a position to conclude the death was by suicide.⁶⁰

39. Insp. Brendan Fitzpatrick, of the RCMP “E” Division Major Crimes Section in British Columbia, testified the RCMP’s approach to death scenes was similar to those described by S/Sgt Clark and Det. Insp. Olynyk. He testified, “[t]he number one rule would be that any death investigation is suspicious until proven otherwise,”⁶¹ but added the RCMP’s approach to the scene is also dependent on forming opinions about the nature of the death as suspicious or non-suspicious. The constable or investigator at the scene should obtain information concerning the witnesses present or the circumstances concerning the report of the death. He or she must also preserve evidence by securing the scene and would contact an NCO or senior investigator, if available, to attend.⁶² The RCMP also makes available advisory NCOs who will attend the scene and assist with the assessment.⁶³ The RCMP members at the scene then analyze the information available, and their determinations dictate the next steps.

40. Insp. Fitzpatrick testified the RCMP members in “E” Division, as a general rule, do not release the scene until after an autopsy is complete.⁶⁴ If there is a suicide note, or the means of death suggest a suicide, it is important to corroborate such evidence and seek information from the family and neighbourhood inquiries as to the deceased’s state of mind. The coroner will be involved and will provide direction as to where the investigation is going.⁶⁵ Until there has been a determination the death is non-suspicious, the RCMP preserves and gathers evidence as though conducting a criminal investigation, to ensure any prosecution is not compromised.⁶⁶

41. Where a death is determined to be non-suspicious, the RCMP “E” Division conducts an investigation on behalf of the coroner.⁶⁷ A non-suspicious death will probably remain with the responding constable or investigator, who will coordinate with the coroner.⁶⁸ All evidence at the scene of a non-suspicious death is seized at the direction of the coroner.⁶⁹ The investigating officer should conduct neighbourhood inquiries to determine whether there are observations or other circumstances needing to be considered and take a statement from the last person to see the deceased alive.⁷⁰

42. Insp. Fitzpatrick testified that, when there is any belief the death is suspicious or was an outright homicide, it becomes an investigation for the RCMP or for the local police force, and all evidence will be seized by the police. Forensic identification specialists will be called to attend, examine, process and document the scene, and the coroner will be consulted about the actions being taken and the extent to which the remains can be disturbed. The forensic identification specialist video-records and photographs the scene, and takes DNA swabs of material such as blood. A blood-spatter analyst could be called in for a suicide where necessary.⁷¹

Initial investigation failures at the death scene

43. In this case, the investigators do not appear to have fully understood either the purpose of the sudden death investigation or their role in that investigation – which was, from the outset, to determine whether there was any indication Cpl Langridge had died as a result of foul play.⁷² When asked if the entire focus was to determine whether any foul play was involved, Sgt Ritco agreed, but then added his function was also “to find out what actually happened to Cpl Langridge.”⁷³

44. That said, the CFNIS investigators did not ask themselves why they were at the scene of Cpl Langridge’s death or what specifically needed to be done in the circumstances. The investigators failed to assess the scene and death critically and failed to determine the level of suspicion associated with the death to focus and adjust their approach. The CFNIS members appeared to appreciate the fact the Office of the Chief Medical Examiner had authority in sudden death investigations, but did not appreciate the nature of Mr. Caufield’s function as the ME Investigator, which was to investigate the cause and manner of Cpl Langridge’s death.⁷⁴ The CFNIS members also did not appreciate their own function, which was to determine whether there was anything suspicious about the death that required further investigation by the police.

45. Unlike the EPS,⁷⁵ the CFNIS WR does not conduct investigations of sudden deaths for the benefit of the ME.⁷⁶ As a result, the role of the CFNIS investigators is limited to aspects requiring police investigation, and does not involve conducting a more

general investigation into the cause and manner of death. The investigators involved in this case did not appear to appreciate this distinction.

Incorrect understanding of jurisdiction by CFNIS investigators

46. Police services can become involved in sudden death investigations in either of two ways: pursuant to their police jurisdiction or on behalf of an ME or Coroner.⁷⁷ The *National Defence Act*⁷⁸ authorizes MP to exercise police powers in enforcing the Code of Service Discipline over CF members who are subject to it.⁷⁹ In 1972, the *Criminal Code*⁸⁰ was amended by the *Criminal Law Amendment Act*,⁸¹ bringing MP members into the definition of “peace officers” under the *Code*.⁸² The Supreme Court of Canada has ruled, following this amendment, MP members are authorized to enforce the *Criminal Code* on CF property and with respect to CF members subject to the Code of Service Discipline.⁸³

47. The closing submissions of the subjects incorrectly frame the jurisdictional issue as “who owns the scene?” Their submissions state, “[...] the scene belongs to the ME or Coroner, depending on the jurisdiction. This means the NIS was working alongside and collecting evidence on behalf of the ME, whose job is to determine conclusively the cause of death.”⁸⁴ The subjects submit MCpl Ritco and Sgt Bigelow were investigators acting under the authorization of the ME and the provincial *Fatality Inquiries Act* at the scene of Cpl Langridge’s death, which conferred upon them the powers and responsibilities of an ME Investigator.⁸⁵

48. The subjects’ submissions provide inconsistent and contradictory explanations of the CFNIS’ role at the scene. The subjects maintain Mr. Caufield “owned the scene” and they took direction from him. Yet they also maintain they were conducting an independent investigation.⁸⁶ This explanation suggests confusion as to the role of the CFNIS in investigating a suicide, which also appears in the evidence before the Commission.

49. Maj Daniel Dandurand responded to the Fynes’ concerns about the time that elapsed before Cpl Langridge’s body was removed, by stating:

Here's the thing -- the thing is, Sheila, the medical examiner owns the scene [...]. It's actually not my scene until he attends, and until he says what's to happen. And actually [...] the military police follow his directions explicitly. I mean, he's going to -- if he says "do this", then we do it. If he says 'seize that bottle', 'Grab that 26-ounce bottle', 'Grab that pill case', then that's what we do [...]. And then once he's satisfied -- or she -- once they are satisfied that their direction has been followed, and they determine what occurs, then we have the scene, and we can process it for all the other criminal/forensic processing that we need to do.⁸⁷

50. For his part, MWO Watson testified that, while the CFNIS would be wholly in charge of the scene and the investigation in the event of a criminal offence like a sexual assault within their jurisdiction, CFNIS investigators will in practice take direction from the ME in the case of a sudden death.⁸⁸ Although it was his view the MP are not within the scope of the Alberta *Fatality Inquiries Act* and cannot act as ME Investigators,⁸⁹ he testified: "When there is a sudden death the ME owns that scene and he can provide direction on what he wants to be conducted," adding, every investigator who has ever worked for him would follow the ME's directions in a sudden death investigation.⁹⁰

51. According to Sgt Bigelow, when MWO Watson contacted him about Cpl Langridge's death and requested his assistance with the investigation, he was instructed to wait along with MCpl Ritco before going to the scene because, in sudden death investigations, the death scene is controlled by the ME.⁹¹

52. MCpl Ritco testified the scene "belonged" to Mr. Caufield as the ME Investigator. As such, MCpl Ritco waited for Mr. Caufield to grant him permission to enter the scene before he began to examine and process the room.⁹² He testified the ME is "the one that does the autopsy or the toxicology. He is the one that gives the final report to say what the cause of death was [...] And how. It's his crime scene or his scene, I should say."⁹³ However, MCpl Ritco also testified when a sudden death occurs, he would effectively be conducting a parallel investigation into the death. He stated he does not require the permission of the Chief Medical Examiner to commence such an investigation, but the investigation should not interfere with the ME's investigation:

[The ME] has primary [jurisdiction] over the scene and, if need be, witnesses and all that if there is anybody there, right? He dictates what -- like this person to be interviewed or you're not allowed to go into here. You're not allowed to touch this or I need this. So I'm still doing my investigation but I still have to -- he still has say in the matter.⁹⁴

53. Just like the subjects did at the outset of the investigation, it should be noted the complainants also misconstrued the roles of the CFNIS and the ME Investigator. They did not appreciate the different requirements for CFNIS members and the ME Investigator. The submissions of the complainants discuss who owns the scene. The opinion obtained by the complainants through the Solicitor General and Public Safety for Alberta, upon which the complainants' view of this question appeared to be based, seems to have been premised on an assumption only one entity – the CFNIS or the ME Investigator – has jurisdiction to investigate a sudden death on a CF base. In reality, each has different roles.

54. The police and the ME or ME investigator have somewhat overlapping but largely complementary jurisdiction with respect to a sudden death scene. In Alberta, legislation gives MEs the function of determining the cause and manner of death as well as the identity of the deceased, the date, time and place of death, and the circumstances under which death occurred.⁹⁵ In pursuing this function, the ME or ME investigator at a sudden death scene has the power to cordon off or secure the scene, to enter the scene without a warrant, and to seize anything that may be directly related to the death without a warrant.⁹⁶ Additionally, the ME has the power to authorize members of the RCMP, other peace officers and members of police services responsible for policing in Alberta to assist the ME in carrying out his or her investigation. In such cases, the authorized police officers exercise the powers of the ME to secure a scene, enter a scene, and seize items related to the death.⁹⁷ However, they can only exercise these powers if authorized to do so by an ME.⁹⁸

55. In this case, it appears the CFNIS investigators were unable to act as ME Investigators at all. The CFNIS is not identified in the provincial legislation and does not appear to meet the statutory criteria for designation as a ME Investigator. Even if the statute did allow for the CFNIS investigators to act in this case as ME Investigators, nothing Mr. Caufield did indicated he authorized the CFNIS to act on his behalf, nor was there an indication anything the CFNIS investigators did at the scene was done on his behalf. In fact, MCpl Ritco testified before the Commission his investigation was conducted “on behalf of the military”, and not on behalf of the ME.⁹⁹ He remarked the

items he seized were taken under his powers as a peace officer, stating, “It was DND property. Corporal Langridge, it was his room. So I seized it under [...] my investigation.”¹⁰⁰

56. The coroner or ME has a primary mandate to draw conclusions about the cause and manner of death through an examination of the body. While a coroner or ME does not “own” the scene, he or she can seize evidence in furtherance of that investigation. The CFNIS, like any police force, is responsible for investigating the possibility of foul play or criminal activity. A coroner or ME’s office typically leads investigations into non-suspicious or non-criminal deaths, with police acting in support.¹⁰¹ Meanwhile, police forces will lead investigations into suspicious or criminal deaths, and the ME or ME Investigator at the scene takes a more passive role and completes their work when it will not interfere with the police effort.¹⁰² The ME will normally not be called in as quickly for a suspicious or criminal death in order to give police at the scene time to assess the scene and to bring in forensic personnel as needed.¹⁰³

ASSESSING THE SCENE AND THE EVIDENCE

57. Given the complex nature of sudden death investigations, there is no exact formula to follow in order to determine when and on what basis foul play can be ruled out. However, there are certain issues an investigator ought to have foremost in mind. They include examining the death scene and body for evidence of foul play; creating a chronology of the deceased’s final hours and days; and investigating whether there were any circumstances in the deceased’s life to suggest foul play was more or less likely as contributing to the death. These inquiries generally focus on three key elements of the investigation, sometimes referred to as the “Golden Triangle”:¹⁰⁴ the scene, the post-mortem examination, and the history of the deceased. They may require the employment of a variety of police investigation techniques, including but not limited to: crime scene investigation, forensic analysis, interviewing, and documentary review.

58. Other police investigators outside the CFNIS make assessments about the scene and the nature of the death from the information available. The police panel members were conscious of the need to avoid tunnel vision and foreclosing of options but also

stressed the importance of forming hypotheses.¹⁰⁵ The investigators at the scene must decide whether the death is suspicious. The circumstances of the scene dictate what will be necessary to properly make that determination.

59. Both the scene and Cpl Langridge's body provided information. That information ought to have been identified and analyzed to establish the circumstances of Cpl Langridge's death. Investigators should be cautious not to rush to conclusions. They must remain open to the possibility of information arising at a later date, inconsistent with the prevailing theory of the case and capable of changing the entire nature of the investigation. As a result, reasonable measures must always be taken to gather and preserve evidence, whose relevance may only become clearer at a later date. However, an investigator's job is to analyse and form opinions based on the information available to determine what needs to be investigated and how.

60. A February 2008 draft revision to Chapter 7, Annex I to the MPPTPs stated, "There shall be no presumption of suicide at the outset of any death investigation. All manners of death must be considered and eliminated through investigation."¹⁰⁶ Colonel R.M. (Rod) Lander, who was the Deputy Provost Marshal Police between 2004 and 2007 and Army Provost Marshal in 2008, testified he issued a Police Policy Bulletin containing this amendment in 2005 as a temporary revision to the 2004 Annex to the MPPTP, and stated "[...] this [draft 2008 revision] or something very close to it was the amendment that was issued."¹⁰⁷

61. The evidence suggests this was the policy in place at the time of Cpl Langridge's death. The subjects of the complaint knew there was a need to rule out the possibility of foul play in Cpl Langridge's death and a need to keep "an open mind."¹⁰⁸ However, the extent to which any possible manner of death was investigated or eliminated by MCpl Ritco and Sgt Bigelow is unclear. The 2008 draft revision of MPPTP Chapter 7, Annex I (as well as the July 2004 version)¹⁰⁹ directed members investigating a suicide to "focus on determining that the wounds to the subject were in fact, self-inflicted."¹¹⁰ The work done by the investigators following their arrival at the scene provides no indication they understood what to look for at the scene of a sudden death. It appears their approach did

not include reading the scene and the area around the building for information and evidence as to whether anyone else was involved in the death. Instead, they proceeded to process the scene in minute detail, but apparently without thinking about the purpose of the evidence gathered.

Determining whether the death was suspicious

62. From the outset, it should have been clear Cpl Langridge's death was not suspicious. This went unnoticed. Although the investigators testified their goal was to rule out foul play,¹¹¹ nothing in the investigative record reveals any attempt to link what they observed at the scene with any conclusion about the likelihood of foul play. In fact, many revealing signs of a non-suspicious death were present, but there was no attempt to identify and record these for the purpose of analyzing the scene.

63. The CFNIS members did not adapt their process to respond appropriately to the circumstances. MCpl Ritco testified he did not make any initial determination as to whether the scene was suspicious or whether there was anything to indicate the death was other than a suicide by hanging. He appeared to form no opinions at all, testifying, "I can't make that determination at that point in time. I had just got there. I needed to process the scene entirely to find out what exactly was going on."¹¹² In his testimony, Sgt Bigelow acknowledged, at that point in time, he did not suspect foul play,¹¹³ but stated he believed no assessment could have been made until the scene had been processed. Notably, Sgt Bigelow's notes from the evening of March 15, 2008, refer to the barracks room as a "suicide scene," perhaps suggesting he was more influenced by the ME Investigator's evidence at the scene than he recalled in testimony.

64. ME Investigators, with considerable experience in assessing sudden death scenes, assess the evidentiary requirements of the scene and the body in deciding how best to proceed. Mr. Caufield testified his initial examination of the body is his primary concern because this determines the nature of the investigation.¹¹⁴ If the death appears to be non-suspicious, he will take approximately six to eight photographs of the body, search the scene for items potentially connected to the death, and await the arrival of the removal service.¹¹⁵ If there was an injury to the body or some other indication making the death

appear suspicious, the ME Investigator would notify law enforcement, such as the EPS or the RCMP, to have forensic identification officers and major crimes investigators attend.¹¹⁶

65. If evidence of foul play had been uncovered by the CFNIS members or the ME Investigator at the scene, it is unlikely Mr. Caufield would have ordered Cpl Langridge's body moved or removed before the scene had been fully processed. Mr. Caufield's readiness to move Cpl Langridge's body and his opinion the death was consistent with a classic suicidal hanging¹¹⁷ strongly reflect an assessment that no foul play was involved in the death. This is also reflected in the fact Mr. Caufield informed the investigators an autopsy would not be conducted on the body, and he would only run a series of toxicology tests on samples from Cpl Langridge's body. He informed them this would take several months to complete.¹¹⁸

66. Had the CFNIS investigators analyzed the scene purposefully, they should have understood what steps were necessary for the investigation. This initial analysis would have told them what to look for as they searched for evidence. If they were investigating the possibility of foul play, they should have identified all potential points of entry to the room and assessed if there were any indications of another person entering or exiting.¹¹⁹ Nothing about the doors and the window in the room suggested any forced entry into Cpl Langridge's room or indicated anyone was present when he died. Neither MCpl Ritco nor Sgt Bigelow appeared to draw any inferences from the fact the door to the room was locked when MCpl Hurlburt attempted to enter. Sgt Bigelow was asked whether he or MCpl Ritco had checked the door to the barracks room for any sign of forced entry while they photographed. He replied, "I don't think we went out of our way to check it but it was observed that there was no forced entry." He did not recall who made this observation.¹²⁰ It did not appear in either his notes or MCpl Ritco's notes, or otherwise within the GO File. MCpl Ritco acknowledged during his testimony there was no sign of forced entry, but he did not consider this during the investigation.¹²¹ During the video recording of the scene, MCpl Ritco opens the door to the shared washroom, noting the door was locked from the side of Cpl Langridge's room. This made the bathroom another very unlikely point of entry or exit.

67. The one plausible means of entry or exit was hardly noted. The barracks room was on the third floor of the building and the window to the room was open. This was readily apparent to the CFNIS members – the video recorded at the scene featured the sound of wind rattling the blinds, and MCpl Ritco referred to the open window as the cause of the noise. An investigator attempting to determine if foul play occurred should have identified the window as a plausible point of entry or exit. As the room was on the third floor, significant effort would have been required to enter the window, and this could leave behind impressions in the ground or even rope, a ladder or other climbing equipment. The CFNIS investigators did not examine the window or search the grounds below the window for evidence of entry or escape. They did not examine and photograph the exterior of the building¹²² or search the area outside the building where the room was situated for anything of evidentiary value.¹²³

Drawing inferences from the body

68. A great deal of information can also be obtained from the body itself, through both an investigator's own observations and relying upon the observations of a coroner, medical examiner or ME Investigator. While death scene investigators will not have the expertise of these medical professionals, a competent and experienced investigator will nonetheless be aware of and draw inferences from what the state of the deceased's body may reveal about how he or she died.

69. S/Sgt Clark of the EPS testified the opinion of the Medical Examiner as to whether a death was suspicious is very important.¹²⁴ An ME has a great deal of credibility and will be specifically asked to examine sudden death scenes when there is uncertainty as to whether a death was suspicious. Where a representative of the ME's Office concludes, for example, the bruising of a body is not suspicious for a given reason, this will be given considerable weight by the investigators in making determinations about the nature of the death. Det. Insp. Olinyk testified OPP investigators also consider the opinion of the coroner to be very important.¹²⁵

70. Mr. Caufield expressed his opinion Cpl Langridge's death was a suicidal hanging. He began his assessment by confirming Cpl Langridge was deceased¹²⁶ and, within

approximately ten to 15 minutes,¹²⁷ had formed the opinion “ [...] it was pretty classically a suicidal hanging.”¹²⁸ He observed Cpl Langridge did not have any visible injuries, suggesting there was no attack or struggle prior to his death.¹²⁹ Mr. Caufield also observed Cpl Langridge's feet were in contact with the ground the entire time, meaning all he had to do at any point was stand up (or otherwise put his weight on his feet), and take the pressure off of his neck, to stop himself from asphyxiating. Further, it would have been nearly impossible for someone to maintain Cpl Langridge in this position without creating injuries or marks. The ligature itself was secured with knots tied around his neck and the chin-up bar. This was a relatively simple contrivance a person could prepare and carry out alone.¹³⁰

71. Mr. Caufield testified about other indications of suicidal hanging, including the dark patches of lividity evident in Cpl Langridge’s arms, hands and feet. Lividity is dependent on gravity relative to the body at the time of death. The patterns were entirely consistent with hanging and not consistent with the case of a person who died in a different position and was subsequently posed in a hanging position.

72. Mr. Caufield testified hangings are generally suicides and, conversely, homicidal hangings are “extremely rare and quite obvious when you see them.”¹³¹ Similarly, he testified accidental hangings, such as in the case of autoerotic asphyxiation, are also rare.¹³²

73. MCpl Ritco did not have sufficient understanding of matters such as post-mortem lividity or how it was significant with respect to analyzing the scene in a sudden death investigation.¹³³ Specifically, he did not appreciate the pooling of blood observed on Cpl Langridge’s hands and arms provided a strong indication the position Cpl Langridge was found in was the position he was in when he died.¹³⁴ MCpl Ritco was correct in testifying lividity can have bearing on determining the time since death,¹³⁵ but this was not its chief significance to an immediate appraisal of the scene – and there is no evidence he gave the implications of this post mortem indicator any consideration at the time. In fact, MCpl Ritco was so guarded against forming any opinions at the scene, he did not realize the significance of Mr. Caufield’s opinion that it would be highly unlikely there would be no

visible wounds or signs of a struggle if a healthy young man was conscious while someone attempted to hang him against his will.¹³⁶ He did not or could not form an opinion from the information about the position of the body and the evident lividity about the nature of the death and whether it was likely other persons were involved.

74. Later, in the video taken by MCpl Ritco, when the body is lowered and placed onto a stretcher, Mr. Caufield explains Cpl Langridge had no signs of petechial hemorrhaging in his eyes. These marks appear where asphyxiation was interrupted by relaxation of the pressure around the neck and then tightening again. The presence of petechiae could indicate there was some manner of struggle where the pressure came off and was reapplied. The absence of these marks suggests there was no struggle. Sgt Bigelow noted the absence of petechiae in the GO File.¹³⁷

75. The information available to Mr. Caufield at that time indicated Cpl Langridge did not attempt to stand up to relieve the asphyxiation prior to his death. This further contributed to the ME Investigator's conclusion the death was consistent with a suicidal hanging.

Failing to apprehend the clear indications

76. Between the information readily apparent to an experienced investigator and the information provided by the ME Investigator, it was clear:

- The door to the barracks room was locked from the inside, as was the door to the shared washroom, and there was no sign of forced entry into the room;
- Room F314 was on the third floor of the building, meaning it could not have been easily entered through the window;
- There was no sign of a struggle within the room, which would be expected if a physically healthy young man was hanged against his will;
- Post-mortem lividity indicated the position in which Cpl Langridge's body was found was the same position in which he died;
- Cpl Langridge had no injuries on his body which suggested an assault or a cause of death other than hanging, and there were no defensive wounds;

- Cpl Langridge did not exhibit any petechiae, strongly suggesting there was no struggle;
- Cpl Langridge's feet were in contact with the floor, meaning he could have stood up at any time before losing consciousness;
- The knots of the ligature around Cpl Langridge's neck, and the point at which it was affixed to the chin-up bar in the room, were simple knots a single individual could have tied for himself;
- A chair was found immediately behind Cpl Langridge, possibly for Cpl Langridge to stand on before dropping to the floor to hang himself.¹³⁸ Its relevance did not appear to have been noted;
- Cpl Langridge left a suicide note to his family;
- Cpl Langridge had removed his watch, necklace, and rings, and placed them beside the suicide note; and
- Information was received before attending the scene indicating Cpl Langridge had spoken of suicidal ideation in the past.

77. The initial information was overwhelming that the cause of death was suicide. Mr. Caufield's investigation led him to quickly form the opinion the death was a classic suicidal hanging.¹³⁹ He testified, "[...] there was nothing from the death scene and Cpl Langridge's body or any of those types of things that made us feel it was anything other than a suicide."¹⁴⁰

78. Sgt Bigelow recorded in his notes Mr. Caufield had provided his opinion the death was the result of an "obvious hanging" at the scene, but Sgt Bigelow testified this did not mean the death was a suicide but, rather, meant only "[...] the person that was in front of us is deceased, was deceased because of hanging."¹⁴¹ He conceded he did not have an independent recollection of the events and was relying on his notes in providing that interpretation. In fact, as noted above, the video recording of the scene commenced with MCpl Ritco reporting the ME Investigator had previously entered the room and given his opinion he suspected the death was a suicide. Sgt Bigelow testified he did not suspect foul play had been involved at the time Cpl Langridge's body was lowered, adding, however, that he could not "make that assessment until we've processed everything."¹⁴²

79. Sgt Bigelow testified he and MCpl Ritco were bound by standards and rules for processing a scene, making it necessary to do a thorough job to rule out foul play. He stated, “We're trained to process it to a certain standard, right, and we're not going to deviate from that just because [Mr. Caufield] says it's an obvious suicide, right? It's our credibility on the line.”¹⁴³

80. Both MCpl Ritco and Sgt Bigelow claimed not to have placed much weight on Mr. Caufield's opinion. They were asked if Mr. Caufield's opinion had any bearing on their approach. MCpl Ritco testified he was unable to make any assessments before processing the scene.¹⁴⁴ He maintained he could not narrow down the possibilities at that stage and had to keep an open mind.¹⁴⁵ For his part, Sgt Bigelow testified the opinion of the ME Investigator had no impact on the decisions he made for processing the scene.¹⁴⁶

81. The investigators recorded Mr. Caufield's observations¹⁴⁷ and took pains to document the scene precisely as it was found, but it does not appear they put this information to use in terms of making a preliminary assessment about the scene or the manner of Cpl Langridge's death. They failed to analyze the information and evidence gathered at the scene and apply it to any hypotheses. The only guidance MCpl Ritco and Sgt Bigelow were given by their superiors on the day of the suicide was to take their time and be thorough.¹⁴⁸ This they did. However, lacking in experience and adequate supervision in conducting his first sudden death investigation, MCpl Ritco did not appreciate whether any pieces were missing and had little idea of what to do with the evidence and information he so painstakingly gathered.

SPECIFIC ISSUES REGARDING THE PROCESSING OF THE SCENE: HANDLING THE SUICIDE NOTE

82. Cpl Langridge left a suicide note for his family and placed it prominently on the desk in his barracks room. He wrote:

Sorry but I can't take it anymore. I love you Mom, Shaun, James, Mike, Grandma, Aunti, Tom. Please know that I needed to stop the pain. XOXO Stu

PS I don't deserve any kinda fancy funeral just family. TY.¹⁴⁹

83. The suicide note was collected as potential evidence, but the note was never the subject of any investigation or forensic examination.

84. The note was not revealed to the family for over fourteen months, long after the conclusion of the 2008 investigation.¹⁵⁰ This meant Cpl Langridge's last wishes were not known to his family until long after his funeral. The failure to disclose even the existence of the note was, naturally, the cause of considerable frustration and pain for the complainants.

Expert views on handling suicide notes

85. The value of a defined plan and methodical analysis is illustrated by how other police services adapt their investigation process based on the circumstances of the death and the scene. Where a suicide note is found at the scene, a number of steps can be taken, including seizing the note, maintaining continuity, and authenticating it through testing. However, these are only undertaken when there is actual suspicion about the death because such steps require significant expenditures of time and resources.

86. All three members of the police panel agreed they would only seize the original suicide note as evidence for their own investigation if there was suspicion about the death. In such a case, they would take measures to authenticate the note.

87. S/Sgt Clark explained the ME Investigator leading the investigation is responsible for seizing all exhibits where the death is believed to be non-criminal in nature and will take possession of any suicide notes found at the scene. The police only take a copy of the suicide note.¹⁵¹ However, in the case of a suspicious or criminal death, where investigators have reason to believe the suicide may have been staged, it becomes essential to seize the original suicide note and retain its continuity as evidence. In such cases, S/Sgt Clark testified the EPS will "absolutely" test the note for authenticity, using methods such as handwriting analysis and fingerprinting.¹⁵²

88. Similarly, Insp. Fitzpatrick testified the RCMP will only seize the original of a suicide note for their own investigation if a death was considered suspicious and otherwise will only seize it under the direction of the coroner.¹⁵³ Where a death appears

suspicious, the RCMP will authenticate the suicide note through fingerprinting, DNA swabs, and handwriting analysis. They will even seize the pad of paper used for the suicide note and the pens in the house.¹⁵⁴

89. Det. Insp. Olynyk testified, where a death appears to be the result of a suicide, the suicide note is only seized at the coroner's direction and for the benefit of the coroner's investigation.¹⁵⁵ Where there was any belief the death might have been suspicious, the OPP will test the suicide note to confirm its authenticity. The investigators obtain handwriting samples from the family of the deceased and submit the note for examination at their Centre of Forensic Sciences.¹⁵⁶

How was the suicide note handled by the CFNIS?

90. In contrast, the suicide note, like the rest of the evidence collected at the scene, was never evaluated or later examined or even revisited by the CFNIS members. Between 1733 hrs and 1821 hrs, Sgt Bigelow took notes concerning the contents of the barracks room. He copied out the text of Cpl Langridge's suicide note word-for-word.¹⁵⁷ A copy of the note was scanned into the GO File, and the text of the note was typed into a text box by Sgt Bigelow.¹⁵⁸ At 1912 hrs, MCpl Ritco seized the suicide note, placed it into an evidence bag and gave it to Sgt Bigelow.¹⁵⁹ As he did with the other items seized at the scene, he wore latex gloves to prevent contamination of any latent fingerprints or DNA evidence, which may have been present.¹⁶⁰

91. The precautions taken with the suicide note indicated MCpl Ritco understood it could be highly relevant should evidence of foul play emerge. Keeping the suicide note in the evidence bag at all times,¹⁶¹ Sgt Bigelow photocopied the note and provided a copy to Mr. Caufield.¹⁶² The next day, it was placed into MCpl Ritco's temporary evidence locker, where it remained until April 9, 2008, when it was transferred to the CFNIS evidence room.¹⁶³ The suicide note was not accessed or noted again until June 1, 2009.¹⁶⁴

92. Had there been any real question whether Cpl Langridge died of foul play, the note should have been tested to verify its authenticity. Sgt Bigelow was asked if any thought was given to running fingerprinting or handwriting analysis tests to authenticate

the suicide note. He replied, “At that time, no.”¹⁶⁵ Nevertheless, he explained a handwriting sample should have been obtained in case it became necessary to confirm Cpl Langridge wrote the note. He testified he did not know why a handwriting sample was not obtained in this case.¹⁶⁶ For “equivocal” death investigations (that is, investigations in which the conclusions are open to different interpretations depending on the facts, victimology and circumstances of the death), the CFNIS SOP states handwriting samples of the deceased should be collected for comparison, even if a suicide note is not immediately found.¹⁶⁷ This SOP was not in effect in March 2008, but it reflected best practices with respect to a suicide note found at a sudden death scene.¹⁶⁸

93. In this case, the ME Investigator did not require the original of the suicide note. That is a telling fact. During his testimony, Mr. Caufield explained his office’s practice with respect to suicide notes found at the scene of a sudden death:

The practice has changed. There was a time that we always -- we would always seize the original suicide note, primarily for concerns about the possibility of questions being raised that would require perhaps handwriting analysis, that type of thing. We did that for many years. We would seize the original, photograph it, keep it and then try to get, you know, property back to the family, those types of things. It was decided -- because we never, ever had an issue with handwriting analysis, we decided we're complicating things by doing that, so we had come to agree that a photocopy of a note was fine if, you know, someone else needed it, whether that's a significant grieving relative or, like in this case, another agency wanted it. As long as we had a good facsimile of the note, we're satisfied to have that.¹⁶⁹

94. Mr. Caufield testified he would want to have the original suicide note in circumstances where a suicide did not appear to be straightforward, such as when a family is concerned the deceased had been murdered and the suicide staged to deflect suspicion. Where criminal aspects to the death are suspected, the Office of the Chief Medical Examiner of Alberta will “absolutely [...] seize the note.”¹⁷⁰ In the case of Cpl Langridge’s suicide note, Mr. Caufield testified he had no reason to be uncomfortable with only a photocopy of the suicide note because it was such a clear case of suicide and mere analysis of the evidence, without forensics, was enough to establish there was no foul play.¹⁷¹

95. As was the case with Mr. Caufield’s expressed view to the effect Cpl Langridge’s death was consistent with suicide, MCpl Ritco testified the presence of the suicide note

did not influence his view of the scene or cause him to discard the possibility of foul play.¹⁷² Sgt Bigelow testified the suicide note was kept in the evidence bag from the moment it was seized and was retained as potential evidence. He explained if it was determined Cpl Langridge's death had been the result of foul play, it would be essential to preserve the potential to retrieve fingerprints from the note. MCpl Ritco testified he also thought about the possibility of testing for fingerprints and traces of DNA as well as handwriting analysis when he seized the suicide note.¹⁷³ Yet nothing relating to the suicide note appeared in MCpl Ritco's Investigation Plan (IP).¹⁷⁴

96. Given the lack of evidence suggesting anything other than suicide, there was objectively no need to conduct tests on the suicide note. MCpl Ritco's testimony only illustrates the confusion as to purpose with which the CFNIS members acted when processing the scene.

SPECIFIC ISSUES REGARDING THE PROCESSING OF THE SCENE: WAS DISRESPECT SHOWN TO CPL LANGRIDGE'S BODY?

97. The complainants allege Cpl Langridge's body was treated with disrespect in a number of ways. From their perspective, the nearly two-hour period between the arrival of the CFNIS and the removal of Cpl Langridge's body was unreasonable. They contend unnecessary investigative steps taken prior to the removal of Cpl Langridge's body compounded the delay. They allege Cpl Langridge's body was not lowered sooner because the CFNIS members viewed Cpl Langridge as a defaulter, unworthy of the respect otherwise shown to a deceased soldier. They allege he was simply dismissed as a troublemaker and a "waste of rations" by those present at the scene of his death.¹⁷⁵ They were concerned anyone entering or exiting the barracks room had to squeeze past Cpl Langridge's body to avoid disturbing it. They contend no evidence would have been lost by lowering Cpl Langridge's body sooner.¹⁷⁶ The complainants also submit the proper procedure would have been to lower Cpl Langridge's body promptly and check for vital signs.

98. The position of the complainants is the CFNIS members possessed the authority to order Cpl Langridge's body lowered prior to being removed. Mr. Fynes testified the

ME Investigator had no jurisdiction over a body on federal property.¹⁷⁷ He also testified he obtained an opinion, via email, from the office of the Solicitor General and Public Safety for Alberta stating the primary jurisdiction to investigate a sudden death on a Canadian Forces base within the province lies with the military police and the CFNIS.¹⁷⁸

Who had authority over Cpl Langridge's body?

99. The subjects of the complaint and the ME Investigator are in agreement Mr. Caufield had the *sole* authority over any decision to lower or remove Cpl Langridge's body. When Maj Dandurand and MS Eric McLaughlin interviewed the complainants in November 2009, they explained the provincial ME possessed jurisdiction over the body even on federal property, and the CF relied on provincial coroners and MEs just as civilian police forces did.¹⁷⁹ Maj Dandurand stated the ME "owns" the scene. When the Fynes raised these concerns with Col Gerard Blais, Director of Casualty Support Management in 2010, the CFNIS provided a written explanation concluding the provincial coroner or ME had responsibility over the movement of a body. It read, "The decedent cannot be removed until authorization has been provided by the Lead Investigator who receives direction from the coroner."¹⁸⁰

100. The evidence confirms the CFNIS investigators were not empowered to decide when Cpl Langridge's body could be lowered or removed. The police panel unanimously confirmed the police should not move or disturb the body at the scene unless absolutely necessary – for example, where it may be possible to preserve a life – and, with few exceptions, will not touch or move a body without the authorization of the coroner or ME.

101. Insp. Fitzpatrick testified that, in British Columbia, under no circumstances can the deceased be touched or tampered with until the coroner has given police the authority to do so.¹⁸¹ S/Sgt Clark testified it was the ME's responsibility to lower a body in a case of suicide by hanging and the authority to move the body rests with the ME.¹⁸² Det. Insp. Olinyk testified bodies in criminal and non-criminal deaths are the responsibility of the coroner's office, and any time the OPP members at a death scene cut down, move or touch a body, this is done in discussion with the coroner and forensic officers.¹⁸³

102. Depending on the circumstances of the death, either the ME's Office or the investigating police force of jurisdiction has the overall lead on the investigation. In **all** cases, the *Fatality Inquiries Act* makes it clear the Chief Medical Examiner has statutory authority over the body at a sudden death scene in Alberta. Certain deaths, including sudden deaths, must be reported to the ME's Office,¹⁸⁴ and an ME must investigate the death once such deaths are reported.¹⁸⁵

103. Mr. Caufield testified this authority covers the entire province of Alberta, including military bases. No other agency has this jurisdiction.¹⁸⁶ Moreover, under the statute, the ME is deemed by law to have taken possession of the body as soon as he or she has been notified of the death.¹⁸⁷ There is no evidence a CF base in Alberta is excluded from the application of the provincial *Fatality Inquiries Act*. It was Mr. Caufield's evidence the ME has sole authority to determine whether, when and how a body can be moved – both in cases where the body is on a military base and in all other cases.¹⁸⁸

104. In light of these facts, the only reasonable conclusion is Mr. Caufield had the sole authority over the handling and movement of Cpl Langridge's body.

Why was Cpl Langridge's body not lowered sooner?

105. Since a fairly lengthy period of time passed before Cpl Langridge's body could be removed, Mr. Caufield was asked what the practice of his office was with respect to potentially lowering a hanged individual's body prior to the arrival of the removal service. He said his office generally will not lower or cut down a hanging body until the ME or ME Investigator present are ready to remove the body from the scene.¹⁸⁹ In exceptional circumstances, where the body is in a public area and its presence would be disruptive, they might take steps to lower the body. The medical examiner's strong preference is to leave the deceased in place until removal.

106. Mr. Caufield stated he requires 30 to 40 minutes at most to examine the body in a case such as this.¹⁹⁰ In fact, within 12 minutes¹⁹¹ of attending the barracks room, Mr. Caufield completed his initial examination and photography commenced.¹⁹² According to

MCpl Ritco, the scene belonged to the ME Investigator, and thus he waited for permission from the ME Investigator to enter the scene.¹⁹³ MCpl Ritco testified he sought Mr. Caufield's permission to take photographs and video of the scene after the latter's initial examination of Cpl Langridge's body. MCpl Ritco testified Mr. Caufield had no difficulties and advised he could begin examining the scene; this did not impede his work. He noted Mr. Caufield's only comment at that point was to ask for medical records of Cpl Langridge's medication.¹⁹⁴ MCpl Ritco began to photograph and video-record the entire barracks room prior to the removal of Cpl Langridge's body.

107. MCpl Ritco and Sgt Bigelow were asked to explain the length of time to remove Cpl Langridge's body. MCpl Ritco was puzzled by the complaint he let Cpl Langridge's body hang for four or even five hours. MCpl Ritco did not believe he was responsible for any delay. He emphasized first, he thought only an hour and a half had elapsed between his arrival at the scene and the removal of Cpl Langridge's body; and second, he was not in a position to decide when Cpl Langridge's body could be lowered.¹⁹⁵ MCpl Ritco explained, "[...] if he [Mr. Caufield] wanted Corporal Langridge to be cut down, he would have directed me to cut him down."¹⁹⁶ His recollection was there had been a lengthy wait for the body removal service to attend the scene, and he photographed and video-recorded the scene with Mr. Caufield's permission while they awaited the arrival of the body removal service.¹⁹⁷

108. MCpl Ritco's initial approach was to catalogue everything at the scene by taking photographs of the room and its layout, the position and state of the deceased, and then to video-record the entirety of the scene.¹⁹⁸ The investigators processed the entire room, rather than only the area around Cpl Langridge's body.¹⁹⁹ MCpl Ritco testified, when starting to process a scene, the CFNIS' "mandate" is to take photographs and video of the scene – both, if possible.²⁰⁰ MCpl Ritco took approximately 85 photographs of the scene. Sgt Bigelow remained in the room and took notes during this phase. His 11 pages of notes describe the scene and the appearance of Cpl Langridge's body, details about the ligature, and even the temperature of the room (18 degrees Celsius).²⁰¹ At 1821 hrs, Sgt Bigelow wrote in his notebook, "MCpl Ritco starts to videotape suicide scene." He encountered technical problems, however, and the recording was interrupted. The

videocassette was replaced and recording resumed at 1841 hrs.²⁰² The video begins with Sgt Bigelow opening the door to Cpl Langridge's room and with MCpl Ritco reporting the ME Investigator had previously entered the room and had given his opinion he suspected the death was a suicide.

109. The video progresses to a close-up of Cpl Langridge's face and shows images of the chin-up bar, the ligature and Cpl Langridge's body hanging in place. The video records details such as Cpl Langridge's clothing, the lividity patterns evident in his arms and hands, the cyanosis in his face, and also demonstrates his feet are in contact with the floor as he continues to hang.

110. The video records the small bed along the west wall, Cpl Langridge's clothing and the suicide note on the desk. It provides a close-up of the suicide note and then shows MCpl Ritco, while wearing gloves, moving the pen, which had been laid on the note, away so he could read the message aloud.

111. It is not clear everything MCpl Ritco documented was relevant to the investigation or at least necessary to be recorded prior to removing the body. Essentially, all contents of the room, down to minute details, were noted on video and identified by MCpl Ritco. Excluding footage of the body, its immediate surroundings, and a quick sweep of the room, this detailed survey of the contents of the room lasted approximately from 1848 hrs until 1906 hrs, at which point the body removal technicians entered with Mr. Caufield. This meant the detailed survey of the room accounted for nearly 20 minutes of the 27 minutes of footage recorded by MCpl Ritco before Cpl Langridge's body was removed.

112. The photographing and video-recording of the scene took slightly over an hour and a half with Cpl Langridge's body still hanging throughout the period.²⁰³ Mr. Caufield and two personnel from the body removal service entered the room at 1907 hrs.

113. Mr. Caufield testified the process of lowering and removing Cpl Langridge's body depended, to some extent, on the nature of the scene and the circumstances of the body, including whether the knot around the neck of the deceased is simple or complex.

In Cpl Langridge's case, both knots were simple. The belt could not be cut because it would likely have untied itself. For that reason, Mr. Caufield stated it was best to simply untie the knot at the point it connected to the chin-up bar, and leave the slip knot tied around Cpl Langridge's neck, so at least the knot around his neck was preserved.²⁰⁴ Accordingly, the removal personnel wrapped a sheet around the body (in order to avoid any contamination, as well as for ease of movement and to avoid biohazard exposure),²⁰⁵ and then lifted the body to take the weight off the knot tied to the chin-up bar. Mr. Caufield untied the knot at the point where it was attached to the chin-up bar and Cpl Langridge's body was lowered onto a stretcher.

114. In all, three hours and 47 minutes had elapsed since Cpl Langridge's body was discovered, and one hour and 46 minutes had elapsed since the CFNIS investigators arrived at the scene. Cpl Langridge's body was removed from the scene at 1916 hrs.²⁰⁶

115. Sgt Bigelow testified they discussed the ME Investigator's expectations concerning the scene and evidence after they had arrived at the scene and the ME Investigator had conducted his assessment of Cpl Langridge's body. Sgt Bigelow indicated they wanted to understand what Mr. Caufield wanted, so as to avoid "stepping on his toes" or otherwise doing anything incorrect.²⁰⁷ Sgt Bigelow testified he and MCpl Ritco also discussed their own expectations with the ME Investigator as to what was necessary for them to properly process the scene. He indicated it was important to address these points before the processing of the scene began.²⁰⁸ MCpl Ritco elaborated in his testimony Mr. Caufield was unfamiliar with how the CFNIS conducted a sudden death investigation. MCpl Ritco and Sgt Bigelow explained what they intended to do and the ME Investigator had no problems with their approach.²⁰⁹

116. Mr. Caufield testified the time span between his arrival at the scene at 1721 hrs, and removal of the body nearly two hours later, seemed "a little bit unusual" for a case such as this.²¹⁰ When asked why so much time had elapsed, Mr. Caufield testified he was waiting for the CFNIS investigators to complete processing the scene:

Well, I think just primarily that we had that secondary investigative unit involved, the military police investigation. And it's simply that we have another -- you know, they have other policies and procedures that take longer. For instance, we wouldn't -- we certainly

wouldn't videotape a suicidal hanging, so that amount of time just would have just not been there. A suicidal hanging, we may have taken, you know, anywhere from maybe four to six or eight photographs in total. So they did a very thorough investigation, and that took longer than what we would normally do in this type of setting.²¹¹

117. Mr. Caufield testified MCpl Ritco had asked him to wait before removing the body to allow him to photograph and videotape the scene precisely as it was. In the spirit of cooperation, he agreed with the request.²¹² He also testified, had there been a pressing need to wrap the matter up – for example, if another death report had come in where Mr. Caufield was required to attend – he would have asked the CFNIS investigators to “wrap it up.”²¹³ Mr. Caufield testified, while the CFNIS investigators processed the scene, he spent most of his time simply waiting.²¹⁴

118. Determining the time the body removal service arrived is important because Mr. Caufield would not have moved the body before their arrival – meaning, had they arrived later, any delay would have been the removal service’s responsibility. There are conflicting versions of the timing leading up to the removal of Cpl Langridge’s body. Either the removal service personnel were delayed and did not arrive until approximately 1900 hrs, and MCpl Ritco worked to process the scene while awaiting them, or they arrived early at approximately 1748 hrs (nearly an hour and a half before the body was removed), and the delay was caused by MCpl Ritco’s photography and video-recording.

119. Mr. Caufield testified, in general, the precise time at which the ME Investigator will contact the removal service is dependent on how long the investigator believes he or she will need to complete the initial assessment of the scene and the body. The removal service is responsible for other contractual work, such as funeral homes, and their time of arrival at a sudden death scene is situation-dependent. However, there is a contractual requirement for them to endeavour to arrive within one hour of being contacted.²¹⁵

120. Mr. Caufield testified timing is relatively important when making use of the body removal service. Should a case be more complicated and require additional investigative processes, the result will be in the removal personnel “just kind of standing about not doing anything. They can ultimately be paid overtime for being there over a certain period of time.”²¹⁶ The overtime clause in the contract with the body removal service is

evidence of normal practice. Ordinarily, one would expect the service to arrive and work quickly.

121. Mr. Caufield testified where the ME Investigator wanted the removal service to attend at the scene at their first available opportunity, he or she would contact the removal service while en route to the scene.²¹⁷ This was Mr. Caufield's usual practice.²¹⁸

122. MCpl Ritco and Mr. Caufield had no actual recollection or notes of the arrival of the body removal service. MCpl Ritco believed they waited until after 1900 hrs for the removal service to arrive, testifying “And when the body removal came – the exact time of the body removal, I don’t know, ‘cause I was still in the room. But when the body removal came, they removed Corporal Langridge.”²¹⁹

123. Although there were no explicit records kept, nor testimony heard, concerning the time the body removal service arrived, there is documentary evidence suggesting they arrived shortly after MCpl Ritco, Sgt Bigelow and Mr. Caufield. Sgt Van Delen gave a statement to the CFNIS at the base fire hall in which he reported the CFNIS members and the ME Investigator arrived at 1725 hrs.²²⁰ He indicated, when he spoke to Mr. Caufield, he was told the assistance of the fire department was not required because Mr. Caufield was expecting two more personnel to arrive shortly. Sgt Van Delen then wrote the fire personnel waited until the additional “medical personnel [likely the body removal service] arrived before turning control of the scene over to NIS at 1748 hrs.”²²¹ No other medical personnel arrived at the scene after the paramedics of the St. Albert Fire Service Ambulance had attended at 1602 hrs and departed at 1610 hrs, and there is no evidence of any personnel other than the removal service attending the scene to assist the ME Investigator.

124. While MCpl Ritco and Sgt Bigelow testified they did not ask Mr. Caufield to wait to remove the body and were waiting for the arrival of the removal service while they worked, they also stated the time taken was reasonable and the extensive and detailed photographs were absolutely necessary.

125. In effect, it was MCpl Ritco's testimony he was going about his business processing the scene and waiting for Mr. Caufield to make a decision about when to lower Cpl Langridge's body.²²² Then, when the body removal service personnel arrived, they removed Cpl Langridge's remains, and he resumed processing the scene.²²³ On the other hand, MCpl Ritco also testified he made the decision about the extent of photography necessary prior to removal of the body. He explained the determination was based on his training regarding how crimes scenes are processed.²²⁴ This is inconsistent with any suggestion the CFNIS members were not responsible for the time taken in the removal of the body and were simply doing what they could while waiting for the removal service to arrive.

126. Sgt Bigelow, similarly, testified he did not recall a request by either himself or MCpl Ritco for Mr. Caufield to wait until the processing of the scene was complete before removing the body. He only recalled, "We asked him if it was okay to process and he gave us the thumbs up."²²⁵ Nevertheless, Sgt Bigelow also testified the scene was treated as an unexplained sudden death and not an apparent suicide. He testified the reason Cpl Langridge's body was not removed earlier was because it would not have been appropriate. "[I]t was still part of the crime scene and for us to do our job properly, an assessment of what we're capturing, unfortunately the body had to remain."²²⁶ The necessary implication of this testimony is the investigators would not have thought it appropriate to interrupt the filming had Mr. Caufield wished to proceed with lowering and removing Cpl Langridge's body.

127. Further, MWO Watson had informed Sgt Bigelow he and MCpl Ritco should take all the time they needed to process the scene:

I would have -- paraphrasing, but I'm going to get to the gist of it -- don't rush that scene, I don't care if -- and don't release that scene until you're done processing it, I don't care if that body stays four days, don't release it until you're done processing that scene.²²⁷

128. He explained he gave this direction because, in a previous negligence investigation, he had authorized the release of a scene too quickly and important evidence was jeopardized.²²⁸ He did not want MCpl Ritco and Sgt Bigelow to make the same mistake. MWO Watson testified he expected MCpl Ritco and Sgt Bigelow to exercise

their judgment and discretion in determining when to move the body, but he believed it appropriate to take over 90 minutes to process the scene.²²⁹

129. MCpl Ritco may well have kept Mr. Caufield and two contracted body removal personnel waiting as he photographed and video-recorded the scene, during which time they could do nothing. The evidence from the firefighter's statement suggests the body removal personnel attended the scene very shortly after the CFNIS investigators and ME Investigator did. Furthermore, Mr. Caufield was a disinterested party and his evidence about the usual practice with respect to the body removal service and about being asked to wait before removing the body, supports the conclusion the service arrived long before Cpl Langridge's body was removed. In light of this, it appears quite likely there was no long wait for the removal team to arrive. Moreover, it may well be the case the body removal service was waiting at the scene since 1748 hrs, roughly one and a half hours before Cpl Langridge's body was finally taken out of the room. However, the exact timing of the arrival of the body removal service was not definitively determined.

Assessing the investigative steps taken by CFNIS investigators before the body was removed

130. The subjects submit Cpl Langridge's body was not left hanging for an inappropriate amount of time²³⁰ and, in processing the scene, MCpl Ritco behaved professionally in keeping with his training. They also submit the CFNIS expects its investigators to document the scene of a sudden death thoroughly. This includes videotaping the scene and taking photographs. According to the subjects' closing submissions, investigators must document the crime scene as they would a homicide, even when it appears to be a suicide.²³¹ The main objective is to determine whether the death was caused by a criminal act and to ensure evidence is preserved.

131. Det. Insp. Olynyk provided a clear description of what the OPP major crimes investigators do before the body is moved. The approach to the body and the area immediately around the body is video-recorded and photographed prior to the removal and post-mortem; the focus is entirely on the area around the deceased to preserve potential evidence.²³² A description of the room is also written. The body can be moved

after this is complete. In fact, the OPP go even further to protect the integrity of the scene and the evidence after the body is removed. The scene will be kept secure and not searched until the completion of the post-mortem examination.²³³ Evidence is only seized when the failure to seize something immediately could potentially compromise the evidence.²³⁴

132. Insp. Fitzpatrick testified the RCMP “E” Division takes similar steps, videotaping the approach to the scene from the outside in, recording the body from multiple angles and taking close-ups, and making every effort to avoid contaminating whatever evidence may potentially be present. The same process is followed until a death is determined to be suspicious or non-suspicious, and the RCMP are extremely careful to avoid losing or contaminating evidence. Thus, the scene is not released until the conclusion of the autopsy.²³⁵

133. S/Sgt Clark testified the steps required prior to removing a body differ depending on whether the death is deemed suspicious or non-suspicious. In the case of a non-suspicious death, no photographs are taken by the EPS, but the ME will photograph the body and the area around the body. The body is then removed and there is no video recording.²³⁶

134. Mr. Caufield and the police panel members provided a range of durations considered typical from the initial arrival at the scene to the removal of the body. Mr. Caufield testified that, in a case such as this, no more than 30 to 45 minutes would have been required before the body could be moved.²³⁷ Det. Insp. Olinyk testified, assuming the location was not remote, the body would likely be removed within six to eight hours.²³⁸ Insp. Fitzpatrick testified, in the case of a non-suspicious and straightforward death, the body would generally be removed within hours. S/Sgt Clark testified, in the case of a non-suspicious death in Edmonton, his experience was, the time between the arrival of the first member at the death scene and the removal of the body by the ME Investigator and the body removal service was anywhere between one and three hours.²³⁹

135. It is the Commission’s view there was nothing unreasonable about the length of time between the arrival of the CFNIS investigators at the scene and the time when Cpl

Langridge's body was removed. The steps taken and the time involved in processing the scene and removing the body certainly fall within the reasonable range of what could have been done. The elapsed time was close to the ranges established by the testimony of the policing panel, although somewhat longer than what would be required in a similar case by either the Edmonton Police Service or by the ME Investigator.

136. Less than four hours elapsed between the discovery of Cpl Langridge's body and its removal from the scene, but less than two hours of that time is attributable to the actions of the CFNIS investigators. While the inexperience of the investigators may have resulted in their taking more time, it is not appropriate to fault them. The CFNIS investigators did what they thought they had to do to process the scene and preserve evidence. The evidence and the testimony indicate they were making a genuine attempt to do a good job. It is difficult to fault the CFNIS investigators for doing too much.

137. The question, nevertheless, must be asked whether the steps taken by the CFNIS prior to the removal of Cpl Langridge's body were reasonable in the circumstances. Mr. Caufield was asked to describe what he normally requires from the scene prior to the removal of a body in a case like that of Cpl Langridge. He testified, in addition to gathering the information required under the *Fatality Inquiries Act* and carefully examining the body, he and the police officers present will search the scene as well. The time taken to search the scene depends on the location and the area to search.²⁴⁰

138. MCpl Ritco's initial work was of assistance and there is no suggestion it was unnecessary to photograph and video-record Cpl Langridge's body. Mr. Caufield requested some of the photographs MCpl Ritco had taken of the body because his camera malfunctioned, and he was unable to take photographs of his own as he normally would. MCpl Ritco provided all of the photographs he took at the scene.²⁴¹ The question is whether it was necessary in the circumstances to then exhaustively document the scene before Cpl Langridge's body was removed.

139. Mr. Caufield was asked whether, for his purposes as a medical examiner investigator, certain steps taken by MCpl Ritco and Sgt Bigelow were necessary prior to removing the body:

Q. Now, for your purposes, prior to removing the body, is it necessary to fully inventory the contents of the room?

A. No.

Q. Is it necessary to take pictures of the items in the room?

A. No.

Q. Is it necessary to videotape the items in the room?

A. No.

Q. Is it necessary to videotape the room and the body?

A. For our purposes, no.²⁴²

140. In his approach, MCpl Ritco did not assess the information available at the scene to make even a tentative determination as to whether the death was suspicious. He did not limit the recording to the body and the area around the body, which would generally be the focus prior to the removal of the body to capture the relevant areas exactly as they were. In Sgt Bigelow's assessment, it was not sufficient to limit the initial processing to photographs and video-recordings of the area surrounding Cpl Langridge's body. This was because, "[...] if there's anything potentially proven later, through the course of the investigation, to say that there was foul play, if we don't do our process proper, that's evidence lost, right, and that doesn't help to support the case of potential foul play."²⁴³ It was, in his opinion, both reasonable and necessary to completely photograph and take video of the entire scene, including the comparatively lengthy process of video-recording the contents of the room and the washroom, prior to the removal of Cpl Langridge's body.²⁴⁴

141. The evidence amply establishes the value and importance of conducting investigations with focus and purpose – and, in particular, that skilled investigators guide those investigations by formulating sound hypotheses, relying upon and continually testing them against all the available evidence and information. A reasonable investigation begins with measures intended to further those aims, which can be adjusted and adapted, as the circumstances require. This flexibility is important because what is reasonable for investigators to do during a suspicious death may not be reasonable for a

death that is not suspicious. “Keeping an open mind” at the expense of critical thought and analysis is just as counterproductive to a sudden death investigation as rigidly engaging in tunnel vision. Here, not everything done by MCpl Ritco and Sgt Bigelow prior to the removal of Cpl Langridge’s body was reasonable in the circumstances.

142. Certain steps were taken because the *process* was given more importance than the *analysis*. The usefulness or reasonableness of photographing and recording video of the entire scene beyond the immediate area of Cpl Langridge’s body has not been established. The meticulous cataloguing of the entire scene contributed to most of the delay before Cpl Langridge’s body was removed. Under the circumstances, and in view of the abundance of available evidence, there was simply no reason to suspect Cpl Langridge’s death was in any way suspicious. These steps do not seem to have been taken because they were reasonable or helpful, or because important evidence might be lost, but essentially in the interest of completeness.

143. MCpl Ritco was instructed to take his time and be thorough. However, the evidence beyond the area immediately around Cpl Langridge’s body would not have been altered by the removal of the body and there was no urgent requirement to capture it. The extensive photography and video-recording came at the expense of removing Cpl Langridge’s body at the first realistic opportunity. The delay in the removal of Cpl Langridge’s body caused great distress to the family. The delay cannot be attributed to Mr. Caufield, who agreed to wait in the spirit of cooperation.

144. While the time taken by the CFNIS to process the scene was within a reasonable range, and it cannot be known with certainty whether the body removal service was kept waiting or whether they arrived later, the Commission is not convinced all the steps taken by the CFNIS members before removing the body were necessary or reasonable in the circumstances.

145. However, there was no evidence of any disrespect to Cpl Langridge in following this process. While a lack of experience on the part of the CFNIS investigators may well have played a role in the delay, there is no evidence this delay was in any way motivated by any negative opinions about Cpl Langridge.

Should Cpl Langridge's body have been covered?

146. In addition to complaints about the delay before Cpl Langridge's body was lowered and removed, the complainants allege the CFNIS investigators showed disrespect to Cpl Langridge's body because they failed to cover the body before it was lowered and removed. The complainants' belief is, because of the rumours Cpl Langridge was a defaulter, his remains were not shown the same respect as would have been accorded another CF member. It is their belief this was the reason Cpl Langridge's body was left uncovered, and they are greatly concerned by the implication his body was on display for any gawkers to see.

147. The evidence received and the testimony heard by the Commission was clear, unequivocal and unanimous in establishing the body of the deceased should not be covered at the scene, as evidence could be compromised, contaminated or removed by any sheet or similar item draped over the body.

148. Insp. Fitzpatrick testified he could not imagine a situation where a body would be covered by police – even where it was in plain view to the public. There are other ways to conceal the body than draping anything over it. To do otherwise would contaminate the evidence.²⁴⁵

149. S/Sgt Clark agreed a body should never be covered. Where a body was hanging in view of the public, he would take steps to control traffic and block access to the scene.²⁴⁶

150. Det. Insp. Olinyk testified he would not cover a body in any way, and the dignity of a deceased was better protected by barricading the area or closing off an area or scene.²⁴⁷ Mr. Caufield likewise testified the essential principle was the preservation of information and evidence. He testified the ME's Office does not cover a body while awaiting removal regardless of the location.²⁴⁸

Was Cpl Langridge's body exposed to passersby?

151. There is no evidence Cpl Langridge's body was made into a spectacle or was the subject of either gawking or of the general curiosity of passersby. It is true, as is clearly

shown in the video, Cpl Langridge's body was immediately visible to anyone passing by the room if the door were open.²⁴⁹ However, there is ample evidence the MP members kept the door closed or guarded to ensure both the scene and Cpl Langridge's body were secure and off-limits prior to the arrival of the CFNIS investigators.²⁵⁰

152. While the evidence indicates the door was open for some duration of the processing of the scene, there is also ample evidence military police members remained in the corridor to divert anyone not connected to the investigation away from the doorway and into the stairwells at opposite ends of the corridor.

153. MCpl Bruce-Hayes testified the door to the barracks room was generally open while the scene was processed.²⁵¹ He was outside in the hallway in this time, and he and Cpl Broadbent instructed persons in the hallway not to walk past the barracks room when the door was open, but to turn around and go on to the exits at either end of the corridor.²⁵² Mr. Caufield testified he specifically recalled at least one instance of MP or CFNIS members stopping individuals in the hallway and refusing to allow them to proceed until the work had completed and the door could be closed.²⁵³

154. Kirk Lackie, who was a comrade and friend of Cpl Langridge from 2004 onwards, described his experience of the efforts by Military Police members to protect Cpl Langridge's body and secure the scene immediately after the discovery of his death:

[...] [After realizing that Cpl Langridge was dead] I just left and I ran across the fields to the shacks, and by the time I got there, there's, you know, several EMs, firemen and military police there. And then I tried to go down the hallway to Stu's room and the military police officers stopped me. He goes, "You can't go down there right now". I was like, "I'm just going down and check on my friend". And he goes, "You can't go down there right now". And I said, "Well, can you tell me what's going on?" and he was like, "No, I can't tell you". And I said, "Well, can you tell me if it's my friend?" I said, "His name is Stu Langridge". He says, "I can't you [sic] anything right now." He says, "You're going to have to go outside and wait until everything gets cleared up".²⁵⁴

155. The evidence supports the conclusion the integrity of the scene and the dignity of Cpl Langridge's body were protected by the CFNIS and military police members. There is no basis for concluding disrespect was intended or shown to Cpl Langridge by not covering his body or allowing it to be viewed by passersby.

Contact with the body

156. In their final submissions, the complainants also suggest the failure to promptly lower Cpl Langridge resulted in further indignity and disrespect because the CFNIS members allegedly had to “squeeze” past his body when moving into and out of the room. The subjects submit, to the contrary, MCpl Ritco was careful not to disturb anything in the room, and there was enough space to get past Cpl Langridge's body without touching him.²⁵⁵

157. Sgt Bigelow testified it was possible to move past Cpl Langridge's body without touching it. He estimated there was a two-foot gap between Cpl Langridge's body and the wall.²⁵⁶ Cpl Hurlburt, on the other hand, testified it was not possible to move past Cpl Langridge's body without touching it.²⁵⁷ Mr. Caufield testified it was “fairly easy” to enter the room and move past Cpl Langridge without touching his body.²⁵⁸ MCpl Bruce-Hayes testified a stockier person would have had difficulty going past Cpl Langridge without touching his body.²⁵⁹ In the video taken at the scene, it is clear the space available was narrow. Mr. Caufield is a tall, slim man and is shown in the video easily moving past Cpl Langridge's body without making contact. On the other hand, the video appears to show two somewhat stockier body removal personnel both jostling Cpl Langridge's body slightly as they entered.

158. Overall, the evidence shows, so long as care was taken, it was possible to move carefully past Cpl Langridge's body without contacting it. Such movements appear to have been infrequent. It is perhaps possible MCpl Ritco and Sgt Bigelow may have touched Cpl Langridge's body on the way in or out of the room. That does not amount to any show of disrespect. The evidence establishes it was inappropriate for the CFNIS to lower or move Cpl Langridge's body without the authorization of the ME Investigator. Any access to the barracks room required some movement past Cpl Langridge's body until he could be removed. While it appears MCpl Ritco's investigative steps created a delay before Cpl Langridge's body could in fact be removed, there is absolutely no evidence of any intention to show disrespect. There was also no evidence proper care was not taken to avoid disturbing his body.

159. In the end, the evidence does not establish any disrespect to Cpl Langridge's body.

PROCESSING THE SCENE AFTER THE REMOVAL OF THE BODY

160. After Cpl Langridge's body was removed, MCpl Ritco and Sgt Bigelow processed the scene and seized exhibits seemingly at random. They do not appear to have asked themselves what they were investigating, whether the death appeared suspicious, or what might be relevant evidence of foul play. They did not seize or take custody of exhibits for the benefit of Mr. Caufield.²⁶⁰ Sgt Bigelow testified, although he and MCpl Ritco understood the ME had authority over the body, "it was our investigation so we were allowed to process this."²⁶¹

161. The CFNIS investigators believed their role was to treat all scenes precisely the same way, and did not take measures to focus or adjust their approach based on an analysis of the circumstances and information available. Sgt Bigelow testified the approach to processing the scene and seizing exhibits was in no way related to the level of suspicion surrounding the circumstances of the death. Any scene would be processed the same way, whether foul play was suspected or not.²⁶²

162. In all, MCpl Ritco and Sgt Bigelow seized a number of items to be used as exhibits, divided into 12 bagged collections. These included:

Exhibit 1: Cpl Langridge's ID card and Alberta drivers licence, a money clip, a leather card holder, a debit card, and a medical card;

Exhibit 2: Cpl Langridge's suicide note;

Exhibit 3: Cpl Langridge's Blackberry device and its charger and leather case;

Exhibit 4: An MP patrolman's notebook;

Exhibit 5: Pamphlets, medical forms and an envelope pertaining to the *Mental Health Act* belonging to Cpl Langridge;

Exhibit 6: Literature pertaining to ending drug and alcohol abuse;

Exhibit 7: Personal correspondence received by Cpl Langridge including get well cards;

Exhibit 8: A Holy Bible (New International Version);

Exhibit 9: A blue water bottle containing approximately 500 ml of clear substance that they believed (but were not sure) was water;

Exhibit 10: A Tim Horton's coffee cup approximately half full of what they believed (but were not sure) was coffee;

Exhibit 11: Paperwork concerning admittance to a medical facility and a biohazard bag; and

Exhibit 12: An XXX video, a collection of tools, a book, and a teddy bear.²⁶³

163. MCpl Ritco and Sgt Bigelow also seized all personal items in the room, expecting these would be returned to the next-of-kin. They then made a video recording of the bagged exhibits and personal effects. Ultimately they removed everything belonging to Cpl Langridge from the barracks room, acting more or less as a clean-up crew.

164. It is important to understand why some items were seized as exhibits, and why some were not. MCpl Ritco testified about his thinking in determining what to seize at the scene:

The other stuff, the evidence, where the 12 or 13 items, like the suicide note, the water bottle, the coffee cup with the coffee in it, the Bible, the -- the AA literature and all that. That stuff, I felt, could have been relevant to me in my investigation. As I was at the beginning of the investigation, treating it as a sudden death, I don't know what direction it's going to go at. I find a suicide note, I find the stuff around it, so, yeah, it may have something to do with -- with if there was foul play.

Q: Okay. Do I understand, then, that you seized these items for their physical properties, that is whether you would find fingerprints on the --

A: Fingerprints, DNA, possible writing analysis, possible numbers, names that may -- because I'm keeping an open mind. I just walk in there, I don't really know -- not that I don't really know, I don't know what's going on, so I'm treating it as the worst-case scenario, and then I'll rule out -- I'll rule out as I go. So I'm not going to discard something because it appears to be a suicide. And there's a suicide note, so I'm not going to say, yeah, it's definitely a suicide, and just leave it as that. I'm going to say, okay, fine, there's -- it appears to be a suicide, the ME had mentioned that it's consistent with a suicide, there's a suicide note; however, I'm keeping an open mind. Maybe there's foul play; maybe there's not. So I'm gathering the items as the big picture [...].²⁶⁴

An erratic approach

165. Throughout their testimony, the subjects of the complaint reiterated a belief the steps taken in processing the scene, and the length of time which elapsed in doing so, were necessary to avoid contaminating evidence in case it was later determined the death was the result of foul play.

166. An investigative aid included in July 2004 and February 2008 revisions of Annex I to MPPTP Chapter 7, titled “Guide: Deaths, SA/SAA and Sexual Assaults,” states, “All deaths must be handled [in accordance with] the same stringent standards as [a] homicide.”²⁶⁵ MCpl Ritco testified he believed this policy was in effect in March 2008, and he processed the scene accordingly.²⁶⁶ When the Fynes raised their concerns with Col Blais in 2010, the CFNIS provided a written explanation concluding the process was treated like a homicide. It stated, “In matters where the cause of death is unknown, all incidents shall be treated as homicide investigations. The intent is to secure the scene and prevent the loss of potential evidence, and to ensure that the scene is not contaminated”.²⁶⁷

167. It is unclear this standard applied in a case like Cpl Langridge’s death scene. If the CFNIS investigators were treating the barracks room as a homicide scene, they did not do a very good job of it. At times, they applied exaggerated or unnecessary caution while missing obvious and essential steps for preserving and collecting evidence. As a result, the goals of the 2008 Sudden Death Investigation – and of any potential homicide investigation that could have become necessary – were frustrated.

168. The investigators did process the scene in the manner they thought best. They cannot be faulted for not knowing in advance what evidence would prove to be relevant. But the fact remains they did not exercise solid judgment in determining what to seize. MCpl Ritco’s thinking concerning the exhibits cannot be discerned from his notes or actions, and it is difficult to understand why he chose to seize certain items but not others, or what he intended to investigate in doing so. For example, a teddy bear sitting in Cpl Langridge’s window was collected as potential evidence for no apparent reason, and nothing further was done with it. On the other hand, the pen left on top of the suicide

note, and likely used to write it, was moved close to the time the note was seized, but the pen was not seized as an exhibit.

169. MCpl Ritco took photographs of the sink in Cpl Langridge's barracks room, focusing on several cigarette butts lodged in the sink's drain and a wad of used chewing gum several inches to the right of the drain. He also recorded close-up video footage of the sink's contents. However, not one of these items was seized into evidence nor referred to again. It is possible MCpl Ritco was simply taking photographs and recording the video of everything at the scene as a matter of routine without questioning the usefulness of such photographs or videos.

170. MCpl Ritco transferred the exhibits seized at the scene to his temporary locker on March 16, 2008.²⁶⁸ They were transferred to the evidence room on April 9, 2008. Although he seized some items that could be tested to reveal potential evidence of a crime, such as the water bottle, the coffee cup, or the suicide note, MCpl Ritco ultimately did not test any of these items. He testified tests were not warranted because the indications at the time pointed to suicide. He retained the evidence in the event evidence of foul play emerged as the investigation progressed.²⁶⁹ MCpl Ritco testified he treated the evidence as potentially pointing to a worst-case scenario of homicide and seized it with this in mind. His aim was to rule out foul play as he went.²⁷⁰

171. However, MCpl Ritco and Sgt Bigelow took no fingerprints from the scene and collected no evidence samples from either the scene or Cpl Langridge's body. Because the pen apparently used to write the suicide note was never seized, there was no way to test it for fingerprints or to confirm it was indeed the pen used. Had any indication of foul play emerged, vital evidence would have been missing.

172. The nature of the death made it clear there was no need to test any of the exhibits and MCpl Ritco cannot be faulted for not having done so. What is more important, and of much more concern, is MCpl Ritco never seemed to ask: "Do I *need* to seize this and, if so, *why*?" and "Will I *need* to test this?" He did not return to examine the evidence and assess whether it was still potentially relevant, and what, if anything, should be done with

it to aid the investigation. The items were, in effect, seized as a matter of course and then forgotten. It was never clear why some steps were taken and some steps were not.

Preserving evidence and preventing contamination

173. The CFNIS and the subject members explained the preservation of evidence and the prevention of any contamination of the scene or the body were of the greatest importance, because failing to take all due care could have jeopardized any criminal investigation or proceedings that might have followed. The written response from the CFNIS to the Fynes following their complaint to Col Blais about their belief Cpl Langridge's body was not treated respectfully indicates concerns about contamination were paramount:

The methodology used to collect evidence at a potential homicide scene is extremely lengthy and labour intensive. Due care to collect all possible evidence is paramount as once the crime scene is released, any uncollected evidence not seized may be lost to the investigation admissible in criminal proceedings. If Corporal Langridge had been taken down during the process, it would have further contaminated the crime scene and which [sic] could potentially have had a significant impact on the criminal investigation.²⁷¹

174. Although the CFNIS members explained their process as being necessary, the work done was incomplete and insufficient for the purposes of meeting the rigorous evidentiary requirements of a criminal prosecution. Worse, the hypothetical prosecution of a suspect in Cpl Langridge's death could have been jeopardized by problems such as the failure to conduct a forensic examination of the scene and to prevent its contamination, as well as the failure to obtain complete evidence about who may have entered the scene or come into contact with Cpl Langridge's body and any items within the room.

175. If the CFNIS investigators were processing the scene as a crime scene, effort should have been made to follow the existing policies and procedures.²⁷² The 2004 revision of Annex C ("Evidence Procedures") to MPPTP Chapter 7 makes clear the importance of preventing contamination and preserving evidence at a crime scene.²⁷³

176. MCpl Ritco was questioned about his efforts to determine whether there had been any contamination of the scene or any disturbance to the continuity or preservation of

evidence between the time of the hanging and the time he arrived. He testified he spoke with Cpl Bruce-Hayes, who was the first MP to arrive at the scene, and gained information concerning who entered the room, what they did, the path they took, and whether they touched or removed anything.²⁷⁴ Cpl Bruce-Hayes noted Cpl Langridge's body had been touched by personnel from the fire department when they checked for any vital signs.²⁷⁵ Statements from MCpl Munro and MCpl Bowen indicated both had entered the room and touched the body when confirming a lack of vital signs.²⁷⁶ MCpl Munro had also taken the wallet from the desk in Cpl Langridge's room. Paramedics also attended the scene and checked the body for vital signs.²⁷⁷ MCpl Ritco did not interview the ambulance personnel who attended the scene.²⁷⁸

177. There is no information as to precisely who touched the body or whether any other items in the room were disturbed. MWO Watson recognized in his testimony the notes taken by Cpl Bruce-Hayes were not sufficient for investigators to know the path ambulance personnel took into the room or whether the ambulance personnel touched other objects in the room.²⁷⁹ To the extent it was necessary to confirm the evidence at the scene, the investigative team should have considered immediately interviewing Cpl Hurlburt, who discovered Cpl Langridge's body,²⁸⁰ the firefighters who attended at the scene and confirmed the death,²⁸¹ and the ambulance crew who also entered the scene and reconfirmed the death.²⁸² All of these persons should have been questioned in regards to: the path or paths they took into and out of the room where Cpl Langridge was found; whether they touched or moved the body, and if so, where and how; and whether they touched or moved anything in the room aside from the body.

178. MCpl Ritco testified, as he progressed through the scene, he would avoid contaminating evidence and make a written or mental note of anything that stood out and then avoid that area. Seeing Cpl Langridge's body at the entrance to the barracks room, he was concerned not to touch the body "in any way, shape or form until I absolutely photographed and videotaped the entire scene to preserve anything because once he is moved then the continuity, if there was evidence is lost."²⁸³ MCpl Ritco entered the scene relying only on latex gloves to prevent contamination. This suggests either he did not

believe the death was at all suspicious, or if he did, he did not grasp the need for taking strict precautions at the scene of a potential homicide.

179. Including Cpl Hurlburt, who had discovered the body of Cpl Langridge, at least five people had touched the body before MCpl Ritco and Sgt Bigelow arrived at the scene. At least one item at the scene was handled, and MCpl Ritco testified he did ask whether any other items were disturbed, although he did not believe so.²⁸⁴ Knowing there had been some disturbance of the room and some contact with the body prior to his arrival at the scene, MCpl Ritco testified he would have to rule out the DNA or fingerprints of the first responders should the evidence suggest Cpl Langridge died as a result of foul play. However, MCpl Ritco and Sgt Bigelow took no fingerprints from the scene, collected no evidence samples from the scene or the body, and in general did not take the measures for gathering and preserving evidence that would have been expected in a homicide investigation.

180. MCpl Ritco testified he never followed up on the possibility of contamination because, “There was no indication of foul play at the end.”²⁸⁵ Indeed, there was no reason in the circumstances to expect an investigator to collect fingerprints or DNA evidence from the scene – or from any of the personnel who had entered the room. The Commission would not expect MCpl Ritco to have done so. However, there is a fundamental problem with the approach taken by the CFNIS members if one takes at face value the repeated assertion the scene had to be processed to the standard of a homicide. The rationale for the manner in which the scene and the body were to be handled is inconsistent with what was actually done. Neither the body nor the scene were treated in accordance with that standard.²⁸⁶ It would have been impossible to perform any analysis had evidence later come to light Cpl Langridge had died as a result of foul play.

181. Evidence was inconsistently packaged in evidence collection bags – sometimes individually, sometimes in lots with other items. Exhibit 12, as described earlier in this chapter, contained a jumble of personal items.²⁸⁷ Seized items should not be packaged together, so as to prevent cross-contamination and loss of evidence, as is made clear in the 2004 revision of Annex C (“Evidence Procedures”) to MPPTP Chapter 7.²⁸⁸

Moreover, the manner in which some evidence was photographed is not consistent with notes recorded at the scene by Sgt Bigelow.²⁸⁹

182. The protective clothing worn was insufficient to prevent the contamination of the scene. According to a 2011 revision of CFNIS Standard Operations Procedure 237, “Locard's Principle postulates that there will be an exchange of material any time objects come into contact with one another. To avoid contaminating the scene, ensure all persons entering the scene wear proper forensic protective clothing.”²⁹⁰ This provides a clear indication of best practices for ensuring the integrity of the evidence-gathering process. Sgt Bigelow was asked to explain when investigators are required to go through a scene in a full forensic suit and the circumstances in which wearing gloves would be sufficient. He believed it depended on the expectations of the department. When he worked with the RCMP, where the death was the result of a suicide or was not suspicious, the general practice was for investigators to use gloves and exercise caution as to what they touched. Where the death was, in his words, a “serious homicide,” however, forensic analysts, “the CSI guys,” would process the scene wearing full body suits.²⁹¹

183. The evidence from the police panel indicates factors such as the nature of the death and the conditions at the scene itself tended to dictate the forensic evidence gathering requirements and precautions against contamination. S/Sgt Clark testified the EPS will only send out its Identification teams, who wear full protective forensic suits, to the scenes of suspicious deaths. Non-suspicious death or apparent suicides are too numerous to be treated the same way, and in such cases forensic evidence gathering and precautions against contamination are “a non-issue.”²⁹²

184. Insp. Fitzpatrick testified, for major crime investigations, forensic specialists were required to wear full forensic “bunny suits,” protective footwear, and possibly even masks and breathing apparatuses depending on the biohazard risks. Otherwise, the use of protective forensic clothing depends on the situation, with an emphasis on good judgment, training, and best practices to determine how to proceed.²⁹³

185. Det. Insp. Olinyk testified forensic officers will normally wear biohazard suits at a scene examination as much for their own protection as for protecting potential evidence.²⁹⁴

186. To process a scene to the standard of a homicide demands far more stringent measures than simply wearing latex gloves. The Commission is left wondering how CFNIS members believed they were facing even a potential homicide when they entered the barracks room and interacted with the scene and Cpl Langridge's body, given they did so inadequately prepared and protected.

187. MCpl Ritco may himself have caused evidence to be lost. In the video-recording made of the processing of the scene – both before and after Cpl Langridge's body was removed – MCpl Ritco wears gloves throughout his exploration of the room and its contents, but does not wear them after the contents of the room had been moved. At 2259 hrs, MCpl Ritco and Sgt Bigelow finish removing the evidence and effects from the barracks room. MCpl Ritco then performs a final walkthrough of the empty room. He is shown on video opening doors and drawers with his bare hands to demonstrate all of Cpl Langridge's personal effects had been removed. If any fingerprints or other relevant forensic evidence were present in the room, they could have been contaminated or obliterated at this point.

188. Had MCpl Ritco and Sgt Bigelow actually thought themselves to be at the scene of a suspected homicide, it is almost unthinkable they would have entered the scene without taking the most exacting measures to prevent the loss or contamination of evidence.

DEVELOPING A FLEXIBLE APPROACH TO SUDDEN DEATH INVESTIGATIONS

189. A responsive, appropriate and purposeful approach to scene contamination was at least contemplated by some of the MP policies. The 2004 revision of Annex C to MPPTP Chapter 7 called for the use of protective clothing when gathering evidence and advised, “[t]he scene to be examined will dictate the type of protective clothing to be worn, boots, hats, gloves, suits, etc.”²⁹⁵

190. The evidence gathering and preservation approaches taken by the CFNIS investigators in this case would make much more sense if they were treating the investigation as *a probable suicide* –a non-suspicious death. It would not have been necessary to take exhaustive measures to prevent the loss or contamination of evidence, to wear more protective gear than latex gloves, to gather handwriting samples to verify the authenticity of the suicide note, to seize the pen apparently used to write the suicide note, and to collect fingerprints and trace evidence from the scene. Under this scenario, it would become clearer why Cpl Langridge’s Bible was seized with its bookmark and an underlined passage (Revelations 21) noted as a potential indicator of his state of mind.²⁹⁶ It is difficult to reconcile the fact MCpl Ritco stated he treated the scene as a potential crime scene with the actions he took.

191. It may well be MCpl Ritco’s understanding of his approach to processing the scene was influenced by the MPPTP policy in place at the time which required that all deaths be handled in accordance with the same stringent standards as homicide.²⁹⁷

192. The expert evidence heard by this Commission establishes the importance of a flexible approach to sudden death investigations.²⁹⁸ While it is likely all death scenes should initially be approached with the premise they may be homicides, an overly rigid approach, which results in every sudden death literally being treated in an identical manner, discourages and impedes investigators from assessing the evidence and facts and forming hypotheses about what has happened. Although it is essential an investigation not be constrained by tunnel vision or rigid conclusions, these hazards are wholly distinct from the formulation of working hypotheses. A sound hypothesis must be continually and rigorously tested, but it is a fundamental guide for an investigation. For these reasons, thought should be given to carefully developing an investigation policy which abandons a one-size-fits-all approach for every sudden death, and instead promotes the use of good judgment and the ongoing assessment of the facts and evidence obtained to test hypotheses and allows for CFNIS resources to be used accordingly. Here, once the likelihood of suicide became stronger, the investigators ought to have conceived of a hypothesis about Cpl Langridge’s death and ascertained what would be necessary to confirm or challenge this theory.

193. Whenever the “potential homicide” approach is taken, it should be done properly and consistently. Rigorous steps should be taken to prevent contaminating the body or the scene and prevent any potential loss of evidence. If CFNIS policy continues to require any sudden death to be handled with the same stringent standards as a homicide until it is proven to be a result of suicide,²⁹⁹ care should be taken to avoid any contamination of the scene or the body. The scene should only be entered and processed while investigators are wearing appropriate protective clothing. Anyone who has entered the room since the discovery of the death should be interviewed to identify what may have been disturbed or touched.

194. In all cases, the scene should be processed purposefully, based on an evaluation of the evidence and information available. CFNIS members at the scene should report their observations and the available information to a superior (such as a case manager) with significant experience in the conduct and supervision of sudden death investigations. Together with the coroner or ME, the CFNIS members at the scene and their superior should make an initial determination as to the possible nature of the death and the most appropriate approach to gathering evidence. However, if there is any reason to believe the death may have been the result of foul play or is otherwise suspicious, investigators should proceed as though the death were a homicide.

195. As an alternative, consideration could be given to sealing a sudden death scene wherever possible and feasible until the medical cause of death has been determined, avoiding both contamination of evidence and the loss of evidence.

196. Consultation and evaluation between CFNIS members and the ME or coroner should aid investigators in identifying what will be important for search and seizure purposes. Once the body is removed, evidence should be collected with a view to determining the manner of death, and investigators should revisit and evaluate the evidence as the investigation progresses. All evidence seized should be carefully preserved and stored in separate evidence collection containers.

PROCEEDING WITH THE SUDDEN DEATH INVESTIGATION

Understanding what to investigate

197. Following their processing of the scene, the removal of Cpl Langridge's body, and the collection of evidence, the investigators were in a position to determine what, if anything, was necessary for the purposes of a sudden death investigation. The members of the CFNIS investigative team testified the purpose of their investigation was to rule out foul play.³⁰⁰ To the extent this means they were focused on foul play as an alternative to suicide, the actual investigation conducted does not seem focused on that issue. Most of the investigative work undertaken was primarily concerned with investigating the suicide watch issue.³⁰¹ The other investigative steps taken appeared to lack focus and direction. It was not clear their potential relevance to ruling out foul play was thought through or understood by the investigators.

198. Gathering and assessing evidence regarding Cpl Langridge's final days may have assisted investigators in creating a chronology of the sequence of events leading to his death. This may be important to ruling out foul play or identifying issues related to the death which merit further investigation. In creating a chronology, investigators may identify potential witnesses or avenues of investigation and may improve their own understandings of the events leading up to the death. This can assist investigators in making a timely determination of whether foul play was involved and may help them identify any inconsistencies in the evidence that require further investigation. At the very least, investigators should aim to gather information with respect to the deceased in the hours preceding the death³⁰² and should likely focus on at least the final three days.³⁰³ In this case, the investigative team did not create any such chronology.³⁰⁴ There is no record in the investigation file of Cpl Langridge's final hours to help establish where he was or what he was doing with any certainty.

199. Indeed, there is no chronology of the period of time following Cpl Langridge's discharge from his thirty-day stay in hospital³⁰⁵ until his death, representing the final ten days of his life. The investigation file contains only small glimpses of Cpl Langridge's activities following his discharge. There is no indication the circumstances of the

discharge were investigated, and no indication Cpl Langridge's living arrangements and work situation during this ten day period were investigated in any depth.

200. To the extent they felt unable to come to a conclusion after processing the scene, the investigators ought to have considered the two most plausible theories of how the death resulted; either it was a suicide, or it was in some way the result of foul play. In developing their IP, the investigators should have been guided by the evidence from the scene and should have directed their investigation towards challenging these theories. The investigative team did not appear to use the evidence from the scene, interviews, or other investigations in any such manner. The evidence does not appear even to have been reviewed aside from MCpl Ritco tagging as personal property on March 19, 2008, certain items initially seized as evidence.³⁰⁶

201. Rather than analyze the evidence at hand, the investigators seem to have been focused on gathering even more evidence. MCpl Ritco did testify, "I go into an investigation and I let the evidence dictate on what the outcome is going to be [*sic*],"³⁰⁷ and emphasized he kept an "open mind" throughout the course of the investigation. He only reached a conclusion on the cause of death when he concluded his investigation report,³⁰⁸ which was on or about June 2, 2008.³⁰⁹ He stated, in the course of the investigation:

[...] everything I was gathering -- all of the evidence that I was gathering, it **obviously** was pointing toward a suicide, **but I didn't want to make that determination right then and there, because I hadn't gathered everything up yet.** So, yeah, it was pointing toward a suicide, and **there was no suspected foul play**, but it wasn't until the end of May that all of the pieces of the puzzle were put together, and it was a suicide.³¹⁰
[Emphasis added]

202. It appears, however, from the conduct of the investigation and his testimony, MCpl Ritco misunderstood the meaning and purpose of keeping an open mind. Far from suggesting an open-minded approach, his evident reluctance to actually follow the evidence suggests an exagerrated fear of premature conclusions – a fear that was perhaps the combined result of inexperience, limited supervision, and official admonishments against succumbing to police tunnel vision.³¹¹ The investigative team appeared to believe they could not make a determination on the issue of foul play until

every possible piece of evidence was collected, as though an exercise of judgment or selectivity would amount to police tunnel vision. This is not a correct investigative principle. Worse, the evidence the investigators continued to collect was not always relevant to this determination, and where it was, its relevance did not always appear to be understood by the investigators.

Witness interviews

203. The CFNIS investigators should have considered canvassing the residents of the floor of the building in which Cpl Langridge's barracks room was located and possibly those on adjacent floors. As it stands, there is very little information in the investigation file relating to his activities and state of mind on the day of, and in the days preceding, his death. It is not known who the last person to see Cpl Langridge alive was, as the issue does not appear to have been investigated. There is nothing in the investigation file to confirm what Cpl Langridge was doing on the day of his death aside from accounts from duty staff they were told he was doing laundry.³¹² Ascertaining Cpl Langridge's activities during his final days and on the day of his death may have been valuable in helping the investigators form an impression of his state of mind. Cpl Langridge's neighbour was interviewed on March 17, 2008, by a base MP member,³¹³ but provided little information aside from stating he had heard noises in Cpl Langridge's room such as the door being opened and closed and a chair being moved in the early morning.³¹⁴ MCpl Ritco indicated in his notes he "determined that [the neighbour] still may be needed to be interviewed as his statement was vague."³¹⁵ There is no indication the neighbour was subsequently interviewed by the investigators.

204. If there are unanswered questions following the investigation of the death scene and neighbourhood canvass, investigators may conduct witness interviews to help determine whether foul play may have been involved. It is difficult to overstate the value of witness interviews to any investigation, and this value is even greater when the focus of the investigation is upon the events of a deceased person's last days. Mr. Caufield testified, when investigating suspected suicide, investigators should attempt to identify any history of suicidal ideation or past suicide attempts, as well as any evidence of

significant life events which may have prompted an individual to take her or his own life.³¹⁶ The information obtained from witnesses depends first upon successfully identifying the witnesses most likely to have the most pertinent information. Investigators must be prepared to expand and amend their witness list depending on what they learn.

205. In this case, the investigators conducted several interviews in the months following Cpl Langridge's death. They did not interview Cpl Langridge's family, common-law partner, or any of his treating physicians, either civilian or military. They did interview Cpl Langridge's Adjutant,³¹⁷ the Duty Staff,³¹⁸ and his work supervisor,³¹⁹ although the latter was interviewed about a month after Cpl Langridge's death. The RSM was interviewed over two months after the death.³²⁰ The only friend of Cpl Langridge's interviewed was Cpl Jon Rohmer.³²¹

206. The failure to interview the Fynes and Ms. A meant the investigative team was unaware of many potentially relevant matters, including the allegations that Cpl Langridge was ordered out of hospital and placed under a suicide watch. MCpl Ritco admitted in testimony these allegations would have been useful to him in directing his investigation.

207. The decision not to contact Ms. A appears to have been made by or in conjunction with WO Tourout on May 15, 2008,³²² long after when she ought to have been interviewed. WO Tourout testified Ms. A was not interviewed because "at that point we had the medical records. So there was [...] no requirement to interview her."³²³ MCpl Ritco testified it was determined "at the end of the investigation [...] it was irrelevant to interview her because it was a suicide."³²⁴

208. MCpl Ritco testified he had considered interviewing the Fynes. He agreed they should have been interviewed, and indicated, he believed it was an oversight on his part they were not listed as potential witnesses in his IP.³²⁵ He also recalled speaking with WO Tourout about the possibility of interviewing Mrs. Fynes and being told it was not necessary.³²⁶ WO Tourout could not recall precisely why MCpl Ritco was instructed there was no need to call Mrs. Fynes, but believed it was related to the fact the investigators had obtained Cpl Langridge's medical records which "gave [them] the

history of his service.”³²⁷ MWO Watson similarly could not recall precisely why MCpl Ritco was told there was no need to interview Mrs. Fynes. However, he testified, “I can only suggest to you that he was a 28-year-old male in the military, and I would not have seen a need to speak to the mother in this situation to further the investigation” and he added, the background information the investigators required was obtained from “medical authorities” and Cpl Langridge’s colleagues, and this information would have been sufficient for their investigation.³²⁸

209. As the subjects pointed out in their final written submissions, it is not necessary for investigators to interview every potential witness who may have relevant information.³²⁹ However, the selection of the witnesses to be interviewed must be based on an assessment of the relevance of the information they are likely to possess and its importance to the investigation. In this case, some of the assessments made were not reasonable, and as a result, witnesses with significant and relevant information were disregarded.

Scope of the investigation

210. The bulk of the investigative work following the interview of Cpl Hurlburt on March 19, 2008, was not aimed at determining whether Cpl Langridge’s death was caused by suicide or foul play. The interviews of MCpl Fitzpatrick,³³⁰ MCpl Bowden,³³¹ CWO Ross,³³² and Capt Richard Robert Hannah³³³ dealt largely with issues related to an alleged suicide watch and Cpl Langridge’s conditions (which may have suggested possible negligence),³³⁴ rather than issues related to ruling out foul play as an alternative to suicide.

211. Maj Brian Frei, DCO CFNIS at the time of this investigation, testified at the hearing, “best practice would be to separate” the two investigations. However, he acknowledged it was not a common practice of the CFNIS at the time.³³⁵ MCpl Ritco was correct; the issue of negligence ought to have been investigated.³³⁶ Although it might have been better to make it the subject of its own subsequent investigation rather than diverting investigative focus from the issue of whether the death was suicide,³³⁷ the

Commission understands this is not always how an investigation is conducted, nor is this necessarily the only way to investigate effectively.

Ruling out foul play

212. The investigators did not rule out foul play as an alternative to suicide until two and a half months after Cpl Langridge's death.³³⁸ It is difficult to pinpoint with certainty exactly when, based on the facts available at the time, foul play, as opposed to suicide, could as a practical matter have been ruled out. However it seems this could have been done within days of the death, if not on the very day of the death as a result of processing the scene. Certainly, there is little reason to believe foul play as an alternative to suicide could not have been all but conclusively ruled out before Cpl Langridge's funeral on March 26, 2008.³³⁹ MWO Watson testified this was, from all appearances, an uncomplicated investigation, and the ruling out of foul play should not have taken more than three or four days.³⁴⁰

213. The delay in arriving at a conclusion, for practical purposes, that the death was a suicide appears to be rooted in a failure to differentiate between the concept of ruling out foul play as an alternative to suicide and concluding an investigative file. Concluding a file requires all investigative procedures and documents necessary for a file to be completed and in order, to the point of allowing for the investigators and their supervisors to sign off on the investigation. On the other hand, investigators can rule out foul play, for practical purposes, prior to concluding their investigative files. Investigators can make early determinations on relevant issues prior to completing all the technical requirements for the files. The investigative team may have been correct the file would require a report from the ME prior to being concluded, but it could have ruled out foul play, for practical purposes, prior to receiving the ME's report.

214. In his testimony, MCpl Ritco did not agree he could have concluded on the cause of death sooner than he did, citing the fact this was his first investigation of a suicide. This hesitation to come to what he considered a potentially premature conclusion may be linked to the failure to analyze the investigative steps taken and the evidence collected in terms of their significance in either confirming or refuting foul play. In his testimony, he

was unable to identify what sort of possible foul play he was investigating after March 19, 2008.³⁴¹

215. WO Tourout, meanwhile, testified that following the investigators' examination of the crime scene "an analysis of that would lead [MCpl Ritco] to believe that there was no foul play."³⁴² He added it was a "fair assumption" the investigators knew all they would about the crime scene, physical evidence, and possible leads to foul play by March 17, 2008.³⁴³

216. The CFNIS investigators explored Cpl Langridge's personal life, physical and mental health, past suicide attempts, addictions issues and relationships. Notwithstanding the complainants' allegations this sort of exploration was unnecessary and excessive in the context of a sudden death investigation, the expert evidence is to the contrary.³⁴⁴ Where there is an apparent suicide, aspects of the deceased's personal life may be canvassed to discern circumstantial evidence as to whether or not it was in fact a suicide. Evidence of suicidal ideation, past suicide attempts, or chronic mental health disorders like depression or bipolarity may lead to such inferences. Evidence of personal traumas, substance abuse, or relationship problems may indicate a person's life circumstances were unstable, again leading to possible inferences as to the likelihood of suicide. These sorts of details, though not determinative, may be of assistance to investigators in helping to understand the deceased and whether there were any signs confirming the possibility of suicide or making it unlikely.

217. The investigators received a good deal of input on these issues during their early interviews, providing a strong indication Cpl Langridge's death was a suicide and not the result of foul play.

218. On March 17, 2008, Capt Mark Lubiniecki reportedly told the investigators Cpl Langridge had at least two prior suicide attempts and had attended and quickly discharged himself from drug rehabilitation, which was brought about after a failed drug test for cocaine. He also noted Cpl Langridge's common-law relationship was unstable and possibly ending. Capt Lubiniecki reportedly stated Cpl Langridge was living at the

Regiment under conditions in an effort to “prove he was more committed to changing his ways.”³⁴⁵

219. The next day, Cpl Rohmer told investigators Cpl Langridge had attempted suicide at least twice in the past and “had an alcohol problem, drug problem, relationship issues, and financial problems.” He stated he had personally been at Cpl Langridge and Ms. A’s house to remove an electrical cord from the basement, reportedly used by Cpl Langridge to attempt suicide. Cpl Rohmer discussed Cpl Langridge’s erratic behaviour and “coke” use and alluded to rumours of a possible suicide watch for him in the weeks preceding his death.³⁴⁶

220. Sgt Hiscock also provided information about the suicide watch rumour, stating he had been told on the day of Cpl Langridge’s death by either the off-going Duty Officer or MCpl Fitzpatrick about the suicide watch.³⁴⁷ He added he had heard Cpl Langridge had relationship problems and mental health issues.³⁴⁸

221. On March 19, 2008, the investigators interviewed Cpl Hurlburt,³⁴⁹ who told them there were rumours in recent weeks Cpl Langridge was suicidal and a suicide watch had been planned. He also relayed other rumours Cpl Langridge might have been suicidal in the previous year, although he added others thought Cpl Langridge’s talk about suicide at that time had not been sincere.³⁵⁰ The investigative team did not seem to have made use of this evidence at the time to assist in ruling out foul play.

222. On April 9, 2008, the investigators obtained a police report from the RCMP. It revealed Cpl Langridge had been reported as a “missing unstable person” on June 25, 2007,³⁵¹ the date of his first suicide attempt.³⁵² On the same date, MCpl Ritco spoke with the ME Investigator, who stated ten of the eleven tests had been conducted, and unless the final test came back as a “hit”, the death would be ruled a suicide. MCpl Ritco also noted the ME Investigator indicated, “since **there appears to be no foul play of any sort**, and all test [sic] are coming back negative,” all that was required from MCpl Ritco was a list of medication prescribed to Cpl Langridge.³⁵³ He further reported Mr. Caufield requested photographs of the scene and the police report for his file. MCpl Ritco wrote in

his notes: “briefed him that I was not done, can wait, told I will have to speak to MWO refer report [*sic*].”³⁵⁴

223. By this point, nearly a month following the death, in addition to unearthing no evidence to suggest foul play and having information from witness interviews pointing to a troubled medical and personal history, which included talk of suicide and suicidal attempts or gestures, the investigators now also had a tentative conclusion of suicide from the ME.

224. On April 22, 2008, the investigators interviewed MCpl Fitzpatrick. He reported he had reviewed Cpl Langridge’s personnel file when Cpl Langridge came to work for him in 2007. The file reportedly detailed the events of his first suicide attempt, which MCpl Fitzpatrick relayed to the investigators.³⁵⁵ He further reported, on one occasion when Cpl Langridge was working for him, Cpl Langridge had been AWOL so MCpl Fitzpatrick had called the MP, which sent a member to Cpl Langridge’s house. The MP member reportedly found him incoherent after taking a number of sleeping pills.³⁵⁶ That same day, according to MCpl Fitzpatrick, Ms. A went to his office and reported Cpl Langridge was “doing drugs.”³⁵⁷ The remainder of the interview dealt in large part with the alleged suicide watch, which MCpl Fitzpatrick described as being a pre-emptive guard list organized in the event a suicide watch needed to be held.³⁵⁸ His account of events was questioned by the testimony of MCpl Bowden on May 5, 2008. She stated, she had been told by MCpl Fitzpatrick the list of names was being compiled “for a watch on Langridge for suicide.”³⁵⁹

225. This discrepancy notwithstanding, the evidence suggested the Regiment was concerned about the possibility of Cpl Langridge committing suicide. The concern had risen to the point where either a suicide watch was being organized or a list of names was being gathered in the event a suicide watch needed to be put in place urgently.

226. On May 15, 2008, MCpl Ritco attended at the ME’s office and met with the ME Investigator. At that time, he received various documents officially confirming Cpl Langridge died as a result of suicide by hanging.³⁶⁰ Even with this material in hand, MCpl Ritco was not prepared to rule out foul play. He testified before the Commission

the ME's report, "was one of the biggest pieces of the puzzle", but he still had more to do before he could conclude his report.³⁶¹

227. On May 27, 2008, MCpl Ritco interviewed Capt Hannah.³⁶² Capt Hannah stated it was "on the public record" Cpl Langridge was living at LDSH because he was perceived to be at a heightened risk of suicide.³⁶³ Capt Hannah went on to state Cpl Langridge was cooperative during his time at LDSH; he was not making any suicidal gestures and stated he was not suicidal.³⁶⁴ Capt Hannah stated he could not answer the question of why Cpl Langridge committed suicide³⁶⁵ but theorized it could have been the result of attention-seeking behaviour³⁶⁶ or cocaine use.³⁶⁷ He also reviewed the medical records with MCpl Ritco, which he had obtained with respect to Cpl Langridge, in order to assist MCpl Ritco in understanding what they meant. Although the records were arguably incomplete, they did contain significant information indicating Cpl Langridge was deeply troubled.

228. MCpl Ritco testified the medical records indicated Cpl Langridge "was in and out of hospitals. In the past, [...] he had attempted suicide. And [...] he was ... seeking counsellors for help." However, he did not draw any inferences from these facts and only concluded they were evidence there was "something wrong."³⁶⁸

229. It is difficult not to conclude, at some point, the thread had been lost as to the purpose of the investigation, and it had been transformed into a free-floating investigation into Cpl Langridge himself. This impression is bolstered by the fact, even at this point, the investigation did not end. On May 29, 2008, MCpl Ritco requested a forensic analysis of Cpl Langridge's BlackBerry mobile phone by the CFNIS Integrated Technological Crime Unit ('ITCU'). He wanted an analysis of all calls, email and text messages and a search for terms like "kill", "hurt", "cocaine" and "suicide."³⁶⁹ MWO Watson supported the request.³⁷⁰ He noted the analysis was to be done to find "any evidence that may explain the reason for Cpl LANGRIDGE's suicide" and to learn who sold illegal drugs to Cpl Langridge.³⁷¹ He also noted, "the investigation into this incident is complete" but still concurred with the request for the analysis.³⁷² Ultimately, when he became aware of the technical difficulties associated with conducting this analysis, MCpl Ritco decided against proceeding further, noting, "one of the main reasons for gaining access into the

BlackBerry was for intelligence purposes.”³⁷³ The mobile phone search initiative was unnecessary in the context of a sudden death investigation.

Too much investigation?

230. As was alluded to earlier, the complainants allege the CFNIS investigators were excessive in probing unnecessary and irrelevant aspects of Cpl Langridge’s life. They contend the investigators failed to focus on ruling out foul play as a potential cause of Cpl Langridge’s death in a reasonable time, examined irrelevant issues, and enlarged the scope of the investigation far beyond what was appropriate.³⁷⁴ It is true the 2008 Sudden Death Investigation periodically digressed into topics that were perhaps outside its proper focus and/or dwelled upon even potentially relevant topics excessively.³⁷⁵ With that said, however, it would be unreasonable to unduly circumscribe the investigation at an early point before knowing how it would unfold. Aside from the mobile phone search, the topics being investigated, including the details of Cpl Langridge’s personal life and medical history, were appropriate and potentially relevant to a sudden death investigation, and certainly to a police investigation of culpable negligence. However, the way those topics were pursued and the failure to use them to draw relevant conclusions and to rule out foul play in a timely manner were not appropriate. There is no basis to conclude this was the result of any improper motive. Like other flaws in the investigation, they seem largely the product of inexperience and inadequate supervision.

MP AND CFNIS POLICIES

231. As part of their response to the complainants’ allegations, the written submissions of the subjects state the investigators adhered to all relevant policies and procedures in force at the time. It is therefore necessary to consider the relevant policies, both in terms of the subjects’ compliance and, more generally, in terms of the adequacy of those policies to provide appropriate guidance.

The policies in force at the time: MPPTP Chapter 7

232. The relevant policy in place for sudden death investigations was an MPPTP Annex regarding the investigation of deaths, sexual assaults, and offences related to small

arms.³⁷⁶ The policy provided a general overview regarding how each of these matters should be approached, including examining potential crime scenes and what issues should be investigated.

233. The portion relating to sudden deaths occurring on or in relation to a Defence Establishment begins with a general statement for such investigations:

All deaths will be handled [in accordance with] the same stringent standards as homicide. Once a death is proven to be a result of suicide then it shall be turned over to the local CO for an administrative investigation as per CFAO 19-44. This applies as well for attempted suicides.³⁷⁷

234. The expert evidence heard by this Commission establishes the importance of a flexible approach to sudden death investigations.³⁷⁸ While it is likely all death scenes should be approached under the premise they may be homicides and the resulting processing should be thorough and objective, all death investigations should not be handled the same way.

235. Investigators ought to use their experience and judgment, in conjunction with the input of their supervisors, to determine whether a death scene appears to be criminal or non-criminal. In this case, as discussed earlier in this chapter, the investigative team neither processed the scene nor conducted the remaining investigation to the standard of a homicide investigation. Much of what they did was likely unnecessary.

236. The 2008 revision of Annex I to chapter 7 of the MPPTP goes on to categorize deaths in three ways: (1) homicide; (2) suicide; and (3) natural death.³⁷⁹ If a death is deemed not to be natural, the CFNIS will be the primary investigative service.³⁸⁰ The policy then addresses the response of MP members to death scenes. It encourages responding MPs to take life-sustaining measures where appropriate or, if death is evident, to isolate the scene and prevent unauthorized access. MPs are directed to request an ME, coroner or medical officer to attend the scene and to notify the CFNIS. Further, they are to identify and isolate persons with knowledge of the death where possible. Finally, the policy notes, “if the coroner cannot state death was due to natural causes, CFNIS shall continue with the investigation.”³⁸¹

237. In practice, it should be noted, while it is both appropriate and necessary to report a death to the coroner or ME under provincial legislation,³⁸² it may not be appropriate to request the coroner or ME attend the scene immediately. If the death is suspicious and the scene needs to be processed, the expert evidence heard by this Commission suggests the police force with jurisdiction should be the first to investigate it, even before the ME is called in. Investigators or forensic units, or both, should seek to examine the scene with as little potential contamination as possible, which includes waiting to call in an ME or ME's investigator until the scene is processed.³⁸³

238. In this case, it seems the MP members who responded to the scene followed this section of the policy. They cordoned-off the scene, notified the ME Investigator and the CFNIS, and spoke with Cpl Hurlburt, who had discovered Cpl Langridge.³⁸⁴ However, once the ME Investigator had made it clear he believed the death was a suicide and the CFNIS had processed the scene, they should have considered the impact of the ME's opinion on what further steps were necessary or appropriate for their own investigation. Certainly in terms of ruling out foul play, it does not appear there were many further investigative steps necessary, although several follow up interviews may have been appropriate.

What is to be investigated according to the MPPTP

239. Annex I to chapter 7 of the MPPTP states at paragraph 6, entries reporting deaths within SAMPIS are to identify "the cause of death", whether the member was on duty at the time of death, and "when possible, who or what caused the death."³⁸⁵

240. In terms of deaths which may have been suicides, the MPPTP states:

The investigation into suicide or attempted suicide should focus on determining that the wounds to the subject were in fact, self-inflicted. [...] Administrative details (previous attempts, possible causes, marital status[,] alcohol or drug dependencies, etc.) need not be actively pursued and should only be reported if they are offered unsolicited to MP. It must be recognized that a Board of Inquiry or Summary Investigation designed to determine the administrative details will be initiated and will report relevant facts to the appropriate departmental authority.³⁸⁶

241. The second statement in this MPPTP is problematic. All of these issues, if appropriately investigated, are relevant to sudden death investigations. If investigators uncover evidence of previous issues, which could have causal links to the death, these should not be disregarded. Rather, they ought to inquire about them and question whether any such evidence suggests suicide is more or less probable as a cause of death. Despite the fact a Board of Inquiry or Summary Investigation will also address these issues, they are relevant to the police investigation to help rule out the possibility of foul play.

242. In this case, the investigators obtained information about a number of issues the MPPTP states should not be pursued or reported on, including: several previous suicide attempts;³⁸⁷ diagnoses made on several occasions of different mental health disorders, including possible PTSD;³⁸⁸ a recent separation from his common-law spouse;³⁸⁹ a failed drug test for cocaine;³⁹⁰ and a reported history of heavy drinking.³⁹¹ MCpl Ritco suggested this section of the policy was inapplicable as he was investigating a sudden death, not a suspected suicide.³⁹² It is perhaps more relevant to say this policy is an artificial limit on an investigation into either a sudden death *or* a suspected suicide. Evidence related to these issues may suggest a person was suicidal or suicide was a possibility and can be of great assistance in ruling out foul play as an alternative to suicide. In the particular case of Cpl Langridge, it also may have indicated the possibility of culpable negligence on the part of the Regiment in relation to his death.³⁹³

243. The issue in this investigation was not that it ranged into “administrative details” about Cpl Langridge’s life, but instead, that this evidence was not used to test and rule out the possibility of foul play in a timely manner.

244. Overall, what is notable in the MPPTP is its failure to provide guidance about the purpose of a sudden death investigation or the rationale for the steps being mandated in light of that purpose. Ultimately, the MPPTP is too brief, provides too little guidance, and some of the guidance it does provide is problematic. The extent to which the Sudden Death Investigation was in accordance with these guidelines offers no useful response to the complaints, but the fact that elements of the guideline were not followed is also not itself a relevant criticism.

A new protocol: CFNIS SOP 237

245. Subsequent to the conclusion of the investigation into Cpl Langridge's sudden death, the CFNIS introduced CFNIS SOP 237 ("Sudden death investigation & next of kin briefings"),³⁹⁴ a new SOP, which now supplements the existing MPPTP. It appears both the MPPTP and CFNIS SOP were in force as of the end of this hearing. In many ways the SOP is useful to fill in gaps in the MPPTP, but some classification and definitional problems remain, and at least one of its instructions conflicts with the MPPTP with no explanation or guidance given on how the conflict is to be resolved. As with the MPPTP, there is still no statement of purpose outlining the ultimate goal or goals of a sudden death investigation. The new SOP begins by stating, "All suspicious deaths will be handled [in accordance with] the same stringent standard as a sudden death until determined otherwise by the investigative process."³⁹⁵

246. The SOP then classifies deaths in four ways, (as opposed to the three categories in the MPPTP): homicide, suicide, accidental (motor vehicle accidents or industrial), and natural.³⁹⁶ It cautions investigators, "Do not make assumptions or lose evidence based on misconceptions and inexperience."³⁹⁷

247. The general meaning of this direction is clear. Investigators are to be cautious in making assumptions and slow to take steps that might compromise the integrity or the availability of evidence. It is difficult to quarrel with such advice as a guiding principle. If applied too literally, however, the result can be paralyzing and counterproductive.

248. In the case of the 2008 Investigation, the investigative approach taken was in literal compliance with the direction. MCpl Ritco and his case manager had little if any experience in sudden death investigation. They were careful not to lose any item that might perhaps at some point hypothetically become evidence. They kept an "open mind" to a fault, refusing to entertain any assumption about suicide despite an overwhelming accumulation of evidence pointing in that direction.

The respective roles of the CFNIS and coroners according to the SOP

249. The SOP addresses the relationship between the CFNIS and the ME or coroner in a sudden death investigation, stating the coroner usually determines the cause of death (e.g., “asphyxiation”) while the police determine the manner of death “through investigative steps such as interviews, canvassing, scene processing, autopsy results or lab submissions.”³⁹⁸

250. The section does not differentiate between investigations of criminal or suspicious deaths and investigations of non-suspicious deaths in terms of its application. Evidence before this Commission suggests best practices mandate different divisions of responsibility between police and coroners for different death scenes.

251. The distinction set out in the section between “cause of death” and “manner of death” in terms of the respective legal jurisdiction assigned to coroners and police remains vague despite the illustrations cited as to how the police carry out their role. The notion the categories cited result in different roles is especially problematic in jurisdictions like Alberta where the *Fatality Inquiries Act* directs MEs are to determine, “(d) the cause of death, and (e) the manner of death.”³⁹⁹

252. The SOP does attempt to offer direction with respect to the legal jurisdiction of police and coroners (or MEs). Paragraph 10 first cautions investigators to be aware of their authority at death scenes, adding, “Each region [Detachment] must consult their respective Provincial Coroner’s Act or relevant statute to ensure that their practices are congruent with Provincial requirements.”⁴⁰⁰ And continues, “Where there is no suspicion of foul play, you are generally permitted to act under the authority of the respective Province’s Coroners Act.”⁴⁰¹

253. These instructions require some qualification.

254. Evidence before this Commission suggests the CFNIS may not, in fact, have a well-defined legal relationship with the ME or coroner of a jurisdiction. MWO Watson and Maj Frei both testified the MP are not recognized under provincial Police Acts,⁴⁰² putting in question their authority under the provincial Coroners’ Acts. Maj Frei testified

the CFNIS consequently did not have a formalized relationship with the coroners and MEs and required better coordination with these officials in order to understand the ME's or coroner's needs for an investigation.⁴⁰³

255. MP members do not appear to be authorized to act as ME Investigators under the Alberta *Fatality Inquiries Act*⁴⁰⁴ or to exercise similar powers under the other provincial Acts. In addition, both Ontario⁴⁰⁵ and Alberta⁴⁰⁶ require authorization from the coroner and ME respectively to do so. In the absence of formalized recognition as a police service within the meaning of provincial legislation, the CFNIS is unlikely to have the lawful ability to act.

256. The Commission heard no evidence and there were no submissions from the parties regarding any steps taken by CFNIS WR to ensure its practices are congruent with provincial requirements.

Guidance as to actions and responses at a death scene

257. The SOP goes on to detail appropriate responses and actions for CFNIS members upon arriving at a death scene. It directs investigators to:

- isolate person(s) who may have knowledge of the death and request a formal interview;
- request Forensic Identification services from the local police force if not readily available within CFNIS;
- conduct in-person canvasses of the area; and
- attempt to establish a timeline of the deceased's movements and activities prior to the death and the subsequent response.⁴⁰⁷

258. These directions echo expert evidence before this Commission.⁴⁰⁸

259. Other aspects of the SOP appear more problematic. The SOP directs, "investigators must refrain from making any remarks speculating as to the cause or manner of death to the public, other professionals involved in the investigative process or other MP."⁴⁰⁹ It also states, "Do not make assumptions in your notebook such as "I

believe it is suicide” at the preliminary stages of the investigative process. Remember the investigative conclusion is at the end of the investigation.”⁴¹⁰

260. These directions are likely related to concerns about the possible impact on an eventual prosecution of speculative statements made by the investigators, in the event the speculation turns out to be wrong. It is understandable the CFNIS would have concerns about such early opinions being used in the context of eventual criminal proceedings to cast doubt on the subsequent investigative work having resulted in the prosecution. However, these concerns are best addressed by requiring members to identify their initial thoughts or hypotheses as such in their notes or conversations and document thoroughly any changes in those hypotheses or in the orientation of the investigation and the reasons for those changes.

261. Requiring the investigators to refrain from expressing, discussing or documenting any preliminary hypotheses about the suspected cause of death, as the current SOP does, could have negative consequences for the investigation. While there is value in having investigators approach a death scene with an open mind, there appears also to be value in having them collaborate with colleagues.

262. S/Sgt Clark testified the police may call in an ME for an opinion when they are conducting a sudden death investigation.⁴¹¹ It would seem counterproductive if investigators were not permitted to discuss the suspected cause of death with that ME. The ME may help to support or refute investigators’ initial impressions, or clarify any questions or concerns. The ME may also discern evidence from a body, which a police investigator may not, and may then alert the investigator to issues not otherwise apparent to her or him. While the focus should still be on thorough, dispassionate processing of the death scene, communication among and between investigators and MEs should help to ensure nothing is missed.

263. Also problematic on the basis of the Sudden Death Investigation in this case is the direction to investigators to remember conclusions come at the end of the investigation. While, in one sense, the statement is straightforward, namely an investigative conclusion marks the end of the investigation, it is also capable of a different, less straightforward

interpretation, namely, conclusions can only be reached when an investigation comes to an end. Insofar as this might imply investigators should hold off coming to conclusions until every aspect of the investigation is finished, it might lead to an approach like that of the investigators in this case, resolutely holding off on drawing any conclusions until every possible investigative avenue had been exhausted and every step had been completed. That is not a reasonable approach. The evidence of the police panel members was clear. Investigators should be flexible and open-minded in their approach but must also exercise their judgment and form and test hypotheses in the course of the investigation.⁴¹²

264. The SOP does provide other useful directions regarding steps and issues to be addressed in the course of a sudden death investigation with resonance for the current case. It directs investigators to inquire into the circumstances of the reporting of the death, including identifying who called emergency services and why, and obtaining a record or recording of any such call. It instructs investigators to determine if a scene has been disturbed, and if so, how, including identifying any persons who responded to the scene and what actions they took at the scene. Investigators are directed to attempt to identify who last saw the deceased alive, where, and under what circumstances. They are further directed to identify whether the injuries and position of the body are consistent with the other purported facts at the scene.⁴¹³ These directions are consistent with the expert evidence before this Commission as to best practices.⁴¹⁴

265. Like the MPPTP, the SOP states, “the investigation into attempted suicide or suicide should focus on determining that the wounds to the subject were in fact, self-inflicted.”⁴¹⁵ Significantly, the SOP adds the instruction to investigators to “gain a comprehensive understanding of the background of the deceased, including medical and psychological state (medication or alcohol consumption).”⁴¹⁶

266. This instruction seems flatly contrary to what the MPPTP says about not pursuing such issues. In his testimony, MWO Watson agreed the MPPTP and the CFNIS SOP are contradictory on this point. When asked how he would resolve the contradiction, he stated he would refer to the more recent policy.⁴¹⁷ While there is logical merit to this

approach, it should be noted, strictly speaking, there is nothing in the MPPTP or CFNIS SOP on which to base a resolution to the conflicting instructions. The expert evidence before this Commission confirms the CFNIS SOP offers the better guide to investigating sudden deaths. However, the MPPTP still remains in force, making it desirable for steps to be taken to align the two.

267. The SOP goes on to provide direction to investigators in conducting interviews of a deceased's family members, stating, "It is sometimes necessary to interview the family of a CF member days or weeks following a sudden death."⁴¹⁸

268. Where deaths are not suspicious, investigators are instructed to advise the family's AO, who can then "mobilize support mechanisms such as a Padre to be made available should the family member require such support after the CFNIS investigator has completed the interview."⁴¹⁹ This direction is relevant in terms of issues arising from the contacts between the CFNIS and the Fynes in this case.⁴²⁰

269. While the SOP still lacks a clear articulation of the purpose and goals of a sudden death investigation to help investigators to contextualize the instructions it contains, based on the history of the 2008 Sudden Death Investigation and the expert evidence before this Commission, it represents a helpful improvement over the MPPTP.

270. The Commission considers it essential for future sudden death investigations to have clear policy statements and directives. To achieve such an outcome, both the CFNIS SOP and the MPPTP should be reviewed thoroughly and harmonized to the extent possible. Consideration should also be given to revise the SOP to articulate, in a clear manner, the goals and purposes of a sudden death investigation.

4.1.2 Investigating Negligence

ALLEGATIONS

271. The complainants allege the 2008 Sudden Death Investigation was inadequate with respect to the question of whether possible CF negligence played a role in or was responsible for Cpl Langridge's death. The complainants allege the CFNIS members did not properly identify the issues to be investigated and did not investigate issues that presented themselves or were specifically brought to the attention of CFNIS members by the complainants.⁴²¹ Mrs. Fynes told CFNIS members she believed Cpl Langridge had not been provided adequate medical care by either the CF or the civilian medical system, and the CF inappropriately ordered Cpl Langridge to leave the hospital where he was being treated in March 2008 despite his complaints of suicidal intent.⁴²² The complainants believe this alleged negligence contributed to Cpl Langridge's suicide,⁴²³ and they maintain these issues were not adequately investigated.⁴²⁴

272. The complainants also allege the CFNIS members did not investigate the underlying causes of Cpl Langridge's death in a complete and unbiased manner. According to the complaint, the CFNIS members were selective in the information they obtained and included in the course of the Sudden Death Investigation, and the selection was neither objective nor impartial.⁴²⁵

273. The complainants further allege the 2008 Sudden Death Investigation was aimed at exonerating the LDSH Regiment chain of command and other members of the LDSH and the CF more generally of any responsibility in Cpl Langridge's death.⁴²⁶

274. Additionally, they allege the conclusions drawn by the CFNIS members were unreliable because they were based on incomplete facts including numerous unexplored contradictions and discrepancies. In particular, they allege contradictory and inconsistent answers were obtained in the investigation regarding the question of whether a "suicide watch" was planned or conducted by members of the LDSH or base medical personnel prior to Cpl Langridge's death.⁴²⁷ By way of illustration, the complainants assert in their closing submissions:

The outcome of the 2008 investigation was that there was no negligence of the LdSH Chain of Command, but this flies in the face of the fact that the only two persons who were interviewed had a vested interest in the matter. If there had been negligence associated with a suicide watch, both CWO Ross and Capt Hannah would have been involved and implicated in the negligence.

Prior to being investigated, both CWO Ross, and Capt Hannah would have been aware, at least residually, that it was their actions that were being investigated. MCpl Ritco had a duty to probe further in an attempt to corroborate the statements made by both of WO Ross of the LdSH and Capt Hannah. He did not.⁴²⁸

275. The complainants allege the CFNIS failed to investigate in a timely manner the potential criminal or service offences which may have been committed by members of the CF including the LDSH chain of command, prior to Cpl Langridge's death. According to their complaint, conduct requiring further investigation, follow-up and analysis was not adequately investigated by CFNIS members during the 2008 Sudden Death Investigation.⁴²⁹

276. Finally, the complainants allege the CFNIS investigators failed to investigate potential service offences committed by CF members in the application of (or failure to apply) mandated suicide prevention policies in Cpl Langridge's case.⁴³⁰ According to this complaint, CFNIS investigators failed to investigate what policies were applicable and whether they were followed, or whether a suicide prevention policy existed within the LDSH at the time of Cpl Langridge's death. In this connection, the complainants also allege the CFNIS members failed to investigate the question of whether the CF was required to conduct a Summary Investigation for each instance of attempted suicide by a member, and whether this was done in Cpl Langridge's case.⁴³¹

RESPONSE TO THE ALLEGATIONS

277. These allegations are categorically rejected by the subjects. With respect to the allegation the investigation into topics such as potential negligence and the suicide watch was inadequately conducted, the subjects' closing submissions state MCpl Ritco testified he actively pursued the investigation into the existence of a suicide watch at the time of Cpl Langridge's suicide while he awaited the ME's report. They note MCpl Ritco testified he was open to the possibility of finding evidence members of the LDSH had been negligent either under the *Criminal Code* or the *Code of Service Discipline*.⁴³²

Moreover, the subjects' counsel argue WO Tourout "guided" and "supported" MCpl Ritco's plan to look into the possibility of negligence.⁴³³

278. In terms of the scope of the negligence investigation, the subjects argue the investigation was properly limited to the question of whether Cpl Langridge was on the defaulters list and/or under a suicide watch when he died, rather than focused on the question of whether the CF should have conducted such a watch.⁴³⁴ They contend this question was not within the mandate of the CFNIS, as there was no evidence of an onus on the CF to initiate a watch under the circumstances.⁴³⁵

279. The closing submissions submit the evidence gathered by MCpl Ritco indicated some efforts had been made to organize a suicide watch for Cpl Langridge in March 2008, but because neither CWO Douglas Ross nor Cpl Langridge had wanted such a watch, no watch was stood up.⁴³⁶ They note MCpl Ritco and Sgt Bigelow interviewed witnesses directly involved in developing and implementing the conditions placed on Cpl Langridge and deny the witnesses provided inconsistent or contradictory information.⁴³⁷ Instead, the subjects' counsel contend, in pursuing the question of whether Cpl Langridge was a defaulter or under a suicide watch when he died, MCpl Ritco and Sgt Bigelow learned:

This watch was organized at the request of the base hospital, in case it came to the point where Cpl Langridge needed constant supervision.

Senior members of the LdSH did not believe that Cpl Langridge was on a suicide watch or defaulters at the time he died.

The conditions in place at the time Cpl Langridge passed were for structure and Cpl Langridge agreed to them.

On March 14, 2008, the day before he died, Cpl Langridge attended at the medical unit to refill his prescription and was not documented as having any problems.⁴³⁸

280. In the subjects' view, once the CFNIS had evidence Cpl Langridge was living under conditions that were not a suicide watch, but rather were imposed for structure, they were able to rule out the possibility of negligence or negligent performance of a military duty.⁴³⁹ The subjects' counsel point out the CFNIS cannot start or continue an investigation without a reasonable suspicion an offence may have been committed.⁴⁴⁰ In

light of the conclusion no offence was committed, it was unnecessary for MCpl Ritco to take any further investigative steps. Any issues, such as the purpose of the conditions Cpl Langridge lived under, whether Cpl Langridge agreed to them, and whether or not a plan existed for further treatment, were irrelevant to either a service offence or a criminal investigation. These questions were, in the subjects' submission, administrative matters for the military to examine.

281. MCpl Ritco testified he never formed a reasonable suspicion negligence was involved in Cpl Langridge's death.⁴⁴¹ He also testified he did not see it as his task to determine if there was any reason for someone else to investigate potential negligence.⁴⁴² Instead, his investigation concerned the death of Cpl Langridge. He also testified, throughout the investigation, "nothing came up to tell me that there may have been some negligence [...]."⁴⁴³ He testified he was never told in any interviews of LDSH personnel the conditions Cpl Langridge lived under prior to his death were a suicide watch.⁴⁴⁴ He acknowledged receiving inconsistent information in response to various questions. This made it difficult to reach definitive conclusions concerning what happened during Cpl Langridge's last weeks,⁴⁴⁵ and the alleged suicide watch.⁴⁴⁶ However, MCpl Ritco testified this inconsistent information did not hinder him from concluding Cpl Langridge's death was a suicide and closing the investigation.⁴⁴⁷

282. MCpl Ritco denied he failed to conduct the necessary follow-up and analysis to resolve the contradictions and discrepancies in the information he obtained concerning the suicide watch.⁴⁴⁸ He testified he focused his investigation on ruling out foul play since he was unable to determine whether Cpl Langridge had been subject to a suicide watch.⁴⁴⁹ MCpl Ritco testified he did not feel it was necessary, for example, to follow-up on Mrs. Fynes' complaint that Cpl Langridge was not provided proper medical care by either the military or civilian medical systems. He kept this information "in the back of my mind" but felt it did not have a great deal of relevance.⁴⁵⁰ MCpl Ritco said this was because he believed, when he spoke to Mrs. Fynes, what he was tasked with investigating was whether Cpl Langridge died as a result of foul play.⁴⁵¹

283. Sgt Bigelow testified it would not have been the role of the CFNIS to investigate the suicide prevention policies in place within the LDSH at the time of Cpl Langridge's death. It was his view the CFNIS investigates possible criminal offences, and not the policies that were or were not in place.⁴⁵² He agreed, in some circumstances (such as where they were considering service offences against any individuals), investigators would look into the question of whether the policies were followed, but stated a BOI would be the more appropriate means of examining the existence and adequacy of any suicide prevention policies in place as a part of its inquiries concerning administrative processes. He also testified he was not involved in any investigation of whether the suicide prevention policies were being followed or what those policies stated.⁴⁵³

284. With respect to the allegation the CFNIS failed to investigate potential criminal or service offences committed by CF members prior to Cpl Langridge's death, WO Tourout, MCpl Ritco's case manager during the 2008 Sudden Death Investigation, testified MCpl Ritco's work on that file was "investigatively sound."⁴⁵⁴ It was WO Tourout's view MCpl Ritco did the best job he could with the information available to him at the time.

285. MCpl Ritco disagreed with the allegation he was selective in the information he obtained and included in the investigation. He testified he attempted to gather as much information as possible "to prove without a shadow of a doubt that Cpl Langridge did commit suicide and there was no foul play."⁴⁵⁵ He testified the CFNIS takes pride in conducting thorough investigations, and its investigators work as long as necessary. He also denied his investigation was intended to exonerate the CF of responsibility in Cpl Langridge's death or to attack Cpl Langridge's character.⁴⁵⁶ MCpl Ritco appeared to believe the evidence spoke for itself. He testified his investigation revealed Cpl Langridge was a troubled man dealing with many personal issues, who had attempted suicide in the past, had been in and out of hospitals, may have been on a suicide watch, may have been given conditions for structure, and who ultimately killed himself in his room.⁴⁵⁷

286. Sgt Bigelow categorically denied the allegation the CFNIS did not investigate Cpl Langridge's death in a complete and unbiased manner and the allegation CFNIS members

were predisposed to exonerate the LDSH and the CF of responsibility in his death. According to Sgt Bigelow, if the information he and MCpl Ritco acquired during the 2008 Sudden Death Investigation led them to believe any service offences had been committed by LDSH members, “we would have gone after them, no doubts or questions at all.”⁴⁵⁸

NEGLIGENCE AND THE SUICIDE WATCH

What was done to investigate potential negligence?

287. MCpl Ritco’s Investigation Plan (IP) appears to identify two questions about potential negligence to be investigated in connection with Cpl Langridge’s death:

2. was Cpl Langridge on ‘suicide watch’ or ‘defaulters’; (completed)

[...]

13. possible negligent actions on behalf of CF, resulting in possible involvement in death (completed)⁴⁵⁹

288. In the hours following Cpl Langridge’s death, it was suggested to MP and CFNIS members he had been under a suicide watch.⁴⁶⁰ After this, the existence of a suicide watch became a central topic in the Investigation Plan and in the interviews conducted by MCpl Ritco.⁴⁶¹ While the IP identified the potential suicide watch and “possible negligent action” related to Cpl Langridge’s death as separate items, in the investigator’s view, this was not to be a comprehensive investigation into potential negligence.⁴⁶² This meant setting aside nearly any examination of Cpl Langridge’s last weeks and days, which would have determined whether or not criminal negligence or negligent performance of duty may have contributed to his death. Instead, the investigation was very narrowly defined.⁴⁶³ To the extent the matter of negligence was pursued, the CFNIS investigators were focused on the question of a suicide watch.⁴⁶⁴ In this view, it was only if Cpl Langridge was, in fact, subject to a suicide watch and still able to commit suicide that further investigation into negligence would have been necessary.⁴⁶⁵

289. Asked how he pursued the question of CF negligence, MCpl Ritco testified he merely included an entry about possible CF negligence in his investigation plan as a

“reminder” to himself to investigate potential acts of negligence (or have someone else investigate it) if any evidence of it surfaced during the investigation.⁴⁶⁶ According to MCpl Ritco, had some evidence arisen suggesting a service offence may have contributed to Cpl Langridge’s death, he or someone else would have investigated it.⁴⁶⁷ He testified he did not consciously bring the question of service offences to the foreground during the investigation. Rather, MCpl Ritco explained, as with other matters left unconsidered in the 2008 Sudden Death Investigation, he was “[...] keep[ing] my mind wide open. I’m not narrowing in on one thing or the other. I’m – if something comes up where it piques my interest or it’s part of the investigation, yeah, I’ll explore it. But nothing came up.”⁴⁶⁸

290. WO Tourout, his case manager, testified, although the possibility of negligence arose early in the investigation, it did so only because of rumours of a suicide watch.⁴⁶⁹ In fact, WO Tourout testified that after March 16, 2008, the majority of the investigative activity in the 2008 Sudden Death Investigation concerned the alleged suicide watch.⁴⁷⁰ However, he testified that because MCpl Ritco ultimately concluded a suicide watch had not occurred, there was no need to investigate possible negligence.⁴⁷¹ He did not believe it was necessary to investigate any other potential negligent acts.⁴⁷² WO Tourout testified he saw questions like, “should there have been a suicide watch?” to be the domain of a BOI.⁴⁷³ In fact, WO Tourout testified negligence was not given any particular attention in the investigation.⁴⁷⁴

291. MWO Watson also testified the threshold for launching a negligence investigation would have been evidence Cpl Langridge was on a suicide watch or evidence medical authorities had recommended a suicide watch before he killed himself.⁴⁷⁵ He also testified, absent such evidence of a suicide watch, he saw no need to investigate any other possible negligence by the Regiment or the potential influence the conditions Cpl Langridge lived under might have had in his decision to commit suicide.⁴⁷⁶ To do otherwise would have been to conduct “a witch hunt.”⁴⁷⁷

292. In the course of a number of interviews with LDSH personnel and other CF members, MCpl Ritco asked a number of questions aimed at determining whether Cpl Langridge was the subject of a suicide watch at the time of his death. These included the

interviews with Unit adjutant Capt Lubiniecki, Sgt Hiscock, Cpl Hurlburt, MCpl Bowden, MCpl William Fitzpatrick, Cpl Rohmer, Unit RSM CWO Ross, and Acting Base Surgeon Capt Hannah. He testified he compiled his list of witnesses based on the information he amassed between the date of Cpl Langridge's death on Saturday, March 15, 2008, and Monday, March 17, 2008. He testified the witnesses were selected based on "who I wanted to go interview or potentially could interview or see or speak with or what I had to gain, it's just a thought process."⁴⁷⁸

Interview with Capt Lubiniecki

293. Capt Lubiniecki was interviewed on March 17, 2008. Notes of the conversation were taken by Sgt Bigelow,⁴⁷⁹ and he typed a more detailed account of the interview based on these notes and his own recollection into SAMPIS a day later⁴⁸⁰ – possibly with assistance about some details from MCpl Ritco.⁴⁸¹ Regrettably, because the interview was not recorded, there is no transcript.

294. On the day of Cpl Langridge's death, the investigators learned Cpl Langridge had failed to report in at the expected time, and he may have been under a suicide watch or defaulters when he died,⁴⁸² but the evidence suggests it was during Capt Lubiniecki's interview the investigators became aware Cpl Langridge was living under a set of conditions put in place by members of the LDSH chain of command when he died.⁴⁸³ Capt Lubiniecki stated Cpl Langridge was neither on defaulters nor on a suicide watch, and provided them with a copy of the list of conditions:

1. Cpl Langridge Will Wear uniform during normal duty hours and perform duties as directed by the RSM.
2. A Normal Work Day will be from Mon-Fri. 0800-1630 daily. Weekends will be free unless otherwise directed By the RSM
3. He will have freedom of movement with the following restrictions:
 - a) He will live in the Reg [Regimental] Duty Center, bedded in the defaulter's room.
 - b) At no time will his door be closed.
 - c) He will have a curfew [of] 2100 hrs daily.

- d) He will report to the Duty Officer every two hours on the hour daily.
- e) There will be no escorts required except under the following conditions:
 - i) He will, when required to attend any and all appointments given to him by his health care providers, do so under escort.
 - ii) If he chooses to attend AA Meetings he will be escorted to and from the meeting area. The escort(s) will not attend the meetings with him.
- f) All prescribed medication will be held by the Duty Officer. It is still the member's responsibility to take the prescribed dosage at the appropriate times.
- g) When he leaves the confines of the Harvey Bldg he will inform the Duty Officer of where he is going and a contact phone number. Para C and D still apply.⁴⁸⁴

295. Sgt Bigelow's police notebook indicates Capt Lubiniecki explained to the CFNIS investigators Cpl Langridge made two previous suicide attempts before March 2008.⁴⁸⁵ The first was in the summer of 2007, when he was found intoxicated and making preparations to asphyxiate himself with carbon monoxide piped into his running Jeep. The second attempt was in February 2008 while he was a patient at a mental health facility.⁴⁸⁶ Capt Lubiniecki told the CFNIS investigators Cpl Langridge had been admitted to a drug rehabilitation program after his first suicide attempt but discharged himself shortly thereafter. The second attempt was described in SAMPIS as having taken place while Cpl Langridge was "in a mental hospital in Edmonton," and this was made known to Capt Lubiniecki by the padre.⁴⁸⁷ Capt Lubiniecki added that in February 2008, Cpl Langridge admitted himself to the "Alberta Health Centre" (AHE) for thirty days. According to Sgt Bigelow's notes of the interview, Cpl Langridge was scheduled to go to a rehabilitation clinic in Ontario following his thirty days of hospitalization.⁴⁸⁸ However, his request to attend was ultimately denied by the military medical community, which the written notes stated did not support sending him. This was due to missing "a couple" of AA meetings⁴⁸⁹ and Cpl Langridge's lack of conviction at Edgewood,⁴⁹⁰ as well as the cost of the program.⁴⁹¹ The more detailed SAMPIS entry indicates he informed the investigators the cost to attend would have been \$50,000.⁴⁹²

296. According to Sgt Bigelow's SAMPIS entry, Capt Lubiniecki told the investigators, instead of attending the residential substance abuse treatment program,

“Cpl LANGRIDGE was then turned over to the LDSH, where the RSM and Adj compiled a schedule of tasks that Cpl LANGRIDGE would have to adhere to, as he indicated he would like to forge forward and become more committed as a soldier.”⁴⁹³ Capt Lubiniecki is noted as stating Cpl Langridge was neither under a suicide watch nor part of the defaulters’ parade, but was under the conditions in order to demonstrate he was “more committed to changing his ways.”⁴⁹⁴ According to the SAMPIS entry, Cpl Langridge complied with the conditions and “went without incident” until March 12, 2008.⁴⁹⁵ At that time, the interview account reports, Cpl Langridge admitted himself to the Royal Alexandra Hospital for approximately forty-eight hours (this series of events in fact took place on March 11, 2008).

Interview with Cpl Rohmer

297. During his interview with MCpl Ritco on March 18, 2008, Cpl Rohmer, a long-time friend of Cpl Langridge, provided extensive details about a 2007 suicide attempt by Cpl Langridge, to which he and another of Cpl Langridge’s friends, Cpl Jason Hillier, had been witnesses. Cpl Rohmer informed MCpl Ritco that Cpl Hillier notified the LDSH of the suicide attempt.⁴⁹⁶

298. Perhaps more significantly, Cpl Rohmer also discussed watches conducted or proposed for Cpl Langridge by the LDSH. He alleged one or more members of the LDSH chain of command requested he and Cpl Hillier stay with Cpl Langridge in hospital to “watch” him following the June 2007 suicide attempt. Cpl Rohmer stated Cpl Hillier was in regular contact with the Regiment during this time.⁴⁹⁷ Cpl Rohmer also told MCpl Ritco he heard a suicide watch was planned a week prior to Cpl Langridge’s death, although he was unaware whether it was ultimately carried out.⁴⁹⁸ He did not believe it was, because the check-ins and conditions Cpl Langridge lived under in his last days did not meet his understanding of a suicide watch, which he felt required direct, 24-hour monitoring.⁴⁹⁹

299. When asked by MCpl Ritco, Cpl Rohmer expressed his opinion Cpl Langridge should have been watched before his death:

I'm kind of iffy if it's out of line, if it's bad for them, I don't know, but I want to know if the Regiment knew his condition, knew he was suicidal when he wasn't being watched, you know.

[...] I know now after talking and hearing that he had two-hour check-in times, I guess, but **the Regiment knew** all about all of his – I don't know about all of his problems, but **they knew that he had tried to kill himself. They knew that he had alcohol and drug problems.**

And, you know, I -- I think -- this is just me finally getting up, like asking the question. Like I don't -- 'cause like **why wasn't he being watched?**⁵⁰⁰ [Emphasis added]

300. MCpl Ritco asked for clarification from Cpl Rohmer, clearly comprehending Cpl Rohmer was alleging the assistance provided was inadequate and asking him if he believed the LDSH could have done more because they knew he was suicidal. Cpl Rohmer confirmed this, concluding “two hours is a lot of time” to allow between check-ins and indicating a constant watch was necessary in order to “protect him from himself.”⁵⁰¹

Interview with Sgt Hiscock

301. MCpl Ritco and Sgt Bigelow interviewed Sgt Hiscock on March 18, 2008.⁵⁰² Sgt Hiscock was the NCO assigned to the duty desk at the LDSH HQ building on March 15, 2008. One of his responsibilities was to monitor Cpl Langridge. He was on duty when Cpl Langridge died.⁵⁰³ Sgt Hiscock informed MCpl Ritco he relieved the outgoing duty officer the morning of Cpl Langridge's death. The duty officer briefed him about Cpl Langridge and his conditions. Sgt Hiscock was told he was to be conducting a “suicide watch” on March 15, 2008, by either the off-going duty officer or by MCpl Fitzpatrick.⁵⁰⁴ He added that, in his opinion, what was in place was not a suicide watch; he had conducted suicide watches in the past, and those on the watch would never leave the person being watched alone. Cpl Langridge was allowed up to two hours on his own without having to report in to the duty staff.⁵⁰⁵

302. Sgt Hiscock wavered as to the nature and purpose of the conditions. He understood the reason for monitoring Cpl Langridge related to the knowledge of his mental health problems and recent release from hospital.⁵⁰⁶ He believed the conditions had to do with providing Cpl Langridge with structure in the hope this would help him

deal with his issues, but also stated this seemed “strange.”⁵⁰⁷ “[...] I should have asked a lot more questions. I should have got a lot more information, but -- I don't know. I guess it was a suicide watch, but it wasn't really a suicide watch.”⁵⁰⁸ This ambiguity may have been a consequence of a meeting he had with CWO Ross, the Regimental Sergeant Major, the day before his interview. Contrary to what Sgt Hiscock recalled having been told about the suicide watch when he spoke to the MP on the day of the suicide, CWO Ross told him Cpl Langridge was not under suicide watch, and the conditions were meant to provide Cpl Langridge with structure while also maintaining his dignity.⁵⁰⁹ Sgt Hiscock told MCpl Ritco, if the chain of command truly believed Cpl Langridge were suicidal, “these restrictions would have been vastly -- a lot more robust.”⁵¹⁰ MCpl Ritco was left with unanswered questions about the purpose of the conditions and whether or not they were meant as a form of suicide watch.

Interview with Cpl Hurlburt

303. Cpl Hurlburt was aware of previous suicide watches in the military. During a March 19, 2008, interview, he told MCpl Ritco he took part in a suicide watch on the base when he first arrived and described his understanding of it as keeping a 24-hour watch to ensure the individual in question did not harm themselves.⁵¹¹ More importantly, Cpl Hurlburt told MCpl Ritco he had heard he was going to be part of a suicide watch team approximately one week prior to Cpl Langridge's death.⁵¹² He was contacted by MCpl Bowden, who informed him she was organizing a suicide watch. The proposed suicide watch came about after Cpl Langridge “was at the CDU [Care Delivery Unit] and he freaked out and said he was gonna kill himself or something.”⁵¹³ Cpl Hurlburt and a few other squadron members stood ready for suicide watch duty, but he was later notified this would not be necessary. Cpl Hurlburt knew little about Cpl Langridge's situation after that, except some of the conditions Cpl Langridge had to live under.⁵¹⁴ At this point in the interview, MCpl Ritco asked Cpl Hurlburt, “Would you not say that was a suicide watch?” and Cpl Hurlburt agreed Cpl Langridge was subject to a suicide watch on March 15, 2008.⁵¹⁵

304. Cpl Hurlburt said some troopers in the squadron office with him the day the watch was planned used the term “suicide watch” as did MCpl Bowden. It appeared Cpl Langridge’s distress was common knowledge among these CF members, who informed him about Cpl Langridge having “freaked out” at the CDU.⁵¹⁶ Cpl Hurlburt also told MCpl Ritco, Cpl Langridge had recently been the topic of gossip within the Regiment regarding his previous suicide attempts and his substance abuse problems.⁵¹⁷ MCpl Ritco asked Cpl Hurlburt if he recalled the names of any of the people who spoke with him, or who were to conduct the suicide watch with him, but he said there were too many new names and faces in the Regiment for him to recall.⁵¹⁸

Interview with MCpl Fitzpatrick

305. In his interview, MCpl Fitzpatrick stated he was contacted by MWO Kevin Mulhern, the HQ Sergeant-Major, to set up a guard list for a pre-emptive suicide watch following Cpl Langridge’s discharge from the AHE.⁵¹⁹ The order had come down from CWO Ross. Cpl Langridge had just been released, and no one had been briefed on his condition. A list was being set up in the event a suicide watch was needed. MCpl Fitzpatrick recalled either CWO Ross or MWO Mulhern telling him Cpl Langridge “will not leave your eyesight.”⁵²⁰ MCpl Fitzpatrick asked MCpl Bowden to create a list of members available for the watch. She replied with an email entitled, “Here is the suicide watch list.”⁵²¹ MCpl Fitzpatrick recalled printing the email, but he informed MCpl Ritco he consciously deleted the word “suicide” from the document before doing so, as he feared someone might take offence to the term “suicide watch.”

306. Shortly thereafter, MCpl Fitzpatrick was out of his office when Cpl Langridge found the email or, apparently, a different version of the same message. MCpl Fitzpatrick claimed “... somehow the e-mail got printed again without that word being deleted -- right -- and he seen it on my desk, because somebody else must have printed it and put it on my desk.”⁵²² MCpl Fitzpatrick told MCpl Ritco and MS McLaughlin (who took notes), while he had no idea how this happened, he suspected Cpl Langridge saw the email on his computer and printed it again.⁵²³ Cpl Langridge was apparently very upset about the watch and, when he saw CWO Ross walk by, he called him into MCpl

Fitzpatrick's office where he showed him the email. CWO Ross was livid and when MCpl Fitzpatrick returned, he was told to find MCpl Bowden. She was brought to MCpl Fitzpatrick's office, and MCpl Fitzpatrick heard CWO Ross tell her to "Go to my office, and fuckin' take a seat, and I'll be there" before tearing up the email.⁵²⁴ MCpl Fitzpatrick added he was called by MWO Mulhern approximately twenty minutes later and told to "[s]tand down on the guard. There is no guard."⁵²⁵ He was told all the duty staff were to do was ensure Cpl Langridge took his medication properly. MCpl Fitzpatrick told MCpl Ritco all of the materials he possessed related to the watch list were shredded.⁵²⁶

Interview with MCpl Bowden

307. On May 5, 2008, MCpl Ritco interviewed MCpl Bowden about largely the same topics MCpl Fitzpatrick discussed. She was certain, even before the interview started, he would want to know about the suicide watch list.⁵²⁷ In her account of the watch list episode, Cpl Bowden told MCpl Ritco she was in her office approximately one week prior to Cpl Langridge's death (likely Friday, March 7, 2008)⁵²⁸ when MCpl Fitzpatrick came in and stated, "I need a list of people who can do a watch on Langridge for suicide."⁵²⁹ MCpl Fitzpatrick asked her to send him an email with the names and contact numbers of members available to conduct the watch. MCpl Bowden canvassed the availability of the members of her squad and then compiled the list in an email and sent it to MCpl Fitzpatrick. In contrast to MCpl Fitzpatrick's description of the format of the email message, MCpl Bowden told MCpl Ritco she would only have used the word "watch" as a subject heading or title, and certainly not "suicide watch," if she even used a heading or title at all.⁵³⁰ The term "suicide" would only have appeared in the body of the message rather than as a prominent heading.

308. MCpl Bowden indicated when she spoke with CWO Ross, he asked her who had authorized her to use the word "suicide." She answered that no one had given her authority.⁵³¹ She was aware other suicide watches had been conducted, and, from her perspective, the word "suicide" had been used when she was first asked by MCpl Fitzpatrick to compile the list.⁵³² CWO Ross told her "[a]t no point did I authorize Master

Corporal Fitzpatrick to use the word 'suicide.'”⁵³³ CWO Ross ripped up the printed suicide watch email in front of her.⁵³⁴

309. MCpl Bowden told MCpl Ritco that MCpl Fitzpatrick subsequently gave her the official word the watch was cancelled.⁵³⁵ She believed there was already someone watching Cpl Langridge at the time the watch was cancelled.⁵³⁶ MCpl Bowden also stated she and “the whole Regiment” were aware Cpl Langridge had attempted suicide before and had been hospitalized as a consequence.⁵³⁷ Soldiers would periodically be sent to the hospital to visit him.⁵³⁸ She was also aware of two previous suicide attempts by Cpl Langridge and stated Cpl Langridge had been put under watches in the past.⁵³⁹

310. At the end of the interview with MCpl Bowden, MCpl Ritco commented he was receiving conflicting information about the nature of the watch and where it came from.⁵⁴⁰ For that reason, MCpl Ritco testified he interviewed CWO Ross to “put to bed” the issue of a suicide watch.⁵⁴¹

Interview with CWO Ross

311. CWO Ross was the RSM and responsible for discipline within the LDSH. During his interview on May 23, 2008, he told MCpl Ritco a “24-hour, 7-day-a-week watch” was initially organized for Cpl Langridge in March 2008 in case it needed to be put into action.⁵⁴² He asked MCpl Fitzpatrick to put together a list of names for such a watch after clinical staff from the base clinic called him to ask for assistance in supervising Cpl Langridge. He explained it was initially unclear what Cpl Langridge’s circumstances were, how much freedom he would have and what the Regiment’s responsibilities might be. CWO Ross stated the abortive watch “[...] wasn’t considered or called, from me, a ‘suicide watch’; that wasn’t the purpose of it.”⁵⁴³ CWO Ross asserted he lacked the legal authority to impose such a watch, explaining the Regiment could have only “legally” put Cpl Langridge under a “24-hour, 7-day watch” if the “medical system” informed him Cpl Langridge was suicidal.⁵⁴⁴

312. CWO Ross asserted it was MCpl Bowden’s mistake to call it a suicide watch, due to some miscommunication. CWO Ross advised MCpl Ritco that when a distraught Cpl

Langridge approached him and showed him MCpl Bowden's email about the watch, Cpl Langridge was the one who ripped it up. CWO Ross told him "[t]his is not what this is all about."⁵⁴⁵ CWO Ross also denied being aware of Cpl Langridge's medical circumstances beyond addiction problems and having gone to the hospital frequently, "and that he was suffering with some sort of PTSD."⁵⁴⁶ He denied knowing anything about Cpl Langridge's background or current situation.

313. CWO Ross talked to Cpl Langridge's addictions counsellor and the base surgeon to better understand the situation. To him, it became apparent "[...] this guy is not being a soldier. He needs to have some structure in his life. We can provide that for him."⁵⁴⁷ Accordingly, on March 7, 2008, he put together a list of conditions he felt would assist Cpl Langridge and sought input by email from the base surgeon as to any medical requirements to add to the list.⁵⁴⁸ Capt Hannah replied on March 7, 2008, with a set of medical employment limitations requiring Cpl Langridge to abstain completely from alcohol and drugs not prescribed by a physician, to comply with the treatment plan including remaining under the supervision of the LDSH, and to attend all scheduled appointments directed by the medical service.⁵⁴⁹ CWO Ross incorporated these limitations into the measures he had in mind and they became part of the conditions,⁵⁵⁰ in addition to those quoted earlier. He privately explained them as a whole to Cpl Langridge.⁵⁵¹ CWO Ross told MCpl Ritco the conditions allowed Cpl Langridge some freedom, but also:

[...] structure from a day-to-day sort of routine. Put him back in uniform, so he started acting like a soldier, not wearing civilians all the time. Getting certain things that he had to do throughout the day, and then we also provided him the opportunity, if he wished to go to one of his local meetings, addiction meetings and all that, 'We'll drive you there. We'll drive you there, you call us when you're done, we'll come back and get you.'

So that's the sort of latitude that we offered him. [...] But here's the medical side of the house, you're not allowed to drink alcohol, you're not allowed to take prescription drugs without the doctor's consent [...] or take any sort of medication without a doctor's consent.⁵⁵²

314. CWO Ross stated the Regiment watched Cpl Langridge as best they could.⁵⁵³ The conditions were seen as a means of helping Cpl Langridge out as best as the Regiment could, based on both "medical suggestions" and what "we felt we were legally obligated

to do [...].”⁵⁵⁴ CWO Ross informed MCpl Ritco the purpose of the conditions was solely to help Cpl Langridge gain the structure necessary for him to go to treatment.⁵⁵⁵

315. According to CWO Ross, Cpl Langridge was required to come physically to the duty centre, report in, and essentially say, “Here I am. I’m still good to go.”⁵⁵⁶ This way, the Regiment would know “that there was nothing wrong, he wasn’t hurt or anything.” His curfew was to ensure he would not be going outside the building past a certain point, “regardless of what was going on, and that was it. He wasn’t going out any more of that night.”⁵⁵⁷ CWO Ross also informed MCpl Ritco the Regiment did not administer Cpl Langridge’s medication; they simply made sure it was available. Taking it was his responsibility. However, despite the clearly worded condition stating, “At no time will the door [to the defaulter’s room] be closed,” CWO Ross said Cpl Langridge could close the door to have private time. It was entirely up to him, and there were no issues with him doing so.⁵⁵⁸ MCpl Ritco did not inquire about this apparent contradiction.

316. CWO Ross stated there was no set time limit for the conditions. The determining factor would be Cpl Langridge demonstrating he could abide by rules and regulations – that he would do what he was told, keep his appointments, and so on, proving to the medical side he was on track and ready to attend residential substance abuse treatment. It could have taken two weeks, or even a month. He explained Cpl Langridge was required to prove himself before the medical side would spend more money on his treatment.⁵⁵⁹

317. In terms of the nature of the conditions, Sgt Bigelow asked CWO Ross if the conditions were “set in stone,” as though they were orders. CWO Ross stated they were, and stated a breach of those conditions would “absolutely” be equivalent to a soldier breaching orders from a superior.⁵⁶⁰ If Cpl Langridge failed to return to the duty centre by his 2100 hrs curfew, for example, CWO Ross stated there would probably have been an AWOL charge.

318. CWO Ross told MCpl Ritco, Cpl Langridge had no problems whatsoever when told about the conditions. He was “quite happy with that,”⁵⁶¹ and said, “I need structure. I need somebody to tell me what to do’, and he thanked me for doing that, sitting him down and giving him a straight-nosed talk.”⁵⁶² However, Cpl Langridge soon wanted the

imposed conditions relaxed, and his requests were denied. Cpl Langridge first approached Capt Lubiniecki to request greater latitude. Capt Lubiniecki spoke with CWO Ross, who decided to deny the request:

[...] I said no. I think two hours is enough. He wanted more, and I said you've got to prove to us that you can handle what you're doing now. You know, can you abide by those regulations that have been set up for you now. You can abide by them, [and] then at the end of this weekend [...] I'll re-evaluate it.⁵⁶³

319. On the Wednesday or Thursday prior to his death, Cpl Langridge attended at sick parade and again requested for his conditions to be relaxed:

He had gone to the doctor's, the doctors phoned me later in the morning and said, 'Listen, what's going on with this guy? He's saying he can't handle what you're doing,' yada yada yada [...]

So I said we've been asked to help, we're doing what we can. I think it's just [...] another ploy of him not wanting to be a soldier, and carrying on, and doing what he's expected to do. So he said, 'Yeah, I tend to agree with you.'

So then he hung up, and I'd say, maybe 10 minutes later, he phoned back and said, 'Okay, he just said he's suicidal, so I have no option other than to admit him to the hospital.'⁵⁶⁴

320. CWO Ross said Cpl Langridge was released after spending approximately 24 hours in hospital. He stated, "And they said there's nothing we can do. He's no danger to anybody. So they released him. [...] And then, that weekend, he committed suicide."⁵⁶⁵ CWO Ross appeared to concede even the two-hour check-in interval was too long to keep Cpl Langridge safe, but said, "I don't know what more we could have done from there; I really don't."⁵⁶⁶

321. The interview concluded with CWO Ross expressing his desire "to see some closure to this as quickly as possible."⁵⁶⁷

Interview with Capt Hannah

322. On May 27, 2008, MCpl Ritco met with Capt Hannah to discuss Cpl Langridge's mental health and previous suicide attempts. He asked Capt Hannah about Cpl Langridge's previous suicide attempts he had become aware of, including the June 2007 attempt, an overdose of medication, attempts to hang himself at his residence and the

suicide attempt in February 2008, which took place while Cpl Langridge was at the Royal Alexandra Hospital. Capt Hannah stated he reviewed Cpl Langridge's file after his death. He noted all the suicide attempts were documented in the file, and MCpl Ritco "hit, certainly, the highlights."⁵⁶⁸ He added there were other incidents in the file, which may also have been suicide attempts, but it was difficult to say with certainty because they were not necessarily as straightforward or overt as those referred to by MCpl Ritco.

323. Capt Hannah's opinion about Cpl Langridge's mental health situation over the previous year was that a person would never be in a chronic or constant state of "being suicidal," and it was not an ongoing illness that could be labelled.⁵⁶⁹ Instead, suicidality was situational and varied from day to day depending on factors such as mental health issues, life changes and drugs and alcohol. Capt Hannah stated he would not classify a patient as suicidal over a long period of time unless they exhibited daily suicidal thoughts or behaviours, although Cpl Langridge was "absolutely" at higher risk of suicidality than other patients.⁵⁷⁰ Capt Hannah noted it was "certainly on the public record" Cpl Langridge was living at the LDSH duty centre because he was perceived to be at a heightened risk for suicide and required additional supervision.⁵⁷¹

324. Earlier in the investigation, MCpl Ritco had initiated a request from the base clinic for Cpl Langridge's medical records pertaining to his mental health and received the file,⁵⁷² and he sought Capt Hannah's assistance in interpreting the records in the context of the 2008 investigation. After interpreting various clinical terms and personality disorder diagnoses included in Cpl Langridge's mental health records, Capt Hannah was asked about Cpl Langridge's discharge from the Alberta Hospital at Edmonton (AHE) in March 2008. MCpl Ritco was seeking information about the period between his discharge and his being subject to the conditions. Capt Hannah did not know where Cpl Langridge lived after his discharge but remembered he began living within the LDSH lines on March 7th, 2008.⁵⁷³ Capt Hannah told MCpl Ritco, based on the medical records, Cpl Langridge attended Care Delivery Unit C ("CDU(C)") on March 7, 2008, at the insistence of his Base Addictions Counsellor (BAC) after continued problems with drinking and drug use and complaints from Ms. A about harassment. Cpl Langridge accepted there was a problem and asked to be sent to the AHE. However, the AHE was

unable to take him, and Cpl Langridge was unwilling to go to the Royal Alexandra Hospital instead. He denied being suicidal, but:

That not being good enough, we offered him an opportunity for him to live in the LdSH, where he could be – have someone that could keep a close eye on him. He wanted extra supervision, he wanted someone to keep an eye on him. LdSH agreed to that, and so he was allowed to move in.⁵⁷⁴

325. MCpl Ritco asked Capt Hannah if Cpl Langridge had been on a suicide watch before March 7, 2008. Capt Hannah said he “had no idea” and stated Cpl Langridge was under the care of base medical personnel, but did not reside at the base medical clinic as it did not function as a hospital.⁵⁷⁵ Capt Hannah explained he simply did not know if there was a suicide watch between Cpl Langridge’s discharge from the AHE and March 7, 2008.⁵⁷⁶ Capt Hannah stated he was consulted by the LDSH as to Cpl Langridge’s conditions on March 7, 2008, which he said were instituted to provide Cpl Langridge with “structure” and “support.”⁵⁷⁷ At the time, Cpl Langridge had not indicated he was suicidal, but was asking for extra support, so the decision was made to provide him with that support “and this was a plan that he accepted and agreed to, and was willing to do.”⁵⁷⁸ Capt Hannah advised MCpl Ritco the LDSH did not force Cpl Langridge to reside within the duty centre. Instead, his behaviour was to be closely monitored, with people keeping an eye on him in a structured environment. According to Capt Hannah, the LDSH was responsible for administering his medication, including reminding him of the times for taking his medication.⁵⁷⁹

326. Capt Hannah did not believe Cpl Langridge was suicidal on March 14, 2008, the day before his death. Cpl Langridge attended the base clinic for a prescription renewal and reported no particular difficulties. When asked by MCpl Ritco why Cpl Langridge was attempting suicide, Capt Hannah speculated Cpl Langridge was repeatedly acting out as a result of borderline personality traits in order to be the centre of attention and:

[...] at some point, some people get frustrated that people stop making them the centre of attention, and -- or pay them too much attention, and take away their privileges in society, and in that case, then, I think -- my opinion – some people will say, ‘Fine. I’ll show you. I really will kill myself.’, and they do.⁵⁸⁰

327. Capt Hannah also speculated Cpl Langridge might have committed suicide because it was the day of another soldier's funeral "and someone else was the centre of attention that day, not him."⁵⁸¹ He also supposed Cpl Langridge had been drinking or using cocaine that day. Finally, he also guessed the cause could have been a combination of all of the above. Capt Hannah concluded, no matter the reason, the LDSH "went above and beyond the call of duty and really tried to accommodate the member in a way that was unique, and I think very flexible and supportive [...]."⁵⁸² Finally, Capt Hannah advised MCpl Ritco, as far as he knew, the arrangements had been made for Cpl Langridge to go to residential substance abuse treatment if he had been able to adhere to the structure given to him, and he "absolutely" would have gone.⁵⁸³

MCpl Ritco's conclusions about the suicide watch

328. It was clear from the witness evidence set out above that some form of watch was planned for Cpl Langridge, although information about the purpose of the watch was contradictory. Sgt Hiscock,⁵⁸⁴ Cpl Rohmer,⁵⁸⁵ Cpl Hurlburt,⁵⁸⁶ MCpl Fitzpatrick,⁵⁸⁷ and MCpl Bowden⁵⁸⁸ each reported to MCpl Ritco that a suicide watch was either planned or conducted for Cpl Langridge. Although Sgt Hiscock was equivocal as to whether the planned watch was a suicide watch, he appeared to have wavered only after an intervention by CWO Ross.⁵⁸⁹ MCpls Bowden and Fitzpatrick each reported having been directly involved in the process of planning the watch on behalf of CWO Ross. Additionally, some witnesses indicated suicide watches were not unknown in the CF and had even been conducted for Cpl Langridge at various times of crisis, including in March 2008.⁵⁹⁰

329. MCpl Ritco indicated he concluded Cpl Langridge was not under a suicide watch at the time of his death, accepting the assertions made by CWO Ross and Capt Hannah as to what was planned for Cpl Langridge and what was ultimately done. As MCpl Ritco testified:

"[...] because of all the mixed information I was getting whether he was on one or he wasn't on one, I had to make a decision on: okay, was he on one or wasn't he on one? So I spoke with the person that would – ultimately that directed it, and that was Chief Ross. He said [...] it wasn't a suicide watch, so I took it at face value that it wasn't a suicide watch."⁵⁹¹

330. Despite this apparently categorical statement, MCpl Ritco's testimony on this question was ultimately somewhat equivocal. On his second day of testimony, he said he was actually unable to reach a conclusion whether Cpl Langridge was "on 'suicide watch' or 'defaulters'" despite having noted on his IP at the time this issue was "completed."⁵⁹² MCpl Ritco also stated he was not able to reach any conclusions as to the purpose of the conditions to which Cpl Langridge was subject in the last days of his life, nor answer the question whether Cpl Langridge voluntarily submitted to them.⁵⁹³

MISUNDERSTANDING NEGLIGENCE

331. Given the narrow understanding of negligence in the 2008 investigation as essentially requiring evidence of a failed suicide watch,⁵⁹⁴ and given MCpl Ritco's conclusion a suicide watch was not being carried out at the time of Cpl Langridge's death (or more precisely, given his inability to conclude one was being carried out), it is not surprising MCpl Ritco testified he encountered no evidence of CF negligence in the course of his investigation.⁵⁹⁵ This conclusion appeared to satisfy his superiors. WO Tourout testified, if evidence arose to substantiate the suggestion Cpl Langridge may have been the subject of a suicide watch when he died, then there might have been reason to consider the possibility of negligence on someone's part. Because the suicide watch was never confirmed, there was no need for a negligence investigation.⁵⁹⁶ Similarly, MWO Watson testified he was satisfied enough investigation had been done to come to a conclusion on the issue and warrant closing the file,⁵⁹⁷ asserting once the question of the suicide watch was resolved, "we're done."⁵⁹⁸

332. The CFNIS members fundamentally misunderstood the concept of negligence. Investigators and supervisors mistakenly viewed the suicide watch as a necessary precondition to a finding of negligence. They defined both "suicide watch" and "negligence" very restrictively. Even so, MCpl Ritco was unable to answer the very question the subjects identified as being singularly relevant: whether there was a suicide watch being conducted when Cpl Langridge took his own life. More importantly, MCpl Ritco did not consider whether, based on the evidence, other sorts of conduct might have

constituted negligence, nor what potentially negligent acts and omissions by the LDSH or by base medical personnel might have looked like.

333. MCpl Ritco did not seem to understand how such negligent acts or omissions could even hypothetically have resulted in Cpl Langridge's death, meaning he had little conception of how this question could be investigated or even what to look for. Conceiving a botched suicide watch to be the only possible grounds for a negligence investigation, the CFNIS investigators still failed to investigate the matter thoroughly or properly while ultimately leaving other critical questions about the watch and about potential CF negligence unanswered.

334. Critical questions concerning potential negligent acts and omissions by members of the LDSH and base medical personnel were not even contemplated, let alone asked or investigated. MCpl Ritco testified he was mindful evidence of potential negligence might arise, and testified he would have appropriately noted this evidence and if it did, would have ensured he or someone else at the CFNIS investigated the matter. However, this was simply not possible without an informed understanding of the possible duties of care by the CF or its members towards Cpl Langridge, and what potential acts or omissions by LDSH members and base medical personnel might have constituted a breach of such duties.

335. The investigators should have been looking to answer the question whether the CF as a whole, but in particular members of the LDSH and base medical personnel, had a duty to keep Cpl Langridge safe from harm.⁵⁹⁹ Even if it were determined there was no general duty of care for the military to keep its members safe, there still would have been a question as to whether, in Cpl Langridge's particular circumstances, a specific duty may have arisen for the military to keep him safe.⁶⁰⁰

336. In simple terms, investigating possible negligence would have required the CFNIS investigators to consider two scenarios, the first being negligence by omission: whether the CF failed to take reasonable steps to keep Cpl Langridge safe in the circumstances.⁶⁰¹ The second scenario would have been negligence by commission: whether the CF took any steps that created a danger to Cpl Langridge's safety.⁶⁰²

337. Aside from the question of whether Cpl Langridge was under a suicide watch, there are unanswered questions about whether a suicide watch was planned and/or put in place in all but name and whether Cpl Langridge's conditions constituted a *de facto* suicide watch. If such a watch was planned but not carried out, was the decision not to mount a suicide watch reasonable in the circumstances? This would also require answering questions such as, "what sort of watch was being planned, if not a suicide watch?" as well as whether a duty existed to put measures in place, which would protect Cpl Langridge from harm, whether explicitly called a "suicide watch" or not.

338. Even accepting the claims made by LDSH members that Cpl Langridge was not under a suicide watch and was not on the defaulters list or otherwise being disciplined, important questions arise such as why Cpl Langridge was required to sleep in the defaulters room and obey other conditions in March 2008 if not for his safety. If safety was a factor in the development of the conditions, were the conditions reasonable for that purpose? If they were not developed for purposes of safety, did the "structure" they imposed on Cpl Langridge cause or contribute to his death? Were the conditions negligently executed or administered in some way that put Cpl Langridge at risk of harm? These questions seem never to have been considered let alone pursued.

What was missed: Interviews not conducted

339. Key witnesses with information highly relevant to the negligence issue were never approached for interviews. In some cases, such as with Mrs. Fynes and Ms. A, it was decided by MCpl Ritco's superiors interviews were unnecessary despite the fact they would clearly have possessed intimate knowledge of Cpl Langridge.⁶⁰³

Failure to interview Ms. A

340. MCpl Ritco did not interview Ms. A, Cpl Langridge's common-law spouse, in the course of his investigation, although she was initially identified in his IP as a witness who should be interviewed.⁶⁰⁴ When asked about this decision, he testified she "[...] was in the back of my mind to be interviewed, but, as the investigation carried on, at the end of

the investigation it was deemed that it was irrelevant to interview her because it was a suicide.”⁶⁰⁵

341. Ms. A had a great deal of information about Cpl Langridge’s final weeks. In a statutory declaration in support of an application for survivor benefits made in July 2009, she described important aspects of her relationship with Cpl Langridge and Cpl Langridge’s last weeks.⁶⁰⁶ Had Cpl Ritco interviewed her, he would have almost certainly obtained information highly relevant to the 2008 Investigation, which very likely may have warranted further investigation into potentially negligent actions.

342. Ms. A attested in her statutory declaration, Cpl Langridge’s certification was reviewed after his 30-day stay between February 5 and March 5, 2008, at the AHE. According to the declaration, Cpl Langridge’s doctor asked that he remain at the hospital for another 30 days, and Cpl Langridge himself wanted to stay. She attested he was finally making progress in the hospital and was frightened of leaving, but the CF requested his release into its care for two weeks of close supervision, after which he would be eligible to attend another rehabilitation centre. According to Ms. A, Cpl Langridge was told the time at base was mandatory if the military was going to continue to assist with his treatment.⁶⁰⁷ Ms. A went on to say Cpl Langridge accepted the CF’s offer of help:

On March 5, 2008 Stuart began living on the base and the military advised me that he would be safe. They ensured [*sic*] me that Stuart would be under constant supervision, which they referred to as “suicide watch”. They promised that Stuart would attend Addictions Counseling on a daily basis, and Alcoholics Anonymous Meetings as often as possible. During this time, Stuart and I spent as much time together as possible. I would visit him on base, and other times he would leave the base to visit me (either with permission or by evading his caregivers).

Stuart and I remained committed to each other over the last two weeks of his life. Until sadly, against the military’s promises, he was left alone in his room on the base.⁶⁰⁸

343. Ms. A reaffirmed this version of events in her testimony during the Commission hearings.⁶⁰⁹ She testified Cpl Langridge slowly made progress and began to regain optimism and make plans for the future while he was at the AHE in February/March 2008. According to Ms. A, Cpl Langridge felt safe at the AHE and wanted to stay. His hope was to remain at the AHE until he could be flown to a residential substance abuse

treatment centre.⁶¹⁰ He told her he did not feel he could “screw up” or “fall off the wagon” there, as he was eventually refused grounds privileges due to past abuses and “wasn’t really allowed to go outside even,”⁶¹¹ developments which were corroborated in his medical records.⁶¹²

344. However, he later informed her he had been told to return to base at the end of his 30-day certificate, where he would stay “under full supervision,” being watched constantly.⁶¹³ She testified Cpl Langridge called her and told her he was scared to leave the hospital and did not want to go the night before he was to return to the base. She explained they considered their options, but the expense of addiction (or substance abuse) treatment meant they had little choice but to acquiesce. Cpl Langridge then told her he trusted the LDSH to keep him safe.⁶¹⁴

345. Ms. A testified she learned from Cpl Langridge himself his return to base was mandatory and this was confirmed to her by Cpl Langridge’s addictions counsellors or a base psychologist.⁶¹⁵ She testified the assurance Cpl Langridge would be subject to a suicide watch came from Cpl Langridge’s addictions counsellors and possibly also in a conversation with Capt Lubiniecki. After the passage of time, she could no longer recall if the term “suicide watch” was used explicitly, but she testified her understanding from the conversations she had was Cpl Langridge would be watched by someone 24 hours a day.⁶¹⁶ Ms. A also testified she was told Cpl Langridge would be looked after and she was not to worry.⁶¹⁷

346. These allegations are unproven, but they are serious enough that anyone investigating the possibility of negligent actions related to Cpl Langridge’s death would immediately appreciate their importance. MCpl Ritco readily acknowledged during his testimony this information would have been useful to the 2008 investigation.⁶¹⁸

347. MCpl Ritco testified the decision not to interview Ms. A was made following discussions with WO Tourout. His notes record WO Tourout believed “[...] really there was no reason to speak with the common-law [spouse].”⁶¹⁹ MCpl Ritco could not recall the basis of this decision, but he believed it was made because the view at the time was that the investigators possessed sufficient information.

348. WO Tourout testified he deemed it unnecessary to interview Ms. A because it was believed they required no more than what was contained in Cpl Langridge's medical file.⁶²⁰ When presented with the information in Ms. A's declaration, he acknowledged it was information not available to the investigators through any other means. Nevertheless, he was dismissive of Ms. A's account, explaining it was not supported by the medical documents that had been obtained. This explanation does not appear well-founded because, to substantiate such accounts, it would first have been necessary for the investigators and their superiors to know the allegations even existed. They did not because they had never spoken to Ms. A.

349. WO Tourout subsequently acknowledged no documents pertaining to Cpl Langridge's hospitalization in February/March 2008 had actually been requested.⁶²¹ Regardless, WO Tourout also dismissed Ms. A's allegations that Cpl Langridge was effectively ordered out of the hospital by the LDSH, that his close supervision was planned from even before his discharge, and that Ms. A was assured Cpl Langridge would be protected by a suicide watch.⁶²²

350. It seemed the failure to seek information from this witness was being justified by the fact no other details about the allegations were obtained; however, this resulted from the failure to investigate the issue. With apparent reluctance, WO Tourout conceded in his testimony that had he been aware of Ms. A's allegations, he would have expected Sgt Ritco to follow up and investigate them in order to determine whether or not they were true.⁶²³

351. MWO Watson testified he did not see the relevance to the 2008 investigation, or to the suicide watch question specifically, of interviewing Ms. A.⁶²⁴ When MWO Watson was presented with Ms. A's allegations, he was surprisingly dismissive of their significance. In particular, he did not believe the allegation that Ms. A was promised Cpl Langridge would be under a suicide watch could be true because she also said he was able to leave the base on his own or by evading his caregivers. If he were under suicide watch, he would not be permitted to leave.⁶²⁵ This objection seems to miss the point entirely. It ignores the possibility Cpl Langridge may have been subject to a botched or

inadequate suicide watch, or that a suicide watch was planned and promised but, perhaps negligently, was not implemented. These were precisely the issues that needed to be pursued in a negligence investigation.

Failure to Interview Mrs. Fynes

352. Mrs. Fynes was also never interviewed. MCpl Ritco testified it was an oversight not to include the Fynes in his IP, but stated, “[...] they were still in the back of mind that I potentially could have interviewed them.”⁶²⁶ As with Ms. A, the decision not to interview the Fynes was made by MCpl Ritco’s superiors.⁶²⁷ The Fynes did make their own efforts to call MCpl Ritco. MCpl Ritco attempted to return the call made to him by Mr. Fynes and ended up speaking with Mrs. Fynes. Otherwise she would never have been contacted. When they did speak, Mrs. Fynes made several allegations about Cpl Langridge being poorly treated by the civilian and military medical systems before he died.⁶²⁸ MCpl Ritco testified he did not recall ever discussing with WO Tourout the possibility of formally interviewing Mrs. Fynes as a result of this call and testified the allegations did not alert him to any further issues requiring follow-up or investigation.⁶²⁹

353. The Commission heard testimony from Mrs. Fynes stating she too was told by base medical personnel in the last days of Cpl Langridge’s life in March 2008 he would be placed under a “suicide watch,” and like Ms. A, was also told she was not to worry.⁶³⁰ When she asked what the watch entailed, she was told it would be “eyes-on, 24/7” observation and Cpl Langridge was being kept at the duty centre in order for this to be facilitated. She testified she was also told “no news was good news,” and if anything changed or the watch was removed, she would be contacted. Like Ms. A, Mrs. Fynes alleged the source of the assurance Cpl Langridge would be looked after was one of Cpl Langridge’s addictions counsellors. Mrs. Fynes specifically identified the counsellor as Dennis Strilchuk.⁶³¹

354. WO Tourout did not have a strong recollection about the decision not to interview Mrs. Fynes, but he testified the decision was again likely made because Cpl Langridge’s medical records appeared sufficient to provide background information. He did not recall ever discussing the possibility of interviewing Mr. Strilchuk with MCpl Ritco.⁶³² When

MWO Watson was presented with Mrs. Fynes' allegations, he testified he did not consider them relevant to the investigation. He testified her information would only be relevant if she was given information contradictory to what the CFNIS received from the same sources (for example, if CWO Ross had told her something contradictory to what he had told the CFNIS about a watch).⁶³³ Surprisingly, MWO Watson appeared unprepared to accept that any information Mrs. Fynes may have been given by a different source about a suicide watch would be relevant to the investigation:

MS COUPLÉE: Okay. And if she received the information from a different source, someone you did not speak to, would that have been relevant?

CWO (RET'D) WATSON: Again, they formed the opinion through their investigative steps that he was not on suicide watch. So they were confident in that matter and they didn't pursue it any further.

MS COUPLÉE: So the fact that Mrs. Fynes may have been told that he was, you don't consider that to be relevant.

CWO (RET'D) WATSON: No.⁶³⁴

355. This defensive posture is troubling, particularly given MCpl Ritco's equivocation in his testimony as to his ability to reach conclusions about even the most fundamental question of whether there was a suicide watch or not. It is difficult to understand the view that, once the investigators had concluded there was no suicide watch mounted, there was no need to pursue the allegation that one had been promised.⁶³⁵

356. When he was asked whether it would have been important to interview Mr. Strilchuk to determine where this information came from had the CFNIS investigators been aware of it at the time of the 2008 investigation, MWO Watson conceded it possibly would have been.⁶³⁶ However, he doubted any such information would have led the investigation in a different direction because "[w]e still would have found evidence to support the fact that there was no suicide watch regardless of what this individual said to Mrs. Fynes."⁶³⁷

Failure to interview Lt Dunn

357. Other lost opportunities included the failure to interview Lt Dunn, the duty officer for March 14, 2008, who, according to Sgt Hiscock, had briefed him about Cpl Langridge

being under a “suicide watch” on the morning of March 15, 2008. MCpl Ritco failed to identify Lt Dunn despite having obtained Cpl Langridge’s last sign-in sheet, which identified the duty officer as “L.D.”⁶³⁸ MCpl Ritco did ask Cpl Hurlburt if he knew who the outgoing duty officer was, but Cpl Hurlburt stated he did not know.⁶³⁹ The issue was not raised with later witnesses or investigated further. When Lt Dunn appeared before the Commission, he testified he had been given a quick briefing during the handover from the outgoing duty officer on March 14, 2008, in which he was instructed about his duties with respect to Cpl Langridge.⁶⁴⁰

358. Lt Dunn testified he was made aware of the conditions to which Cpl Langridge was subject, and “I knew he was at risk for suicide and that we had to watch him, that he had to check in with me at least once every one or two hours and that I had to make sure he took his medication and that he was actually sleeping in the defaulters’ room.”⁶⁴¹ His understanding of the conditions was Cpl Langridge was at risk of committing suicide and he was to be monitored in the effort to prevent this, although he wasn’t sure if the term “suicide watch” was ever used.⁶⁴²

Failure to interview Cpl Langridge’s close friends

359. The CFNIS investigators did not investigate the matter of who had ordered the first suicide watch purportedly conducted for Cpl Langridge when he was in hospital in June 2007. The CFNIS investigators interviewed Cpl Langridge’s friend, Cpl Rohmer, and he discussed the suicide attempt with them. He also mentioned Cpl Hillier was present at this time and – significantly – had been in regular contact with the Regiment while they were at hospital with Cpl Langridge.⁶⁴³ The investigators also learned Cpl Rohmer had drifted away from Cpl Langridge.⁶⁴⁴ Having gained all this information, they nevertheless did not interview Cpl Hillier, who Cpl Rohmer described as Cpl Langridge’s “best friend.”⁶⁴⁵ As a consequence, they gained no information about Cpl Hillier’s role in what was apparently a suicide watch conducted with the Regiment’s knowledge and approval after one of Cpl Langridge’s previous suicide attempts.

360. When asked about the June 2007 watch, Cpl Hillier testified he reported the suicide attempt to the LDSH chain of command the night of the incident and remained

the better part of two days at the hospital with Cpl Langridge, periodically providing information to the LDSH.⁶⁴⁶ Although Cpl Hillier testified he believed the watch was not a suicide watch, he also testified he received a text indicating the LDSH was preparing to send members to relieve him and Cpl Rohmer at the hospital.⁶⁴⁷ He also testified knowledge of Cpl Langridge's suicide attempt was widely circulated throughout the Regiment.

361. The CFNIS investigators also did not interview other close friends of Cpl Langridge to determine if they had information relevant to the investigation, such as Kirk Lackie, who testified he subsequently attempted without success to contact the investigators through the MP Garrison in order to provide them with information about Cpl Langridge. At the hearing, Mr. Lackie testified the LDSH took steps to keep Cpl Langridge under watch in March 2008.⁶⁴⁸ MCpl Ritco testified he had never heard Mr. Lackie's name before.⁶⁴⁹ The information from these witnesses, had it been obtained, might have alerted the investigators to the possibility Cpl Langridge's suicidal ideation was widely known and some structured watches may have even been undertaken by the LDSH in response.

Failure to interview members of the LDSH Chain of Command

362. MCpl Ritco did not question information provided to him by the members he interviewed within the LDSH chain of command. As a consequence, the investigators chose not to contact high-ranking officers for interviews. Yet these were the officers who made certain decisions regarding Cpl Langridge.

363. After Capt Lubiniecki's interview on March 17, 2008, MCpl Ritco did not interview any other members of the LDSH chain of command, such as LCol Pascal Demers, Maj Earl Jared, or Maj Trevor Cadieu. The only other interview of a senior LDSH member was MCpl Ritco's interview of CWO Ross. He stated he would have conducted such interviews, but they were not necessary because he trusted the Adjutant, Capt Lubiniecki, spoke for the entire chain of command. MCpl Ritco testified his assumption was based on his 15 years of experience within the CF.⁶⁵⁰ He added, "I have to take [his] word for it, right, sir?"⁶⁵¹

364. A senior member of the chain of command, Maj Jared, who was never interviewed by the CFNIS, was the OC of the LDSH HQ Squadron in March 2008. Cpl Langridge came under his supervision in 2007 following his transfer to that squadron after a failed drug test. Along with CWO Ross and Capt Hannah, he played a significant role in determining what would happen to Cpl Langridge in March 2008. MCpl Ritco had several interactions with Maj Jared in the spring of 2008 concerning Cpl Langridge's personal effects, owing to Maj Jared's role as a member of the Committee of Adjustment dealing with Cpl Langridge's service estate, but did not interview him about the investigation.⁶⁵²

365. Had MCpl Ritco interviewed Maj Jared in 2008, he would very likely have obtained information inconsistent with what he had been previously told by CWO Ross. The version of events, as recounted in Maj Jared's testimony, contradicts some of the information CWO Ross provided to MCpl Ritco in May 2008. The Commission finds it difficult to reconcile these two versions.

366. In May 2008, CWO Ross originally told MCpl Ritco he had devised the conditions with input from Capt Hannah. CWO Ross provided MCpl Ritco with an email chain indicating, on the afternoon of March 7, 2008, he sent an email message to Maj Jared and Capt Lubiniecki containing "direction and restrictions," "control measures," and medical employment limitations constituting the conditions Cpl Langridge would be required to abide by.⁶⁵³ CWO Ross forwarded that message to Capt Hannah on March 10, to which the doctor replied, "Outstanding, thanks."⁶⁵⁴

367. However, Maj Jared testified CWO Ross came into his office with a different draft email message about the new conditions earlier on March 7, 2008. His recollection was the CF medical system intended to release Cpl Langridge to the LDSH and CWO Ross had consulted with either Capt Hannah or Mr. Strilchuk, giving rise to the requirement Cpl Langridge had to comply with the treatment plan, including "remaining under the supervision of the LDSH."⁶⁵⁵ To Maj Jared, this meant additional supervisory measures because it was taken for granted the CF already supervises its soldiers. Indeed, Maj Jared testified:

The initial conditions that were proposed to me, I believe, involved CF members watching Corporal Langridge constantly with the intent of preventing him from committing suicide. I did not agree with the measures or the draft document that was put in front of me, and I discussed the measures with the regimental sergeant major, Mr. Ross. The resulting measures are as you see here [...].⁶⁵⁶

368. Maj Jared confirmed he understood what CWO Ross originally proposed was a suicide watch.⁶⁵⁷ In contrast to CWO Ross' assertion a suicide watch was never intended and he had only considered planning for a 24/7 watch "if it came to that" in the face of unknown medical requirements for Cpl Langridge,⁶⁵⁸ Maj Jared's testimony was CWO Ross had himself proposed a suicide watch over Cpl Langridge, and it was only because Maj Jared disagreed with the proposal that the watch was scrapped. Whether or not these two versions of events can be reconciled, at the very least they raise significant questions about the conclusions reached by the CFNIS members concerning the suicide watch issue.

369. CWO Ross did not mention Maj Jared at any point in his interview with MCpl Ritco about a suicide watch, a "24/7 watch" or about the final conditions. His interview appears to imply: CWO Ross himself decided not to conduct any manner of watch over Cpl Langridge; the conditions were imposed for structure and not for medical reasons; and CWO Ross did not initially have any knowledge Cpl Langridge was suicidal before Cpl Langridge's March 11 admission to the Royal Alexandra Hospital.⁶⁵⁹ Having been confronted with Maj Jared's testimony during his own appearance before the Commission, CWO Ross surmised Maj Jared "[...] could have very well been aware of my initial course of action of putting together a possible 24 and 7 watch [...]"⁶⁶⁰ Beyond that, CWO Ross testified he did not remember the content of the discussions he had with Maj Jared about a watch over Cpl Langridge or about the conditions ultimately imposed.⁶⁶¹

370. CWO Ross testified the conditions were the product of his discussions with Capt Hannah but would not have been written in isolation from Maj Jared or Capt Lubiniecki. He reiterated, his view of the purpose of the conditions changed following "[...] the continued discussions that I had with Dr. Hannah as to what exactly they wanted, what the long-term goal, if you will, if you want to call it that, what was the purpose of it, what

was the intent, and it certainly changed my focus and my direction that led me to those conditions.”⁶⁶²

371. In his testimony, CWO Ross initially affirmed his 2008 statement the 24/7 watch was not intended to be a suicide watch.⁶⁶³ He insisted the 24/7 watch was “very quickly dropped” and was not intended to prevent Cpl Langridge from harming himself.⁶⁶⁴ In further questioning, however, CWO Ross was taken back to the initial request for a 24/7 watch, and he was asked to confirm such a watch would have been functionally a suicide watch with the goal of preventing Cpl Langridge from harming himself. He then conceded, initially at least, it “was a possible course of action that we may have had to taken [*sic*],”⁶⁶⁵ and added “[h]ad we had to do that, yes, that’s what we would have had to do.”⁶⁶⁶ CWO Ross also testified, having reviewed his 2008 CFNIS interview, nothing in that interview struck him as inaccurate or requiring a change.⁶⁶⁷

372. Had MCpl Ritco interviewed Maj Jared in 2008, he may well have been led to consider at least the possibility one or more witnesses were incorrect about the arrangements planned and ultimately made during Cpl Langridge’s last days. Such information would have required the CFNIS members to consider a much more probing investigation of the available witnesses. MWO Watson testified he did not know why Maj Jared was never interviewed. He was not aware Maj Jared was involved in determining whether a suicide watch would be conducted or what the nature of the conditions should be.⁶⁶⁸ He testified he did not consider Maj Jared’s evidence relevant, stating it seemed to him Maj Jared simply disagreed with CWO Ross’s “final direction,” and dismissively stated, “That’s his opinion --.”⁶⁶⁹

Failure to interview key medical personnel

373. The base medical personnel interviewed by the CFNIS members were not Cpl Langridge’s treating physicians. MCpl Ritco testified Capt Hannah informed him he was not Cpl Langridge’s treating physician when he sought his assistance to help understand the medical records he received in response to his request for Cpl Langridge’s mental health file. Capt Hannah said his interaction with Cpl Langridge had been “very brief,” and Capt Hannah did not believe it had anything to do with Cpl Langridge’s suicide.⁶⁷⁰ In

fact, Capt Hannah only saw Cpl Langridge once, and only for about an hour, on March 7, 2008.⁶⁷¹

374. MCpl Ritco was asked if he gave any thought to interviewing Cpl Langridge's treating physicians. MCpl Ritco responded:

When Dr. Hannah's name was given -- I forget the doctor that says that that's the person you should speak with -- I assumed that, being the Base Surgeon or Acting Base Surgeon, he or she would have an insight on the patient. So when I went to speak with him, I had full intentions or I was under the impression that he knew full well the conversation I was going to have with him and was up to speed on Corporal Langridge.⁶⁷²

375. Despite Capt Hannah's unfamiliarity with Cpl Langridge, MCpl Ritco testified he felt the information Capt Hannah provided to him about Cpl Langridge's circumstances was sufficient, evidently trusting Capt Hannah's position of authority. MCpl Ritco spoke with only one other doctor, Dr. Robin Lamoureux, who saw Cpl Langridge briefly for a prescription renewal the day before his suicide. MCpl Ritco testified he did not find the interview sufficient to give him any insights into Cpl Langridge's state of mind prior to his death because Dr. Lamoureux's interaction with Cpl Langridge was very brief.⁶⁷³ MCpl Ritco did not interview any of Cpl Langridge's base addictions counsellors, such as Mr. Strilchuk or the mental health team nurses who worked with Cpl Langridge.

376. MCpl Ritco also did not interview any of the civilian doctors who treated Cpl Langridge. Such interviews could have included: Dr. Bernard Sowa, who was the attending physician at the AHE when Cpl Langridge was committed for 30 days between February 5 and March 5, 2008; Dr. Jack Chu, who was the attending physician for several of Cpl Langridge's admissions at Royal Alexandra Hospital after suicide threats in 2007 and early 2008; and Dr. David Block, who was the attending physician for Cpl Langridge's two-day admission to the Royal Alexandra Hospital just days before his death.⁶⁷⁴

377. Dr. Sowa testified about Cpl Langridge's state of mind, providing details about his treatment and progress the witnesses MCpl Ritco interviewed simply could not provide. He had ordered "close observation" for Cpl Langridge repeatedly throughout his AHE hospitalization.⁶⁷⁵ This was a precaution ordered when staff were "particularly

concerned about a patient” who was “particularly acutely suicidal” or exhibiting sudden, unstable changes in behaviour. It meant Cpl Langridge was not permitted to leave the unit and a nurse was required to check on him every 15 minutes to ensure he was physically unharmed and emotionally well.⁶⁷⁶

378. Dr. Sowa testified Cpl Langridge admitted to having attempted suicide in late February 2008.⁶⁷⁷ On March 4 and 5, 2008, Cpl Langridge exhibited great anxiety about returning to base. Looking at the notes recorded by the AHE nursing staff, Dr. Sowa explained he understood this as the source of the anxiety. He testified, “Clearly, he wasn't happy about going back to the base, and he was apprehensive as to what kind of plans they had for him. From my understanding, they wanted him there to attend drug rehab programs [...]”⁶⁷⁸ Dr. Sowa testified Cpl. Langridge seemed to be less anxious after speaking with “Leo” at the base to learn more about the situation and this was likely because “[...] he was assured he wouldn't be resuming his normal military duties, whatever they were, so that was my understanding of that. And it looks like at that point, there was also a consideration that it might be Ontario rather than BC where he would be going for his treatment, drug rehab treatment.”⁶⁷⁹

379. Dr. Sowa worked extensively with Cpl Langridge during his stay at the AHE and testified he believed Cpl Langridge would have responded negatively to the treatment he received at the base upon his return. He believed the conditions actually put into place for Cpl Langridge would have been “highly provocative” to him, and Cpl Langridge would see the conditions as “extremely punitive.”⁶⁸⁰ He also testified the conditions were contradictory. On the one hand they provided for Cpl Langridge to be kept in a room where he could be observed, – suggesting to Dr. Sowa there was consensus Cpl Langridge might harm himself – yet, on the other hand, they imposed normal workdays upon him. He believed this suggested “fuzziness” about where Cpl Langridge was situated in terms of his recovery and about what needed to be done. Dr. Sowa added he would have exercised great caution with a patient who was being discharged, in terms of resuming work, and would have urged a gradual return only, even if that individual (unlike Cpl Langridge) had been particularly keen to do so.⁶⁸¹

380. Had the CFNIS sought Dr. Sowa's evidence, serious questions might have arisen about Cpl Langridge's stability upon his return to base. There was also evidence available, which strongly indicated a suicide watch was being planned for Cpl Langridge upon his return. Had the matter been pursued with medical witnesses who were actually involved in the events, there seems little doubt issues about the understanding of the LDSH chain of command and medical communities concerning the need to ensure Cpl Langridge's safety would have come to the forefront.

381. At the very least, further investigation was warranted. Instead, the statements made by Capt Lubiniecki, CWO Ross, and Capt Hannah became MCpl Ritco's conclusions. The CFNIS members accepted this evidence without critical analysis and did not follow up on the assertions made in any meaningful way. The apparent deference of the CFNIS members meant logical, critical questions went unasked and relevant issues remained unexplored.⁶⁸²

382. MWO Watson testified he did not have any concerns about the fact the investigators relied on the denials made by CWO Ross and Capt Hannah about the suicide watch. He explained if, after the interviews, evidence came to light Capt Hannah and CWO Ross had deceived the investigators, the investigation would then focus on them.⁶⁸³ With respect to whether there had been any independent confirmation Cpl Langridge was not on a suicide watch, MWO Watson testified he believed this had been obtained.

The subjects' explanations

383. Even based on the evidence compiled by the CFNIS investigators, it would seem there was reason to go beyond the accounts given by CWO Ross, Capt Lubiniecki, and Capt Hannah during the 2008 investigation. MCpl Ritco had amassed contradictory evidence about the possible suicide watch even before seeking the assistance of CWO Ross and Capt Hannah to put the question to rest. WO Tourout testified he was not concerned the two persons who would "clearly" be implicated in allegations of negligence concerning the suicide watch were the only two interviewed about it.⁶⁸⁴ He stated, "[...] we had no reason to believe otherwise. [...] There was no other evidence to

suggest that they were lying.”⁶⁸⁵ This assertion is unsatisfactory because failing to conduct the due diligence expected in the investigation is simply not the same as finding no evidence.

384. In cross-examination, MWO Watson was asked by his counsel to explain the standard for deciding how many witnesses should be interviewed and how much information should be tracked down in an investigation – essentially, “how far do you go as investigators?”⁶⁸⁶ He explained the standard was to “[...] interview enough people, and it's irrelevant to me whether it's two people or one hundred and two people, how many they interview until they're satisfied that their investigation is complete and they have all the information they require.”⁶⁸⁷

385. When asked if there was an expectation the CFNIS investigators would “interview every possible person out there who might have information to bear on the issue,” MWO Watson replied timeliness and the relative value to the investigation of the information to be obtained from a given witness were important considerations.⁶⁸⁸ While this may generally be true, the issue is whether the interviews conducted were sufficient to allow CFNIS investigators to conclude they had enough reliable information to terminate the investigation of potential negligence, let alone the suicide watch issue. The long list of witnesses with potentially relevant information who were never interviewed – and those for whom it was decided no interview was necessary – appears to belie any such assertion.

386. The failure to interview Ms. A, Mrs. Fynes, Dr. Sowa, and Mr. Strilchuk is particularly striking given the information they may have been able to give the CFNIS about Cpl Langridge’s last days and the treatment he received. The failure to interview CF personnel such as Maj Jared, Lt Dunn, and Cpl Hillier meant information about suicide prevention efforts planned before and during March 2008 was left undiscovered.

CONTRADICTIONS AND INCONSISTENCIES

387. Although MCpl Ritco, it appears, ultimately concluded there was no suicide watch in place at the time of Cpl Langridge’s death, it was clear from the evidence he

gathered some form of watch had been planned for Cpl Langridge. Information about the purpose of the watch and the subsequent conditions was inconsistent. Some witnesses stated Cpl Langridge was to be watched, but not for the purpose of preventing him from committing suicide. Some witnesses told the CFNIS Cpl Langridge was under a suicide watch in substance if not in name. Some witnesses went further and indicated, not only were suicide watches known within the CF, but they had been expressly conducted for Cpl Langridge in March 2008 or after prior attempts at suicide.

Apparent inconsistencies in Sgt Hiscock's accounts of the arrangements for Cpl Langridge

388. One of these unexplored inconsistencies involved Sgt Hiscock's references as to what was arranged for Cpl Langridge. Sgt Hiscock provided conflicting statements regarding the nature of the supervision provided for Cpl Langridge. On the day of Cpl Langridge's death, MCpl Christina Mahoney, an MP member,⁶⁸⁹ recorded Sgt Hiscock's statement in her MP notebook following the discovery of Cpl Langridge's body. She reported Sgt Hiscock said, "Cpl LANGRIDGE **was on suicide watch** and had been sleeping at the Unit lines since approx one week."⁶⁹⁰ Sgt Hiscock added in this account that Cpl Langridge was required to report in to the Unit every two hours and, following a missed check-in, Cpl Hurlburt was sent to find him, resulting in the discovery of his body.

389. During his interview with MCpl Ritco, Sgt Hiscock first stated he was told he was conducting a suicide watch, although he believed it would not have been a suicide watch by his understanding of the term. When asked to describe what Cpl Langridge's situation was, if not a suicide watch, Sgt Hiscock replied it was more "a structured program [...] like an extra duty thing so we could just keep an eye on the guy and help him."⁶⁹¹ Sgt Hiscock could not explain why Cpl Langridge would be subject to the conditions if not for fear that he would harm himself.⁶⁹² MCpl Ritco did not probe further. Later in the interview, Sgt Hiscock revealed he met with CWO Ross the day before his interview and was essentially told the watch was not a suicide watch, but intended for "structure."⁶⁹³

390. According to Sgt Hiscock, CWO Ross explained to him Cpl Langridge's conditions were developed in conjunction with his mental health care providers to provide him with structure while preserving his dignity. Sgt Hiscock suggested to MCpl Ritco the conditions were a discreet attempt to avoid conducting a formal suicide watch, "so that [Cpl Langridge] could still do stuff without having, like I say, a guy standing there watching you, you know, take a crap."⁶⁹⁴

391. When asked to explain what his understanding of Cpl Langridge's situation was after the meeting with CWO Ross, Sgt Hiscock stated he believed Cpl Langridge was under a suicide watch, "but put the little quotation marks around it."⁶⁹⁵ He added Cpl Langridge was not a defaulter and felt Cpl Langridge was "not really on suicide watch" because he was not being watched constantly. Sgt Hiscock also suggested "imposed restrictions" might be an appropriate term to classify Cpl Langridge's situation. In his typed summary of the interview, MCpl Ritco noted: "Sgt HISCOCK was under the impression Cpl LANGRIDGE was not a defaulter, nor on suicide watch, that the conditions were [*sic*] in place to give Cpl LANGRIDGE a controlled structure program to follow. Sgt HISCOCK **further related this information came from the RSM the day prior.**"⁶⁹⁶ MCpl Ritco did not ask Sgt Hiscock about the statement he gave to MCpl Mahoney. He did not inquire why Sgt Hiscock's statement had changed.⁶⁹⁷

392. When MCpl Ritco interviewed CWO Ross on May 23, 2008,⁶⁹⁸ he did not inquire into the issue of CWO Ross's meeting with Sgt Hiscock the day before his CFNIS interview.⁶⁹⁹ MCpl Ritco did not ask CWO Ross about the reasons for this intervention and evidently did not find it significant. When MCpl Ritco was asked during his testimony what he made of the fact Sgt Hiscock's statement changed after his meeting with CWO Ross, he only replied "I didn't – nothing there, sir."⁷⁰⁰

393. MCpl Ritco's supervisors also did not see any issues with the inconsistent information about a suicide watch. WO Tourout testified the issue of Sgt Hiscock changing his account was of "more relevance" to MCpl Ritco than to him.⁷⁰¹ Like MCpl Ritco, moreover, WO Tourout appeared to exhibit considerable deference to the chain of command, to the extent he implied rank entailed credibility. In particular, WO Tourout

explained he was unconcerned about Sgt Hiscock changing his statement regarding the suicide watch after CWO Ross met with him because “[Sgt Hiscock] had no reason not to believe [CWO Ross]. People will believe one thing until they are told whether or not it’s correct or incorrect. If Sergeant Hiscock believed that initially, [it was a suicide watch], and he was told later by Chief Ross that it wasn’t, then he would accept the change, unless there was proof otherwise.”⁷⁰²

394. Similarly, when he was taken through Sgt Hiscock’s conflicting statements, MWO Watson testified, “I think it would be appropriate to ask MCpl Mahoney if that’s actually what was said.”⁷⁰³ MWO Watson dismissed any concerns over the inconsistent accounts, as he was satisfied MCpl Ritco’s investigation did not uncover any evidence of a suicide watch.⁷⁰⁴

The December 2007 suicide watch

395. Sgt Hiscock’s testimony at the Commission revealed more than the narrow scope of his CFNIS interview in March 2008. As Sgt Hiscock recalled, he learned in December 2007 members of the LDSH were arranging a suicide watch for Cpl Langridge. Sgt Hiscock testified he was approached by WO Boudar and told a 24/7 suicide watch for Cpl Langridge was necessary. He and WO Boudar attempted to come up with a list of names of people willing to take Cpl Langridge home with them and watch him over the holidays.⁷⁰⁵ The watch was required until Cpl Langridge’s next meeting with his counsellor. He believed it would be roughly a week. Cpl Rodney Bartlett volunteered to watch Cpl Langridge.

396. The Commission was able to call Cpl Bartlett, who was a friend of Cpl Langridge, as a witness. Due to the passage of time, Cpl Bartlett’s recollection of these events was not strong, deepening the consequences of the failure of the CFNIS members to investigate the matter thoroughly. He believed the watch took place in the winter, as Sgt Hiscock said, but for only one night, and suggested it might have been in February 2008⁷⁰⁶ – possibly after Cpl Langridge’s discharge from the RAH on February 4, 2008. Cpl Bartlett testified he was instructed to watch Cpl Langridge, to prevent him from leaving his house, and to prevent him from harming himself.⁷⁰⁷ Cpl Bartlett was “fully

aware that it was a suicide watch,” and reported back to WO Boudar (his superior in HQ squadron) about it.⁷⁰⁸ Cpl Bartlett also testified he was aware of a suicide watch list “floating around the regiment” at another point – he believed it was before the watch he conducted, because he recalled being unable to participate. He did not know what happened with this list.⁷⁰⁹

QUESTIONS NEVER ASKED OR NEVER FOLLOWED UP

397. Apart from the fundamental conceptual failures, another of the principal deficiencies in the 2008 investigation of the negligence issue was the failure to obtain relevant and important information. The existence of such information was evident from information already obtained. Yet, CFNIS members failed to follow up on questions and allegations brought to their attention.

Previous suicide attempts

398. After speaking to Capt Lubiniecki, MCpl Ritco knew at least some members of the LDSH chain of command were aware of Cpl Langridge’s June 2007 and February 2008 suicide attempts. It would have been appropriate at this point for MCpl Ritco to probe further into the Regiment’s knowledge of Cpl Langridge’s past suicidal behaviour in order to evaluate the assertions the conditions were put in place purely for structure and the claim no suicide watch had been planned for Cpl Langridge.

399. MCpl Ritco failed to ask any questions of any other witnesses, including CWO Ross, as to their knowledge of previous suicide attempts. In his testimony at the Commission hearings, CWO Ross confirmed he was aware of multiple suicide attempts. He testified he knew of the June 2007 suicide attempt.⁷¹⁰ He was also aware of an incident in October 2007 in which Cpl Langridge appeared to have made another suicide attempt by way of an overdose of medication.⁷¹¹ Had MCpl Ritco explored this issue with the LDSH witnesses, he might have become aware of the need to investigate what was known about the risks to Cpl Langridge and to reconcile this with what was actually done for him.

The allegation of inadequate care

400. The CFNIS investigators did not follow up on the allegation,⁷¹² made by Mrs. Fynes in the spring of 2008, that Cpl Langridge received inadequate care from the military and civilian health care units. Mrs. Fynes also informed MCpl Ritco she was greatly troubled by Cpl Langridge's treatment in hospital, and believed he was improperly released from hospital in February 2008 while he was in a suicidal state. While Cpl Langridge's treatment in the civilian medical system would clearly have been beyond the jurisdiction of the CFNIS to investigate, MCpl Ritco testified Mrs. Fynes' allegations about the medical care provided by the military did not alert him to anything he felt needed to be followed up in the 2008 investigation,⁷¹³ although he denied this meant her information was irrelevant to him:

What I'm saying is [...] that at the time when I spoke with Ms Fynes, when she mentioned that I was dealing with a sudden death. [...] So it was my back of my mind, but did it have a lot of relevance? No, because I was dealing with a sudden death. I wanted to find out: Was it foul play? Did Corporal Langridge die at the hands of somebody else or was it a suicide or other means -- or other things?⁷¹⁴

401. MCpl Ritco possessed information, which made it readily apparent⁷¹⁵ Cpl Langridge had been admitted to both the Alberta Hospital at Edmonton and the Royal Alexandra Hospital shortly before his death (including an admission to the RAH just days before his suicide). The records would have yielded significant information about Cpl Langridge's stability and state of mind in this period, but MCpl Ritco did not request any medical records pertaining to those admissions despite Mrs. Fynes' complaint about inadequate care by the military medical system, and despite information from Capt Lubiniecki about these hospital admissions. He assumed these records would have been included in his request for Cpl Langridge's medical file from base mental health services.⁷¹⁶ Due to that assumption, he testified, it never occurred to him to ask for further records.⁷¹⁷ He conceded it would have been helpful to his investigation to obtain these medical records.

Lack of details on Cpl Langridge's final days

402. There are critical gaps in what is actually known about Cpl Langridge's last days. The CFNIS investigators seem not to have tried to fill in those gaps, despite the clear relevance to the conditions Cpl Langridge faced upon his discharge from the hospital, plans to ensure his safety and stability, and the intention of the conditions arranged two days after his release from hospital. CWO Ross and Capt Hannah spoke of developing the conditions on March 7, 2008, but were unaware of Cpl Langridge's living arrangements and any conditions he was living under before. CWO Ross told MCpl Ritco he was not certain but did not believe Cpl Langridge was out of hospital before that date,⁷¹⁸ and when Cpl Langridge first came to the LDSH he "started right into" the conditions.⁷¹⁹ MCpl Ritco actually attempted to clarify the timing, because he understood the "suicide watch list" incident took place at some point before the conditions were imposed on Cpl Langridge, and CWO Ross agreed his release must have occurred some time before the conditions were put in place. He stated he believed the hospital release, the suicide watch email, and the conditions all fell very close together and possibly occurred on the same day.⁷²⁰ CWO Ross was unable to provide further information. However, CWO Ross also mentioned the arrangements were made because Cpl Langridge had nowhere else to go. He heard a rumour Cpl Langridge was sleeping in his vehicle, but explained he only learned of this after the barracks room had been arranged.⁷²¹

403. The medical records MCpl Ritco obtained provided the timeline for Cpl Langridge's discharge from the AHE, but the CFNIS members never determined what happened to Cpl Langridge between the time of his discharge from AHE on March 5, 2008, and the imposition of the conditions on March 7, 2008, including where Cpl Langridge was living.⁷²² MCpl Ritco testified each witness had a version of where he was living and why he ended up in the defaulters room.⁷²³ As a result, he never did learn what actually transpired:

[...] Like I said, sir, I kept getting mixed -- I was told that at one point in time he was living in his vehicle -- depending on who you spoke with. Hence, the reason that I was speaking with his unit to try and figure out exactly where he was living to find out what he was doing up to the days prior. [...] Like I said, I got information that he was living in his vehicle. Then I got told that, no, it wasn't, that he was staying in the defaulters'. Then there was information that he was actually residing in his room.

To this day I don't know, sir.⁷²⁴

404. Had MCpl Ritco interviewed Ms. A, he might have learned Cpl Langridge and Ms. A were discussing his living arrangements before his discharge from the AHE. In her testimony, Ms. A disputed the contention Cpl Langridge had been assigned a room at the duty centre because he had nowhere else to go before he went to residential substance abuse treatment.⁷²⁵ The townhouse they had rented was gone but, according to Ms. A, they had hoped to live together at Ms. A's new residence, and Ms. A then learned Cpl Langridge was required to live on the base:

They told me that they had given him a room in the barracks, in the shacks, but that he was to spend most of his time behind the duty desk and that if he missed anything or misbehaved at all, which I think might have taken place by the second day, he ended up sleeping in the bed behind the duty desk in Lord Strathcona's Horse Building.⁷²⁶

405. Maj Jared, OC of Cpl Langridge's squadron, also had no knowledge of what happened to Cpl Langridge between March 5 and March 7, 2008. He did not think Cpl Langridge had been discharged from the AHE before March 7, 2008, and knew nothing about any release or other arrangements before this date.⁷²⁷ His understanding was the defaulters room was arranged for Cpl Langridge on March 7, 2008, because he had nowhere else to stay and the defaulters room was the most expeditious arrangement that could be made on a Friday afternoon.⁷²⁸ He also testified he thought Cpl Langridge was under the care of the military medical system upon returning to base, and if Cpl Langridge had been released from the AHE before March 7, 2008, then he must have been at the base clinic.⁷²⁹

406. However, Capt Hannah and the primary care nurse, Charlene Ferdinand, said there was no place for Cpl Langridge to live within the military medical system as there were no in-patient beds, and they could only provide treatment during the daytime.⁷³⁰

407. The investigation of potential negligence should have included efforts to sort out the disagreement on where Cpl Langridge resided or what conditions he was living under between his release and the imposition of the March 7, 2008 conditions. The inconsistent information raises questions regarding how the LDSH planned to receive and treat Cpl

Langridge on his return from the hospital. The records suggest a room in the barracks was arranged for Cpl Langridge on March 4, 2008.⁷³¹ Despite this, where Cpl Langridge actually resided between March 5 and March 7, 2008, remains unclear.

408. MCpl Fitzpatrick told MCpl Ritco he had been instructed by CWO Ross to have a room in the “shacks” (the barracks block) available for Cpl Langridge upon his discharge from hospital in March 2008, as he would be residing there for the time being.⁷³²

However, MCpl Fitzpatrick also told MCpl Ritco (and testified) Cpl Langridge slept in the defaulters room from the first night of his release.⁷³³ Capt Hannah’s notes of the morning of March 7, 2008, suggest Cpl Langridge was already residing in the defaulters room before March 7, 2008, referring to already existing arrangements: “Member directed by Unit to live in company lines to enhance supervision. [Member] upset with this plan.”⁷³⁴ When asked about this, CWO Ross acknowledged this strongly suggested Cpl Langridge was already residing in the defaulters room.⁷³⁵

409. The evidence obtained by the CFNIS investigators suggested the LDSH and base medical personnel made certain arrangements for Cpl Langridge’s return and those arrangements were quickly changed. Things may not have gone as planned. This should have raised questions about Cpl Langridge’s stability and safety at the time, and the purpose or appropriateness of any measures put into place. Due to the failure to pursue such questions, we simply do not know what happened, or why, or what the impact on Cpl Langridge could have been.

Other issues not investigated or followed up

410. The narrow understanding of negligence and a suicide watch meant the CFNIS investigators were not prepared to look further and consider the possibility a deficient watch was arranged, which was potentially a negligent act, or no watch was arranged when one should have been, which was potentially a negligent omission. As a consequence of failing to conduct key interviews, the CFNIS investigators did not discover and thus failed to investigate whether any assurances were given to Cpl Langridge’s parents or common-law spouse that he was being kept safe and/or was under a suicide watch. Additionally, the CFNIS members failed to follow up on MCpl

Bowden's statement Cpl Langridge had been under previous suicide watches,⁷³⁶ and this watch was already underway when it was cancelled.⁷³⁷ This information gains even greater significance following the testimony of Mr. Lackie, who was never interviewed by the CFNIS, who stated a "partner" reportedly accompanied Cpl Langridge from the duty centre during activities like meals as part of a "suicide watch."⁷³⁸ Pursuing these questions would have been highly relevant for determining what was planned in response to Cpl Langridge's suicide attempts and what was known by the chain of command about his mental state. This, in turn, would have enabled the investigators to understand how a duty of care towards Cpl Langridge, if one existed, was understood and being discharged.

Were the conditions a *de facto* suicide watch?

411. The contention that the conditions by which Cpl Langridge was required to abide for the last week of his life were put into place purely for structure and support, demanded further scrutiny. Beyond testifying his mind was "always open" during his investigation, MCpl Ritco testified he did not recall whether he contemplated investigating the true purpose of the conditions, or whether he ever formed any hypothesis on the matter.⁷³⁹

412. Rigid definitions of what would constitute a suicide watch, or might have been negligent conduct, impeded the investigation of negligence. The LDSH leadership generally gave evidence it would be difficult and onerous to place Cpl Langridge under a suicide watch that restricted his freedoms, and thus they did the best they could under those circumstances. WO Tourout had his own understanding of what a suicide watch looked like and, because of this, discounted the possibility the CFNIS investigators should have examined the actions taken concerning Cpl Langridge instead.

413. WO Tourout testified he understood the relatively liberal and voluntary nature of the conditions to mean they could not constitute some manner of suicide watch.⁷⁴⁰ He gave the example of Cpl Langridge being able to leave LDSH lines, and even the base, with permission. He testified this would never be allowed under a strict suicide watch. WO Tourout noted Cpl Langridge successfully committed suicide while living under the conditions, and used this to infer there was never a suicide watch, because, under a

suicide watch, “there is little or no chance that a person is going to be successful in the commission of suicide.”⁷⁴¹ This is a circular understanding of a suicide watch, and it ignores the fact a suicide watch can only prevent the commission of suicide if it is executed properly, that is, non-negligently. This again was precisely part of the issues the CFNIS should have pursued in a negligence investigation.

Were the conditions for structure and support?

414. MCpl Ritco failed to ask why, if the conditions were for structure and support as claimed, they included measures such as requiring Cpl Langridge to sleep in the defaulters’ room and to keep the door open at all times, as well as to make timed check-ins.⁷⁴² MCpl Ritco was never able to answer the question he put to Sgt Hiscock: “If they didn’t think he was going to hurt himself, why even put these conditions on him?”⁷⁴³ MCpl Ritco testified, “I never did found out [*sic*] the reason why he was on conditions if the – if they believed that he wasn’t going to hurt himself, no, sir.”⁷⁴⁴

415. This was a question investigators should have pursued thoroughly, given the conflicting, and possibly self-serving, answers given during the 2008 investigation.

416. When MCpl Ritco interviewed CWO Ross, he asked him if there was any other purpose to the conditions other than gaining structure in support of going to substance abuse treatment. CWO Ross simply said “uh-uh.”⁷⁴⁵ However, the conditions were created with members of the LDSH chain of command having some awareness of Cpl Langridge’s medical condition, previous hospitalization, and previous suicide attempts, and witnesses testified the purpose of the conditions was at least in part to ensure Cpl Langridge’s safety.

417. LCol Demers testified he understood conditions, such as residing in the defaulters’ room and checking in every two hours, were meant to provide structure for Cpl Langridge, but also “[...] to try to prevent another suicide attempt like the one in June where he had driven away. We knew that if he was away for over two hours that there was a possibility that he was off trying that same type of thing again [...]”⁷⁴⁶

418. During the 2008 CFNIS interview, upon reviewing his notes, Capt Hannah told MCpl Ritco, Cpl Langridge had attended the CDU(C) at the insistence of his BAC and reported numerous problems with substance abuse and harassment, and Cpl Langridge informed Capt Hannah he needed “close supervision to protect himself and his ex-girlfriend, and he asked to be referred to Alberta Hospital.”⁷⁴⁷

419. Capt Hannah was asked about his 2008 statement that, because the AHE was “full,” and because Cpl Langridge refused to go to the RAH and denied suicidality, he offered Cpl Langridge “an opportunity for him to live at the LDSH where he could be – have someone that could keep a close eye on him.”⁷⁴⁸ The statement suggests the purpose for having Cpl Langridge live at the LDSH was to give him the close supervision he requested and ensure he was being watched. Capt Hannah agreed the reason Cpl Langridge sought close supervision at that time was because he felt he was a risk to himself and possibly Ms. A.⁷⁴⁹ Capt Hannah denied the aim was to prevent Cpl Langridge from harming himself, but acknowledged, again, Cpl Langridge was at a higher risk of suicide, and it was a “good idea” to have someone keep an eye on him.⁷⁵⁰ Capt Hannah also testified suicidal ideation comes and goes and “[a] person may be suicidal in one instance and not suicidal in another. Suicidality is a difficult thing to pin down sometimes.”⁷⁵¹ In fact, in justifying the need to give Cpl Langridge conditions for structure and support prior to going to residential treatment, Capt Hannah described Cpl Langridge as “unstable and suicidal and having acute problems.”⁷⁵²

420. The evidence makes it clear there was a widespread awareness within the LDSH and medical community that Cpl Langridge needed to be kept safe. Because the conditions were put in place with that knowledge, the underlying intention and the sufficiency of the conditions to prevent him from harming himself were live issues.

421. During the 2008 interview, Capt Hannah told MCpl Ritco Cpl Langridge was assigned to the defaulters’ room in order to receive “extra supervision.”⁷⁵³ When asked what he understood this to mean in terms of Cpl Langridge’s risk of suicide, MCpl Ritco testified, “Well, from his statement here, [...] I take this is that he was staying at the LDSH [...] **because he was a higher – higher risk than normal people that are out on**

the street,” meaning “something to do with [...] **suicidal tendencies and attempted suicides.**”⁷⁵⁴ Indeed, Capt Hannah told MCpl Ritco in the CFNIS interview, “it’s certainly on the public record” Cpl Langridge was living at LDSH because he was perceived to be at a heightened risk of suicide.⁷⁵⁵ MCpl Ritco disagreed with the suggestion this meant Cpl Langridge was being given extra supervision because he was at a higher risk of suicide, however, and testified, “I don’t take the suicide. I take that he needs extra supervision.”⁷⁵⁶ Though MCpl Ritco was, at the time, unable to determine the purpose of any extra supervision, in his testimony when pressed, he conceded he now believed Capt Hannah was speaking about suicidal risk as the impetus for the conditions.⁷⁵⁷

422. In his testimony Maj Jared denied the final version of the conditions was intended to ensure Cpl Langridge’s safety, but he also testified at least one of the measures was specifically intended to prevent Cpl Langridge from harming himself – specifically, by a drug overdose:

[...] and there is a correction made with respect to medication. I will say these conditions were imposed on Corporal Langridge as a result of some of the recent experience we had within the regiment, including an individual -- I believe the term was "confined to barracks" within the same room that Corporal Langridge would be staying in -- **overdosing on his own medication**, which is why included in this documentation, you will see comments about the member's medication. **Because we had an individual in that room overdosing on it, the medication would be held by the duty officer.** The duty officer would not be responsible to decide on the dosage for the member, but the member would then request the medication from the duty officer and take the dosage as appropriate.⁷⁵⁸

The purpose of the watch conditions

423. Evidence appears to indicate members of the LDSH chain of command foresaw Cpl Langridge might try to harm himself and were aware of the need to implement some measures to prevent that harm. The potential implication is there was recognition of a wider duty to protect Cpl Langridge, and the conditions were developed, at least in part, with the risk of harm in mind. The failure of the CFNIS members to follow leads and recognize relevant evidence meant they did not undertake any examination of this issue.

424. Despite the fact there was evidence the conditions were developed with the input of members of the LDSH chain of command and medical personnel,⁷⁵⁹ and witnesses such as Capt Volstad and LCol Demers⁷⁶⁰ testified the conditions were vetted by CF legal advisors, there was scant evidence both at the time and during the hearings as to the purpose of the conditions. Had the purpose been investigated in 2008 when memories were fresher, more substantial information might have been obtained. CWO Ross was unable to explain why the condition, as written, required the door be kept open at all times, except that it may have been his “initial thought” when first contemplating close supervision for Cpl Langridge.⁷⁶¹ Capt Lubiniecki testified he could not explain the reason for the “open door” policy.⁷⁶² Maj Jared testified he believed the door was to be kept open in order to allow Cpl Langridge to “interact with the duty staff,” and it was a “minor” supervisory measure.⁷⁶³

425. The evidence is vague in terms of explaining what this requirement was meant to do, if not what was clearly implied, which was Cpl Langridge was understood to be at risk of harming himself and, believing themselves unable to confine him or guard him at all times, the members of the Regiment devised the requirement to prevent or minimize the harm Cpl Langridge could do to himself while within Regimental lines.

426. Similarly, the 2100 hrs curfew would seem to suggest an attempt to limit Cpl Langridge’s time away from the close supervision possible within the duty centre without actually detaining him. The evidence about this condition was only explored during the hearings and did not wholly explain the purpose of the condition. CWO Ross testified the 2100 hrs curfew was imposed to limit Cpl Langridge’s exposure to drugs and alcohol.⁷⁶⁴ Capt Lubiniecki believed this requirement would prevent Cpl Langridge from being able to go to establishments that served alcohol, but conceded this did not stop Cpl Langridge from going out for a drink prior to 2100 hrs.⁷⁶⁵

427. The origins of the conditions – the intention to prevent a very unstable and frequently suicidal soldier from harming himself – have to be taken into consideration when interpreting the requirements imposed on Cpl Langridge. This is not to say the conditions had a single purpose. But requiring a soldier to check in regularly, to reside in

a highly public area, to keep the door to his room open, and to ask for his daily dosages of medication to prevent overdose attempts, may be evidence of a purpose above and beyond offering him “structure and support” alone. Rather, it may be there was real concern Cpl Langridge was unstable and was going to harm himself. As LCol Demers testified, with an actual suicide watch taken off the table, these “highly unusual” conditions were seen as necessary:

We have never done anything like this before, but it was the best that we could come up [with] between the unit and the doctor to try to provide some kind of control measures in an attempt to assist Cpl Langridge.

It was uncomfortable in a sense that we had never done this type of thing before. It's a restriction of his freedoms, but we saw what could happen when he had too much freedom, if you will.⁷⁶⁶

428. WO Tourout was asked if he ever came to a conclusion about the purpose of the conditions placed on Cpl Langridge if they were not because the LDSH believed he would harm himself. WO Tourout endorsed the view Cpl Langridge had actively sought structure and wanted to be under the conditions in order to go on to further treatment.⁷⁶⁷ In his opinion, the conditions could not simply be related to Cpl Langridge being suicidal because the military “had no reason to believe at that point and there were no indications from the hospital that he was suicidal at that point. So, he wasn't -- the conditions were in relation to structure and not to keep him alive.”⁷⁶⁸ WO Tourout reached this conclusion despite Cpl Langridge's 30-day certification for being a risk to himself, which had ended only days previously, and despite Mr. Strilchuk's complaint about the need for close supervision because Cpl Langridge was “totally non-compliant” with the restrictions he contracted to prior to March 7, 2008.

429. WO Tourout considered Mr. Strilchuk's observation Cpl Langridge had to be sent back to the LDSH for close supervision to mean “monitoring”; specifically, Cpl Langridge would be sent to the defaulters' room “so he could be monitored, observed, not 24 hours a day.”⁷⁶⁹ He was unable to say what Cpl Langridge would have been monitored and observed for, beyond speculating having something to do with restraining Cpl Langridge from abusing alcohol or drugs. Even on this he was uncertain:

Well, it would have been -- then that would have been between a doctor -- I'm not sure what their intention was. Their intention was, from our understanding, was to provide him a structure. So, the structure would have been in close supervision, reporting in every... and be sure he takes his medication. Would that have prevented him from abusing, no, because he was still away for two hours at a time.

MR. FREIMAN: Exactly. And if we're looking for the reasons for the conditions, what would the reason be for having him report every two hours?

MWO TOUROUT: Just so to maintain some -- to give him some -- he knows -- to see if he can deal with timings. [M]ilitary, our world revolves around timings, from basic training right to retirement, we have to be somewhere at a certain time of the day and if you're not, then that's not in accordance with military -- the way the military runs. So, the best way to ensure -- to see if someone's acceptable with conditions or of structure is to see if they can make timings, so [...].⁷⁷⁰

430. WO Tourout testified it was likely Cpl Langridge was required to live at the LDSH under supervision because of his drug use while in hospital. On the other hand, he acknowledged it would have been impossible to prevent Cpl Langridge from abusing substances because of the two-hour interval between check-ins.⁷⁷¹ The difference between the rationale and the execution of such monitoring and structure may raise an implication of potential negligence in the design of the conditions and/or the manner in which they were administered.

431. Based on the evidence gathered during the 2008 investigation and the Commission's hearings, it appears one of the purposes of the conditions may have been to provide Cpl Langridge extra supervision and prevent him from harming himself, while satisfying the concerns voiced by officers and legal advisors about mounting an explicit suicide watch.

432. CWO Ross testified he did not believe there would have been any legal obstacles to imposing the conditions because they were not imposed as a form of discipline.⁷⁷² This reinforces the possibility the conditions were seen by those involved in designing and implementing them as the path of least resistance to meet the goal of keeping Cpl Langridge safe.

433. The characterization of the conditions by CF members as being purely for structure does not appear to fit well with the conditions themselves as well as with evidence obtained by the CFNIS investigators or readily available to them. The

conditions included measures to supervise Cpl Langridge to prevent him from harming himself. He was required to live at the duty centre, where staff were present 24 hours per day, and he was required to keep his door open to allow them to monitor him. Moreover, the evidence demonstrates, the duty officers for March 14 and 15, 2008, were under the clear impression they were to watch Cpl Langridge because he was at risk of committing suicide. It is difficult to reconcile the conclusions reached about the conditions with these observations.

Were the conditions suitable for their intended purpose?

434. Related to the complainants' allegation the CFNIS members did not investigate potential acts of criminal negligence or service offences is the possibility the conditions were inadequate for their intended purpose. The CFNIS investigators did not investigate the adequacy of the conditions, and they did not investigate whether imposing such conditions in the absence of disciplinary proceedings constituted the service offence of abuse of a subordinate.

435. MCpl Ritco testified he did not investigate whether the conditions were suitable for giving Cpl Langridge structure and demonstrating he was capable of going on to residential substance abuse treatment.⁷⁷³ Sgt Bigelow testified the issue of whether Langridge's conditions were suitable to either protect or assist him should have been investigated. However, he was unaware whether this was done.⁷⁷⁴

436. This leads to the question of whether the design and administration of the conditions may itself have been negligent and, as a result, may have contributed to Cpl Langridge's death. There is evidence to suggest, whatever the stated purpose of the conditions, they were at least in part intended to ensure Cpl Langridge's safety. Even if the conditions were adequate for this purpose, they would only be effective if Cpl Langridge's compliance and his progress could be monitored. Because of a limited focus, the CFNIS members were unaware of how the conditions were to be enforced. They did not investigate the extent to which those ensuring Cpl Langridge followed the conditions were familiar with the nature and purpose of the conditions or the implications of inadequately supervising him.

437. CWO Ross informed MCpl Ritco all duty staff were provided with a copy of the written conditions.⁷⁷⁵ The duty staff were also told they must log all of the times Cpl Langridge left the building, the times at which he checked in with the duty officer, and the times at which he returned.

438. MCpl Ritco asked a number of personnel responsible for ensuring Cpl Langridge abided by his conditions whether they were aware of these conditions and knew what they were supposed to do. Although several answered they were not aware, he did not investigate further or reach conclusions about the matter.⁷⁷⁶

439. The effectiveness of the conditions as a means of protecting and supervising Cpl Langridge seems also to be put in question by apparently contradictory understandings of how they were to be followed. The evidence uncovered during the 2008 investigation, or what would have been available to the CFNIS investigators, made these contradictions apparent and raised the possibility the administration of the conditions was inadequate.

Administration of the check-in condition

440. One such issue had to do with Cpl Langridge's regular check-ins. CWO Ross told MCpl Ritco, Cpl Langridge had to come to the duty centre every two hours to check in, and he repeated this in his testimony.⁷⁷⁷ Many other witnesses indicated the check-ins could be done by telephone. Capt Hannah testified, "he could do that by phone as long as he informed whoever was on the other end of the line where he was."⁷⁷⁸ Maj Jared testified his recollection was Cpl Langridge could have checked in every two hours by telephone.⁷⁷⁹ Lt Dunn testified his understanding, as a duty officer at the time, was Cpl Langridge could check in by telephone.⁷⁸⁰ Capt Lubiniecki did not recall the arrangements, but he testified he believed the conditions called for Cpl Langridge to phone in on a scheduled basis "just to confirm that everything was well."⁷⁸¹

441. If Cpl Langridge could check in with the duty desk by telephone every two hours, this meant his movements were not being effectively monitored. He could be anywhere and doing anything, especially if he called from a mobile phone. The CFNIS investigators did not determine if the phone number Cpl Langridge left as a contact number was a

mobile phone number or a landline. Sgt Hiscock testified the number Cpl Langridge left at the duty desk was for his mobile phone, and it was this number he called repeatedly on March 15, 2008, when Cpl Langridge failed to check in.⁷⁸² He also testified the only way he knew where Cpl Langridge was located was by what was written on the sign-in sheet. Maj Jared also believed Cpl Langridge could leave a mobile phone number.⁷⁸³ He acknowledged this meant the LDSH could never really know where Cpl Langridge was or what he was doing, but testified that, if there were duties to assign to him, the number provided still meant they had a way to reach him.

442. Significantly, only the sign-in sheet for the day of Cpl Langridge's death was ever obtained by the CFNIS investigators. The investigators did not determine what happened to the sign-in sheets for the eight prior days Cpl Langridge spent under the conditions.⁷⁸⁴ They were never found, and their conspicuous absence was unexplained. Additionally, the CFNIS members did not investigate whether it was sufficient to simply accept Cpl Langridge's repeated check-in reports that he spent nearly the entirety of his last day in the shacks "doing laundry."⁷⁸⁵ Sgt Hiscock testified Cpl Langridge signed in personally each time after 0905 hrs on March 15, 2008. He assumed Cpl Langridge was in the shacks doing laundry.⁷⁸⁶ During his CFNIS interview, Sgt Hiscock stated he was told Cpl Langridge was going to the barracks to do laundry on March 15, 2008, but it was not Cpl Langridge who provided him with that information. In his testimony, Sgt Hiscock no longer recalled who gave him that information. He acknowledged, in hindsight, it was unusual Cpl Langridge would spend so much time doing laundry and admitted he should have questioned him. However, because that was a particularly busy Saturday for the Regiment, and because Cpl Langridge was still checking in, it was not high on the list of competing priorities.⁷⁸⁷

The administration of other conditions

443. Other aspects of the effort to monitor and enforce the conditions were also unclear, and again, would have warranted investigation in connection with possible negligence. While the purpose of keeping the door to the defaulters' room open at all

times was to monitor Cpl Langridge's well-being, the CFNIS investigators did not determine whether or not the door was actually kept open.

444. The CFNIS investigators also did not ascertain whether Cpl Langridge took his medication as directed. The information the CFNIS investigators obtained in 2008 showed Cpl Langridge's prescription medications were intended to treat depression, anxiety and insomnia.⁷⁸⁸ Failing to take them might have affected his state of mind.⁷⁸⁹ Sgt Bigelow testified his understanding was the duty personnel were not verifying Cpl Langridge was taking his medication, and he was responsible for this on his own.⁷⁹⁰ CWO Ross testified this to be the case as well.⁷⁹¹ Witnesses, such as Lt Dunn, testified they understood they did have to ensure Cpl Langridge took his medication.⁷⁹² Capt Hannah did not testify whether Cpl Langridge's compliance with his prescribed medications was in any way monitored or enforced, but, during his CFNIS interview, he told MCpl Ritco the LDSH was responsible for ensuring Cpl Langridge took his medication appropriately and on time.⁷⁹³

Controlling access to alcohol and illicit substances

445. The conditions required Cpl Langridge to abstain from alcohol and narcotics. There was no realistic way to ensure his compliance, particularly in light of the problems in monitoring his movements. The CFNIS investigators were told by Capt Hannah in 2008 that Cpl Langridge's substance abuse was likely inducing mood disorders, which led to suicidal behaviour, and his periodic bingeing triggered suicide attempts.⁷⁹⁴ Without attempting to draw conclusions about Cpl Langridge's state of mind or the reasons for his suicide attempts and his ultimate suicide, it is nevertheless clear the CFNIS investigators had cause to investigate whether Cpl Langridge was appropriately supervised. Cpl Langridge's safety was possibly at risk in the absence of such supervision. CWO Ross acknowledged in his testimony there was no way to monitor Cpl Langridge's compliance concerning drugs, but argued the duty staff would have detected the smell of alcoholic beverages and notified him if Cpl Langridge had been drinking.

446. Ms. A testified Cpl Langridge was able to leave the base on multiple occasions, sometimes by sneaking out, and was consuming alcohol. This contrasts with the

assurance she testified was given to her by Cpl Langridge's addiction counsellors, "he was never alone and therefore there wasn't any time for him to be doing drugs or drinking or trying to hurt himself."⁷⁹⁵ Not having interviewed Ms. A, the investigators were unaware of this evidence.

447. Despite the obvious difficulties in preventing Cpl Langridge from accessing alcohol and illicit substances with the relative freedom he enjoyed at the LDSH, Capt Hannah testified it was actually better for Cpl Langridge to be back at the base than in hospital. Looking back at the incident on March 7, 2008, when Cpl Langridge requested to be sent to the AHE, Capt Hannah testified he felt Cpl Langridge was upset with the requirement to live in company lines because "he didn't like to be told what to do," and speculated the LDSH wanted to impose more stringent rules:

Corporal Langridge -- it hasn't been really stated -- while he was at the Alberta hospital previously, had been using cocaine while he was in the hospital. I would wonder whether or not he felt that it would be less obvious, **he could get away with using cocaine while he was in the hospital, where it would be very difficult to do that in the Strathconas.** Perhaps it was a method to avoid that type of having people around. I don't know, to be honest.

Q. Would it be difficult for him to use cocaine while he was with the Strathconas?

A. **I think it would be. His behaviour would certainly change. There are people around. He's in uniform. There would really be no opportunity to -- it would be very awkward to go out to the smoking area or use cocaine in a place like that, where in an anonymous place like a hospital where he's not wearing the uniform, it would be much easier to do it.** There would certainly be more people around the Strathconas who knew him and knew what he was doing, much like if he lived in a small town. Everyone is going to know who you are as opposed to if you live in downtown Ottawa. No one knows or cares who you are, and you become an anonymous face.⁷⁹⁶ [Emphasis added]

448. This might have been an unsound assumption, and would be particularly troubling if it played any role in the determination of where Cpl Langridge would be safest and most stable or what supervision was appropriate. The medical records and the testimony of Dr. Sowa indicate, when it became clear Cpl Langridge was accessing narcotics while at the AHE, his grounds privileges were revoked. This caused him considerable frustration, but in general the AHE had a much greater ability to restrict his movements than the LDSH, particularly when he became unstable, because, despite having originally admitted himself to the AHE on a voluntary basis, Cpl Langridge was placed under a 30-

day certificate for the duration of his stay. In fact, Capt Hannah conceded in his testimony it would have been impossible to prevent Cpl Langridge from using narcotics under the conditions imposed at LDSH.⁷⁹⁷

449. The evidence above casts doubt on the effectiveness of the conditions as a mechanism for protecting Cpl Langridge from harm. This raises the possibility the conditions were negligently put into effect, negligently administered, or both, and the further possibility such potential negligence contributed to Cpl Langridge's suicide.

450. Taking Cpl Langridge out of hospital for the purpose of preventing him from accessing drugs and alcohol may imply the CF and base medical personnel undertook to do better. At the AHE, Cpl Langridge could be controlled and observed to a much higher degree, and yet was able to find ways to access drugs unless medical personnel restricted his freedom of movement. With a stated focus on substance abuse prevention and stabilization,⁷⁹⁸ the conditions imposed by the Regiment were in some ways strict, but if the purpose was actually to do better than the civilian medical system, they were unsuccessful.⁷⁹⁹ If Cpl Langridge was required to abstain from abusing substances but provided ample opportunity to access those substances without his movements being meaningfully monitored or controlled, that may be another indication of possible negligence.

The condition to reside in the defaulters' room

451. Another issue in the design and administration of the conditions raised by the evidence was the requirement for Cpl Langridge to reside in the defaulters' room. Capt Hannah testified Cpl Langridge was assigned to the defaulters' room for several reasons – first, because he had no other place to live.⁸⁰⁰ However, before his discharge from the AHE, arrangements had been made for Cpl Langridge to reside in barracks. Capt Hannah testified the value of keeping Cpl Langridge in the defaulters' room was also the reassurance of constant company:

If you're sleeping in your Jeep or you're in a hotel room by yourself, you have nobody to talk to. If it's 3:00 in the morning and you feel like killing yourself, who do you phone? Do you phone somebody and wake them up and get them out of bed? I would argue that most people are reluctant to pick up their phone and call people at 3:00 in the morning,

recognizing that they are most likely sleeping where, at the Strathconas with the Duty Officer there awake and on duty 24 hours a day, he had access. I think that recognizing suicidal behaviour comes and goes, absolutely.⁸⁰¹

452. This was a mistaken perception. Duty personnel may all be asleep during the night; they have beds in a room beside the defaulters' room in the duty centre; and there was no requirement one member present had to be awake at any given time.⁸⁰² This might prompt questions whether keeping Cpl Langridge in the defaulters' room at night served the purpose of keeping him safe.

453. Capt Hannah testified if Cpl Langridge felt suicidal at any point, he would be "in a place with people around him that know him and care about him, and if he has a question, there is someone available at all times."⁸⁰³ The notion Cpl Langridge would be in the company of people who cared about him – or were even friends – at the duty centre was mistaken. No matter the good intentions and professionalism of the duty centre staff, the evidence demonstrated duty officers like Lt Dunn were not friends with Cpl Langridge.⁸⁰⁴

454. Sgt Hiscock admitted he was contemptuous to Cpl Langridge the day he died.⁸⁰⁵ He testified he made an assumption Cpl Langridge was faking a claim of having PTSD for personal gain. When Cpl Langridge talked to Sgt Hiscock about his medication and having bad dreams, Sgt Hiscock testified he responded by rolling his eyes, sighing, and saying "Oh, here's another one."⁸⁰⁶ Sgt Hiscock testified he would still have made derisive comments and reacted negatively, even knowing what he does now.⁸⁰⁷

455. Cpl Langridge's troubles were widely known, and it is not clear he would have felt cared for in a public area frequented by soldiers, some of whom considered him "a waste of oxygen."⁸⁰⁸ The CFNIS investigators possessed some information about the scrutiny, skepticism, and even hostility Cpl Langridge faced in March 2008, and it was an open question whether residing at the duty centre had a positive or negative impact on his safety and supervision.

456. In the same way as a failed suicide watch might raise issues of negligence, even if the conditions did not amount to a "suicide watch" but were nevertheless intended to

prevent Cpl Langridge from harming himself, it seems relevant to ask whether they were adequate for that purpose given his fate. If not, were they so inadequate for the purpose of keeping Cpl Langridge safe as to constitute negligence?

457. The evidence indicates the conditions may have been insufficient for their intended purpose and may have been poorly administered. They may have been incapable of providing Cpl Langridge with structure and may have been inadequate to prevent him from harming himself. Monitoring and enforcement of the conditions appear to have been lax; personnel appear to have been unclear as to what was required; and there is evidence Cpl Langridge was not always compliant. Because he could check in by telephone from essentially any location, Cpl Langridge seems to have been given ample time on his own, for practical purposes unaccountable and unsupervised, to come to harm. He was still able to access alcohol and drugs, and his health and state of mind during his intense and unstable final days seemed to go unnoticed and without comment. If there was a duty to keep Cpl Langridge safe, or if the CF assumed such a duty, these would all be relevant matters in assessing possible negligence.

Did the conditions contribute to Cpl Langridge's death?

458. The CFNIS investigators viewed the existence of a suicide watch as essential to any finding negligence played a role in Cpl Langridge's death. Consequently, WO Tourout did not believe the conditions were relevant to possible negligence. He accepted the assertion by CWO Ross and Capt Lubiniecki the conditions were for structure and relied on this definition to distinguish the conditions from a failed suicide watch. In his view, because the conditions gave Cpl Langridge some time to himself, they were different from a suicide watch.⁸⁰⁹ According to MWO Watson's testimony, the following issues related to the conditions were irrelevant to the investigation:

- (1) whether Langridge agreed to the conditions put on him;
- (2) what the purpose of the conditions was;
- (3) whether the requirement Langridge had to sleep with the door open was a sign the conditions were a form of suicide watch;

- (4) whether there was a plan to send Langridge to treatment in Ontario;
- (5) whether there was a plan to release Langridge from the military if he failed to comply with his conditions;
- (6) whether and how the conditions were being enforced; and
- (7) whether the conditions themselves could have contributed to Langridge committing suicide.⁸¹⁰

459. What should have been evident to the CFNIS investigators, based on the information obtained during the 2008 Investigation, was that Cpl Langridge was unstable, was reacting poorly to the conditions, had requested changes to the conditions, and those requests were denied. There was evidence available to the CFNIS investigators suggesting the conditions were not voluntary, and Cpl Langridge was required to return to the base to abide by the conditions and prove himself before he would be authorized to go on to treatment.

460. On March 11, 2008, Cpl Langridge reported active suicidal thoughts regarding the prospect of going back to work. Regardless of what the appropriate response by the LDSH or the base medical community should have been, the impact of the conditions on Cpl Langridge was relevant. MCpl Ritco testified he did not pursue the matter of Cpl Langridge's suicidal statements 4 days before his death. He testified the main relevance of this incident was that it "just shows that Corporal Langridge was dealing with issues."⁸¹¹ Sgt Bigelow was asked if he and MCpl Ritco investigated whether this specific suicidal ideation changed anything in terms of the potential legal limitations or obligations on the Unit with respect to a possible suicide watch. He replied they did not.⁸¹² This position meant CFNIS members did not consider the possibility the conditions may have constituted negligence contributing to Cpl Langridge's death.

Did Cpl Langridge agree to the conditions voluntarily?

461. The CFNIS members did not investigate in depth whether Cpl Langridge voluntarily agreed to the conditions imposed on him in March 2008. This matters because if Cpl Langridge found the conditions intolerable, the flexibility of the conditions and the

potential consequences for disobeying them might have had significant repercussions with respect to his stability and state of mind. MCpl Ritco received conflicting information about whether Cpl Langridge voluntarily agreed to the conditions. Capt Lubiniecki testified he had no role in the formulation of Cpl Langridge's conditions. However, he testified his understanding was Cpl Langridge had voluntarily submitted to the conditions and the requirement to reside at the duty centre.⁸¹³ After Cpl Langridge's death, Capt Lubiniecki sent a Significant Incident Report to Ottawa HQ indicating Cpl Langridge "was residing in the regimental duty centre under his own admittance in conjunction with regimental direction."⁸¹⁴ He could not recall how he obtained this information.⁸¹⁵

462. The notes taken at Capt Lubiniecki's 2008 CFNIS interview make reference to the fact he spoke to Capt Hannah about Cpl Langridge's request to live in the shacks rather than in the duty centre and Cpl Langridge's attempt to convince Capt Lubiniecki there was no need to "come in" (possibly a reference to the reporting-in period). Sgt Bigelow wrote, "**Agreed with steps unit taking on forcing Cpl Langridge** committed to taking course."⁸¹⁶ The word "forcing" is potentially significant as it may suggest Cpl Langridge was being compelled into doing something linked to his ability to participate in the substance abuse treatment he sought. Little is known about the request or its context. At the time of Capt Lubiniecki's testimony, the Commission had not obtained Sgt Bigelow's notebook, which was unfortunately never scanned into the SAMPIS system. The summary of the interview in SAMPIS, prepared by Sgt Bigelow, did not refer to this passage.⁸¹⁷ As a consequence, Capt Lubiniecki was not asked to testify about this incident. This passage raises obvious questions.

463. CWO Ross' evidence was he and Cpl Langridge had a lengthy discussion about the conditions. He recalled, at the end of the conversation, Cpl Langridge "was very happy about it. He thanked me stating that he needed some structure, he wanted to be a good soldier, he wanted to get on with things, and he seemed very, very compliant with it."⁸¹⁸ CWO Ross testified he would not have imposed the conditions if Cpl Langridge had been unwilling.

464. On the other hand, when Cpl Langridge subsequently requested a change to the conditions and made it clear he was extremely unhappy under them, CWO Ross refused.

465. CWO Ross testified he did not feel enough time had elapsed for Cpl Langridge to “prove” to him, “I’m complying with everything you are asking me to do. I have shown you that over a period of time. I’m now asking for some additional leeway.”⁸¹⁹

Regardless if these constraints were initially voluntary, this requirement may be relevant to the issue of their possible impact on Cpl Langridge’s state of mind on a going forward basis.

466. Additionally, the consequences Cpl Langridge faced for failing to comply with the conditions could have been serious. CWO Ross stated in his CFNIS interview, the conditions had the force of orders and Cpl Langridge could have been charged with a service offence or deemed AWOL for failing to obey them. He testified, “There is [*sic*] consequences to any soldier who does not follow direction.”⁸²⁰ Again, this could have been relevant to understanding Cpl Langridge’s state of mind. Failing to abide by conditions he found onerous and intolerable could have resulted potentially in serious disciplinary action.

Compliance with conditions as a prerequisite for substance abuse treatment

467. There is also evidence Cpl Langridge was told he would not be eligible for drug treatment unless he agreed to the imposition of conditions. This may have meant Cpl Langridge was in a nearly impossible situation – his treatment was predicated on making progress he may not have been capable of without that treatment itself, or something analogous to it.

468. Ms. A testified Cpl Langridge was told, at the time of his AHE release, returning to the base was mandatory if the CF was going to send him for further substance abuse treatment. CWO Ross testified he believed compliance with the conditions would have played a “very large part” in the final decision, and it was his understanding, until Cpl Langridge demonstrated compliance with the conditions, the medical side was unwilling to send him.⁸²¹

469. Capt Lubiniecki informed MCpl Ritco during his CFNIS interview the medical community would not incur the expense to send Cpl Langridge to residential substance abuse treatment without him demonstrating he could comply with the conditions. He also testified his understanding was the medical personnel did not support Cpl Langridge attending a second course until he proved he could attend scheduled AA meetings.⁸²²

470. Capt Hannah testified compliance with the conditions was never a prerequisite for Cpl Langridge being sent to the rehabilitation program.⁸²³ He testified he recognized people struggling with addictions typically misbehaved, and it would be circular to expect individuals who needed treatment to prove they could straighten themselves out. He also testified he told Cpl Langridge on March 7, 2008, he needed “to behave himself. He needs to smarten up, stop using alcohol, stop using drugs.”⁸²⁴ When asked about a base clinic record stating, “Discharged from Alberta Hospital today for a trial of good behaviour to see if capable of going to addiction treatment centre,”⁸²⁵ Capt Hannah initially rejected the word “precondition” in reference to the treatment.⁸²⁶ He testified the treatment centre was not a place to send someone who “is incredibly unstable and suicidal and having acute problems.”⁸²⁷ A person would need to be at least somewhat stable and cooperative and capable of sitting down to “have a civilized conversation with someone who may have a different opinion than he will [...]” before doing so.⁸²⁸ Capt Hannah endorsed this more qualified version of “precondition,” adding “[...] you don’t have to be perfect – don’t get me wrong – but you need to kind of at least show that you can follow some routine [...]” He explained sending someone to treatment was very expensive. He believed the cost was in the tens of thousands of dollars. He acknowledged, “in a sense,” Cpl Langridge’s treatment was conditional on his good behaviour, but denied this meant there was a condition that “You must behave. Otherwise, we will never send you to treatment.”⁸²⁹

471. As with many aspects of the evidence about the suicide watch and conditions, this may raise questions. If Cpl Langridge was not stable enough to go to treatment, and if he was suicidal, non-compliant and unable to follow routines, why was he brought back from the AHE? Why would he be subject to voluntary conditions in an environment ill-

equipped to handle him, under the authority of doctors who could not provide him 24-hour care, and with military members unwilling to supervise him constantly?

472. Capt Hannah's testimony highlights the conundrum. He testified he told Cpl Langridge he could not go to the treatment program until he demonstrated he could follow some rules. If Cpl Langridge was unable to demonstrate this, and was instead "struggling" and "acutely ill," Capt Hannah told him, then "[...] we really can't send you to a treatment program that doesn't have the facilities to deal with that. We will have to do something else [...]"⁸³⁰ specifically, sending Cpl Langridge to the AHE or RAH, "in the direct care of a psychiatrist."⁸³¹ Either Cpl Langridge was well enough to go to treatment by being able to meet the conditions, or he was not well enough and could not satisfy the conditions, and would likely have to return to a hospital equipped to handle him. This not only seems like the essence of a precondition to treatment, but also appears to rely on the assumption Cpl Langridge was well enough to be taken out of the hospital in the first place.

The impact of the conditions on Cpl Langridge

473. It is clear Cpl Langridge loathed the conditions, but the CFNIS investigators did not examine the significance of his request for a loosening of the restrictions upon him, including a reduction in the frequency of reporting. MCpl Ritco testified the matter had relevance in terms of "[...] just trying to find out what was going on. So it did have some relevance. But [...] did it have an impact on my outcome of my investigation? No."⁸³² There was also no investigation into the possibility the denial of his request for a revision to the conditions triggered a further decline in his condition.

474. Sgt Bigelow's notes provide some details about Capt Lubiniecki's 2008 CFNIS interview and refer to Cpl Langridge's request to adjust the conditions. During the interview, Capt Lubiniecki recounted Cpl Langridge had requested his check-in interval be increased from two hours to three hours.⁸³³ Capt Lubiniecki informed Cpl Langridge he would lessen the requirements if Cpl Langridge could prove himself. Cpl Langridge was expected to prove himself over the weekend (presumably the weekend of March 15 and 16, 2008, given the conditions had only been imposed the Friday of the weekend

before). According to Sgt Bigelow's notes, Capt Lubiniecki gave a note to a MCpl Banks to pass to Cpl Langridge. This was placed on Cpl Langridge's pillow. The Commission knows little about the request because it was only documented in Sgt Bigelow's notebook.

Cpl Langridge's workload

475. Another condition with which Cpl Langridge seems to have struggled concerns the workload expected of him. CWO Ross testified, under the conditions, he would have assigned Cpl Langridge "very meaningful jobs, all things that any soldier would probably have to do at some point or another." This would include taking out garbage, cleaning out oil pans underneath the LDSH vehicles, and cleaning and polishing trophies.⁸³⁴ He did not recall what he actually assigned Cpl Langridge to do, although there is evidence Cpl Langridge was assigned similar duties even before the conditions were imposed.⁸³⁵

476. There was also evidence Cpl Langridge was required to work between 0800 hrs and 1630 hrs, which would have been half an hour longer than normal. CWO Ross told MCpl Ritco in his 2008 interview, "[t]he only thing I asked him to do was to work a half-an-hour beyond everybody else. Half-an-hour beyond everybody else. [...] Just because I wanted to do that, to be quite honest."⁸³⁶ This appears to indicate this was done essentially on a whim. When asked about this, CWO Ross testified this was done to make Cpl Langridge available in case any work came up at the last minute, which the RSM required to be done before the end of the day.⁸³⁷ He testified there "was some talk" about the fact Cpl Langridge had only been working three half days per week⁸³⁸ prior to this, but he did not know all the details.⁸³⁹ CWO Ross justified this dramatic change in working conditions by stating he assumed medical personnel would have objected to this requirement if they had had any concerns about its suitability.

477. There was evidence Cpl Langridge was suffering from chest pains and panic attacks triggered by work even before the conditions were imposed.⁸⁴⁰ There was also evidence Cpl Langridge reacted extremely poorly to the work requirements under the conditions and may have had suicidal thoughts as a result.⁸⁴¹ This raised the possibility Cpl Langridge actually found the imposed work expectations devastating.

478. Capt Hannah testified he had no idea what Cpl Langridge's work hours were before the conditions were imposed.⁸⁴² He believed there was no intention to assign Cpl Langridge extra work hours but, on being presented evidence Cpl Langridge had been working reduced hours before his hospitalization, Capt Hannah was unconcerned. He disputed Cpl Langridge was actually required to work full days under the conditions. He contended Cpl Langridge spent most of his time attending appointments, and his duties could have been "anything" depending on the RSM's instructions and "could include doing nothing, presumably."⁸⁴³ He agreed he would have had an issue had Cpl Langridge been ordered to work five days a week, eight and a half hours a day. He would have contacted Capt Lubiniecki about it. Capt Hannah testified he did not believe this was the case.⁸⁴⁴

479. The duty centre sign-in sheets were never recovered. These might have cast some light on what a weekday looked like for Cpl Langridge during the last week of his life. In particular, his duties, appointments, supervision and workload might have been laid out for the investigators. However, all they could discern from the evidence was how Cpl Langridge spent his last Saturday. Considering the conditions were imposed on a Friday afternoon, and Cpl Langridge was requesting a change to the conditions and urgently seeking admission to hospital by the following Tuesday, there was at least some cause to ask what the weekdays might have had in store and whether Cpl Langridge's work week may have precipitated a further decline in his condition.

480. Medical records obtained by MCpl Ritco from the base CDU(C)⁸⁴⁵ note Cpl Langridge attended the CDU(C) on March 11, 2008, in a state of crisis. He complained he had gone two nights without sleep and was working during the day when he was formerly on half days, and he had to report in every two hours after work. Cpl Langridge was described as tearful and anxious, and the note recorded, upon realizing he would be forced back to work that day, he said "he would rather kill himself than go back to work."⁸⁴⁶ On this basis, Cpl Langridge was referred to the RAH and remained there between March 11 and 13, 2008. This appears to be the incident reported to CWO Ross by medical personnel and described in the transcript of his 2008 CFNIS interview.

481. Capt Hannah testified he felt the fact Dr. Robert Turner, who wrote the notes, sent Cpl Langridge to the hospital because he was suicidal was an appropriate response.⁸⁴⁷ He testified that “only three days later, [Cpl Langridge] was doing quite well and was happy with the situation.”⁸⁴⁸ According to him, the fact Cpl Langridge was upset one day and not upset another day did not mean “[...] that the whole thing was a terrible idea or that he was unhappy all the time [...] He certainly said to [Dr. Robin Lamoureux] that he was doing fine.”⁸⁴⁹ Capt Hannah pointed to Cpl Langridge’s attendance at the CDU(C) on March 14 for a prescription renewal as “very clearly imply[ing]” he believed he needed the prescription and did not intend to kill himself at that point.⁸⁵⁰ Capt Hannah suggested Cpl Langridge’s instability stemmed from being in withdrawal from cocaine, likening the effects to the upset and irrationality of quitting smoking.

482. MWO Watson testified it “[c]ould have been”⁸⁵¹ relevant to the investigation that Cpl Langridge sought a relaxation of the conditions and his request had been denied. The evidence indicated a seemingly distraught Cpl Langridge stated he found the conditions unbearable and a return to work worse than death. However, MWO Watson testified the records made by Dr. Turner on March 11, 2008, were “relevant,” in that the investigators took copies of them, but he felt it was not significant for the question of whether the conditions could have contributed to Cpl Langridge’s suicide. He explained the fact Cpl Langridge was later discharged from the hospital (having first mistakenly testified Dr. Turner himself had released Cpl Langridge after noting these concerns) indicated the physicians were not concerned he would harm himself, meaning Cpl Langridge’s frustration with the conditions was not relevant to his suicide.

483. MWO Watson did not know why Dr. Turner was not interviewed.⁸⁵²

484. On the whole, the CFNIS members failed to recognize or act on evidence of actions undertaken by LDSH personnel and base medical personnel that might potentially have created dangers to Cpl Langridge or exacerbated existing dangers. The conditions may not have been adequate to prevent Cpl Langridge from harming himself. The conditions apparently seemed intolerable to Cpl Langridge. The failure to take

appropriate measures to ensure his safety in light of such an extreme reaction might also potentially have been implicated in his death.

Was a suicide watch planned?

485. The CFNIS interviews of MCpl Fitzpatrick, MCpl Bowden, and CWO Ross all suggested a watch was planned upon Cpl Langridge's release from the AHE. Members such as MCpl Bowden provided evidence suicide watches did occur within the CF, and she testified she was specifically asked to put together a list of personnel able to conduct a suicide watch for Cpl Langridge before CWO Ross cancelled it.⁸⁵³ MCpl Bowden told the CFNIS investigators the watch was already underway, with a member accompanying Cpl Langridge in the room behind the duty desk, before it was cancelled.⁸⁵⁴ She also stated Cpl Langridge had previously been the subject of a suicide watch.⁸⁵⁵

486. MCpl Ritco told the Commission, after conducting all of his interviews he concluded, "that there was a watch being set up -- personnel to watch Corporal Langridge, if need be, 24/7."⁸⁵⁶ This conclusion does not appear in his Concluding Remarks⁸⁵⁷ or anywhere else in the investigation report. MCpl Ritco also testified he was unable to determine whether this meant a suicide watch was planned.⁸⁵⁸ CWO Ross told MCpl Ritco the planned watch was a 24-hour a day watch, for an unnamed purpose different from a suicide watch.⁸⁵⁹ MCpl Ritco testified he "took it as there wasn't a suicide watch"⁸⁶⁰ and accepted these assertions to be conclusive.⁸⁶¹

487. MCpl Ritco relied on an assertion that does not seem capable of withstanding much scrutiny. The obvious question was never posed. If the watch was not a suicide watch, what was it for? Further, if it was a suicide watch, why was it cancelled, and was the cancellation reasonable in the circumstances? Each question about the suicide watch raised further questions, or should have. It is concerning MCpl Ritco appears to have simply left these matters dangling.

488. MCpl Ritco testified he was unable to come to any conclusions as to the purpose of the 24/7 watch. He could not understand why there would be a constant watch planned if Cpl Langridge were not suicidal, and it was never explained to him.⁸⁶² The paradox

ought to have been revealing in and of itself as the difficulty of answering that question emphasizes the implausibility of its very premise.

489. One answer best fits the evidence obtained by or readily available to the CFNIS investigators. Simply put, a plan had been devised to watch Cpl Langridge to prevent him from harming himself.

The purpose of the planned watch

490. MCpl Ritco did not determine why Cpl Langridge was required to reside in the defaulters' room – possibly as early as March 5, 2008, the day of his discharge from hospital – if he was not on defaulters or not under some form of a suicide watch.

491. CWO Ross' contention he was legally prevented from conducting a suicide watch raised additional questions. What was the basis for CWO Ross' belief? How could it be reconciled with evidence of other suicide watches being organized? And, under which circumstances could such a constraint change? MCpl Ritco did not investigate the assertion the Regiment was not legally able to conduct a suicide watch without explicit direction from a physician. Answering this question would have given the CFNIS members a better understanding of what the LDSH could have done regarding Cpl Langridge, and the potential consequences of taking certain actions. All these questions appear relevant to the issue of negligence.

492. On a related theme, MCpl Ritco failed to inquire why a watch was not conducted after Cpl Langridge's attendance at sick parade the week he died. If, as was suggested to MCpl Ritco, the bar against mounting a suicide watch was the need for medical staff to tell the Regiment Cpl Langridge was suicidal, why was it not mounted once the medical staff informed CWO Ross that Cpl Langridge was actively expressing suicidal thoughts?⁸⁶³ What duties should such information have triggered in the circumstances?

493. MCpl Ritco was asked why he concluded this aspect of the investigation despite being unable to determine the matter. He testified:

Since I spoke with Chief Warrant Officer Ross at the very end of my investigation, there was basically -- he confirmed that with all the rumours that he was on a suicide watch, he

wasn't on a suicide watch; he was in defaulters, he wasn't in defaulters, that's the reason why we went to go speak with Chief Warrant Officer Ross as the discipline person in LdSH, get it right from him what exactly was going on.

So, to answer your question, yeah, basically when we were done speaking with him that I was led to believe that there was no suicide watch, that people were being arranged should Stuart need to be watched, but he said there wasn't a suicide watch and that there was no defaulters.

MR. FREIMAN: Okay. I appreciate you said, "led to believe", but you're an investigator, sir, so one of the things you need to is to draw conclusions.

SGT RITCO: Absolutely.

MR. FREIMAN: Not just being led to believe. So, when you heard that, you heard there might have been a watch but it wasn't a suicide watch, what kind of a watch could it have been if it wasn't a suicide watch?

SGT RITCO: I don't know, sir, but you'd have to ask Chief Warrant Officer Ross that.

MR. FREIMAN: Did you?⁸⁶⁴

494. MCpl Ritco did ask CWO Ross the purpose of the 24/7 watch, but when CWO Ross told him it was not considered a suicide watch, he did not inquire what other purpose there might have been.⁸⁶⁵ Regarding why he did not ask this fundamental question of CWO Ross, MCpl Ritco provided a candid answer:

I was dealing with a sudden death investigation, sir. **I can't think of all the questions.** I mean looking at it back now, with all the issues with the suicide watch and the defaulters, maybe it should have been a question I asked. **At the time I didn't feel it was relevant – [...] – or I didn't feel that I needed to ask it.**⁸⁶⁶ [Emphasis added]

495. When questioned about this during his testimony before the Commission, CWO Ross acknowledged, generally, the purpose of a 24/7 watch is for the protection of the individual being watched.⁸⁶⁷ He also admitted there was very little difference between the 24/7 watch he proposed and a suicide watch.⁸⁶⁸ CWO Ross even conceded the possibility MCpl Fitzpatrick heard the term “suicide watch” from him directly and this caused it to be used throughout the Regiment.⁸⁶⁹

496. During his testimony, CWO Ross was presented with a patient update report from Mr. Strilchuk dated March 7, 2008.⁸⁷⁰ In it, Mr. Strilchuk wrote Cpl Langridge had just returned from a 30-day stay at the AHE, and he had contracted to many restrictions but was “totally non-compliant.”⁸⁷¹ He was so non-compliant, he “had to be sent to his unit

for close supervision.”⁸⁷² Mr. Strilchuk called for employment restrictions prohibiting Cpl Langridge from weapons and from driving, and indicated he required close supervision and monitoring.

497. CWO Ross acknowledged the recommendation for “close supervision” could refer to a 24/7 watch or something similar.⁸⁷³ He did not believe it was possible to do so without a disciplinary or medical reason for such a watch, but agreed it could have been done had the base clinic requested a 24/7 watch. The limiting factor would be the fact LDSH personnel were “not really trained for that.”⁸⁷⁴

498. CWO Ross was then presented with the notes of Capt Hannah’s medical restrictions for Cpl Langridge, also recorded on March 7, 2008.⁸⁷⁵ In it, Capt Hannah directed a three-day period of “supervision @ LDSH.”⁸⁷⁶ CWO Ross was asked if it was his understanding Capt Hannah was directing three days’ worth of supervision and if it was on that basis he devised the suicide watch plan, which was subsequently rejected by Maj Jared. CWO Ross testified he could not recall what he had discussed with Maj Jared.⁸⁷⁷ He denied this conversation caused him to change his mind about the watch and reiterated the change was the result of ongoing discussions with Capt Hannah.

Evidence about the CF and “suicide watches”

499. There is evidence a “suicide watch” is not an officially recognized concept within the CF. Maj Jared testified suicide watches were not an unknown concept but “did not exist” within the Regiment.⁸⁷⁸ On the other hand, many members understood such watches to have been employed in practice. In addition to MCpl Bowden and Sgt Hiscock, Lt Dunn testified he was told to watch Cpl Langridge, and the purpose of doing so was to prevent his suicide.⁸⁷⁹ Maj Cadieu testified he had been involved in and indeed sat on several suicide watches over the years, describing it as a period of 24/7 observation (effectively a guard ensuring constant supervision) when a member credibly threatens harm to himself or herself.⁸⁸⁰ More to the point, when Cpl Langridge was discharged from the RAH in February 2008, Maj Cadieu sent an email message to the LDSH leadership to advise them he was released to his own residence and a friend (likely Cpl

Bartlett)⁸⁸¹ offered to spend the evening with him. Maj Cadieu specifically mentioned the possibility of conducting a “watch”:

BPT [presumably “be prepared to”] provide soldiers to ‘watch’ Cpl Langridge only if directed by the CO/RSM/Adj, after consultation with the HSS community. This is not reqr [required] at this time.⁸⁸²

500. The recipients of this message included Maj Jared, LCol Demers, CWO Ross, Capt Lubiniecki, Capt W.R. Hubbard, and MWO Mulhern. It is not known what if anything was said in reply.

501. Even Capt Lubiniecki, who denied the use of suicide watches within the CF, acknowledged watches of different kinds could be applied to soldiers for multiple reasons, including watching over a member for their health or safety.⁸⁸³ His primary objection to the notion of the CF mounting suicide watches seemed to be the implication the medical community might release persons from their care, having assessed them as not being a danger to themselves, while at the same time requesting a suicide watch for them.⁸⁸⁴ CWO Ross testified, while he had never had to organize a suicide watch, he knew doing so within the CF was a possibility.⁸⁸⁵ This might happen where, for example, an individual was to be watched at the MP cells but, because of a shortage of available MP staff, the Unit would provide the watch instead. He testified it might also happen in a hospital situation where there was a shortage of staff, so members would conduct the watch.⁸⁸⁶

Earlier suicide watches

502. Beyond the evidence suicide watches were not an unknown phenomenon within the CF, there was also evidence available to the investigators suicide watches had been discussed concerning Cpl Langridge in March 2008 and during previous incidents in the last months of his life. Had the CFNIS members interviewed witnesses such as Ms. Ferdinand, a primary care nurse at the base CDU(C) in 2008, they would have learned she had been told in March 2008 a “safety plan” would be put in place regarding Cpl Langridge upon his release from the AHE, and he would be “watched.”⁸⁸⁷ In fact, she had

been part of repeated discussions about the proper level of care and supervision for Cpl Langridge to ensure his safety.

503. Cpl Langridge's decision to remove himself from residential substance abuse treatment in January 2008 was something of a crisis. Don Perkins, a BAC, approached Ms. Ferdinand on January 11, 2008, to inform her Cpl Langridge had left the Edgewood program and was refusing to come to the base clinic for an assessment.⁸⁸⁸ Mr. Perkins was extremely concerned about Cpl Langridge's health because he had attempted suicide before and Mr. Perkins believed he was at risk again. Ms. Ferdinand contacted Capt Lubiniecki to inform him of what had happened and that, having left treatment early, Cpl Langridge was therefore AWOL. She testified her recollection was she told Capt Lubiniecki, Cpl Langridge was at risk of suicide at that time.⁸⁸⁹ According to Ms. Ferdinand, Capt Lubiniecki was initially unable to reach Cpl Langridge but eventually succeeded. Capt Lubiniecki informed her Cpl Langridge was stable and had promised he would not harm himself over the weekend.⁸⁹⁰ Ms. Ferdinand disagreed with Capt Lubiniecki's actions and urged him to bring Cpl Langridge back to the base with MPs, but he did not feel this was necessary. Capt Lubiniecki did not recall having this discussion and had no notes about it, but he did not dispute it had occurred.⁸⁹¹

504. On the night of January 31, 2008, Cpl Langridge put a noose around his neck in an attempt to hang himself at home.⁸⁹² Ms. Ferdinand testified, following Cpl Langridge's ensuing hospitalization at the RAH on February 1-4 2008, she was contacted by Dr. Chu and notified both of Cpl Langridge's impending discharge, as well as the fact he had attempted suicide while in their care.⁸⁹³ This meant Cpl Langridge, who was obviously experiencing distress which put him in danger of further attempts to harm himself, was being released back to the CF.

505. Ms. Ferdinand was frustrated with the fact the civilian hospital would only keep patients for 48 to 72 hours for assessment after being admitted. She was concerned about Cpl Langridge's discharge given he did not seem stable, but she was told he was being discharged because he was not suicidal at that moment in time.⁸⁹⁴ Ms. Ferdinand discussed the impending discharge with Capt Hubbard, the Padre for the Regiment, and

Mr. Strilchuk on February 4, 2008.⁸⁹⁵ No one felt Cpl Langridge should have been discharged, and she testified the base clinic was simply not set up to provide the 24-hour type of care Cpl Langridge required.⁸⁹⁶ Her notes indicated they believed a watch was necessary because, in their view, Cpl Langridge was not stable.⁸⁹⁷ According to Ms. Ferdinand, if Cpl Langridge had had family in the area, the team would have sought someone to assist with ensuring his safety. For someone like Cpl Langridge, they would have had no choice but to involve the Regiment in a suicide watch.⁸⁹⁸

506. A physician would have to decide such a watch was necessary. Ms. Ferdinand testified she was unaware of what happened to Cpl Langridge when he was discharged on February 4, 2008, but she learned from Capt Hubbard on February 5, 2008, the watch was unnecessary because Cpl Langridge had gone to the AHE for an assessment and was being admitted.⁸⁹⁹ She informed Capt Lubiniecki and the acting base surgeon of the development. In light of Maj Cadieu's February 4 email, it is apparent at least some members of the chain of command knew of a proposed watch – and arguably a proposed suicide watch – and the reason it was obviated.

The March 2008 watch

507. Ms. Ferdinand was contacted by the hospital when Cpl Langridge was about to be discharged from the AHE in March 2008.⁹⁰⁰ She testified she was involved in the coordination between the base counsellors, physicians and the LDSH about what would be done with Cpl Langridge while he was at the base. Cpl Langridge's safety was a concern, and she recalled Capt Hannah had contacted Capt Lubiniecki to ensure a "safety plan" was in place. He was preparing a set of limitations while the LDSH made arrangements to carry out the plan. She believed this referred to a watch to be conducted by the LDSH.⁹⁰¹

508. On the morning of March 7, 2008, Cpl Langridge attended the Care Delivery Unit. Capt Hannah's notes record Cpl Langridge was upset and "not following BAC plan."⁹⁰² At this point, Capt Hannah developed the medical employment restrictions to be sent to CWO Ross. Ms. Ferdinand testified she telephoned Capt Lubiniecki on March 7, 2008. He sent her an email later that morning indicating he was currently on leave, but

was copying CWO Ross and Capt Craig Volstad on the message and provided her with their contact information.⁹⁰³

509. In the afternoon of March 7, 2008, Capt Volstad replied to Capt Lubiniecki's email message to say arrangements had been made to "watch" Cpl Langridge over the weekend using phone calls and check-in times.⁹⁰⁴ Capt Hannah informed Ms. Ferdinand the matter had been taken care of, but she did not learn of the conditions or any of the arrangements made.⁹⁰⁵ Capt Volstad, who was not interviewed by the CFNIS in 2008, testified he understood the purpose of the watch was to protect Cpl Langridge from harming himself and from using illicit substances.⁹⁰⁶ He testified his recollection was other members sought legal advice and medical advice as to the best way to proceed.⁹⁰⁷ Capt Volstad's email to Capt Lubiniecki (sent at 1446 hrs on March 7, 2008)⁹⁰⁸ was sent about an hour before CWO Ross emailed the final version of the conditions to Maj Jared and Capt Lubiniecki (at 1535 hours).⁹⁰⁹ Capt Volstad did not recall why so much time passed. It is possible during this interval CWO Ross and Maj Jared were discussing the final version of the conditions. Capt Volstad testified he did not consider the conditions imposed to be part of a "trial of good behaviour." His interpretation at the time was "it was 100 percent to protect the soldier."⁹¹⁰

510. Maj Jared's testimony provides further insight into what happened that afternoon. When CWO Ross presented Maj Jared with the initial version of the conditions to be imposed on Cpl Langridge on March 7, 2008, (which included "CF members watching Cpl Langridge constantly with the intent of preventing him from committing suicide"⁹¹¹), Maj Jared testified he rejected this arrangement because of two major concerns.⁹¹² First, an around-the-clock watch would be overly intrusive on Cpl Langridge. Additionally, he was worried the LDSH crewmen assigned would not be capable of successfully conducting a suicide watch, and **the LDSH would be "[...] accepting a certain amount of liability** of having medically untrained armoured soldiers being responsible for what could be perceived as close or intensive medical care of a member."⁹¹³

511. While CWO Ross later told the investigators the Regiment would not legally have been able to conduct a suicide watch, Maj Jared testified his concern was not about the

legal authority to conduct such a watch. Instead, he sought legal advice about potential liability. He subsequently instructed CWO Ross not to proceed, and in his discussions with CWO Ross, the conditions ultimately imposed upon Cpl Langridge were put into place.

512. Maj Jared testified he was uncertain about the basis upon which to conduct a suicide watch because there was no regulation, QR&O, CFAO, or DAOD referring to suicide watches.⁹¹⁴ He also doubted armour crewmen were trained for such a task, and that the medical side should have been responsible for any such watch. However, he testified he did not dispute it would have been possible operationally to carry out the arrangements CWO Ross originally made – which is, to have soldiers conduct a constant watch over Cpl Langridge within Regimental lines to prevent him from harming himself without having to actually confine him in a prison.⁹¹⁵

513. The evidence obtained during the Commission hearings from witnesses the CFNIS members did not interview and sources the CFNIS members did not pursue, demonstrates there is a great deal of ambiguity and nuance in any assertion “there was no suicide watch.” To be fair to the witnesses, the evidence does not indicate an intention on the part of any witness to be deceptive or misleading at the time of the 2008 investigation or during their testimony at the Commission hearings. Nevertheless, the evidence overwhelmingly supports the conclusion something resembling a suicide watch was at least planned by members of the LDSH upon Cpl Langridge’s return from hospital. Steps may even have been taken towards conducting a watch, although MCpl Bowden’s statement the watch was already underway when cancelled, remains unconfirmed. Members of the base medical staff had recommended Cpl Langridge receive additional supervision. The only identified purpose for the proposed watch was to prevent Cpl Langridge from harming himself.

514. MCpl Ritco conceded in his testimony the evidence from the Unit indicated a plan was made to organize a watch of some sort for Cpl Langridge – a watch would be maintained 24 hours per day, and 7 days per week if necessary.⁹¹⁶ He acknowledged the evidence was consistent in establishing plans were being made in case it became

necessary up until the point when CWO Ross was alleged by MCpl Fitzpatrick to have cancelled the watch.⁹¹⁷ In these circumstances, there is reason to doubt the basis for a conclusion there was no suicide watch.

515. There may well have been possible legal or administrative impediments to conducting such a watch. It could be Cpl Langridge's objections to the scrutiny and constraints of a suicide watch played a role in its cancellation, but this would hardly end the matter for the CFNIS investigators. It is also possible the decision was made without him. To begin, there was information in the possession of the CFNIS members, or readily available to them, indicating individuals within the LDSH chain of command and base medical personnel understood Cpl Langridge to be at risk of harming himself. There was information measures to protect him were being planned. Had the CFNIS interviewed members further up the LDSH chain of command regarding the suicide watch, the CFNIS would presumably have learned one of the key reasons for calling off the suicide watch was a concern about legal liability. Because of the way the CFNIS investigation was conceptualized and conducted, many opportunities to resolve ambiguities and contradictions were put aside, minimized, forgotten about, or dismissed.

Should Cpl Langridge have been on a suicide watch?

516. From the perspective of an investigator looking into the possibility of potentially negligent acts or omissions, the natural next question ought to have been whether the refusal to mount a watch in these circumstances could potentially be negligent. When asked about whether any part of the investigation examined the decision of whether to mount a suicide watch and the reasons for that decision, MWO Watson testified he saw no need to investigate this.⁹¹⁸ MWO Watson subsequently admitted in his testimony he actually did not recall information about this issue coming to his attention. He also testified he would have asked his own superiors for direction had such information been obtained,⁹¹⁹ rather than dismissing it outright. Unfortunately, because of the failure to seek out further details about the proposed suicide watch, that information was never found.

517. If the conditions were intended to prevent Cpl Langridge from harming himself, their failure and the failure to mount a competent suicide watch might well have been evidence of negligence. If one concludes there were no efforts at preventing Cpl Langridge from harming himself, a question that arises is “*Should Cpl Langridge have been subjected to a suicide watch?*” This question was never seriously considered by the investigators. A failure to conduct a watch where one was required might potentially constitute negligent performance of a duty.

518. Had the CFNIS members better understood the concepts of negligence and duty of care, they might have recognized evidence potentially relevant to the possible creation of a duty on the part of the CF to protect Cpl Langridge from harming himself. This included Cpl Langridge’s discharge from a hospital, where he was apparently safe and under considerable oversight and monitoring, to a military environment where he had more freedom, was at greater risk, and was under greater pressure and stigma. The interviews conducted by the CFNIS disclosed Cpl Langridge’s prior suicide attempts were “common knowledge” at the Regiment. The investigation confirmed senior staff were aware of them.⁹²⁰ The investigators also knew Cpl Langridge was actively expressing suicidal intentions three or four days prior to his death and was hospitalized.⁹²¹ Despite this, the CFNIS investigators did not ask whether, even if there was no suicide watch, there was still an obligation on the CF to put measures in place for Cpl Langridge’s safety. They did not consider the possibility it may have been negligent for LDSH to fail to put a competent suicide watch into place. MCpl Ritco,⁹²² WO Tourout,⁹²³ MWO Watson,⁹²⁴ and Maj Frei⁹²⁵ all indicated in their testimonies they believed this question was outside the scope of the investigation. MCpl Ritco testified, “That’s not what I was investigating, sir.”⁹²⁶

519. Sgt Bigelow testified he expected the question of whether a suicide watch was necessary would have come out in the investigation, as it was relevant to the negligence issue, but it was not at the forefront.⁹²⁷ WO Tourout, although he recognized questions about negligence would have been raised if a watch was required and was not conducted, testified the question of whether a watch was in fact required or necessary would not have occurred to him.⁹²⁸ He dismissed the issue as not being a matter for the CFNIS to

investigate.⁹²⁹ Because of the conclusion there was no suicide watch, WO Tourout considered it unnecessary to investigate whether one should have been organized based on what the LDSH knew at the time. He acknowledged the evidence demonstrated the chain of command were aware of Cpl Langridge's previous suicide attempts.⁹³⁰ However, in his view, it was a matter for a BOI.⁹³¹ This brings the matter full circle to the fact the issue of possible negligence was artificially confined by the investigators to simply determining whether or not a suicide watch was in place at the time of Cpl Langridge's death.

520. MWO Watson testified the question of whether Cpl Langridge should have been under a suicide watch was outside the scope of the 2008 Sudden Death Investigation. He acknowledged this could have been the topic of a separate investigation had investigators brought to his attention that a watch should have been conducted.⁹³² Again, this reasoning becomes circular, because evidence of whether a watch should have been conducted was not sought by the investigators or even acknowledged as a possible avenue for investigation. A further consequence of the failure to understand correctly or to address comprehensively the issue of negligence in the 2008 investigation was the fact CFNIS members involved in the 2010 Investigation, who were to look specifically into the issue of potential criminal or service offences arising out of negligence by the CF, also did not themselves ask any of the relevant questions, apparently assuming they had all been resolved in 2008.⁹³³

521. Some personnel within the base mental health team, including Ms. Ferdinand and Mr. Strilchuk, recommended Cpl Langridge be subject to close monitoring or to a suicide watch within the Regiment. It has already been noted they and Capt Hubbard believed a watch was necessary on February 4, 2008, and the CFNIS investigators had notes about this in their possession. The CFNIS members also knew that on March 7, 2008, Mr. Strilchuk recommended Cpl Langridge be subject to close supervision and monitoring, and also recommended work limitations and a prohibition on weapons and driving. Mr. Strilchuk was unable to testify at the Commission hearings owing to ill health, but his affidavit evidence makes it clear he was seriously concerned about Cpl Langridge's mental state on March 7, 2008. As a result, he sought to have Cpl Langridge taken to a

safe place where he would be constantly monitored and accompanied by one or two members who were to be with him at all times.⁹³⁴ There are difficulties with details in Mr. Strilchuk's affidavit.⁹³⁵ Mr. Strilchuk was never interviewed by the CFNIS, meaning his evidence was not obtained at a time when memories were fresher, and his allegations could have been duly investigated.

522. A distraught Cpl Rohmer told MCpl Ritco during his 2008 interview he believed Cpl Langridge should have been under a suicide watch in light of his higher risk of suicide and the fact the Regiment was aware he was suicidal and had made previous attempts. WO Tourout was asked if this was the starting point of a complaint that the LDSH had an obligation to do something about it, knowing what it knew about Cpl Langridge. He denied it was a complaint, merely an opinion held by Cpl Rohmer. In his view, it could not have been the foundation of a complaint because the "totality of the evidence in the report" was "far, far apart" from that opinion.⁹³⁶

Awareness of previous suicide attempts and ongoing risks

523. The issue of whether the LDSH chain of command was aware of Cpl Langridge's previous suicide attempts would have been relevant to the question of whether the CF thereby came under a duty of care to Cpl Langridge to protect him from harming himself. The existence of such a duty and a failure to discharge that duty could be a foundational element of negligence.⁹³⁷

524. There was evidence the LDSH chain of command was well aware of a number of Cpl Langridge's suicide attempts. LCol Demers testified he would not have expected to be briefed by medical staff about Cpl Langridge's suicidal ideation,⁹³⁸ but CWO Ross, for one, was aware of most of Cpl Langridge's suicide attempts, including his explicit suicidal remarks of March 11, 2008.

525. One incident that the evidence makes clear must have been known by at least some of the members of the LDSH chain of command occurred in October 2007, when Cpl Langridge attempted suicide through an overdose of medication. It was discovered

when CWO Ross dispatched Sgt Anick Murrin, the Regimental Sherriff who was under his command,⁹³⁹ to attend at Cpl Langridge's residence when he failed to report to duty.

526. Ms. A testified she went to the base and sought help from the LDSH, telling them Cpl Langridge had "[...] swallowed two whole bottles of pills which, as far as I am aware, were full of his prescription medications [...]." ⁹⁴⁰ Sgt Murrin testified, in late October 2007 she was asked to attend Cpl Langridge's residence because he did not report that morning and because Ms. A contacted the LDSH and asked them to check on him. ⁹⁴¹ After Ms. A provided a key to the residence, Sgt Murrin attended the townhouse with two regimental police members. ⁹⁴² A knock on the front door led to no response. She sent the regimental police around to the back door but again received no answer, so she used the house key to enter the dwelling. ⁹⁴³ Sgt Murrin eventually found Cpl Langridge asleep and difficult to rouse in a bedroom on the second floor. She shouted Cpl Langridge's name, and this finally woke him. ⁹⁴⁴ Cpl Langridge was compliant and got out of bed to use the washroom, but was so drowsy, upon his return he fell back into bed and went to sleep. Sgt Murrin called the base medical clinic for advice, and they told her to call 911 and bring him to a civilian hospital. She did so, and the responding paramedics took him to the hospital along with his medication bottles. ⁹⁴⁵ Sgt Murrin then phoned the RSM, CWO Ross, and gave him an update before returning to base.

527. CWO Ross testified he could not remember the specific conversation he had with Sgt Murrin about the incident, but it would have been normal for the sergeant to report back to him about what took place. When asked if that situation would have led to a heightened awareness something was wrong with Cpl Langridge, CWO Ross replied, "There certainly would be a cause for alarm, I would assume, yes." ⁹⁴⁶

528. MCpl Ritco learned about this incident from Sgt Murrin in April 2008 ⁹⁴⁷ but did not appear to appreciate its significance because Sgt Murrin could not recall the date it took place and denied it was a suicide attempt. In fact, Cpl Langridge was admitted to the short stay mental health unit of the Royal Alexandra Hospital on a Form 1 certificate under the Alberta *Mental Health Act* because of his overdose attempt, with the emergency department estimating he had swallowed 60 to 70 tablets of his prescription

medication.⁹⁴⁸ Records from the hospital indicate the Regiment was contacted during his hospitalization, and in an “official military conversation” about Cpl Langridge’s potential discipline, the physicians were advised neither an arrest nor any charges were pending against Cpl Langridge at that time.⁹⁴⁹

529. MCpl Ritco evidently did not link what he was told by Sgt Murrin with the suicide attempt documented in his May 2008 review of Cpl Langridge’s medical file. There, he noted, on “28/29 Oct 07, [Cpl Langridge] attempted suicide by overdoze [*sic*] (seroquil) [*sic*] with 9-10 beers, while at home, because girlfriend broke up with him, admitted to Royal Alexandra Hospital, no suicide or homicidal thoughts when released on 30 Oct 07.”⁹⁵⁰ MCpl Ritco asked no questions about this or other such incidents of personnel with knowledge of it, specifically members of the chain of command.

530. There were other indications members of the chain of command were aware of at least some of Cpl Langridge’s previous suicide attempts. Capt Hubbard, the LDSH padre, testified Ms. A contacted the duty centre in early February 2008 because Cpl Langridge attempted to hang himself in their townhouse and had been taken to the hospital.⁹⁵¹ Capt Hubbard was on call and notified the chaplain chain of command of the attempt. The base chain of command and LDSH chain of command subsequently learned of the attempt,⁹⁵² and Capt Hubbard testified he recalled speaking to Capt Lubiniecki, Maj Jared, and Maj Cadieu about the suicide attempt after they learned of the incident.

531. Capt Lubiniecki testified he was unaware Cpl Langridge had been admitted to hospital because of a suicide attempt.⁹⁵³ LCol Demers also testified he had no recollection of being informed of this incident.⁹⁵⁴ However, Cpl Langridge attempted suicide again while admitted to the RAH, and Capt Lubiniecki testified he was informed about this further attempt by Capt Hubbard when it happened. The disclosure required some convincing of Capt Hubbard by Capt Lubiniecki, as the former understandably had Cpl Langridge’s confidentiality to consider. Capt Hubbard testified it was very important to Cpl Langridge to live without the shame and stigma of his condition, as this was viewed harshly in the military community.⁹⁵⁵

532. The evidence makes it clear that members of the LDSH chain of command were aware of at least the following incidents of suicide attempts or suicidal ideation:

- When Cpl Langridge attempted suicide in June 2007, it was reported to the LDSH chain of command and an SI was conducted regarding those events;⁹⁵⁶
- When Cpl Langridge attempted suicide in October 2007, CWO Ross dispatched MPs to attend Cpl Langridge's house, and they found him overdosed on medication. He was taken to a civilian hospital, and this was reported back to CWO Ross;⁹⁵⁷
- When Cpl Langridge left Edgewood in January 2008, members of the medical community were greatly concerned about Cpl Langridge's risk of suicide and communicated this concern to Capt Lubiniecki, who reportedly contracted with Cpl Langridge not to harm himself;⁹⁵⁸
- When Cpl Langridge attempted suicide by hanging in early February 2008, there is evidence Capt Lubiniecki, Maj Jared and Maj Cadieu were informed of this by the Padre, Capt Hubbard;⁹⁵⁹
- Cpl Langridge subsequently attempted suicide again while in a civilian hospital, and Capt Lubiniecki acknowledged being told of this attempt by Capt Hubbard;⁹⁶⁰
- Upon Cpl Langridge's release from hospital on February 4, 2008, Maj Cadieu sent an email to Maj Jared, LCol Demers, CWO Ross, Capt Lubiniecki, Capt Hubbard and MWO Mulhern indicating it may be necessary to set up a "watch" for him;⁹⁶¹
- When Cpl Langridge expressed suicidal ideation in March 2008, this was reported to CWO Ross by base medical personnel, and he was aware Cpl Langridge was sent to a civilian hospital.⁹⁶²

THE ULTIMATE QUESTION

533. CWO Ross informed the CFNIS investigators the LDSH could not "legally" put Cpl Langridge under a 24/7 watch unless the medical community said he was suicidal. The CFNIS investigators did not examine this issue. Further, once CWO Ross told MCpl Ritco a doctor had called him and said Cpl Langridge was claiming to be suicidal, the issue of whether this changed the legality of a suicide watch was not investigated.⁹⁶³ Regardless, Maj Jared's testimony that a suicide watch was considered and rejected for

Cpl Langridge on March 7, 2008, indicates Cpl Langridge's stability and propensity for self-harm were active concerns for both the LDSH and the base medical community.

534. It is outside the mandate of the Commission to conclude Cpl Langridge should have been on a suicide watch when he died. But the evidence was there for the CFNIS investigators to examine this question in the context of possible negligence on the part of the CF. It is uncertain whether, in this case, a finding that a watch was not conducted when it ought to have been would support a charge of an offence under the *Criminal Code* or a service offence under the *Code of Service Discipline*⁹⁶⁴ in this case. However, this question and the issues discussed earlier were all matters a focused investigation should have pursued, even if the conclusion would have been charges were not warranted. The failure to even consider these questions is disconcerting.

535. The failure to identify the relevant issues and to develop a competent IP made it inevitable the investigative team would also fail to comprehend the significance of the available evidence, to pursue further evidence or to interview clearly relevant witnesses. All of this compounded an already inadequate investigative effort into some of the most essential aspects of the 2008 investigation.

536. Because the investigators did not turn their mind or properly investigate conduct possibly pointing to negligence in this case, they never got to the stage of assessing the elements of any potential criminal or service offences arising from such possible negligence. As set out elsewhere in this report, all such possible offences include elements of a duty and a failure to discharge that duty.⁹⁶⁵ They also all require that the conduct involved in failing to discharge the duty must be below a certain standard. The standard in the case of both the criminal and the service offences potentially applicable on the facts for the conduct to be "negligent" is high compared to civil negligence. For criminal negligence, the culpable conduct must be of a "marked and substantial departure"⁹⁶⁶ from the standard of care expected of a reasonably prudent person in the circumstances. For the service offence of negligent performance of a military duty, the standard of responsibility requires a marked departure and is based on an objective

assessment of what a reasonable person of the rank and in all the circumstances of the accused would have done.⁹⁶⁷

537. In both cases, as for all criminal or service offences, there is also a mental element or “*mens rea*” which, in the case of negligent conduct resulting in death, requires that the accused either recognize a serious risk to life and safety and they ran that risk anyway, or gave no thought to the risk.⁹⁶⁸

538. The Commission is aware it may very well be the offences could not have been proven, even if some of the conduct could have been considered to be negligent, in light of the high threshold of culpable conduct that would be required in this case for either criminal negligence or negligent performance of a military duty. However, because the CFNIS members never investigated the actual conduct that required investigation, they never got to this stage of the analysis. The Commission’s comments about the failure to investigate the relevant conduct and issues should not be taken to imply the ultimate standard to be applied in deciding whether to lay charges should have been any lower than the usual standard applicable. Rather, the Commission’s view is simply that the information the CFNIS investigators possessed or had the means of obtaining made it clear that there was much more that ought to have been investigated, and to have been investigated to a much greater extent, before any possibility of CF negligence in the death of Cpl Langridge could have been ruled out.

4.1.3 The Investigation Plan

THE PURPOSE OF THE INVESTIGATION PLAN: TO-DO LIST OR CONCEPTUAL TOOL?

539. Through the course of this hearing, the Commission heard varying explanations from CFNIS members as to the purpose of an Investigation Plan (IP). Maj Frei was the DCO CFNIS at the time of the 2008 sudden death investigation and Acting Commanding Officer (A/CO) when that investigation was concluded. At the close of this hearing, Maj

Frei was the CO CFNIS.⁹⁶⁹ He offered the following statement to describe the purpose of an IP:

From my perspective the real value in the investigation plan is forcing the lead investigator to take the time to think through what it is he's investigating, to understand the elements of the offence that's involved; to put some thought into how he is going or she is going to conduct the investigation. The fact that we [document it] and ensure that a supervisor reviews it simply captures those steps in SAMPIS but, like any other plan in the military, there is a common saying within the military that no plan survives first contact. It's the same with investigations.⁹⁷⁰ [Emphasis added]

540. The IP, if employed as described by Maj Frei, encourages an investigator to assess an investigation critically on an ongoing basis, to formulate the questions that must be answered in order to conclude the investigation, and to develop a plan as to how to investigate each issue in order to reach relevant conclusions. The Commission agrees with Maj Frei's characterization and understands this process to be the purpose, and the value, of the IP.

541. Conversely, MCpl Ritco, Sgt Bigelow and WO Tourout each described the IP as a form of "to do" list.⁹⁷¹ MCpl Ritco testified an IP serves to remind him of the steps to take in the course of the investigation and to inform his case manager of what steps he is taking.⁹⁷² Sgt Bigelow offered a more general definition, stating the IP is "just ideas of what [the lead investigator] wants to do."⁹⁷³ WO Tourout explained the IP is broader than the investigation itself, including anything else that comes up in the course of the investigation.⁹⁷⁴

542. Having reviewed the IP and resulting investigation in this case, the Commission finds using the IP simply as a "to do" list impoverishes the investigation. Rather than focusing on what questions need to be answered, the checklist model of the IP is simply a laundry list of topics, steps and memos to self. It does not promote an understanding or critical analysis of the state of the case and does not encourage the investigator to assess the merits of the evidence in order to answer the questions under investigation.

PLANNING AND ORGANIZATION

543. On the whole, an outside observer looking at the IP for the 2008 investigation would have great difficulty ascertaining what the investigators planned to do and why, what remained to be done, what insights they gained, and what new avenues of inquiry they identified. The IP, drafted and revised on March 17 and 31, 2008, respectively, and approved by MCpl Ritco's case manager, WO Tourout, on March 18 and April 1, 2008, reads:

Tasking

MCpl RITCO is tasked to investigate the death of Cpl LANGRIDGE and compile the findings in this report. [...]

Interviews [March 17, 2008]

1. Cpl BRUCE-HAYES (Duty MP) (Completed 16 Mar 08);
2. Cpl BROADBENT (Duty MP); (not required)
3. Capt LUBINIECKI (LDSH ADTJ); (Completed 17 Mar 08);
4. Cpl HURLBURT (LDSH Duty Cpl); (Completed 19 Mar 08);
5. Sgt HISCOCK (LDSH Duty Sgt); (Completed 18 Mar 08); and
6. Cpl HARE (resides in Rm F312). (Completed by Base MPs)

Plan

CFNIS WR will investigate the following in order to gather information/evidence pertaining to this file:

1. current residence of Cpl LANGRIDGE; (Completed)
2. was Cpl LANGRIDGE on "suicide watch" or "defaulters"; (Completed)
3. any documentation pertaining to a "suicide watch"; (Completed)
4. any documentation pertaining to "defaulters"; (Completed)
5. person(s) who notified media and all related information; (Completed)
6. personnel from LDSH tasked to handle the personal effects of Cpl LANGRIDGE; (Completed)
7. confirmation of girlfriend or common law wife; (Completed 17 Mar 08)
8. obtain medical records from UMS in favor of Cpl LANGRIDGE; (Completed)

9. identity and whereabouts of next of kin; (Completed 17 Mar 08)
10. turnover of personnel [sic] effects to proper personnel; (Completed 20 Mar 08)
11. documentation from ambulance emergency services; (not required)
12. description of medication and what side effects it may cause if any; (Completed)
13. possible negligent actions on behalf of CF, resulting in possible involvement in death; (completed)
14. attend Alberta Hospital in order to gain information regarding Cpl LANGRIDGE'S committal/release. (information located on DND medical records)
15. who are Cpl LANGRIDGE'S closest friends; (Completed)
16. tours, missions, or otherwise taskings; (Completed 17 Mar 08)
17. problems within unit; (Completed 17 Mar 08)
18. abuse of alcohol or narcotics; (Completed 17 Mar 08)
19. medical examiner's report (return date at least 4 months) (completed)

TIME ESTIMATE: 4 months [...]

INTERVIEWS: [March 31, 2008]

1. Cpl ROHMER (best friend of deceased) (Completed 18 Mar 08);
2. MWO MAINVILLE (MWO in charge of personal effects); and (Completed 17 Mar 08)
3. [Ms. A] (common law); (decided no need to be interviewed)

Plan

1. Compile 8 (2) (E) for medical records at ASU Edmonton UMS; (Completed 22 Apr 08)
2. Obtain Edmonton Police Services Reports regarding Cpl LANGRIDGE; (Completed)⁹⁷⁵

544. The IP is incomplete and incoherent. It includes no information about the goals of the investigation beyond simply collecting information, about the reasons for selecting certain investigative steps or interviews, or about the reasons for subsequently deciding not to pursue them. Seemingly connected issues are not grouped together, whereas unconnected issues are. Actual investigative steps connected to possible charges are listed

alongside purely administrative issues. Obvious steps and interviews are missing, while irrelevant or less relevant ones are included.

545. Aside from the administrative matters such as Cpl Langridge's residence, relationship status, and next-of-kin, the IP appears to propose steps for investigating the cause and manner of Cpl Langridge's death as well as potential Unit negligence. Completed properly, these planned steps could yield relevant evidence concerning the circumstances of Cpl Langridge's last days and of his death. However, the IP lacks a conceptual vision as an outline of the investigation. It provides no indication about how these proposed steps were intended to inform and organize the investigation.

546. The goal for the Sudden Death Investigation, as identified by MCpl Ritco in his testimony, was to rule out foul play.⁹⁷⁶ However, many of the obvious steps necessary to determine whether foul play had any part in Cpl Langridge's death are not included in the IP. Nothing in the IP relates to any of the evidence obtained at the scene,⁹⁷⁷ to the information and facts ascertained from the position and examination of Cpl Langridge's body, the opinions given by the ME investigator, or the tests subsequently conducted by the ME's office. In fact, the IP does not include steps directed towards one of the most important factors in determining foul play: whether someone was in the room with Cpl Langridge at the time of, or immediately prior to, his hanging.

547. Another glaring omission is the failure to make any mention of the suicide note found at the scene. The existence of a suicide note was clearly of high relevance to the determination of whether foul play was involved in the death. Had there been any realistic suspicion of foul play, the note would have had to be tested to confirm its authenticity, but the IP makes no reference to the possible use of the note during the investigation, or even to the note's existence.

548. The proposed steps in the IP related to medical records, alcohol or drug addiction or work-related issues were all relevant to determine whether suicide was the most likely cause of death. Nevertheless, even here there is little indication the investigators thought through what was being investigated in the manner described by Maj Frei. WO Tourout explained steps 16 ("tours, missions, or otherwise taskings") and 18 ("abuse of alcohol or

narcotics”) were investigated in order to create a background sketch of the deceased; to determine “what may be a contributing factor [to the suicide].”⁹⁷⁸ On the other hand, MCpl Ritco testified he added Cpl Langridge’s abuse of alcohol and narcotics because he was still thinking about the possibility of foul play. He stated:

[...] I just wanted to see what his background was like, to find out if there was some foul play, if there was somebody, like, a suspect; did he attend certain places; did this person - if it was foul play, was this person at the same location. I am keeping my mind open to everything.⁹⁷⁹

549. MCpl Ritco testified nothing of significance resulted from his investigation into Cpl Langridge’s history with alcohol and narcotics.⁹⁸⁰ When asked whether anything from his investigation might indicate Cpl Langridge’s problems with alcohol and narcotics were implicated in his death, MCpl Ritco replied, “I can't really answer that, because I don't know why Corporal Langridge killed himself.”⁹⁸¹ In other words, MCpl Ritco failed to appreciate the relevant question was whether there were serious issues capable of constituting motives for suicide.

550. Similarly, step 17 (“problems within [the] unit”) could potentially identify workplace problems, thus painting a picture of a troubled individual. However, MCpl Ritco testified he was only interested in determining whether Cpl Langridge was “having problems with somebody in his unit, i.e., if it was foul play, or if it turned out to be a homicide, should I be looking in his unit lines. Had he been -- you know, was there somebody after him, or something like that.”⁹⁸² The investigation of whether or not anyone had a reason or intention to harm Cpl Langridge was relevant, but a well-planned and organized investigation would also recognize information about Cpl Langridge’s workplace conduct and interactions over the last months of his life would be relevant to help answer the critical question of whether his behaviour was consistent with an apparent suicide.

551. The same conceptual and analytical problems are apparent when examining the steps relevant to the investigation of possible negligence by the Regiment. Many of the issues listed are indeed relevant, but many other relevant issues are not listed.⁹⁸³ The IP creates the impression the CFNIS members did not ask themselves what constitutes

negligence and why, or what issues would be relevant in such an investigation. Instead, it appears they only asked whether or not Cpl Langridge was under a suicide watch. Step 14 (“attend Alberta Hospital in order to gain information regarding Cpl Langridge’s committal/release”) was clearly relevant and appropriate. This step was never undertaken, and the IP mistakenly indicates the information was obtained by other means.⁹⁸⁴ In fact, the DND medical records obtained instead of the Alberta Hospital records contained little if any relevant information about this hospitalization.

552. The IP also includes a number of steps not relevant to any aspect of the investigation, further suggesting confusion surrounding its planning and purpose:

Step (5): person(s) who notified the media and all related information;
Step (6): personnel from LDSH tasked to handle the personal effects of Cpl Langridge;
and
Step (10): turnover of personnel [*sic*] effects to proper personnel.⁹⁸⁵

553. From the file, it appears MCpl Ritco was concerned about the media issues (Step 5) because, on the morning of March 17, he heard an Edmonton radio station announce a soldier had died at CFB Edmonton.⁹⁸⁶ He testified he had included this in his IP because the CFNIS has its own media relations personnel, and he wanted the chain of command to be aware of this in the event the media needed to be notified of anything.⁹⁸⁷ Including this step suggests a lack of focus on the matters at hand. The identities of personnel tasked to handle Cpl Langridge’s personal effects (Step 6) and the turnover of his effects (Step 10) are similarly irrelevant to the investigation. The inclusion of such “notes to self” with no relation to the investigation is a direct reflection of the IP as an unsorted “to-do list,” rather than a conceptual tool.

554. The investigative steps also include a number of witness interviews. In general, the witnesses listed were appropriate. Each could reasonably be expected to have relevant knowledge regarding the circumstances of Cpl Langridge’s death. The exception is the interview of MWO Remi Mainville. It addressed issues related to the disposal of Cpl Langridge’s personal effects, which was not an investigative issue at all.⁹⁸⁸

555. However, the witness list is incomplete and lacks important details. The IP provides no indication of the possible purpose of the planned interviews. The process used to select the witnesses does not appear to be based on a systematic analysis of the information required or the persons most likely to possess such information.

556. Potentially important witnesses with relevant information were discounted or not included at all. Cpl Langridge's common-law spouse, Ms. A, was initially listed as a witness, but an interview was later deemed unnecessary, and the IP offers no explanation of why the decision to discount a witness with potentially relevant information was made. Cpl Rohmer, who had been one of Cpl Langridge's closest friends, was selected as a witness but, during the interview, the investigators learned Cpl Rohmer and Cpl Langridge had been estranged for most of the previous year.⁹⁸⁹ MCpl Ritco testified Cpl Rohmer had "nothing relevant" to offer to the investigation.⁹⁹⁰ While this view was not wholly accurate in light of the valuable information Cpl Rohmer did provide,⁹⁹¹ it is surprising the investigators made no effort to find closer friends to interview. The list should have been updated to reflect witnesses who might provide information the investigators still required.

557. In addition, many obviously relevant witnesses were never listed. The most striking omissions are Cpl Langridge's parents, Mr. and Mrs. Fynes. They could be expected to have valuable information related to his past history and mental state. The evidence in this hearing has revealed it was MCpl Ritco's case manager and perhaps the Detachment MWO who provided a directive indicating it was not necessary to interview the Fynes.⁹⁹² The list of witnesses in the IP was drafted before this directive was issued on April 15, 2008. MCpl Ritco testified, prior to that date, it was "in the back of [my] mind that I potentially could have interviewed [the Fynes]."⁹⁹³ It is difficult to understand why they were never listed in the IP, while Ms. A, whom MCpl Ritco was also told not to interview,⁹⁹⁴ was and remained listed in the IP. The only explanation MCpl Ritco could offer for the omission was it was due to an oversight on his part.⁹⁹⁵

558. Similarly, members of Cpl Langridge's chain of command were not listed as possible witnesses. Considering the nature of the issues being investigated, particularly in

relation to the suicide watch, it seems many of these individuals might have had information relevant to the investigation. MCpl Ritco testified he considered interviewing witnesses from Cpl Langridge's chain of command, including his OC, Maj Jared, his DCO, Maj Cadieu, and his CO, LCol Demers.⁹⁹⁶ However, no explanation was provided as to why they were never listed in the IP, even as other witnesses who had been identified but not interviewed were listed.

559. The lack of clarity in the IP might be explained by MCpl Ritco's inexperience, but this does not excuse his superiors' lack of guidance. Throughout the investigation, none of the CFNIS WR supervisors intervened to correct misconceptions and gaps in the planning of the investigation or provide additional guidance about the purpose of the investigation. WO Tourout reviewed and approved the IP without making any changes.⁹⁹⁷ MWO Watson did not even look at the IP or provide any direction about the planning of the investigation.⁹⁹⁸

THE "COMPLETED" STEPS

560. The investigative steps and proposed interviews listed in the IP are followed by one of three statements: (1) completed; (2) completed, with a date; or (3) a statement the step was unnecessary or would not be pursued. The use of "completed" in the IP was explained by MWO Watson in his testimony as meaning "the investigator added here that he's looked into it and it's done," and the question has been answered.⁹⁹⁹ The Commission agrees with MWO Watson's view that this is the proper usage. The purpose of the IP is to assist investigators in creating a path to reach conclusions, and marking a step as "completed" should indicate the step has been taken and an answer to the question has been obtained. However, this is not the manner in which MCpl Ritco used the term.

561. It appears when a step was marked as "completed" in the IP, it did not mean the investigator had reached a final conclusion about the question being investigated. Rather, it meant he was not going to pursue the issue any further. The IP is replete with examples. MCpl Ritco marked as "completed" the first step in the IP, identifying Cpl Langridge's residence.¹⁰⁰⁰ Nevertheless, MCpl Ritco testified he received conflicting information and never determined the actual address.¹⁰⁰¹ He agreed this first question was never

answered.¹⁰⁰² The second step in the IP, identifying whether Cpl Langridge was under a suicide watch or on defaulters, is also marked as being “completed.”¹⁰⁰³ However, when asked whether he had come to any conclusion as to whether or not Cpl Langridge was on defaulters, MCpl Ritco testified he had not.¹⁰⁰⁴ He explained, when he added the notation “completed,” what he really meant was:

[...] that topic that I was trying to or that investigation that I was doing had been completed, that I wasn't able to determine whether he was on a suicide watch or he was on -- well, defaulters, yes, but the suicide watch I was not able to determine that.¹⁰⁰⁵

562. Step three, obtaining documentation pertaining to the suicide watch, is also marked “completed.”¹⁰⁰⁶ The CFNIS did obtain some documents about this issue,¹⁰⁰⁷ but at least one crucially relevant document – an email directly related to the request for a list of personnel to conduct a watch for Cpl Langridge – was known to the investigators and yet they decided not to obtain it.¹⁰⁰⁸ This step cannot be said to be “completed” in any ordinary sense of the word.

563. The fourth step in the IP, obtaining any documentation pertaining to defaulters, is also marked as “completed” even though there is no documentary evidence whatsoever in the file pertaining to this issue.¹⁰⁰⁹ No testimony was heard indicating such documentation existed or indicating steps were taken in an effort to obtain it. The fifth step, identifying the person or persons who notified the media of Cpl Langridge’s death, is similarly marked as being “completed.”¹⁰¹⁰ While irrelevant, there is no evidence this matter was pursued or any conclusions were reached with respect to it.

564. The thirteenth step, investigating “possible negligent actions on behalf of [the] CF, resulting in possible involvement in [Cpl Langridge’s] death” is marked “completed” as well.¹⁰¹¹ MCpl Ritco testified he did not actually investigate the issue of potential negligence, but included this step in his IP as a reminder to investigate it if he did find any indication there was negligence.¹⁰¹²

UPDATING AND REVIEWING THE INVESTIGATION PLAN

565. The Commission heard consistent evidence the IP is a 'live' document to be updated and amended as an investigation progresses.¹⁰¹³ Indeed, considering the purpose of the IP, it should be revisited and updated regularly. The benefits of maintaining a current IP are many. Updating the IP encourages the investigator to actively consider the progress and direction of the investigation. It also encourages the investigator to identify the questions needing to be answered and to assess whether sufficient evidence has been gathered on that point. It promotes reaching timely conclusions, and it allows a case manager to review the progress of a case in a condensed format. It also allows the CFNIS Chain of Command to grasp the purpose and progress of the investigation when conducting a review. Where the matter is reviewed by an external body like the MPCC, a current IP allows for a step-by-step assessment of the conduct of the investigation. This is not to suggest an IP must be updated prior to each new investigative step. The IP is a tool to help in conducting an investigation and should not become a bureaucratic hindrance, particularly where new issues may arise suddenly.

566. The IP was amended at various times through the course of the 2008 investigation. The amendment to note the ME's report had been obtained suggests the IP was updated as late as May 15, 2008.¹⁰¹⁴ Unfortunately, the updates were sporadic and inconsistent. Several new investigative steps and three possible interviews were added on March 31, 2008, after two of the three interviews had already been conducted. Meanwhile, many other interviews were conducted without any mention in the IP before or afterwards. WO Tourout could not explain why amendments were not made to the IP to reflect the interviews conducted.¹⁰¹⁵

567. On the whole, the amendments made to the IP provide no indication of the process by which the investigators may have assessed what they had learned and determined how it would impact on the investigative steps required or not required. Nothing in the IP indicates whether any investigative step taken led to further issues being investigated. There is also no indication regarding which steps turned out to be important and which steps were either unimportant or inconclusive. The overall result

was the IP was of little use. The case manager and other supervisors within CFNIS WR could not use the IP to assess whether sufficient steps were being taken to investigate relevant issues or to evaluate any progress made during the investigation. The IP, as written, could also not be used as the basis for any new investigator to discern the purpose or status of the investigation.

4.1.4 The Concluding Remarks

568. At the end of the 2008 investigation late in the spring of 2008, MCpl Ritco was finally able to conclude “[i]t would be absolutely 100 percent that the file is definitely a suicide [...] I laid everything out, said, yeah, definitely without a shadow of a doubt, anybody that reviews this file, it’s a suicide.”¹⁰¹⁶ He was then in a position to write the Case Summary and Concluding Remarks. MCpl Ritco explained the purpose of the Concluding Remarks is to inform those reviewing the file of the outcome of the investigation and whether or not charges are to be laid following the investigation.¹⁰¹⁷

569. WO Tourout described the Concluding Remarks as stating “what the actual outcome” of an investigation is,¹⁰¹⁸ or alternatively, “a brief summation of the investigation.”¹⁰¹⁹

570. MCpl Ritco’s Concluding Remarks state:

On 15 Mar 08, Cpl LANGRIDGE committed suicide by hanging himself with his belt while in his room. **This investigation revealed Cpl LANGRIDGE suffered from alcohol and cocaine addiction which caused him to have mental health issues.** All these issues combined may have been a factor in Cpl LANGRIDGE’s suicide. This investigation also revealed that **the military, in particular LdSH(RC), made several attempts to help Cpl LANGRIDGE in dealing with his problems.** This investigation is concluded.¹⁰²⁰ [Emphasis added]

571. When MCpl Ritco wrote this entry on June 2, 2008, he created two copies containing the same text.¹⁰²¹ The second version was intended to be edited by his case manager, WO Tourout. The practice of CFNIS WR (and perhaps other detachments) at the time was to create two copies of the Concluding Remarks entry in order for

supervisors to make changes for grammar, syntax, brevity and clarity while leaving the original entry intact.¹⁰²² Between June 4, 2008 and June 12, 2008, WO Tourout modified the Remarks.¹⁰²³ The content of the second version he created is different from the original and presumably reflects WO Tourout's editorial intent. It reads:

This investigation revealed that Cpl LANGRIDGE suffered from alcohol and cocaine addictions and subsequent mental health problems. Cpl LANGRIDGE had an extensive documented history of medical treatment, provided to him by base and provincial institutions, and several confirmed previous suicide attempts were discovered. **Despite the efforts of his Unit to provide structure and support to Cpl LANGRIDGE, the medical examiner's report confirmed his death to be a suicide as a result of hanging.** As no further investigation into this matter is anticipated, this investigation is concluded.¹⁰²⁴ [Emphasis added]

572. Both versions of the Concluding Remarks state Cpl Langridge had alcohol and cocaine addictions and link these addictions to his mental health issues. The two versions of the Remarks also make no direct mention of the issue of potential CF negligence in Cpl Langridge's death or of the investigation with respect to the suicide watch.¹⁰²⁵ The only remark possibly relevant to potential negligence is the finding that the LDSH offered Cpl Langridge "help," or "structure and support," in the face of his struggles with addiction, mental health issues, and suicide attempts.

573. The Concluding Remarks caused great pain for Cpl Langridge's family. In their complaint to this Commission, the Fynes allege the Remarks "contained findings that were inaccurate, that the investigator was not qualified to make, and that were aimed at attacking Cpl Langridge's character and exonerating CF members of any wrongdoing or liability."¹⁰²⁶

574. In a previous meeting with the CFNIS and during his testimony before the Commission, Mr. Fynes explained the two main problems he saw with the findings. On the one hand, he believed it was inaccurate to state Cpl Langridge's mental health issues were caused by or subsequent to his addiction issues, and he indicated this was a medical diagnosis the CFNIS members were not qualified to make.¹⁰²⁷ On the other hand, Mr. Fynes believed the comments about the assistance, structure or support provided by Cpl Langridge's Regiment were both inaccurate and irrelevant editorializing by the

investigators.¹⁰²⁸ Mr. Fynes explained it was treatment Cpl Langridge needed, which the Regiment and the CF, in his view, specifically failed to provide.¹⁰²⁹

575. On the whole, the Fynes believe both versions of the Concluding Remarks contained spurious comments about their son's struggles and death. They saw them as essentially praising the military for its efforts while setting aside the possibility anyone but Cpl Langridge himself had a blameworthy role in his death.¹⁰³⁰ By emphasizing a link between Cpl Langridge's addiction issues and his suicide, the Fynes felt the Remarks were "passing blame to the victim,"¹⁰³¹ and presenting Cpl Langridge as "a drunk and [...] a drug addict who made himself sick, and that led to his suicide."¹⁰³² As Mr. Fynes described it:

[...] there are three things in there: It was suicide, **it was his own damn fault**, and **the Army did everything they could to help [him]**.

I'm not happy with that.¹⁰³³ [Emphasis added]

576. In the Commission's view, mentioning addiction issues, mental health issues, and previous suicide attempts in the Concluding Remarks was not, in itself, inappropriate. While the CFNIS members would not be qualified to draw conclusions about the actual causes of Cpl Langridge's suicide, the existence of prior serious problems constitutes circumstantial evidence relevant to confirming suicide as the most likely cause of death. These factors legitimately form part of the aspects to be investigated in a sudden death investigation.¹⁰³⁴

577. However, the Concluding Remarks here go further and comment on the cause of Cpl Langridge's mental health issues. There was no evidence to support a finding Cpl Langridge's mental health issues were "caused" by or were "subsequent" to his addiction issues.¹⁰³⁵ The medical files obtained contained a number of different diagnoses,¹⁰³⁶ and the investigators had not obtained evidence from medical experts qualified to comment on the cause of Cpl Langridge's condition. The one medical professional interviewed during the investigation, Capt Hannah, did emphasize the addiction issues.¹⁰³⁷ However, not having personally treated Cpl Langridge or seen him more than once for a short visit,

Capt Hannah would not have been qualified to draw conclusions about the chronology or cause of Cpl Langridge's medical conditions.¹⁰³⁸ The CFNIS members were certainly not qualified to draw such conclusions themselves.

578. The comments about the assistance or “structure and support” provided by the Regiment are based on equivocal evidence obtained during the investigation. While there were various measures put in place for Cpl Langridge, the evidence raised questions about their adequacy, their sufficiency or even their potential harmful impact.¹⁰³⁹ These questions were not adequately investigated by the CFNIS members involved.¹⁰⁴⁰ As such, there was arguably insufficient evidence to draw the conclusions included in the Remarks, which present the measures taken by the Regiment in a positive light.

579. In this respect, the second version of the Concluding Remarks is particularly problematic. Comparing the two versions, it appears the editing done by WO Tourout changed the tone and implication of the Remarks by converting the previous reference regarding the Unit's efforts to “help” Cpl Langridge into a statement that Cpl Langridge's suicide occurred *despite* the Unit's efforts to “provide structure and support.”¹⁰⁴¹ This was clearly not supported by the evidence, as not enough investigation had been done to enable the members to determine whether the measures put in place by the Regiment were capable of providing assistance or whether they, in fact, contributed to making things worse for Cpl Langridge.¹⁰⁴²

580. The Concluding Remarks were eventually edited by Maj Dandurand to delete the matters complained of by the Fynes.¹⁰⁴³ However, there was no recognition by the CFNIS or its members that the initial Remarks were inaccurate or unsupported by the evidence.¹⁰⁴⁴ The Fynes continued to complain about the initial Remarks having been included in the report, as they alleged “they spoke to a mind-set that was exculpatory for the military and passing blame to the victim.”¹⁰⁴⁵

581. The Commission saw no evidence the findings were aimed at attacking Cpl Langridge's character or at exonerating the Regiment or the CF.¹⁰⁴⁶ In fact, the evidence reveals the members had no such intentions.¹⁰⁴⁷ However, some of the statements in the Remarks were unsupported by the evidence and contained conclusions the members were

not qualified to draw. They also did not fairly represent the investigation conducted, particularly with respect to the suicide watch issue.¹⁰⁴⁸

4.1.5 Supervision and Recordkeeping

SUPERVISION

582. The 2008 Sudden Death Investigation was headed by a lead investigator who lacked relevant experience in such investigations. The inexperience of the lead investigator was mirrored in the lack of experience in sudden death investigations on the part of his immediate supervisor. While there was supervisory input at various points in the investigation, that input was problematic both in terms of guidance on investigative steps – notably, whom to interview – and in terms of its impact on the records in the investigative file.

Policies respecting supervision

583. The MPPTP dealing with Supervision identifies two crucial supervisory positions: the Case Manager and the Senior MP Advisor.

584. The Case Manager is described by the MPPTP as the:

MP assigned [...] to head the overall criminal investigation. This usually includes: direction, correlation of data, assessment of resource/equipment needs, reporting and maintaining information flow, co-ordination of specialty support requirements, and the management of the investigation team members in consultation with the primary investigator. They should possess strong management skills, a thorough understanding of investigative standards and practices, and familiarity with the context in which the investigation is being conducted.¹⁰⁴⁹

585. In testimony before the Commission, WO Tourout, who acted as Case Manager for the 2008 Investigation, stated this policy is a general outline, likely based on the major case management model. He testified: “The [case manager] doesn’t head the investigation; the primary investigator will head the investigation. The case manager will oversee.” The remainder of the description, in his view, was appropriate.¹⁰⁵⁰

586. The Senior MP Advisor, meanwhile, has a more managerial role. MPPTP policy states the Senior MP Advisor “should be familiar with the basic premise of each ongoing investigation.”¹⁰⁵¹ The first responsibility of a Senior MP Advisor on a file is to screen the case. The Advisor is to determine whether a complaint is trivial, frivolous, vexatious, or made in bad faith, and whether it ought to be investigated.

587. Among the responsibilities of MP supervisors is to verify the accuracy and completeness of all reports and investigation files, including the GO file (which is the complete record of SAMPIS text box entries and scanned images generated for an investigation) and the Military Police Investigation Report (‘MPIR’) (which is the disseminated report of the findings of the investigation):

All Military Police reports shall be subjected to rigorous review by the appropriate MP supervisors who have a positive obligation to ensure completion and accuracy of both the reports and the investigations they represent. 100% verification of accuracy is the responsibility at both the Detachment and HQ PM level.¹⁰⁵² [Emphasis in original]

588. In carrying out this function, it was, at the time, typical for MP supervisors to review and edit the Case Summary (which generally summarizes the steps taken in the course of an investigation and any associated relevant facts) and Concluding Remarks (which summarize the findings and conclusions of an investigation) prior to distribution of a completed MPIR. The “vetted” versions of these documents were distributed with the MPIR, though the original versions remained within SAMPIS.¹⁰⁵³ In terms of the editing process, Maj Frei testified a supervisor should make an identical copy of the original document in a new file, change the author code to reflect her or his own badge number, and then make any amendments.¹⁰⁵⁴ This is of particular importance, as SAMPIS does not retain a history of changes made to a document. It saves only the latest version.¹⁰⁵⁵

589. The role of the Senior MP Advisor is removed from conducting or closely supervising ongoing investigations. When an investigation commences, the Senior MP is responsible for ensuring efficient and consistent procedures are used, and that “all available resources are maximized.” The Senior MP Advisor also assigns a case manager to head the overall investigation.¹⁰⁵⁶

Roles and experience of supervisors

590. The two CFNIS members supervising the investigation into Cpl Langridge's death were WO Tourout and MWO Watson. WO Tourout was the Case Manager, directly overseeing and providing guidance to the investigators.¹⁰⁵⁷ MWO Watson acted at the time as Senior Advisor, Detachment Warrant Officer¹⁰⁵⁸ and A/OC CFNIS WR.¹⁰⁵⁹

591. WO Tourout was involved in many aspects of the planning and execution of the investigation. After formally tasking MCpl Ritco as the lead investigator,¹⁰⁶⁰ he reviewed and approved the initial Investigation Plan on March 18, 2008.¹⁰⁶¹ He also reviewed and approved the amended Investigation Plan on April 1, 2008.¹⁰⁶² He testified he interacted with the investigators under his supervision on a daily basis, if required.¹⁰⁶³ MCpl Ritco's notebook reveals he briefed WO Tourout regularly over the course of his investigation.¹⁰⁶⁴ WO Tourout was also involved in making the decisions not to interview Mrs. Fynes and Ms. A.¹⁰⁶⁵ He reviewed and edited all of the investigators' SAMPIS entries¹⁰⁶⁶ and reviewed the final investigation file, noting he agreed with the investigative steps taken.¹⁰⁶⁷

592. Prior to his involvement in this investigation, WO Tourout had not been involved in any sudden death investigation as an investigator or a supervisor.¹⁰⁶⁸ He was aware at the time MCpl Ritco also had no sudden death investigation experience.¹⁰⁶⁹ However, in his view, the fact neither he nor MCpl Ritco had this prior experience was not an issue. WO Tourout stated he had a variety of experience in different types of investigations conducted over the years. He was confident basic level MP training and subsequent courses teach MP members to process crime scenes. He stated investigators apply those principles to crime scene processing across all investigations, adjusting according to specific needs.¹⁰⁷⁰

593. MWO Watson was acting as the Duty Officer for CFNIS WR on the day of Cpl Langridge's death. He received a call from the MP advising him of the death, at which point he contacted Sgt Bigelow. He testified he could have contacted either Sgt Bigelow or MCpl Ritco as both were on duty.¹⁰⁷¹ Sgt Bigelow testified he was neither on duty nor on call, but that he was likely contacted due to a shortage of CFNIS members at the

time.¹⁰⁷² MWO Watson provided basic instruction to the investigators, advising them to take their time in processing the scene and not to release the body or anything else until certain the scene had been processed appropriately.¹⁰⁷³

594. After that point, MWO Watson participated in this investigation mainly as an advisor to WO Tourout and as a liaison with CFNIS HQ. In the course of the investigation, he was consulted by WO Tourout or MCpl Ritco, or both, on some of the issues that arose, including the possibility Cpl Langridge was under a suicide watch at the time of his death¹⁰⁷⁴ and the question of whether or not Mrs. Fynes ought to be interviewed.¹⁰⁷⁵ MWO Watson briefed CFNIS HQ on the investigation through File Status Reports.¹⁰⁷⁶ He also approved the request for a forensic analysis of Cpl Langridge's phone on May 29, 2008.¹⁰⁷⁷ MWO Watson testified his review of the investigative file involved only the Initial Complaint, Case Summary, and Concluding Remarks. He testified that, if he had questions with respect to the file, he would have reviewed the individual SAMPIS entries, but he did not recall doing so in this case.¹⁰⁷⁸

595. Following the conclusion of the investigation, MWO Watson drafted the cover letter accompanying the MPIR when it was distributed.¹⁰⁷⁹ He also drafted the Request for Disposal of Evidence, which was sent to LDSH on October 31, 2008.

596. Unlike WO Tourout, MWO Watson had been involved in a number of sudden death investigations prior to Cpl Langridge's death. The majority of the investigations were while on deployment in theatre in Afghanistan,¹⁰⁸⁰ though he testified he had been an investigator in three sudden death investigations domestically.¹⁰⁸¹ He had never acted as the lead investigator in an investigation of a suicide. As a supervisor, MWO Watson had overseen "numerous sudden death investigations, from accidental to suicides to killed in action (*sic*)."¹⁰⁸² However, he testified he was not involved in the day-to-day conduct of investigations and would only become deeply involved in an investigation if it were necessary.¹⁰⁸³

597. The most experienced member of the team was Sgt Bigelow, who had been part of four to six sudden death investigations while on secondment with the RCMP and at least one suicide investigation with the CFNIS.¹⁰⁸⁴ However, not only was Sgt Bigelow

not the lead investigator, he was not even a member of the investigation cell;¹⁰⁸⁵ and his involvement in the investigation was limited to processing the scene and attending a number of interviews as a note-taker. MWO Watson was clear the only reason Sgt Bigelow was assigned to the case was “because [the CFNIS] needed assistance with fulfilling of the duty and he was on duty that day” and not because of his prior experience.¹⁰⁸⁶ By his own account, Sgt Bigelow’s role in the 2008 investigation following the processing of the scene was limited to assisting MCpl Ritco with interviews and providing some preliminary tutelage, rather than supervision.¹⁰⁸⁷

598. MWO Watson was aware at the time of the investigation that neither MCpl Ritco nor WO Tourout had any prior sudden death experience. He was not concerned by their inexperience and neither took any measures to compensate for it nor supervised them more closely because of it. He testified there were ample resources for MCpl Ritco and WO Tourout to refer to in the event they required assistance. These resources included himself, the RCMP “K” Division, CFNIS HQ and other CFNIS investigators. MWO Watson was confident that, if the investigative team had questions, he would be called; “I had full confidence in Warrant Officer Tourout as a case manager, in Sergeant Bigelow as assistant to the investigation and to Master Corporal Ritco as the lead investigator. I had full confidence in them.”¹⁰⁸⁸ Indeed, it was MWO Watson who recruited MCpl Ritco for the CFNIS, citing his tenacity, thoroughness and professionalism as qualities that convinced MWO Watson that MCpl Ritco would be a talented investigator.¹⁰⁸⁹

Supervisory input in the conduct of the investigation

599. WO Tourout appears to have been actively involved in guiding the course of the investigation, approving the Investigation Plan and subsequently providing direction to MCpl Ritco. He also appears to have been involved (perhaps along with MWO Watson) in significant decisions about interviews, notably in the instructions to MCpl Ritco not to contact Mrs. Fynes¹⁰⁹⁰ and not to contact Ms. A.¹⁰⁹¹ At the hearing, MWO Watson testified he did not recall being involved in the decision not to interview Mrs. Fynes but did state:

[Cpl Langridge] was a 28-year-old male in the military, and I would not have seen a need to speak to the mother in this situation to further the investigation. [...] [T]he background information [investigators] obtained from the medical authorities and his colleagues, in the course of their investigation, and the unit, would have been sufficient.¹⁰⁹²

600. WO Tourout testified he could not remember the reason for that decision. He did not recall the conversation well, but suggested that the reason they were considering whether or not to contact Mrs. Fynes might have had to do with decisions about Cpl Langridge's personal effects. Accordingly, the decision was made that Mrs. Fynes needn't be contacted about this because she was not next of kin.¹⁰⁹³ When asked about the potential value Mrs. Fynes might have had as a witness concerning Cpl Langridge's background, WO Tourout replied that Cpl Langridge's medical records were presumed to contain the relevant background information.

601. From MCpl Ritco's notebook, it appears that WO Tourout made the decision not to interview Ms. A. The notebook for May 2008 records an intention to review medical records, speak with the LDSH RSM (CWO Ross) and Ms. A.¹⁰⁹⁴ MCpl Ritco briefed WO Tourout about the work he intended. The entry continues:

WO T[ourout] feels there is really no reason to speak [with] common-law as mother states he had problems [and] the medical records states attempts to suicide (*sic*), however I should review the medical records first and then come up [with] a final decision.¹⁰⁹⁵

602. On May 27, 2008, a follow-up entry notes MCpl Ritco briefed WO Tourout. Following a notation concerning the need speak to MWO Wason about Cpl Langridge's BlackBerry, MCpl Ritco's entry, then reads: "no reason to speak [with] girlfriend/[common-law]."¹⁰⁹⁶

603. WO Tourout testified the decision not to interview Ms. A was made because the investigative team had the medical records, which "were documentation relating to Corporal Langridge's health, so that was sufficient."¹⁰⁹⁷ MCpl Ritco testified it was "irrelevant to interview her because it was a suicide."¹⁰⁹⁸ MWO Watson testified he did not recall such a discussion and in any event did not see the relevance of interviewing her.¹⁰⁹⁹

604. Given the evident potential importance of both Mrs. Fynes and Ms. A to understanding Cpl Langridge's situation, the decisions not to contact his mother or interview the person the military recognized as his common law spouse are open to question. As discussed elsewhere in this report, these decisions ran contrary to the expert evidence heard by this Commission with respect to interview practice in sudden death investigations.¹¹⁰⁰ Their evidence would also clearly have been relevant to any investigation of negligence. The fact the decisions were made at the supervisory level indicates the issues in the conduct of the investigation were not confined to the investigators on the ground and may have been reflected or even amplified through the guidance offered at the supervisory level.

Supervisory input in the investigative record

605. Supervisors also appear to have had a hands-on role in producing many of the GO file entries.

606. From a review of SAMPIS records for this investigation,¹¹⁰¹ it appears WO Tourout modified nearly every text box entry within the 2008 GO file at some point in the course of the investigation. Nothing in the evidence would suggest his changes went beyond correcting basic grammar and typographical errors. WO Tourout testified the practice at CFNIS WR at the time was to modify a copy of a file's Concluding Remarks for grammar and brevity, in order to (among other things) avoid over-briefing the chain of command.¹¹⁰² It is unclear, however, that this policy extended to the entire GO file. The Commission's concern is not based on any belief that the changes were substantive or had a nefarious purpose. Rather, notwithstanding the benign nature of such corrections, unattributed changes to the records of an investigation file should be avoided because they may conflict with police disclosure requirements. That conflict could potentially jeopardize an ensuing prosecution even when any changes were made in good faith. Perhaps because of the default set-up of SAMPIS, WO Tourout did not create secondary versions in order to preserve the originals; did not change the authorship to reflect he had edited them; nor otherwise indicate what he had edited.¹¹⁰³ As SAMPIS does not retain records of changes,¹¹⁰⁴ it is difficult to determine who is ultimately responsible for what

aspects of the final products in the GO file or the nature of the changes made by WO Tourout.

MPIR documents

607. The MPIR is used to convey the results of an investigation. The investigation “should continue until a clear, comprehensive, and accurate report of all findings can be presented to the appropriate authorities.”¹¹⁰⁵ When an MPIR is released to the CF Chain of Command following the conclusion of an investigation, four documents are provided to the distribution list for that investigation: the Initial Complaint; Case Summary; Concluding Remarks; and a cover letter.¹¹⁰⁶ The distribution list for the documents related to the 2008 investigation included the CO LDSH, CO CFNIS, and CLS.¹¹⁰⁷ CFNIS WR Detachment practice (and evidently the practice of other detachments)¹¹⁰⁸ was for two versions of the investigator’s Case Summary and Concluding Remarks to be created.¹¹⁰⁹ WO Tourout, MWO Watson and Maj Frei testified the second version of these documents is edited by supervisors for grammar, syntax, brevity, and clarity.¹¹¹⁰

608. The original version of the Case Summary, drafted by MCpl Ritco on May 30, 2008, generally details the course of the investigation. It begins by describing the processing of the scene and Cpl Langridge’s vehicle. It continues with the interviews and investigative steps taken with respect to the investigation of the sudden death and of the suicide watch issue.¹¹¹¹ The second version, edited at various times by WO Tourout and MWO Watson, though still bearing MCpl Ritco’s name as the author, is approximately half the length of the original. It omits nearly all details related to the investigation of the suicide watch issue. The effect of these changes is to remove any indication the CFNIS may have been investigating issues relevant to possible negligence by members of the LDSH in relation to Cpl Langridge’s death.

609. With respect to the interview of Capt Lubiniecki, the original Case Summary notes:

On 17 Mar 08, Capt LUBINIECKI (LdSH Adj) was interviewed by MCpl RITCO, were it was learned that Cpl LANGRIDGE had a lot of medical/mental problems, in which he had been attending treatment centers but did not complete any programs. Capt LUBINIECKI stated that Cpl LANGRIDGE had just been discharged from a hospital in

the past couple of days, and had requested to attend a treatment center in On, however due to Cpl LANGRIDGE's track record of not completing any treatment programs, missing AA meeting, and medical appointments, it was decided that Cpl LANGRIDGE needed "conditions" implemented to provide structure for Cpl LANGRIDGE, These conditions also showed that Cpl LANGRIDGE was committed to attending a treatment center in On. Capt LUBINIECKI also provided information that Cpl LANGRIDGE had attempted suicide in past dating as far back as Jun 07. Capt LUBINIECKI in closing made it very clear that Cpl LANGRIDGE had been placed on these conditions for structure only not any form of being on defaulters or on a suicide watch (*sic*).¹¹¹²

610. The Case Summary was edited by both WO Tourout¹¹¹³ and MWO Watson¹¹¹⁴.

The edited version, provided to the LDSH Chain of Command, states:

On 17 Mar 08, Capt LUBINIECKI was interviewed by MCpl RITCO where it was learned that Cpl LANGRIDGE had numerous medical/mental problems and had been attending different treatment centers, however had not completed any programs. Capt LUBINIECKI stated that Cpl LANGRIDGE had been discharged from a hospital in the past couple of days and had requested attendance at a treatment center in ON.¹¹¹⁵

611. Comparing these two versions, the latter omits Capt Lubiniecki's statements that:

- Cpl Langridge's request to attend an addictions treatment facility was not accepted;
- Cpl Langridge failed to attend AA meetings;
- Cpl Langridge was living under "conditions" at the Regiment in an effort to prove he was committed to accepting treatment;
- Cpl Langridge had attempted suicide in the past; and
- Cpl Langridge was not under a suicide watch at the time of his death.

612. These modifications significantly change the focus of the document. Almost all of the omitted issues relate directly to issues connected with possible negligence on the part of LDSH members.¹¹¹⁶

613. This pattern continues throughout the remainder of the document. MCpl Ritco recorded details in the Case Summary about the interviews of MCpl Fitzpatrick, MCpl Bowden, CWO Ross, and Capt Hannah.¹¹¹⁷ These four interviews dealt mainly with the suicide watch issue.¹¹¹⁸ They are omitted entirely from the edited Case Summary.¹¹¹⁹ The references in the Case Summary written by MCpl Ritco illustrating the LDSH chain of

command's knowledge of Cpl Langridge's past suicide attempts and active suicidality have also been omitted from the versions edited by his supervisors. All but one of the several references to the suicide watch in MCpl Ritco's document have been removed. The only statement remaining is attributed to Sgt Hiscock and reads: "Sgt HISCOCK stated that Cpl LANGRIDGE was not on defaulters nor was he on a suicide watch."¹¹²⁰ As detailed elsewhere in this report, this statement does not fully reflect what Sgt Hiscock had reported to investigators.¹¹²¹

614. WO Tourout testified the changes made to the Case Summary concerned grammar and sentence structure and that it had been shortened for brevity, including removing references to statements made about the suicide watch. He stated:

It's [...] to provide the CO [LDSH] with just enough information, a corrected version to make a decision [...] in the event that the CO was going to see or preside over a trial of some sort. [...] [I]f there was any indication that we're trying to change something or hide something we would have taken it out of the Case Summary as well and we did not.¹¹²²

615. He did, however add he did not expect any trial to come out of this case. WO Tourout was asked if the information contained in the edited Case Summary could possibly have suggested to anyone in the chain of command that there were issues that might warrant further examination. While he stated members of the CF chain of command could, if they needed to, order the whole file in order to learn more about the investigation and the issues covered, he conceded that on its face this edited Case Summary would not suggest there was any reason to review the entire file in detail.¹¹²³

616. MWO Watson testified the records indicated he had made changes to the Case Summary, but he did not recall specifically what he had changed.¹¹²⁴ Referred to the section respecting Capt Lubiniecki's interview, he stated the omitted statements were "[i]nformation that really didn't lead to any level of importance on the part of the reader as far as I'm concerned."¹¹²⁵ When asked if it was important to report this information related to Cpl Langridge's conditions and the suicide watch, both of which were investigated by the CFNIS, he stated: "This is reporting on the suicide. [...] [H]ad there been grounds to pursue an investigation on a suicide watch or substantiation that there

was, in fact, a suicide watch, then I would suggest some of that information would be important to the reader.”¹¹²⁶

617. MWO Watson testified he did not see a need to include the interviews of MCpl Fitzpatrick, MCpl Bowden, CWO Ross, and Capt Hannah. Acknowledging it was clear from early on in the investigation there were no suspicions of foul play, and that the next two to three months were spent investigating the suicide watch, he stated he did not believe the interviews needed to be included in the Case Summary “[b]ecause I think this second summary is factual. It tells what transpired. If there was a reason [...] to substantiate another file being opened with regards to [the] suicide watch [...] then that information, I think, becomes relevant to include [in] a case summary.”¹¹²⁷ Overall, MWO Watson was satisfied the second Case Summary was an accurate description of what was learned in the investigation. He testified it is the case manager’s role to ensure the accuracy of the document.¹¹²⁸

618. To the extent the 2008 investigation could be seen as simply addressed to the issue of whether Cpl Langridge’s death was a suicide or involved foul play, the revised Case Summary does indeed “tell what transpired.” As a description of the investigative activity on the file, that characterization appears to be less apt. For most of its duration the investigative activity was focused on the suicide watch,¹¹²⁹ an issue relevant to possible negligence. Whether or not that investigative activity should have been conducted as part of a separate investigation, MCpl Ritco conducted it as part of the sudden death investigation pursuant to an investigation plan which, whatever its shortcomings, was reviewed and approved by his case manager.¹¹³⁰

619. The changes made to the Case Summary are much wider than simply editing for grammar, clarity and brevity. The effect of the changes, intended or not, is to remove any basis for a possible inference that part of the investigation was focused on assessing the possibility of negligence on the part of the Regiment. Whatever the motivation, these changes meant the Case Summary provided an incomplete impression of what was investigated.

620. The Concluding Remarks drafted by MCpl Ritco were also edited by WO Tourout.¹¹³¹ The content of these changes is explored in some detail in Chapter 4.1.4, Concluding Remarks. In effect, the second version seized upon already questionable speculation in the first version and strengthened it to the point that the Fynes believed the message was that Cpl Langridge was responsible for his own suicide despite the CF's efforts to provide him with structure and support. As was the practice at the time,¹¹³² the second version was the only one provided to the LDSH chain of command for review upon the conclusion of the file.¹¹³³

621. WO Tourout denied any intention to change the content beyond making an effort to reword what MCpl Ritco had said,¹¹³⁴ but whatever the intention, the second version contained certain findings that are perhaps more problematic than those in the first version.¹¹³⁵

622. MWO Watson does not appear to have made any modifications to the Concluding Remarks. His cover letter accompanying the MPIR on distribution, drafted July 1, 2008, reads in part:

Investigation into this incident revealed that Cpl LANGRIDGE had a history of drug addiction and mental disorders that he was receiving treatment for from both military and civilian medical professionals. It was also determined that Cpl LANGRIDGE had attempted to commit suicide several times in the past. The Alberta Medical Examiner's report indicated that Cpl LANGRIDGE died as a result of asphyxiation caused by hanging.¹¹³⁶

623. MWO Watson testified he reviewed only the Initial Complaint, Case Summary, and Concluding Remarks.¹¹³⁷ His covering letter omits some of the items found in WO Tourout's revised Concluding Remarks. The covering letter mentions Cpl Langridge's struggles with addiction and mental health issues, but does not include any inference that one followed the other.¹¹³⁸ There is also no mention of an effort to provide structure and support. MWO Watson testified nothing should be read into these omissions as the cover letter was only a brief snapshot of the file, and his view was the relevant information could be obtained through the Case Summary or Concluding Remarks.¹¹³⁹ Not surprisingly, there is no mention in the cover letter of anything connected with the investigation of the suicide watch issue.

624. It was the responsibility of the CFNIS supervisors to ensure the accuracy of the report and the investigation it represented.¹¹⁴⁰ When the investigation records are in any way inaccurate, this should be raised with investigators. When the efforts of supervisors to edit investigation records *themselves* result in inaccurate or problematic statements, this can only compound the failure.

625. Overall, the changes made to the Case Summary or Concluding Remarks were of doubtful value. The edited version of the Concluding Remarks prepared by WO Tourout did add a specific reference to the ME's finding that Cpl Langridge's death was the result of a suicide by hanging, which was germane and important information. However, the edited version contained stronger conclusions about the efforts made by the Regiment to help Cpl Langridge before his death than the remarks made by MCpl Ritco, and, in this respect, neither version was well supported by the evidence gathered during the investigation itself.¹¹⁴¹

Supervision for the 2008 investigation: overall conclusion

626. The overall supervision of this investigation was problematic. The investigative team was not equipped to conduct a sudden death investigation on its own and no steps were taken to compensate for its lack of experience. The interventions at the supervisory level with respect to witness interviews are open to question given the nature of the investigation that should have been conducted. The supervisory amendments to the SAMPIS entries are also open to question.

RECORDKEEPING

Recordkeeping policies, standards, and practices

627. It is essential for investigators to maintain complete and accurate records of the investigations they conduct. As Chapter 6 of the MPPTP states, the purpose and objectives of an MP investigation are "to reconstruct events, gather evidence, identify the elements of the alleged offence, and identify those responsible for it."¹¹⁴² The MPPTP notes any investigation must be thorough, complete and accurate, and immediately recorded in a SAMPIS report.¹¹⁴³ It also notes: "MP investigations are conducted as

much as to exonerate individuals as to implicate them. All information gathered, whether inculpatory or exculpatory shall be reported, regardless of the initial, interim or final decisions with respect to culpability or the laying of charges.”¹¹⁴⁴ It goes on to note all information obtained in background investigations is similarly to be included in the report.¹¹⁴⁵ Thus, the MPPTP stresses the necessity of maintaining complete and accurate records that include all relevant information obtained, whether the information supports a conclusion that an offence was committed or not.

628. At the conclusion of an MP investigation, an MPIR is distributed to relevant authorities for review. The MPIR is meant to convey the facts uncovered and the findings made in the course of an investigation. Investigators are responsible for preparing all GO file entries, which includes MPIRs.¹¹⁴⁶ Meanwhile, MP supervisors are responsible for verifying their accuracy and completeness.¹¹⁴⁷

629. The CFNIS investigators in this case employed three main recordkeeping systems: investigator notebooks, interview recordings, and SAMPIS.

630. Investigators’ notebooks are their primary recordkeeping tool. They permit investigators to take notes while conducting investigations. The notes form an important record of events for investigators as they conduct their investigations and potentially as they prepare for trials or later investigations. Notebooks are referred to when investigators type or dictate their investigative activity reports, and may be reviewed by case managers in the course of an investigation.¹¹⁴⁸ Within the CFNIS, it is typical for investigators’ notebooks to be scanned into the investigation file, though it is unclear whether it is the responsibility of the notebook’s author or the lead investigator to scan the notebook into SAMPIS for the benefit of the GO file.¹¹⁴⁹

631. The MPPTP also outlines practices and procedures for conducting and recording witness interviews. In the normal course, interviews are conducted in teams of at least two investigators, with at least one taking notes.¹¹⁵⁰ If no second investigator is available an interview may be conducted alone.¹¹⁵¹ Interviews are generally recorded in an audio or audio and video (‘video’) format,¹¹⁵² and recording capabilities may be determined by the location of the interview. If an interview is conducted at an MP detachment, it should be

recorded,¹¹⁵³ with the preferred format being video.¹¹⁵⁴ Recordings of interviews are to be classified as official notes and handled with the same care and protection as written police notes.¹¹⁵⁵

632. Even though an interview may be audio or video recorded, investigators are still advised to take certain notes during an interview.¹¹⁵⁶ This is because, in the event charges are laid and a case goes to trial, an investigator may have to explain the context and course of events of an interview. The MPPTP provides the examples of explaining any unusual incidents or prolonged periods of silence on an interview recording.¹¹⁵⁷ MP members are advised to make substantive written notes from interview recordings as soon as possible, explaining in the notes how they were made (for example, from an audio or video recording).¹¹⁵⁸

633. The final, and most comprehensive, recordkeeping system employed by CFNIS is SAMPIS. It is a proprietary records management system that stores documents created or acquired in the course of MP investigations. It provides MP members with the ability to create electronic records of their investigative activities, which are stored under the General Occurrence ('GO') file opened after an initial complaint is received.¹¹⁵⁹ It also allows investigators to scan in documents obtained in the course of an investigation (including, for example, investigators' notebooks, personnel files, and medical records).¹¹⁶⁰ SAMPIS is an online system,¹¹⁶¹ making it accessible to MP members wherever stationed. It is thus a very powerful tool for investigators and the MP as an organization. The final MPIR includes certain of the GO file records contained in SAMPIS.

634. All entries created within a GO file in SAMPIS have a date and document type associated with their creations. The date a document is created is automatically recorded and preserved within the system, even if the document type is subsequently changed. A secondary date, called the "Related date" in SAMPIS entries, is not automatically recorded, but is rather entered by the person creating or modifying an entry.¹¹⁶² Based on the Commission's review of the GO file in this instance, the "Related date" generally indicates the date on which the investigative activity occurred.

635. As with investigators' notebooks, it is essential to an effective investigation that the SAMPIS entries created be complete and accurate.¹¹⁶³ Ultimately, the contents of GO files should be capable of supporting any findings or conclusions made by investigators in the course of their investigations. Any factual inaccuracies or omissions may have the impact of undermining this purpose. It is therefore critical for investigators to be attentive to detail in creating their initial SAMPIS entries and in subsequently preparing any summaries of their investigative activities.

636. The hearing revealed that, once created, SAMPIS entries can be, and routinely are, reviewed and edited by investigators and their supervisors.¹¹⁶⁴ This is of particular importance as SAMPIS does not retain a history of changes made to a document. It saves only the latest version.¹¹⁶⁵

Recordkeeping in this case

637. The recordkeeping practices employed by the investigators indicate they were aware of the importance of maintaining a complete record of the investigation. MCpl Ritco and Sgt Bigelow's notebooks generally record the steps they took in the investigation, from the initial tasking on March 15, 2008¹¹⁶⁶ to the file's conclusion.¹¹⁶⁷ Unfortunately, Sgt Bigelow's notebook was not scanned into SAMPIS. While he accepted responsibility at the hearing for not doing so,¹¹⁶⁸ this was a tremendous oversight on the part of the investigators and their supervisors.

638. The notebooks themselves appear to be well-maintained. The contents are chronologically ordered and late entries are noted as being so.¹¹⁶⁹ At certain points MCpl Ritco has made corrections to his notes and has noted what was changed in the book.¹¹⁷⁰ While it is ideal for investigators to take contemporaneous notes, it is not always possible. MCpl Ritco took the appropriate approach of recording the events and noting if the entry was not made contemporaneously. In this way, he ensured anyone reviewing the notebook would be aware of any changes and where late entries were made. As accuracy is integral to investigation reports, MCpl Ritco's approach helped ensure the contents, as well as the conditions under which they were recorded, are accurately reflected in the report.

639. The entries within the notebooks are generally detailed and indicate what the investigators discovered through the investigative steps they took. Read together with the SAMPIS entries that followed them, they allow the reader to gain a fairly comprehensive understanding of the steps taken by the investigators. However, there is a lack of detail with respect to certain investigative steps the investigators elected not to take, mostly when decisions were made by supervisors.

640. The decisions not to contact Mrs. Fynes and Ms. A in particular are not recorded in any detail in MCpl Ritco's notebook, and were never elaborated upon in SAMPIS entries. From MCpl Ritco's notebook, it is only possible to conclude a decision was made by MCpl Ritco's superiors that he did not need to contact Mrs. Fynes.¹¹⁷¹ It may well be MCpl Ritco was never given an explanation of the reasons for the decision. Similarly, the reasons behind the decision not to contact Ms. A are not recorded,¹¹⁷² and again it is possible MCpl Ritco was never told why it was deemed unnecessary. In any case, the result is that it is impossible to determine from the file the reasons for not interviewing these two potentially valuable witnesses. Nor did MCpl Ritco's supervisors create any SAMPIS entries providing rationales for their decisions. These decisions proved to be controversial, and serve to highlight the great importance of maintaining complete records not only of investigative steps that are taken, but the reasons behind the decisions not to take others.

641. Variances in the nature of and venue for the witness interviews raise several issues. Four video-recorded interviews took place in the CFNIS WR Interview Room with two investigators present. Those interviews were with Sgt Hiscock,¹¹⁷³ Cpl Hurlburt,¹¹⁷⁴ MCpl Fitzpatrick,¹¹⁷⁵ and MCpl Bowden.¹¹⁷⁶ However, Capt Lubiniecki was interviewed in the LDSH Briefing Room,¹¹⁷⁷ and interviews with CWO Ross¹¹⁷⁸ and Capt Hannah¹¹⁷⁹ were held in their respective offices. For these latter three interviews, which were held "off-site," there was no video recording. The interview of CWO Ross took place with two investigators present,¹¹⁸⁰ but MCpl Ritco conducted Capt Hannah's interview alone and took no notes.¹¹⁸¹ To complicate matters more, although there was audio recording for the interviews with CWO Ross and Capt Hannah, there was no

recording made of Capt Lubiniecki's interview. The result was that only partial records of the interview exist and significant information may have been lost.

642. No clear explanation exists for these differences in approach. One explanation was offered by Sgt Bigelow regarding the decision to interview CWO Ross in his office: "[...] just to expedite the process, to get something from him," possibly because of difficulty getting him to the interview room.¹¹⁸² Given that these interviews were voluntary, of course, it may be that this was the best option.

643. Comparing the interview transcripts against the written reports, there appear to be several discrepancies and omissions that call into question the investigators' attention to detail in drafting them. The result is that the GO file may not always indicate fully what was learned during the interviews.

644. Sgt Hiscock's interview summary appears to oversimplify some of his statements to the point it does not accurately reflect what he reported to investigators. He had reported he was told Cpl Langridge was under a suicide watch by either the off-going duty officer or MCpl Fitzpatrick, but that he felt it was odd Cpl Langridge would be allowed so much freedom if it was a suicide watch;¹¹⁸³ "I guess it was a suicide watch, but it wasn't really a suicide watch."¹¹⁸⁴ Sgt Hiscock added CWO Ross had pulled him into his office the day before his CFNIS interview and told him Cpl Langridge was not under suicide watch, but rather a set of conditions meant to provide more structure while still preserving his dignity.¹¹⁸⁵ Despite this meeting, Sgt Hiscock explained to MCpl Ritco he still believed Cpl Langridge was under a suicide watch, "but put the little quotation marks around it,"¹¹⁸⁶ as he believed a proper suicide watch would require more robust conditions.¹¹⁸⁷ In his written summary, MCpl Ritco wrote simply: "Sgt HISCOCK was under the impression that Cpl LANGRIDGE was not [...] on suicide watch", noting the meeting with CWO Ross the day prior.¹¹⁸⁸

645. There were similar issues with Cpl Hurlburt's interview report. He told the investigators that, approximately a week prior to Cpl Langridge's death, he had been informed he was going to be a member of a suicide watch team for Cpl Langridge; although the watch was subsequently cancelled. He added he was not told following this

cancellation that Cpl Langridge was under suicide watch. Reviewing Cpl Langridge's conditions, though, Cpl Hurlburt stated he felt they constituted a suicide watch.¹¹⁸⁹ MCpl Ritco's report omits this final point.¹¹⁹⁰ Thus, there is no indication in the report that Cpl Hurlburt felt the conditions amounted to a suicide watch. Additionally, the source of Cpl Hurlburt's information that Cpl Langridge was going to be under suicide watch is not included in the summary. It states simply he had heard "rumours,"¹¹⁹¹ but given the circumstances in this case and the information from other witnesses, the Commission has difficulty in accepting that notion. To call the various statements and directions about a "suicide watch" or a "watch" going up and down the chain of command "rumour" would be to stretch the meaning of that word. In fact, in Cpl Hurlburt's CFNIS interview, he stated MCpl Bowden told him directly there would be a suicide watch.¹¹⁹²

646. MCpl Bowden's interview summary is a single page in length and is lacking in detail. It does not include her statement to investigators that, prior to the suicide watch being cancelled, there was already an individual keeping watch and attending to Cpl Langridge.¹¹⁹³ Furthermore, the summary omits her statement about Cpl Langridge previously being the subject of "watches."¹¹⁹⁴ Given the centrality of the suicide watch issue, even on the narrow understanding of the negligence question adopted by MCpl Ritco,¹¹⁹⁵ both of these statements were relevant and ought to have been reported in the summary.

647. Given the potential importance of the respective issues to the investigation, the interview summaries raise concerns. WO Tourout testified he reviewed the interview summaries, not the tapes,¹¹⁹⁶ and it would not be reasonable to expect him to review the tapes. Incomplete or inaccurate summaries mean that supervisors may not stay apprised of important details. In the event a full negligence investigation was launched, it would have been important for investigators to determine whether the witness accounts matched the documentary record.

648. Capt Hannah's interview report helps illustrate why investigators should strive to conduct interviews in teams and both take notes and record them. There was an apparent misunderstanding in the report and a subsequent document that may have been avoided

with more attention to detail. The report noted Capt Hannah stated Cpl Langridge had medical records indicating suicide attempts as far back as 2003.¹¹⁹⁷ In fact, Capt Hannah had stated “[Cpl Langridge’s] issues date back as far as 2003” in reference to his mental health diagnoses and drug dependencies.¹¹⁹⁸ In specific reference to suicide attempts prior to June 2007, Capt Hannah had stated: “Are there others where he felt like doing something, or made gestures that aren't documented? That's possible, but I'd be speculating.”¹¹⁹⁹ The mistaken reference to a 2003 suicide attempt then appears in MCpl Ritco’s summary of Cpl Langridge’s medical documents, erroneously creating the impression Cpl Langridge’s suicide attempts dated back far earlier than they did in reality.¹²⁰⁰

649. Beyond the issues with the interview summaries are a number of incorrectly recorded dates throughout the investigation file. The Case Summary provides a good example, noting: Cpl Rohmer was interviewed April 8, 2008; Sgt Hiscock was interviewed April 18, 2008; MCpl Fitzpatrick was interviewed March 22, 2008; and MCpl Ritco’s requests for Cpl Langridge’s medical documents were granted March 23, 2008.¹²⁰¹ In fact: Cpl Rohmer was interviewed March 18, 2008;¹²⁰² Sgt Hiscock was interviewed March 18, 2008;¹²⁰³ MCpl Fitzpatrick was interviewed April 22, 2008;¹²⁰⁴ and MCpl Ritco’s requests for Cpl Langridge’s medical documents were granted April 23, 2008.¹²⁰⁵ These errors create an incorrect timeline of the conduct of the investigation. The erroneous chronology obscures the fact the investigation had lengthy gaps. In reality, no interviews were conducted between March 19 and April 22, 2008.¹²⁰⁶ Investigators should be cautious to ensure their file entries are factually accurate in case they are required to rely on those entries at a later date, such as in preparation for a trial.

650. Overall, the investigators maintained thorough notebooks and ensured they made SAMPIS entries with respect to their investigative activities. However, an apparent lack of attention to detail meant certain important pieces of evidence were not included in those entries. Going forward, investigators should ensure they pay close attention to both the content of their work as well as the technical aspects of it, including dates and times. If they need to rely on their records in the future, it is essential that the records be accurate. This is also essential for proper supervision and oversight of investigations.

FILE STATUS REPORTS

651. CFNIS supervisors were responsible for providing reports to CFNIS HQ under a new reporting system developed during the period Maj Frei served as DCO CFNIS. Maj Frei and LCol Garrick, then-CO CFNIS, introduced a new reporting system between the detachments and CFNIS HQ called File Status Reports. The reports were prepared every two weeks by the various detachments and then provided to HQ so “the leadership element of the [CFNIS] would have situational awareness on all of the investigations going on.”¹²⁰⁷ Case managers would go through their active files with MWO Watson and help prepare the documents. The reports employ a prioritization formula intended to “tell you where to devote your resources to, according to the priority assigned to each investigation.”¹²⁰⁸

652. At the time of the 2008 Investigation, MWO Watson, as Senior MP Advisor, prepared the reports for CFNIS WR.¹²⁰⁹ The first Status Report mentioning Cpl Langridge’s death was sent some time before April 1, 2008.¹²¹⁰ It states the investigation is “in the initial stages.”¹²¹¹ The second Report, dated April 1, 2008, adds to this, stating the investigation is “ongoing and all information acquired will be shared with the Morinville RCMP Department.”¹²¹² The third Report, dated April 8, 2008, simply indicates the investigation is continuing.¹²¹³ A fourth Report, dated May 13, 2008, states: “File may be turning in a different direction **due to information obtained indicating the deceased was on suicide watch when he committed suicide.**”¹²¹⁴ It also states investigators were waiting to obtain Cpl Langridge’s medical records.¹²¹⁵ Reports dated June 3 and 10, 2008 note all documentation has been reviewed, the investigation has been completed and the final report is being written.¹²¹⁶

653. There are numerous issues with these File Status Reports.

654. The April 1, 2008 Report, indicating all information would be shared with the Morinville RCMP department, is apparently in error. MCpl Ritco was unaware of this issue.¹²¹⁷ WO Tourout suggested it could have been a “typo”, related to another investigation ongoing at the time.¹²¹⁸ The statement continues to appear in all subsequent File Status Reports.¹²¹⁹

655. MWO Watson explained the CFNIS does not have the authority to compile a Report of Death, which is required for all fatalities in Alberta,¹²²⁰ implying RCMP assistance would be required in order to complete the Report of Death. According to MWO Watson, what presumably happened is that the ME accepted the CFNIS report as a Report of Death, making follow-up with the RCMP unnecessary.¹²²¹ It may be that the Morinville RCMP detachment was never contacted about the matter – the investigation file notes a conversation on March 19, 2008 between MCpl Ritco and the RCMP, a member of which expressed they were “upset not [to] be called [...] have MWO call.”¹²²² It does not appear any information was shared with the RCMP with respect to the death before then, and it is not clear from the file when (or if) MWO Watson notified the RCMP of the investigation.¹²²³ It may be that the above reference was inserted based on an assumption that in light of the issue of authority to compile a Report of Death, there would be file sharing, but the report seems factually incorrect.

656. The May 13, 2008, File Status Report indicating the file may be turning in a “different direction”¹²²⁴ raises its own set of issues. It appears approximately two months after the investigation began. However, the investigators were initially made aware Cpl Langridge may have been under suicide watch at the time of his death when they first attended the scene¹²²⁵ or the next day.¹²²⁶

657. MCpl Ritco did not know what this notation was intended to mean, as he had heard rumours of the suicide watch from the beginning of his investigation. He stated he was unsure as to what was meant by the statement the file may be turning in a different direction.¹²²⁷

658. WO Tourout explained it was meant to indicate the investigators were querying whether Cpl Langridge was under a suicide watch in order to determine whether a second investigation into negligence needed to be opened. However, nothing was substantiated and so the file did not end up turning in another direction.¹²²⁸ MWO Watson, meanwhile, stated the change in direction would have been the investigators examining whether Cpl Langridge was under a suicide watch.¹²²⁹

659. Maj Frei, then the DCO CFNIS, testified that this Report would suggest to him “an alert investigator had been twigged onto perhaps another avenue of the investigation that needed to be looked at.”¹²³⁰ The update certainly suggested something had changed between April 8 and May 13, 2008 that led investigators to believe Cpl Langridge may have been under suicide watch and the suicide watch was a key topic in most if not all the interviews conducted.¹²³¹ The new development may have been the CFNIS interview with MCpl Fitzpatrick on April 22, 2008, during which he told the investigators about the abortive attempt to assemble a suicide watch for Cpl Langridge in March 2008.¹²³²

660. Overall, the File Status Reports in this case do not serve their intended function. The entries are not always accurate and would not provide CFNIS HQ with meaningful situational awareness. It is difficult to see how these Status Reports could have been used to provide any meaningful oversight for the investigation. The one potentially important notation – indicating a possible new direction “due to information obtained indicating the deceased was on suicide watch when he committed suicide”¹²³³ – came too late in the process, on May 13, 2008, well after the investigation of the suicide watch was underway (and indeed was much closer to the conclusion of the investigation on June 2, 2008, than to the beginning). Moreover, there was no follow-up in the form of meaningful reporting to HQ of the conclusions drawn with respect to this aspect of the investigation.

4.1.6 Search Warrants

661. The investigators entered into, and seized items from, Cpl Langridge’s storage locker¹²³⁴ and Jeep¹²³⁵ without first obtaining search warrants.¹²³⁶ The decision to conduct these warrantless searches raises the issue of whether there was a proper basis to do so, as well as the prior and perhaps more troubling question of the investigators’ knowledge and understanding of their search and seizure powers.

THE SEARCHES CONDUCTED

662. On March 15, 2008, after processing the barracks room where Cpl Langridge's body was found, MCpl Ritco and Sgt Bigelow searched and seized items from Cpl Langridge's locker in the defaulters' room.¹²³⁷ They did not have a key, and so they "had to break into the locker [...] [W]e had to cut the lock off."¹²³⁸ On March 16, 2008, they searched Cpl Langridge's Jeep and seized certain items.¹²³⁹ They had found the keys to the Jeep while processing Cpl Langridge's barracks room.¹²⁴⁰ In both cases, the searches and seizures were conducted without obtaining search warrants.¹²⁴¹

663. Nothing in the investigation file indicates either investigator or their case manager considered the possibility it might be necessary to obtain a search warrant prior to conducting either search. There is no evidence the issue was discussed within the investigative team at the time of the searches. There is also no evidence the issue was brought to members of the CFNIS chain of command or any legal advisor. Similarly, there is no evidence the ME Investigator was consulted on these matters.

RATIONALES PROVIDED FOR THE SEARCHES

664. Both CFNIS investigators in this case testified they did not believe search warrants were required. MCpl Ritco, the lead investigator, stated he believed he was carrying out the investigation on Cpl Langridge's behalf. As a result, he did not think he required any warrant to search the Jeep to acquire evidence related to the death.¹²⁴² Sgt Bigelow (who assisted with the processing of the scene) also believed there was no requirement to obtain a search warrant, and testified "The Coroners Act [actually the *Fatality Inquiries Act*¹²⁴³ in Alberta] allows us to have access to the scene itself, as well as any other places that the person would have been privy to, be it his locker at the LdSH and/or his vehicle."¹²⁴⁴

665. WO Tourout (the case manager) offered a different explanation. When asked about the possible need for a warrant, he testified that because MCpl Ritco had obtained keys to Cpl Langridge's Jeep, no warrant was required. He added, as the locker was "within a DND location," and as the items were seized to "protect" them, no warrant was

required.¹²⁴⁵ When asked if he wanted to reconsider his answers, he explained he believed the Regiment had provided the key to the vehicle and had thus authorized the access. In his testimony WO Tourout added, “as a policeman, if we have a key we don’t need a warrant.”¹²⁴⁶

666. In their written Closing Submissions, the subjects of the complaint argue MCpl Ritco “had authority to search the barracks room, the defaulters room and the jeep” without a warrant pursuant to his powers of crime scene search as well as the powers granted to him by the *Fatality Inquiries Act*.¹²⁴⁷ During oral argument, counsel for the subjects clarified it was the subjects’ position those searches were conducted pursuant to the *Fatality Inquiries Act*.¹²⁴⁸ However, they stated it would not be appropriate for them to take a position as to whether the items were seized pursuant to the Alberta Medical Examiner’s direction, noting the Commission would have to refer back to the subjects’ testimony to determine this point.¹²⁴⁹

INCOMPATIBILITIES BETWEEN THE RATIONALES AND THE FACTS

667. The explanations provided by the investigative team are incompatible with one another and do not appear to be supported by the facts. MCpl Ritco’s stated belief he was conducting the investigation on Cpl Langridge’s behalf does not appear to have a basis. Criminal investigations are conducted by police officers in order to enforce the law, not on behalf of victims, decedents or the government.¹²⁵⁰

668. WO Tourout’s explanation that the Regiment provided the investigators with access to the Jeep is not supported by the facts. In fact, the evidence discloses MCpl Ritco and Sgt Bigelow had simply found the key among Cpl Langridge’s personal effects, retained it and then used it to search the vehicle.¹²⁵¹ Nothing in the investigation file demonstrates the Unit was involved in any way in the search of the vehicle. As for WO Tourout’s view a warrant was not required because the locker was within the DND location, the *National Defence Act* permits COs to issue warrants for the search of CF living quarters, lockers and storage spaces occupied by members subject to the Code of Service Discipline when they are satisfied there are reasonable grounds to believe property therein may provide evidence of an offence under the Act. In such

circumstances, CO warrants may permit entry into, and the seizure of property from, these locations.¹²⁵² No submissions were made by either the complainants or the subjects of this complaint with respect to CO warrants.

669. The testimony of MWO Watson (A/OC CFNIS WR) and Maj Frei (DCO CFNIS),¹²⁵³ is relevant to Sgt Bigelow's stated belief the investigators were authorized under provincial ME legislation to search the locker and Jeep. Both testified the MP are not recognized under the Alberta *Police Act*. MWO Watson stated, as a result, the ME "does not have the authority to direct the military police."¹²⁵⁴ Maj Frei added the MP are not recognized under the provincial Coroners Acts (in Alberta, the *Fatality Inquiries Act*¹²⁵⁵). He stated, the fact the MP are not recognized under these Acts means their relationship with the ME is "less formalized" than it would ideally be.¹²⁵⁶

670. There is, in any event, no indication in the investigation file the investigators searched these locations under such authority. There is no record of any discussion among the investigative team or between the investigators and the ME Investigator indicating this issue was considered. It does not appear Sgt Bigelow's belief was shared by the other members of the investigative team or the ME Investigator at the time these searches were conducted.

THE LAW OF SEARCH WARRANTS

671. Sgt Bigelow's contention about powers of the MP under the *Fatalities Inquiries Act*, as well as that argument's variant in the subjects' final submissions, are essentially legal arguments about the powers of police to search and seize.

672. When conducting searches and seizures, police officers are generally required to obtain a search warrant.¹²⁵⁷ Certain exceptions to this rule exist under common law and statute to allow police officers to search and seize property without a warrant. At common law, police maintain general powers to conduct warrantless searches and seizures on consent.¹²⁵⁸ They also have a power of search without warrant incidental to an arrest¹²⁵⁹ or detention.¹²⁶⁰ Under the *Criminal Code*, meanwhile, there is an exception to the general warrant requirement where the preconditions to obtain a search warrant are

present, but it is impracticable to obtain one due to exigent circumstances.¹²⁶¹ Exigent circumstances include situations where there is an imminent threat of bodily harm to an individual or the loss or destruction of evidence.¹²⁶²

673. The Supreme Court of Canada has recognized there is a reasonable expectation of privacy with respect to motor vehicles and warrantless searches of such vehicles may be conducted only where exigent circumstances require.¹²⁶³

674. The *Fatality Inquiries Act* allows ME Investigators to conduct warrantless searches of, and make warrantless seizures from, any place a body, which is the subject of an investigation, is located, as long as the items seized “may be directly related to the death.”¹²⁶⁴ ME Investigators include (aside from those appointed to the position under the Act):¹²⁶⁵ “Every member of the Royal Canadian Mounted Police or a police service or peace officer responsible for the policing of any part of Alberta pursuant to an arrangement or agreement under section 5(1)(b) of the *Police Act*.”¹²⁶⁶ In order to conduct any such warrantless search or seizure, a ME Investigator must be acting under the ME’s authorization.¹²⁶⁷

APPLICATION TO THE FACTS

675. There may perhaps be arguments capable of justifying the searches performed in this case. However, none were presented in either the testimony of the subjects of the complaint or the submissions of their counsel. The ones that were advanced do not stand up to scrutiny.

676. The subjects’ submissions that the searches and seizures were conducted pursuant to the investigators’ powers under the *Fatality Inquiries Act* appear to stand in opposition to the position put forth by MWO Watson and Maj Frei’s testimony the MP are not recognized under the Alberta *Police Act*, which would appear to preclude them from being authorized as ME Investigators. Maj Frei’s evidence in particular confirms there are doubts even within the CFNIS about this being relied upon as an authorization for its members. Furthermore, the Commission could find no evidence of an arrangement or agreement between the Province of Alberta and the MP to suggest they are a recognized

police force under the *Police Act* or otherwise capable of being authorized as ME Investigators.

677. There is no evidence to suggest the investigators were authorized by the ME to conduct warrantless searches or seizures. While MCpl Ritco testified he provided a list of Cpl Langridge's medications to the ME Investigator at his request, and certain medications were recovered from the Jeep,¹²⁶⁸ there is no indication the investigators were authorized or directed to search the Jeep by the ME in the first place. There is no record in the investigation file and the Commission heard no evidence the ME or ME Investigator authorized the search of the locker. There is no indication the ME Investigator was even made aware of the searches prior to or following their execution.

678. The searches were not conducted on consent or as incident to an arrest or detention. There were no exigent circumstances requiring urgent action by MP members to respond to a potential threat or loss of evidence. The searches also do not appear to have been conducted in accordance with what the subjects' counsel referred to as the "powers of crime scene search."¹²⁶⁹ The locker was in a different building from the location where Cpl Langridge's body was found and his Jeep was parked in a lot outdoors. There does not appear to have been any suspicion either of these two locations was related in any way to the death or was otherwise part of the "crime scene." Even if the subjects were correct in alluding to a power of warrantless search of a "crime scene", it is difficult to see how either of these locations could qualify.

CONCLUSION

679. Reviewing the available documents and testimony, it appears the searches of Cpl Langridge's locker and Jeep were not conducted with proper legal authorization. They were not authorized by or conducted on behalf of the ME or under the *Fatality Inquiries Act* and were not otherwise justified by the common law or the *Criminal Code*. No tenable argument on the facts or the law was presented to justify the warrantless searches.

680. The differing explanations provided about the authority for the searches, along with the absence of any indication from the file or testimony that the issue was

considered prior to conducting the searches, does not reflect well on the investigators' knowledge about their legal authority in connection with searches and seizures. This may not be surprising in light of the broader failure to think through the reasons for conducting the searches in the first place, as noted elsewhere in this report.¹²⁷⁰ At the very least, the apparent gap in understanding the principles of when and why warrants are needed may reflect a deficit in understanding of basic police procedures.

681. Understanding the basic legal requirements to conduct searches and seizures is a critical aspect of CFNIS members' role as investigators. The rules are integral to ensuring evidence is collected in a manner that will pass scrutiny and allow for admissibility in court proceedings when necessary. The investigators and their case managers should, at a minimum, have considered whether consultation with the CFNIS chain of command or a legal advisor was called for. The Commission is troubled by the fact these misunderstandings – including the alarming belief the mere possession of a key justifies using it to gain entry for purposes of a warrantless search – persisted up to the subjects' testimony at the hearing.

4.1.7 Return of Exhibits¹²⁷¹

682. The complainants have alleged CFNIS members failed to dispose of Cpl Langridge's property, seized as exhibits during the investigation of his death, when concluding the investigation. They further allege CFNIS members failed to have the property returned to the complainants in a timely manner.¹²⁷²

683. The evidence discloses CFNIS members did fail to dispose of the property seized as exhibits at the conclusion of the investigation. Adequate processes were not put in place at the Detachment to ensure exhibits were returned in a timely manner. However, when they were notified of this failure, the CFNIS members took reasonable steps to have the property returned to the complainants. Subsequent delays appear to have occurred in returning the property from the Regiment to the complainants, but CFNIS members are not responsible for these delays.

THE PROPERTY SEIZED

684. While processing the scene of Cpl Langridge's death, CFNIS investigators seized 12 exhibits, which included between one and six items of property each. Among the seized items were the suicide note left by Cpl Langridge,¹²⁷³ his personal identification and cell phone, pamphlets and literature relating to drug and alcohol abuse, medical forms, an adult video, and personal correspondence, including get well cards.¹²⁷⁴ Further exhibits were seized while processing Cpl Langridge's Jeep the next day, including prescription drug containers and medical documentation.¹²⁷⁵ Once the property was seized, it was temporarily stored in MCpl Ritco's storage locker before being transferred to the CFNIS evidence room. It does not appear investigators examined the exhibits after seizing them.¹²⁷⁶ At the conclusion of the investigation all property seized – aside from the personal identification and adult video, which had earlier been returned to the LDSH property custodian – remained in the CFNIS evidence room.¹²⁷⁷

WHAT WAS THE MP POLICY FOR THE STORAGE AND DISPOSAL OF EXHIBITS?

685. The MPPTP includes an annex dealing with the collection, handling, disposal and return of evidence in MP investigations.¹²⁷⁸ The Senior MP Advisor is responsible for supervising the storage of seized evidence. He or she is directed to appoint primary and alternate evidence custodians and to ensure all evidence is inspected twice per year. An evidence inspector at the rank of a senior NCM or higher, and not the primary or alternate evidence custodian, must be appointed to conduct these inspections. The evidence inspector is required to complete full reviews of all evidence holdings and submit a report to the Senior MP Advisor for each of the reviews. These reviews include ensuring all current evidence is being handled in accordance with national MP policy and local forensic laboratory policy.¹²⁷⁹

686. The Senior MP Advisor is also responsible for the disposal of exhibits. The MPPTP states generally all exhibits shall be disposed of following the expiration of the appeal period from any court case resulting from an investigation.¹²⁸⁰ An exception to

this policy notes: “Physical evidence collected in the course of an investigation and not used as exhibits at a subsequent trial need not be retained with the status of evidence. Such items may be disposed of as appropriate under other regulations or returned to the rightful owner(s).”¹²⁸¹ In the event there are no judicial proceedings resulting from an investigation and an owner cannot be identified, evidence shall be disposed of within one year of the conclusion of the investigation.¹²⁸²

687. When the time comes to dispose of evidence, the Senior MP Advisor is responsible for requesting disposal instructions from the disposal authority. The disposal authority is the individual or body ultimately responsible for determining whether evidence will be returned to its owner after it is released by the MP.¹²⁸³ The disposal authority may be a local legal officer, Crown Attorney, DPM Police or CO of the Unit involved in an investigation, depending on whether charges were laid as a result of an investigation and the court that heard any resulting case.¹²⁸⁴ The Senior MP Advisor requests the disposal authority to direct the method of disposal and declare ownership of the property.¹²⁸⁵ Where the owner of property is known, the normal protocol is to return the property to that person.¹²⁸⁶ The MPPTP does not specify a method of delivery or whether the MP are to deliver the property directly to the rightful owners or by way of the disposal authority or by some other means.

688. The MPPTP, although it is not written as clearly as it could be on this point, appears to indicate it is necessary to seek disposal authority in all cases, even where items are no longer considered necessary for an investigation or will not be used in court proceedings.¹²⁸⁷ The reason for this requirement is not clear. The CFNIS witnesses who testified before this Commission have not provided consistent explanations about the applicable process or its rationale.¹²⁸⁸

WHAT OUGHT TO HAVE BEEN DONE IN THIS CASE?

689. Property was seized at the scene of Cpl Langridge’s death because investigators apparently believed it may have been relevant to their sudden death investigation.¹²⁸⁹ Holding the seized evidence while investigating the sudden death and the suicide watch issue was not unreasonable.¹²⁹⁰

690. The lead investigator completed his Concluding Remarks on the investigation on June 2, 2008.¹²⁹¹ His Case Manager completed the Supervisor Concluding Remarks on June 12, 2008, indicating he concurred with the investigative steps taken.¹²⁹² MWO Watson, the Senior MP Advisor and Acting OC CFNIS WR, approved the investigation report on July 1, 2008.¹²⁹³ He distributed the report on the same day, with a cover letter detailing the conclusions of the investigation.¹²⁹⁴ The Deputy CO CFNIS reviewed the file on July 3, 2008, and concurred with the findings of the investigation.¹²⁹⁵ No charges were brought as a result of the investigation. It does not appear charges were ever contemplated regarding the sudden death¹²⁹⁶ or the suicide watch¹²⁹⁷ aspects of the investigation.

691. In accordance with MP policy, seized property can be disposed of when the investigative team determines it is no longer required for an investigation. It is possible a review of the evidence, while the investigation was ongoing, could have led CFNIS members to conclude certain items of evidence were not relevant to either aspect of the investigation they were conducting. However, investigators had not ruled out foul play, nor had they reached conclusions about the suicide watch issue, until the investigation was concluded.¹²⁹⁸ For this reason, at the latest, the investigative team ought to have determined the seized evidence could be disposed of at the conclusion of the investigation.

692. The MPPTP does not specify what event or document marks the conclusion of an investigation among the investigator's Concluding Remarks, the Case Manager's Supervisor Concluding Remarks, the OC's approval of the report, the Deputy CO's review or some other possible point. While it is possible the Deputy CO's review could result in a file being referred back to a detachment, the Deputy CO did not sign off on this investigation.¹²⁹⁹ The final sign-off was done by the Acting OC for the Detachment.¹³⁰⁰ It occurred when the report was approved, and the investigation was officially marked as concluded, on July 1, 2008.¹³⁰¹ The investigative team should have begun the process of cataloguing the seized evidence to prepare for its disposal on that date. Given the circumstances of this investigation – Cpl Langridge was a member of LDSH and no

charges resulted from the investigation – the appropriate disposal authority under MP policy was the CO LDSH.

WHAT WAS DONE IN THIS CASE?

693. At the conclusion of the investigation, no attempts were made by the investigative team to begin the process of disposing of Cpl Langridge’s property. No request was sent to the disposal authority, and there does not appear to have been any review of the property held.

694. On September 29, 2008, Mr. Fynes sent an email to the JAG Director of Estates office in Ottawa through his AO, Maj Stewart Parkinson. He identified himself as the executor of Cpl Langridge’s estate and requested a copy of the inventory of Cpl Langridge’s property being held at CFB Edmonton.¹³⁰² Suzanne Touchette, who worked at the JAG Director of Estates office, sent a return email on October 23, 2008, copying MCpl Ritco and authorizing the release of Cpl Langridge’s property. The email noted MCpl Ritco had previously informed the Committee of Adjustments (COA) 13 items remained in CFNIS custody as part of its ongoing investigation. She asked MCpl Ritco to confirm the exhibits were no longer required and, if so, to release them.¹³⁰³

695. MCpl Ritco responded the next day by seeking guidance from Sgt S.B. Miller of CFNIS WR.¹³⁰⁴ He testified he was told “senior staff” would handle the release of the items.¹³⁰⁵ A letter to the disposal authority, the CO LDSH, was drafted and signed by MWO Watson on October 31, 2008.¹³⁰⁶ It is not clear who drafted the letter. MWO Watson testified his normal practice was to draft such letters himself and have the lead investigator draft the list of evidence, though he did not have a specific recollection of drafting this letter.¹³⁰⁷ MCpl Ritco could not specifically recall his role in preparing the letter, but testified he may have compiled the list of items to be returned.¹³⁰⁸ He knew he had at least confirmed the items stored in evidence were no longer required.¹³⁰⁹

696. MWO Watson’s letter noted the investigation into Cpl Langridge’s death was complete, and stated the Regiment CO’s authority was requested to dispose of the exhibits, in accordance with MP policies.¹³¹⁰ It noted, once authority was received, the

items listed would be returned to Cpl Langridge's estate.¹³¹¹ The letter included a list of 13 items seized during the investigation,¹³¹² but did not list the suicide note, of which the Fynes, at that point, were unaware.¹³¹³

697. On November 17, 2008, Mr. Fynes requested all the items, including those seized by the CFNIS, be returned to the estate in one shipment. Capt Eric Angell, then the Adjt LDSH, agreed to this request and appears to have taken charge of returning Cpl Langridge's property to his estate.¹³¹⁴

698. On January 21, 2009, the CO LDSH responded to the CFNIS' request for authority to dispose of the exhibits.¹³¹⁵ He granted authority, and indicated the items could be forwarded to the Regiment for inclusion with the remainder of Cpl Langridge's effects.¹³¹⁶ He noted the effects would be sent to the executor of the estate as soon as possible, and listed Capt Angell as the person to contact for additional inquiries.¹³¹⁷

699. The CFNIS released the seized items on January 26, 2009.¹³¹⁸ The items were released to the LDSH Regiment, to be returned to the estate with the remainder of Cpl Langridge's property. This was the end of the CFNIS's involvement in returning Cpl Langridge's property.

700. It is not clear whether Cpl Langridge's property should have been sent by CFNIS WR directly to the executor of his estate or whether it should have been returned by way of the Regiment. The Regiment had, at the time of the conclusion of the investigation, been storing a number of Cpl Langridge's items, including his Jeep. Given Mr. Fynes' request, it appears returning the property to Cpl Langridge's estate by way of the Regiment was not unreasonable. There is no evidence any delays in returning the property, once it was released to the Regiment, were the result of the CFNIS members' actions.

701. The Commission heard little evidence with respect to evidence inspectors and whether CFNIS WR employed them to conduct the mandated biannual reviews of evidence held. However, CFNIS member testimony suggested returning seized property was not a high priority at the time. In discussing the return of the suicide note to the

Fynes, Maj Dandurand testified the practice, at the time, was that items of evidence were held “until such time as they were disposed of.”¹³¹⁹ He stated such items would come to CFNIS members’ attention as a part of regular evidence reviews, but they were not efficient in promptly returning property.¹³²⁰ He testified, “it was not uncommon for evidence to be held for several years.”¹³²¹ MWO Watson, meanwhile, testified the inspection of the evidence room provided for in the policies would have been “a year-long project in itself,” and indicated he did not carry out any such inspection when he was the Acting OC for the Detachment.¹³²² He also explained no one in the Detachment was specifically tasked with disposing of exhibits, and noted this task was “overlooked” in many investigations.¹³²³ He stated he did not routinely send requests for disposal authority.¹³²⁴ He testified, if it was not for Ms. Touchette’s letter, he would not have drafted his request to the disposal authority in this case.¹³²⁵

CONCLUSION

702. The investigative team in this case did not promptly dispose of the exhibits upon the conclusion of the investigation. This failure appears to have been inadvertent. When MCpl Ritco received Ms. Touchette’s email, he acted quickly to begin the process of disposing of Cpl Langridge’s property. MWO Watson’s letter requesting disposal authority was sent shortly after, and the remaining delay occurred while the CFNIS was waiting for the Regiment’s response. However, had Ms. Touchette not sent her email, there is no indication the CFNIS would have taken any steps to return the exhibits. The evidence in this hearing has revealed there were no adequate processes in place at the Detachment to dispose of evidence.¹³²⁶ The CFNIS members in charge of the Detachment were responsible for this broader failure.

703. While they did not dispose of the exhibits as soon as they should have, the CFNIS members involved in the investigation responded promptly once they were notified of the oversight. Though they are responsible for not disposing of the property immediately at the conclusion of the investigation, any delays encountered once the property was released to the Regiment were not attributable to CFNIS members.

4.1.8 The Quality Assurance Review

704. In early June 2009, following the discovery of the failure to disclose Cpl Langridge's suicide note to the Fynes, the CFNIS initiated a Quality Assurance (QA) review of the investigative file respecting the 2008 investigation.¹³²⁷ The review was conducted by WO Ken Ross,¹³²⁸ then the Acting Detachment MWO for CFNIS WR.¹³²⁹

THE QA REVIEW POLICY

705. A QA review provides an additional potential layer of supervision with respect to an investigation. The relevant CFNIS SOP states the process is intended "to ensure a consistent and high level of investigative service [and] ensure all investigations carried out by [CFNIS] are conducted to a high level of professionalism and in accordance with the law, standard police practices, regulations and SOPs."¹³³⁰

706. The Detachment MWO or WO is responsible for maintaining quality control and conducting QA reviews at the detachment level. The QA review process may be triggered when a complaint is filed, where a file is complex and merits review, or at random.¹³³¹ The review process consists of three phases: a physical review of the file, recommendations for corrective action, and follow-up.¹³³² It is the responsibility of the Detachment MWO or WO to conduct training sessions to address issues identified during the QA review process. An "after action review" is then to be forwarded to the CFNIS HQ CWO on the training and results.¹³³³

707. Following a QA review, the Case Manager is to review the QA report with the applicable investigator(s) and counsel them on any deficiencies, reporting any action taken to the Detachment MWO. The Case Manager is also to ensure all subordinates either attend or review any training sessions resulting from the QA review and is to attend or review the training sessions him or herself as well.¹³³⁴ Investigators are instructed to review the QA report with their supervisor and provide feedback or explanations where appropriate. In addition to attending or reviewing the training sessions, investigators are to action any lessons learned and report on this to the Detachment MWO or WO on an ongoing basis.¹³³⁵

THE QA REVIEW FINDINGS

708. The QA review conducted by WO Ross is dated June 19, 2009.¹³³⁶ The initiating event for the review is stated to be “a complaint brought forward by Cpl LANGRIDGE’s family who were concerned with the lack of optics of the suicide note and the delay in the delivery of the [subject] suicide note.”¹³³⁷

709. The report is divided into four sections entitled respectively: Comments on Investigative Procedures, Comments on Administrative Procedures, Action Taken to Rectify Procedural Problems Discovered, and Recommendations.¹³³⁸

Investigative procedures

710. The opening sentence of the first paragraph of the report informs the reader, “the totality of investigation conducted was found to be technically sound.”¹³³⁹ It also informs the reader, “the observations brought forward were found not to have a direct impact on the investigative integrity of this file.”¹³⁴⁰ Presumably these findings were meant to apply specifically to the four observations cited in the section on investigative procedures.

711. This Commission has found numerous deficiencies in the investigative steps taken in connection with processing the death scene and carrying out the investigation in general.¹³⁴¹ By contrast, the QA only lists two investigative procedures for apparent critical comment. It notes investigators failed to examine and take photographs and videos of the exterior of the building as a follow-up to the discovery that the window to Cpl Langridge’s third floor room was open.¹³⁴² It also notes a failure to authenticate the suicide note or to obtain any handwriting samples for comparison purposes, but then seems to indicate this may not have been necessary due to the scene indicators and the ME Investigator’s initial opinion.¹³⁴³ Another observation in this section notes the investigators did not follow up on a mention by the family of a person they believed responsible for introducing Cpl Langridge to drugs, whom they did not want at the funeral, and indicates this information had now been forwarded to intelligence for follow-up.¹³⁴⁴ The final observation consists of a commendation for appropriate use of resources in conducting background checks.¹³⁴⁵

712. Fixing on the issues of failure to examine the area outside of Cpl Langridge's third storey window and the failure to authenticate the suicide note is particularly striking in light of the fact the investigators also did not employ any forensic measures in examination of the doors, windows, ligatures or hanging apparatus and took inadequate measures to safeguard the scene against contamination.¹³⁴⁶ There is no consideration at all of the investigative procedures taken over the rest of the three month span of the investigation, with the possible exception of the comments in the "Administrative Procedures" section critical of the attempt to investigate negligence. The other two observations seem tangentially related, at best, to investigative procedures for processing the scene or investigating the suicide.

713. Given the limited findings in connection with investigative procedures, it is not surprising the report finds no direct impact on investigative integrity. If what is meant is the validity of the conclusion of suicide by hanging is not brought into question by the deficiencies cited, the observation is correct. However, beyond that, neither limiting the deficiencies to those listed in the report nor the consequent conclusions of investigative integrity or technical soundness seem justifiable.

Administrative procedures and recommendations

714. As might be said about the report as a whole, the section dealing with Administrative Procedures¹³⁴⁷ seems somewhat hastily drafted and is not easy to navigate. It is not always clear whether observations are simply factual notes or whether they are critical comments. Nor is it clear what importance is being attached to any individual observation. Observations of minor deviations from record keeping protocol are interspersed with identification of matters that constitute major deficiencies in the investigative file. Comments about the suicide note are followed by discussions of the disposal of evidence.

715. Some assistance in navigating this section and understanding the intended meaning of its observations may be found in the Recommendations section.¹³⁴⁸ That section seems, as much as anything, to constitute a series of conclusions (followed by a

single recommendation) with respect to some of the observations made in the Administrative Procedures section.

716. In the Recommendations section, the problematic issues with the steps taken in reaching the finding of suicide by hanging are listed as:

- a. clear articulation of the measures which were taken to come to those findings and what they were;
- b. maintenance of a deliberate focus of the investigation in order that only the criminality or lack thereof remains the focus and to ensure that the mandate of the BOI is not assumed by the CFNIS; and
- c. that a cognizant and informed decision is made when to effectively engage the family to advise them of the status of the investigation and to divulge to them, as was in this instance, that a suicide letter existed, when to allow them to view that note and when it is appropriate to release the original note to the family.¹³⁴⁹

No clear articulation of measures taken to come to findings

717. This conclusion seems linked to the critical comments set out in the Administrative Procedures section about the Case Summary and Concluding Remarks in the investigation file. The list cited regarding evidentiary findings omitted from these sections is lengthy and largely accurate.¹³⁵⁰ The evidence before this Commission suggests the omissions may be the result of the investigators themselves never putting together the evidentiary findings in any analytic manner to indicate suicide or to rule out foul play.¹³⁵¹ In any case, this conclusion in the Recommendation section seems justified.

Maintaining a focus only on criminality

718. This conclusion is linked both to a number of the matters discussed in the Administrative Procedures section as well as to the single explicit recommendation in the Recommendations section, namely:

It is recommended that the Case Manager of a suicide file remain focused on the "what" of the investigation and at the very most touch on the "why". Additionally, it is incumbent upon the Case Manager to ensure that the focus remain within the CFNIS mandate rather than assuming, in some instances that of the BOI mandate.¹³⁵²

719. Insofar as they direct investigators to focus on the “what” rather than the “why” in a suicide investigation, both the observation and the recommendation reflect the existing MPPTP at the time of the investigation.¹³⁵³ As such, it was appropriate and defensible to cite this approach in the QA report as the correct investigative framework. However, as set out elsewhere in this report, the evidence before this Commission establishes that framework does not reflect best practices.¹³⁵⁴ Issues related to the “why” are relevant and ought to be pursued in a sudden death investigation in addition to issues related to the “what.”

720. Less defensible in these comments, and in similar comments in the Administrative Procedures section, is the specific suggestion the investigation should deal only with issues of criminality and not with negligence. In its observations about the Investigation Plan in the Administrative Procedures section, the QA report suggests step #13 of the IP dealing with “possible negligent actions ... resulting in possible involvement in death” is not a CFNIS mandate but rather falls within the purview of a Board of Inquiry.¹³⁵⁵ This observation comes after a rather opaque critique of the Investigation Plan for not setting out “the elements of the offence,” which notes this did not impact on the integrity of the investigation because the investigators demonstrated they “approached the sudden death with open minds, not focused solely on suicide as a manner of death.”¹³⁵⁶

721. As discussed at length in this report, negligence is clearly within the mandate of the CFNIS both in terms of the *Criminal Code* offences related to Criminal Negligence and in terms of the service offences of Negligent Performance of a Military Duty and Conduct to the Prejudice of Good Order and Discipline.¹³⁵⁷ The 2008 investigation is deficient in a number of ways relating to how negligence was investigated, but the identification of negligence as being potentially relevant to an investigation of the death of Cpl Langridge is not one of them.¹³⁵⁸

Engaging the family and releasing the suicide note

722. The QA review, in this case, was the result of complaints by the Fynes about how the suicide note was handled. The QA describes this complaint somewhat inelegantly as

dealing with “the lack of optics of the suicide note” as well as with the delay in its delivery to the family.¹³⁵⁹

723. Somewhat buried as point 2(f) of the Administrative Procedures section is the following observation:

detailed in MCpl Ritco's OF2 text box, at para 61, he articulates that at “1700 hrs, 9 Apr 08, Mr. CAUFIELD (ME) returned call, no need to bring items in, as 10 of the 11 tests have been conducted. There appears to be no evidence to support foul play, therefore at this time it will be classified as suicide.” It is at this point consideration by the investigators in consult with the Case Manager, be given to the fact of meeting with the family and providing them with the salient points of the investigation to date and would have presented an opportune time to have the family members review the suicide note to verify the authenticity of the handwriting and possibly give them a copy at that time. If the decision was made not to move forward with any briefings to the family until such time as they received the official report from the ME, the Certificate of Medical Examiner was received 15 May 08, which provided definitive conclusion concerning the manner of death – suicide;¹³⁶⁰

724. The timing issues regarding disclosure of the suicide note are discussed elsewhere in the Commission’s report.¹³⁶¹ While the suggestion the note should have been disclosed to the Fynes at a much earlier time is clearly appropriate, the suggested timing would not have responded to their major complaint of not having had Cpl Langridge’s wishes about his funeral disclosed to them in time for them to comply with them.¹³⁶² The practicalities of the timing being suggested also lead to questions about the utility of the suggestions, namely, the Fynes could have been consulted either at the point the ME provisionally confirmed the death as suicide or at the point of the ME’s final determination. Consulting the Fynes about the authenticity of the suicide note would have made sense in combination with disclosure of the note had it been undertaken before the funeral. By the time the ME Investigator had tentatively or conclusively confirmed Cpl Langridge’s death was suicide, measures to authenticate the note would have had little practical or investigative significance.

725. Section 2 of the Administrative Procedures section continues with two observations in connection with CFNIS dealings with the Fynes, without comment or criticism. It states MCpl Ritco was informed there was no need to contact Mrs. Fynes, and it indicates when he did speak with the Fynes, they did not raise the existence of the suicide note.¹³⁶³ Insofar as this may be read as justifying the failure to disclose the suicide

note or to take steps to contact the Fynes before they contacted the CFNIS, it is not appropriate.¹³⁶⁴

Actions to rectify

726. The section entitled Actions Taken to Rectify Procedural Problems Discovered precedes the Recommendations section, but, practically speaking, it can be seen as a logical extension of the conclusion about the suicide note in the Recommendations.¹³⁶⁵ The remediation measures discussed in the Actions Taken section are entirely confined to the issue of the suicide note. As such, they don't deal with investigative problems discovered by the QA, but rather with the Fynes' substantive complaint.

727. The first of the two paragraphs in this brief section reads:

Resultant of the complaint brought forward by the family of Cpl LANGRIDGE [with respect to] the delay in disclosure of the suicide note; the CFNIS WR Chain of Command has become extremely cognizant of the issue of disclosure of any suicide notes left by the deceased at the scene. Additionally, in depth analysis/discussions have occurred regarding best practices concerning the requirement to engage the families of the deceased members in concert with the respective AOs and have in fact ensured that a more proactive approach is being taken [with respect] to ongoing files being investigated by CFNIS WR.¹³⁶⁶

728. The second paragraph, which can be read either as a Recommendation resulting from the QA review or as a statement about actions the CFNIS has mandated for the future, reads:

In addition to the foregoing, a full debrief of the subj QA shall be incorporated in a Professional Development day for all investigators and Case Manager (TTBD). In the interim more stringent monitoring/case managing concerning these types of issues have/will be implemented. Finally, CFNIS WR is anxiously awaiting the proposed new Victim Services Annex, currently being drafted, which upon receipt will be disseminated by means of a PD session.¹³⁶⁷

729. The evidence before this Commission appears to cast some doubt on these paragraphs either as a description of measures already taken or as a prediction/recommendation of measures yet to take place.

730. It does not appear the report was shared with the investigators or that any professional development day was held as a result of this QA review.¹³⁶⁸ MCpl Ritco

testified he had spoken to WO Ross once, when the report was being finalized.¹³⁶⁹ He testified he had seen the report itself at some point,¹³⁷⁰ but it is not clear when he was provided a copy. Sgt Bigelow, meanwhile, testified he was not provided a copy of the report; and no member of the CFNIS chain of command reviewed the report with him.¹³⁷¹ MWO Watson had also never seen the report prior to these proceedings and was not aware of the recommendations it contained.¹³⁷² Maj Dandurand testified there were no PD days devoted to the report in the Detachment.¹³⁷³

731. As a further exercise of supervision with respect to the 2008 Investigation, the QA report falls short of the mark.

4.1.9 The Consequences of Inexperience

732. The evidence reveals many of the CFNIS members involved in the three investigations conducted in this case had only limited field experience related to the investigation of sudden deaths in a domestic context.¹³⁷⁴ The Commission recognizes some of the members had significant experience in conducting death investigations during deployed operations, particularly with respect to battlefield deaths.¹³⁷⁵ However, the Commission finds there is a significant difference between the conduct of such investigations and the conduct of death investigations in a domestic context. As such, CFNIS members' experience with conducting investigations into battlefield deaths did not constitute adequate preparation for the conduct of sudden death investigations in Canada.

733. The evidence confirms the CFNIS members received appropriate formal training to conduct criminal investigations, including training relevant to the processing of death scenes.¹³⁷⁶ There is no indication the formal training was lacking or inadequate in any way.¹³⁷⁷ However, the Commission finds formal training alone cannot be a substitute for "hands on" field experience. This is why the services of seasoned investigators with significant experience are normally required to provide field assistance and training for other investigators.

734. The lack of experience of members involved in the 2008 Sudden Death investigation was particularly striking. The lead investigator, MCpl Ritco, had never previously conducted a death investigation or attended at a death scene.¹³⁷⁸ His immediate supervisor, WO Tourout, had also never been involved in conducting or supervising a death investigation.¹³⁷⁹ Sgt Bigelow, who attended at the scene with MCpl Ritco, had been involved in four to six death investigations during a secondment with the RCMP, as well as one CFNIS suicide investigation.¹³⁸⁰ He played only a limited role in the 2008 investigation.¹³⁸¹ MWO Watson, the Detachment MWO and Acting OC, who had overall responsibility for overseeing the investigation, had significant experience conducting death investigations in the theatre, but he had limited experience in conducting or supervising death investigations domestically.¹³⁸²

735. Many of the deficiencies observed in the 2008 investigation were a direct result of the lack of experience of the members involved. From the outset, the investigation lacked focus, clear objectives, or a meaningful plan. In the name of keeping an open mind, the members did not form or test hypotheses, and they lacked the flexibility and judgment to respond appropriately to new information or critically assess ambiguity and contradictions in the evidence.¹³⁸³ The apparent overriding concern to avoid arriving at any conclusion until the ME had ruled conclusively, and perhaps not even then,¹³⁸⁴ was largely the result of inexperience. The members also had difficulty adjusting their investigative methods to the evidence uncovered and did not appear to understand how to handle seized items properly, including the suicide note.¹³⁸⁵ The supervisors lacked the necessary experience to provide appropriate guidance and assistance to the investigators and failed to provide this assistance and guidance.

736. While the CFNIS members did have some access to assistance and advice from other police forces, including an RCMP member seconded to the CFNIS,¹³⁸⁶ they did not request assistance.¹³⁸⁷ It is not reasonable to expect inexperienced members to be able to recognize their own shortcomings or needs. Measures must be taken to ensure investigators with significant field experience are involved in leading and supervising investigations.

737. Of particular concern to the Commission, the lack of experience of the members directly involved in the 2008 investigation cannot be treated as an isolated event or circumstance.¹³⁸⁸ The significant lack of experience by those involved in the 2008 investigation may be a reflection of the fact the CFNIS has only been conducting domestic sudden death investigations since 2005,¹³⁸⁹ and in the normal course, incidents of sudden death on Defence Establishment property will not be as frequent as in large urban centers¹³⁹⁰ and will be spread over the entire geography of Canada. It is not surprising the members involved in the 2008 investigation did not have the opportunity to acquire extensive experience.

738. The glaring deficiencies in the conduct of the sudden death investigation identified by this Commission were not recognized at all by the CFNIS or its members. Instead, in the Quality Assurance review subsequently conducted by the CFNIS Detachment, the investigation was found to have been “technically sound.”¹³⁹¹ The CFNIS witnesses, including those in leadership positions, agreed with this conclusion.¹³⁹² They further testified they fully supported the qualifications of the lead investigator to conduct the investigation and stood by the investigation conducted in this case.¹³⁹³

739. The subjects argued in their final submissions that the investigation conducted in this case was thorough and professional.¹³⁹⁴ They submitted all applicable policies and procedures were followed.¹³⁹⁵ They further argued the lead investigator possessed the requisite qualifications to conduct the investigation, as he had prior experience as an MP and CFNIS investigator, and he sought appropriate guidance and assistance from other members where necessary.¹³⁹⁶ The views expressed were consistent with the testimony of the members of the CFNIS and of its chain of command.¹³⁹⁷

740. Based on the testimony of senior leadership, it appears the investigation conducted in this case was not viewed as having fallen below the standards expected for sudden death investigations conducted by the CFNIS. Nor was the lack of experience of the members involved viewed as concerning or exceptional. Neither the very serious deficiencies in the sudden death investigation identified by the Commission nor the lack of experience that led to these deficiencies was recognized as problematic by the CFNIS

witnesses who testified before the Commission, and there is no evidence they have been addressed by the CFNIS. This leads to a possible inference that this investigation may conform to the standards currently expected by the CFNIS for the conduct of sudden death investigations. If this is the case, it is of great concern and highlights the need for the CFNIS to take immediate measures to ensure its members acquire sufficient experience to conduct sudden death investigations.

¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, pp. 3-4.

² Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 5.

³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 203.

⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 203.

⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 138.

⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 147.

⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 188.

⁸ Testimony of MCpl Bruce-Hayes, Transcript of Proceedings, vol. 37, 20 June 2012, p. 6.

⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 188.

¹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 190.

¹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 147.

¹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 148.

¹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 189.

¹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 146.

¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 149.

¹⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 150.

¹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 5-6.

¹⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 19-20.

¹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 121.

²⁰ Testimony of MCpl Bruce-Hayes, Transcript of Proceedings, vol. 37, 20 June 2012, p. 6.

²¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 128.

²² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 122.

²³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 22-23.

²⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 23-24.

²⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 25-26.

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- ²⁶ Exhibit P-147, tab 1, doc. 1422, p. 134.
- ²⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 155.
- ²⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 27-28; Exhibit P-147, tab 1, doc. 1422, p. 134.
- ²⁹ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9.
- ³⁰ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., s. 10(2).
- ³¹ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., s. 19(1).
- ³² Exhibit P-147, tab 1, doc. 1422, p. 134.
- ³³ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 18-19.
- ³⁴ Exhibit P-147, tab 1, doc. 1422, p. 134.
- ³⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 24.
- ³⁶ Final Submissions of the Subjects, pp. 49-50.
- ³⁷ Final Submissions of the Subjects, p. 53.
- ³⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 156.
- ³⁹ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, April 5, 2012, pp. 97-98.
- ⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 501-502.
- ⁴¹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 24.
- ⁴² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 27-28.
- ⁴³ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 27-28.
- ⁴⁴ Exhibit P-147, tab 1, doc. 1422, p. 134; Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 26-27.
- ⁴⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 52-53.
- ⁴⁶ Exhibit P-147, tab 1, doc. 1422, p. 134.
- ⁴⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 42-43.
- ⁴⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 43.
- ⁴⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 88.
- ⁵⁰ See, generally, Testimony of Det. Insp. Olinyk, Insp. Fitzpatrick and S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 163-306.
- ⁵¹ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, p. 175.
- ⁵² Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-181.
- ⁵³ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 181-182.
- ⁵⁴ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 184-185.
- ⁵⁵ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, p. 186-187.
- ⁵⁶ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 192.
- ⁵⁷ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 193-194.

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- ⁵⁸ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 222-223.
- ⁵⁹ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 193-194.
- ⁶⁰ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 195.
- ⁶¹ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, p. 196.
- ⁶² Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 197-198.
- ⁶³ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, p. 199.
- ⁶⁴ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 227-228.
- ⁶⁵ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 207-208.
- ⁶⁶ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 227-228.
- ⁶⁷ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 201-202.
- ⁶⁸ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 198-199.
- ⁶⁹ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 201-202.
- ⁷⁰ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 198-199.
- ⁷¹ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 199-200.
- ⁷² Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 315-317.
- ⁷³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 53.
- ⁷⁴ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., s. 19(1).
- ⁷⁵ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 216-217.
- ⁷⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 51-52.
- ⁷⁷ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 216-217.
- ⁷⁸ *National Defence Act*, RSC 1985, c N-5.
- ⁷⁹ *National Defence Act*, RSC 1985, c N-5, s. 156.
- ⁸⁰ *Criminal Code*, RSC 1985, c C-46.
- ⁸¹ *Criminal Law Amendment Act, 1972*, SC 1972, c 13.
- ⁸² *R. v. Nolan*, [1987] 1 SCR 1212 at 1222-1223.
- ⁸³ *R. v. Nolan*, [1987] 1 SCR 1212.
- ⁸⁴ Final Submissions of the Subjects, p. 51.
- ⁸⁵ Final Submissions of the Subjects, pp. 53-54.
- ⁸⁶ See Final Submissions of the Subjects, pp. 17-18 and 47-52.
- ⁸⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc 1087-B, pp. 129-132.
- ⁸⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 30-32.
- ⁸⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 30-31.
- ⁹⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 30-32.
- ⁹¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 32-33.

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- ⁹² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 43.
- ⁹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 50.
- ⁹⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 51-52.
- ⁹⁵ *Fatality Inquiries Act*, R.S.A 2000, c. F-9, ss.5(3), 5(4), 19(1)
- ⁹⁶ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., s. 21(1).
- ⁹⁷ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., ss. 9(1) and 9(2).
- ⁹⁸ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., ss. 9(1) and 9(2).
- ⁹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 50-51.
- ¹⁰⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 92-93.
- ¹⁰¹ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 179-181; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 101-102.
- ¹⁰² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 24 and 65; *Fatality Inquiries Act*, RSA 2000, c F-9, s. 31.
- ¹⁰³ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 180-182.
- ¹⁰⁴ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 10.
- ¹⁰⁵ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-180, 241-243, and 247-248; Testimony of Det. Insp. William Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 188-193 and 269-271; Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 196-199 and 203-205.
- ¹⁰⁶ Exhibit P-148, tab 3, doc. 1428, p. 4.
- ¹⁰⁷ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 313-315.
- ¹⁰⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 91-92.
- ¹⁰⁹ Exhibit P-6, Collection F, vol. 1, tab 44, doc. 1191, p. 3.
- ¹¹⁰ Exhibit P-148, tab 3, doc. 1428, p. 4.
- ¹¹¹ See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 53-64 and 87-89; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 193-194; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 56-57, 235-236 and 274-275.
- ¹¹² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 42.
- ¹¹³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 63.
- ¹¹⁴ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 23-24.
- ¹¹⁵ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 35-38.
- ¹¹⁶ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 23-24.
- ¹¹⁷ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 26.
- ¹¹⁸ Exhibit P-147, tab 1, doc. 1422, p. 136.
- ¹¹⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1
- ¹²⁰ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 51-52.

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- ¹²¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 221.
- ¹²² Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1
- ¹²³ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1
- ¹²⁴ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 247-248.
- ¹²⁵ Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 249.
- ¹²⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 124.
- ¹²⁷ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 26-27.
- ¹²⁸ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 26.
- ¹²⁹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 25-26.
- ¹³⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 25-26.
- ¹³¹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 25.
- ¹³² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 25.
- ¹³³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 219-220.
- ¹³⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 219-220.
- ¹³⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 219-220; “Livor mortis,” online: <http://en.wikipedia.org/wiki/Lividity>; Part 3 *Investigation of Death*, “The Roles of Police Officers and Coroners,” online: <http://www.in.gov/ctb/files/section301.pdf>, p. 98, cited in Reply Submissions of the Subjects (8 January, 2013), pp. 3 and 20-28.
- ¹³⁶ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 25-26.
- ¹³⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 189.
- ¹³⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 151.
- ¹³⁹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 25-27.
- ¹⁴⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 42-42.
- ¹⁴¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 56-57.
- ¹⁴² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 63.
- ¹⁴³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 60.
- ¹⁴⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 42.
- ¹⁴⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 53-55 and 87-88.
- ¹⁴⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 59-60.
- ¹⁴⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 150-151.
- ¹⁴⁸ Testimony of CWO (Ret’d) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 277-278.
- ¹⁴⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 163.
- ¹⁵⁰ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵¹ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 253-254.
- ¹⁵² Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 254-255.

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- ¹⁵³ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 265-266.
- ¹⁵⁴ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 265-266.
- ¹⁵⁵ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 258-259.
- ¹⁵⁶ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 261-262.
- ¹⁵⁷ Exhibit P-147, tab 1, doc. 1422, p. 135.
- ¹⁵⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 151.
- ¹⁵⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 151.
- ¹⁶⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 101.
- ¹⁶¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 69-70.
- ¹⁶² Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 151.
- ¹⁶³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 104-106.
- ¹⁶⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 631-633.
- ¹⁶⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 70-71.
- ¹⁶⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 183-184.
- ¹⁶⁷ Exhibit P-5, Collection E, vol. 6, tab 13, doc.1246-B, p. 28.
- ¹⁶⁸ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 253-254; Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 265-266; Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 261-262.
- ¹⁶⁹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 40-41.
- ¹⁷⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 41.
- ¹⁷¹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 41-42.
- ¹⁷² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 91-92.
- ¹⁷³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 90-91.
- ¹⁷⁴ See Section 4.1.3, The Investigation Plan.
- ¹⁷⁵ Exhibit P-2, Collection B, vol. 2, tab1, doc 1087-B, pp. 134-135.
- ¹⁷⁶ Final Submissions of the Complainants, pp. 7-8.
- ¹⁷⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 185.
- ¹⁷⁸ Exhibit P-4, Collection D, vol. 7, tab 67, doc. 591, pp. 1-2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 185-186.
- ¹⁷⁹ Exhibit P-2, Collection B, vol. 2, tab1, doc 1087-B, pp. 129-132.
- ¹⁸⁰ Exhibit P-4, Collection D, vol. 1, tab 29, doc 032, pp. 2-3.
- ¹⁸¹ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 198-199 and 213-216.
- ¹⁸² Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 216-221.
- ¹⁸³ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 208-212.
- ¹⁸⁴ *Fatality Inquiries Act*, R.S.A. 2000, c. F-9., ss. 10(1) and 10(2).

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- ¹⁸⁵ *Fatalities Inquiries Act*, R.S.A. 2000, c. F-9., s. 19(1).
- ¹⁸⁶ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 37-40.
- ¹⁸⁷ *Fatalities Inquiries Act*, R.S.A. 2000, c. F-9., s. 22(1).
- ¹⁸⁸ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 37-40.
- ¹⁸⁹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 36-37.
- ¹⁹⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 37-40.
- ¹⁹¹ Exhibit P-147, tab 1, doc. 1422, p. 134.
- ¹⁹² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 26-27.
- ¹⁹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 43.
- ¹⁹⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 52-53.
- ¹⁹⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 59-60.
- ¹⁹⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 60.
- ¹⁹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 60-62.
- ¹⁹⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 39.
- ¹⁹⁹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 46-47.
- ²⁰⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 43.
- ²⁰¹ Exhibit P-147, tab 1, doc. 1422, p. 135.
- ²⁰² Exhibit P-147, tab 1, doc. 1422, pp. 135-136.
- ²⁰³ Exhibit P-147, tab 1, doc. 1422, p. 136.
- ²⁰⁴ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 32-33.
- ²⁰⁵ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 68-69.
- ²⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 124.
- ²⁰⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 43-44.
- ²⁰⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 44-45.
- ²⁰⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 51-52.
- ²¹⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 35.
- ²¹¹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 35-36.
- ²¹² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 35-36.
- ²¹³ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 65-66.
- ²¹⁴ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 28.
- ²¹⁵ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 33.
- ²¹⁶ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 30-31.
- ²¹⁷ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 30-31.
- ²¹⁸ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 33.

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- ²¹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 61-62.
- ²²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 189.
- ²²¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 189.
- ²²² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 81-82.
- ²²³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 60-62.
- ²²⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 79-80.
- ²²⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 53-54.
- ²²⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 53.
- ²²⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 277-278.
- ²²⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 262.
- ²²⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 28.
- ²³⁰ Final Submissions of the Subjects, p. 53.
- ²³¹ Final Submissions of the Subjects, p. 51-52.
- ²³² Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 221-224.
- ²³³ Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 195.
- ²³⁴ Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 211-212.
- ²³⁵ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 227-245
- ²³⁶ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 237-238.
- ²³⁷ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 37-40.
- ²³⁸ Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 251.
- ²³⁹ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, p. 252.
- ²⁴⁰ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 37-39.
- ²⁴¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 235; Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 258.
- ²⁴² Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 39.
- ²⁴³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 54-55.
- ²⁴⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 53-55.
- ²⁴⁵ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 244-245.
- ²⁴⁶ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 245-246.
- ²⁴⁷ Testimony of Det. Insp. Olynyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 246-247.
- ²⁴⁸ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 36-37.
- ²⁴⁹ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 29.
- ²⁵⁰ See Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 22; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 40; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 44; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 188.

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- ²⁵¹ Testimony of MCpl Bruce-Hayes, Transcript of Proceedings, vol. 37, 20 June 2012, pp. 12-13.
- ²⁵² Testimony of MCpl Bruce-Hayes, Transcript of Proceedings, vol. 37, 20 June 2012, pp. 10-11.
- ²⁵³ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 23.
- ²⁵⁴ Testimony of Mr. Lackie, Transcript of Proceedings, vol. 50, 19 September 2012, p. 49.
- ²⁵⁵ Final Submissions of the Subjects, p. 53.
- ²⁵⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 49-50.
- ²⁵⁷ Testimony of MCpl (Ret'd) Hurlburt, Transcript of Proceedings, vol. 45, 11 September 2012, p. 78.
- ²⁵⁸ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 28-29.
- ²⁵⁹ Testimony of MCpl Bruce-Hayes, Transcript of Proceedings, vol. 37, 20 June 2012, p. 10.
- ²⁶⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 51-52.
- ²⁶¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 41.
- ²⁶² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 40-42.
- ²⁶³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 164-165.
- ²⁶⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 90-91.
- ²⁶⁵ Exhibit P-6, Collection F, vol. 1, tab 44, doc. 1191, p. 1; Exhibit P-148, tab 3, doc. 1428, p. 1.
- ²⁶⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 20-21.
- ²⁶⁷ Exhibit P-4, Collection D, vol. 1, tab 29, doc 032, pp. 2-3.
- ²⁶⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, pp. 630-713.
- ²⁶⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 140-142.
- ²⁷⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 91-92.
- ²⁷¹ Exhibit P-4, Collection D, vol. 1, tab 29, doc 032, pp. 2-3.
- ²⁷² Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189.
- ²⁷³ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 2-4 and 8-12.
- ²⁷⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 44-45.
- ²⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 187.
- ²⁷⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 188-190.
- ²⁷⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, p. 180.
- ²⁷⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 46-47.
- ²⁷⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 280-281.
- ²⁸⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 146 and 148.
- ²⁸¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 147 and 157.
- ²⁸² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 149.
- ²⁸³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 43-44.
- ²⁸⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 49.

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- ²⁸⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 49-50.
- ²⁸⁶ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 4-11.
- ²⁸⁷ Exhibit P-147, tab 1, doc. 1422, p. 142.
- ²⁸⁸ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 9-10.
- ²⁸⁹ Exhibit P-147, tab 1, doc. 1422, p. 139.
- ²⁹⁰ Exhibit P-5, Collection E, vol. 6, tab 13, doc.1246-B, p. 12.
- ²⁹¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 50-51.
- ²⁹² Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 301-302.
- ²⁹³ Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 299-301.
- ²⁹⁴ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 298-299.
- ²⁹⁵ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 11.
- ²⁹⁶ **“Then I saw a new heaven and a new earth, for the first heaven and the first earth had passed away,** and there was no longer any sea. I saw the Holy City, the new Jerusalem, coming down out of heaven from God, prepared as a bride beautifully dressed for her husband. And I heard a loud voice from the throne saying, **‘Now the dwelling of God is with men, and he will live with them. They will be his people, and God himself will be with them and be their God. He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away.’**” *Biblica, The Holy Bible (New International Version, Rev. 21)* (Grand Rapids: Zondervan, 1973) [Emphasis indicating passages underlined by Cpl Langridge].
- ²⁹⁷ Exhibit P-148, tab 3, doc. 1428, p. 1.
- ²⁹⁸ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-186 and 236-239.
- ²⁹⁹ Exhibit P-148, tab 3, doc. 1428, p. 1; Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 1.
- ³⁰⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 53-55; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 57; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 13 and 68-69.
- ³⁰¹ See Section 4.1.2, Investigating Negligence.
- ³⁰² Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, p. 204.
- ³⁰³ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 277-278.
- ³⁰⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 34.
- ³⁰⁵ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, p. 1.
- ³⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 272.
- ³⁰⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 54.
- ³⁰⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 88-89.
- ³⁰⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.
- ³¹⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 89.
- ³¹¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 54-56; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 18-19; Testimony of CWO

(Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 123-124; Exhibit P-148, tab 3, doc. 1428, p. 1, p. 4; Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 1.

³¹² Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 66; Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 31.

³¹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 267.

³¹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 132-133 and 269.

³¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 267.

³¹⁶ Testimony of Mr. Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 48-50.

³¹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194.

³¹⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 566-568 and 590-592.

³¹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 611-613.

³²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 614-616.

³²¹ See Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C.

³²² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 113-114.

³²³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 52.

³²⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 38-39.

³²⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 48.

³²⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 47-51.

³²⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 150-152.

³²⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 103.

³²⁹ Final Submissions of the Subjects of the Complaint, p. 59.

³³⁰ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F.

³³¹ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G.

³³² Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H.

³³³ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I.

³³⁴ See: 4.1.2, Investigating Negligence.

³³⁵ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 100-101.

³³⁶ See: 4.1.2, Investigating Negligence.

³³⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 148-149; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 126, 130-131, and 137-138.

³³⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 88-89; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.

³³⁹ Exhibit P-4, Collection D, vol. 10, tab 99, doc. 923.

³⁴⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 278-279 and 281-282.

³⁴¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 227-232.

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- ³⁴² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 69-70.
- ³⁴³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 70.
- ³⁴⁴ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 184-185; Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 204-205.
- ³⁴⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194.
- ³⁴⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 533-535.
- ³⁴⁷ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 85-86.
- ³⁴⁸ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 34-35 and 81-83.
- ³⁴⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 592.
- ³⁵⁰ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 74-76.
- ³⁵¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 93.
- ³⁵² Exhibit P-105, doc. 1382, p. 16; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 274.
- ³⁵³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 235 [Emphasis added].
- ³⁵⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 93-94.
- ³⁵⁵ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 69-70.
- ³⁵⁶ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 77-80.
- ³⁵⁷ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 103-104.
- ³⁵⁸ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 53-54.
- ³⁵⁹ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 25.
- ³⁶⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 258-261.
- ³⁶¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 91.
- ³⁶² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 68 and 91.
- ³⁶³ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 12-13.
- ³⁶⁴ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, p. 42.
- ³⁶⁵ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 26 and 52-53.
- ³⁶⁶ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 18 and 26.
- ³⁶⁷ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, p. 29.
- ³⁶⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 68-72.
- ³⁶⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 623-624.
- ³⁷⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 158-160; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 624.
- ³⁷¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 624.
- ³⁷² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 624.
- ³⁷³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 506-510.
- ³⁷⁴ Final submissions of the complainants, pp. i-vi, 4-5, 17-19 and 29.

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- ³⁷⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 160-171; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 93-95; Section 4.1.3, The Investigation Plan; Section 4.1.1, Investigating the Sudden Death.
- ³⁷⁶ Exhibit P-148, tab 3, doc. 1428.
- ³⁷⁷ Exhibit P-148, tab 3, doc. 1428, p. 1.
- ³⁷⁸ See e.g., Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-186 and 236-239.
- ³⁷⁹ Exhibit P-148, tab 3, doc. 1428, p. 2.
- ³⁸⁰ Exhibit P-148, tab 3, doc. 1428, p. 1.
- ³⁸¹ Exhibit P-148, tab 3, doc. 1428, pp. 2-3.
- ³⁸² E.g. *Fatality Inquiries Act*, RSA 2000, c F-9, s. 10.
- ³⁸³ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 181-182.
- ³⁸⁴ Cpl Hurlburt remained at the scene and was present when MCpl Ritco arrived, but it is unknown if he was actually isolated by the MP members. Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 140.
- ³⁸⁵ Exhibit P-148, tab 3, doc. 1428, p. 3.
- ³⁸⁶ Exhibit P-148, tab 3, doc. 1428, p. 4.
- ³⁸⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-141, 238-239 and 263-264.
- ³⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-141, 238-239, 263-264, 274-276 and 620-622.
- ³⁸⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-141, 193-194, 208-209 and 263-264.
- ³⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-141, 181-183, 193-195, 263-264 and 620-622.
- ³⁹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-141, 238-239, 263-264, 274-276 and 620-622.
- ³⁹² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 19-21.
- ³⁹³ See: Section 4.1.2, Investigating Negligence.
- ³⁹⁴ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 9-15.
- ³⁹⁵ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 9; compare to Exhibit P-148, tab 3, doc. 1428, p. 1: "All deaths will be handled [in accordance with] the same stringent standards as homicide."
- ³⁹⁶ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 9.
- ³⁹⁷ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 9.
- ³⁹⁸ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 10.
- ³⁹⁹ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 19(1).
- ⁴⁰⁰ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 13.
- ⁴⁰¹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 13.
- ⁴⁰² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 30-32; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 170.
- ⁴⁰³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 168-170.
- ⁴⁰⁴ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 21(1).

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- ⁴⁰⁵ *Coroners Act*, RSO 1990, c C.37, s. 16(3).
- ⁴⁰⁶ *Fatalities Inquiries Act*, RSA 2000, c F-9, s. 21(1).
- ⁴⁰⁷ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 11-12.
- ⁴⁰⁸ Testimony of S/Sgt Clark, Insp. Fitzpatrick and Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 163-305.
- ⁴⁰⁹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 11.
- ⁴¹⁰ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 10.
- ⁴¹¹ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, p. 186.
- ⁴¹² Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-180, 241-243 and 247-248; Testimony of Det. Insp. William Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 188-193 and 269-271; Testimony of Insp. Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 196-199 and 203-205.
- ⁴¹³ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 12.
- ⁴¹⁴ Testimony of S/Sgt Clark, Insp. Fitzpatrick and Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 163-305.
- ⁴¹⁵ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 9.
- ⁴¹⁶ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 12.
- ⁴¹⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 138-141.
- ⁴¹⁸ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 14.
- ⁴¹⁹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 14.
- ⁴²⁰ See: Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ⁴²¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 14 and 15, p. 3.
- ⁴²² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 254.
- ⁴²³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 16, 5 Sept 2012, pp. 176-177.
- ⁴²⁴ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 14 and 17, pp. 3-4.
- ⁴²⁵ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 5, p. 1.
- ⁴²⁶ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 2, p. 1.
- ⁴²⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 17, p. 4.
- ⁴²⁸ Final Submissions of the Complainants, p. 27.
- ⁴²⁹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 15, p. 3.
- ⁴³⁰ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 16, pp. 3-4.
- ⁴³¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 16, pp. 3-4.
- ⁴³² Final Submissions of the Subjects, p. 60.
- ⁴³³ Final Submissions of the Subjects, p. 60.
- ⁴³⁴ Final Submissions of the Subjects, p. 60.
- ⁴³⁵ Final Submissions of the Subjects, pp. 60-61.

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- ⁴³⁶ Final Submissions of the Subjects, pp. 61-62.
- ⁴³⁷ Final Submissions of the Subjects, pp. 61-62.
- ⁴³⁸ Final Submissions of the Subjects, p. 61.
- ⁴³⁹ Final Submissions of the Subjects, p. 62.
- ⁴⁴⁰ Final Submissions of the Subjects, pp. 62-63.
- ⁴⁴¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 180.
- ⁴⁴² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 134-135.
- ⁴⁴³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 134-135.
- ⁴⁴⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 134-135.
- ⁴⁴⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 138-139.
- ⁴⁴⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 184-185.
- ⁴⁴⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 138-139 and 184-185.
- ⁴⁴⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 138-139 and 186-187.
- ⁴⁴⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 138-139 and 186-187.
- ⁴⁵⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 52-53 and 138-139.
- ⁴⁵¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 53-54 and 138-139.
- ⁴⁵² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 217-220.
- ⁴⁵³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 217-220.
- ⁴⁵⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 197.
- ⁴⁵⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 193-194.
- ⁴⁵⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 192-193.
- ⁴⁵⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 192-193.
- ⁴⁵⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 318-320.
- ⁴⁵⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-264.
- ⁴⁶⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 60 and 525; Exhibit P-147, tab 1, doc. 1422, p. 148.
- ⁴⁶¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-265.
- ⁴⁶² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 38-40; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 16-17 and 135-137.
- ⁴⁶³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 53-54; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 194-195; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 38-40, 66-67 and 76-79.
- ⁴⁶⁴ Final Submissions of the Subjects, pp. 60-61.
- ⁴⁶⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 264-265.

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- ⁴⁶⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 135-137.
- ⁴⁶⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 16-17.
- ⁴⁶⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 135-137.
- ⁴⁶⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 38-40.
- ⁴⁷⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 70-72.
- ⁴⁷¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 70-72.
- ⁴⁷² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 78-79.
- ⁴⁷³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 78-79.
- ⁴⁷⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 38-40.
- ⁴⁷⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 264-265.
- ⁴⁷⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 112-113.
- ⁴⁷⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 264-265.
- ⁴⁷⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 184-185.
- ⁴⁷⁹ Exhibit P-147, tab 1, doc. 1422, pp. 132-173.
- ⁴⁸⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194; Exhibit P-150, tab 1, doc. 1429, p. 3.
- ⁴⁸¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 161-163.
- ⁴⁸² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 49 and 59-60.
- ⁴⁸³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194; Exhibit P-147, tab 1, doc.1422, pp. 152-153.
- ⁴⁸⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 617-618. There are slight differences between the version Capt Lubiniecki provided the CFNIS at the time of his interview (See Exhibit P-1, Collection A vol. 1, tab 1, doc. 001, pp. 195-196), and the version distributed at the time the conditions were set. The version reproduced above comes from an email from CWO Ross dated March 7, 2008, to Capt Lubiniecki, Maj Jared and Capt Hannah.
- ⁴⁸⁵ Exhibit P-147, tab 1, doc.1422, pp. 152-153.
- ⁴⁸⁶ Exhibit P-147, tab 1, doc. 1422, pp. 152-153; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁸⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193; Exhibit P-147, tab 1, doc. 1422, pp. 152-153.
- ⁴⁸⁸ Exhibit P-147, tab 1, doc.1422, pp. 152-153.
- ⁴⁸⁹ Exhibit P-147, tab 1, doc. 1422, pp. 152-153.
- ⁴⁹⁰ Exhibit P-147, tab 1, doc. 1422, pp. 152-153; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁹¹ Exhibit P-147, tab 1, doc. 1422, p. 153.
- ⁴⁹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 193.
- ⁴⁹⁶ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 119-120.

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- ⁴⁹⁷ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 119-120.
- ⁴⁹⁸ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 117-119.
- ⁴⁹⁹ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 120-122.
- ⁵⁰⁰ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, p. 117 [Emphases added].
- ⁵⁰¹ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 153-154.
- ⁵⁰² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 566-568.
- ⁵⁰³ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 6 and 10-12.
- ⁵⁰⁴ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 85-86.
- ⁵⁰⁵ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 85-87.
- ⁵⁰⁶ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 87-88.
- ⁵⁰⁷ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 88-89.
- ⁵⁰⁸ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 88-89.
- ⁵⁰⁹ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 104-108.
- ⁵¹⁰ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 106-108.
- ⁵¹¹ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-E, pp. 82-85.
- ⁵¹² Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75-76.
- ⁵¹³ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 82.
- ⁵¹⁴ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75-76.
- ⁵¹⁵ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75-76.
- ⁵¹⁶ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 81-83.
- ⁵¹⁷ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 89-91.
- ⁵¹⁸ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 82-83 and 85-87.
- ⁵¹⁹ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 53-54.
- ⁵²⁰ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 53-55.
- ⁵²¹ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 54-56.
- ⁵²² Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 54-55.
- ⁵²³ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 59-60.
- ⁵²⁴ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 54-56.
- ⁵²⁵ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, p. 56.
- ⁵²⁶ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, p. 56.
- ⁵²⁷ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 10-12.
- ⁵²⁸ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 21-22.
- ⁵²⁹ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 13-14.
- ⁵³⁰ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 13-14.

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- ⁵³¹ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 14.
- ⁵³² Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 64-67.
- ⁵³³ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 67-69.
- ⁵³⁴ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 34.
- ⁵³⁵ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 37-38.
- ⁵³⁶ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 35; Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 34-35.
- ⁵³⁷ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 35-36.
- ⁵³⁸ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 35-36 and 39-41.
- ⁵³⁹ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 53-54.
- ⁵⁴⁰ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 68-70.
- ⁵⁴¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 198-201.
- ⁵⁴² Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 2-3.
- ⁵⁴³ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 2-3.
- ⁵⁴⁴ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 9-10.
- ⁵⁴⁵ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 3-4.
- ⁵⁴⁶ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 22-24 and 29-31.
- ⁵⁴⁷ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 2-4.
- ⁵⁴⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 12 and 14-15.
- ⁵⁴⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 617-618.
- ⁵⁵⁰ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 15-16.
- ⁵⁵¹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 15-16.
- ⁵⁵² Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 7-8.
- ⁵⁵³ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 9-10.
- ⁵⁵⁴ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 8-9.
- ⁵⁵⁵ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 22-23.
- ⁵⁵⁶ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 8-9.
- ⁵⁵⁷ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 9.
- ⁵⁵⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 10.
- ⁵⁵⁹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 21-22.
- ⁵⁶⁰ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 27-28.
- ⁵⁶¹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 16-17.
- ⁵⁶² Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 15-16.
- ⁵⁶³ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 10-11.
- ⁵⁶⁴ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 13.

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- ⁵⁶⁵ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 13-14.
- ⁵⁶⁶ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 11.
- ⁵⁶⁷ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 11.
- ⁵⁶⁸ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 5-7.
- ⁵⁶⁹ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 11-12.
- ⁵⁷⁰ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 12-13.
- ⁵⁷¹ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 11-13.
- ⁵⁷² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 277ff.
- ⁵⁷³ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 36-38.
- ⁵⁷⁴ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 38-39.
- ⁵⁷⁵ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 39-40.
- ⁵⁷⁶ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 39-40.
- ⁵⁷⁷ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 40-41.
- ⁵⁷⁸ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 41-42.
- ⁵⁷⁹ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 48-50.
- ⁵⁸⁰ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 25-27.
- ⁵⁸¹ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 50-52.
- ⁵⁸² Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 51-53.
- ⁵⁸³ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, p. 54.
- ⁵⁸⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 525.
- ⁵⁸⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 535.
- ⁵⁸⁶ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75-76.
- ⁵⁸⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 612-613.
- ⁵⁸⁸ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 13-14.
- ⁵⁸⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 568.
- ⁵⁹⁰ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 35.
- ⁵⁹¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 208.
- ⁵⁹² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 27-29.
- ⁵⁹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 249-251.
- ⁵⁹⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 39-40, 66-67 and 72-75.
- ⁵⁹⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 134-138.
- ⁵⁹⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 65-67.
- ⁵⁹⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 84-86.
- ⁵⁹⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 77-79.

⁵⁹⁹ In civil negligence, a duty of care is “an obligation, recognised by law, to take reasonable care to avoid conduct that entails an unreasonable risk of harm to others.” See *Odhavji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 SCR 263 at paras. 45-46. Absent a duty of care, “[a] man is entitled to be as negligent as he pleases towards the whole world [...]”: *Le Lievre v. Gould*, [1893] 1 Q.B. 491 (C.A.), p. 497, cited in *ibid*. The duty of care in civil negligence is determined through a two-step analysis first articulated by the House of Lords in *Anns v. Merton London Borough Council*, [1978] A.C. 728, pp. 751-752: “First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter — in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed or the damages to which a breach of it may give rise.”

The duty of care for criminal negligence is established by the criminal negligence provisions of the *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(a): “Every one is criminally negligent who [...] in doing anything [...] shows wanton or reckless disregard for the lives or safety of other persons.”; and *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(b): “Every one is criminally negligent who [...] in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.” See also Ewaschuck, E.G., *Criminal Pleadings & Practice in Canada* (2d ed.) (Toronto: Canada Law Book, 2013), p. 28-13: “Criminal negligence may be established by acts or omissions (where there is a legal duty) or *both* where the acts and omissions show a wanton or reckless disregard for the lives or safety of others.”

⁶⁰⁰ See for example *Criminal Code*, R.S.C. 1985, c. C-46, s. 215(1)(c): “Every one is under a legal duty ... to provide necessaries of life to a person under his charge if that person (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and (ii) is unable to provide himself with necessaries of life.”; s. 215(2)(b): “(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if [...] with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.”; See *R. v. Peterson*, 2005 CanLII 37972 (ON CA), 201 CCC (3d) 220; 34 CR (6th) 120; 203 OAC 364 (leave to appeal dismissed, 2006 CanLII 6167 (SCC)) at para. 34: “The phrase “necessaries of life” includes not only food, shelter, care, and medical attention necessary to sustain life but also appears to include protection of the person from harm: *R. v. Popen*, (1981), 60 C.C.C. (2d) 232 (Ont. C.A.) at 240. Thus, s. 215(1)(c) obligations are driven by the facts and the context of each case.” Additionally, per section 217 of the *Criminal Code*, where a person undertakes to do an act, the accused is under a “legal duty” to do so if an omission to do the act is or may be dangerous to life. The “duty” may also arise by common law: see Ewaschuck, E.G., *Criminal Pleadings & Practice in Canada* (2d ed.) (Toronto: Canada Law Book, 2013), pp. 28(-6)-28(-7).

⁶⁰¹ *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(b): “Every one is criminally negligent who ... in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.” See also Ewaschuck, E.G., *Criminal Pleadings & Practice in Canada* (2d ed.) (Toronto: Canada Law Book, 2013), p. 28-13: “Criminal negligence may be established by acts or omissions (where there is a legal duty) or *both* where the acts and omissions show a wanton or reckless disregard for the lives or safety of others.”

⁶⁰² *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(a): “Every one is criminally negligent who [...] in doing anything [...] shows wanton or reckless disregard for the lives or safety of other persons.” See also Ewaschuck, E.G., *Criminal Pleadings & Practice in Canada* (2d ed.) (Toronto: Canada Law Book, 2013), p. 28-13: “Criminal negligence may be established by acts or omissions (where there is a legal duty) or *both* where the acts and omissions show a wanton or reckless disregard for the lives or safety of others.”

⁶⁰³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 48-51.

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- ⁶⁰⁴ See for example, Chapter 4.1.3, The Investigation Plan; Chapter 4.1.2, Investigating Negligence; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-264.
- ⁶⁰⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 38-39.
- ⁶⁰⁶ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, pp. 49-54.
- ⁶⁰⁷ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, pp. 49-54.
- ⁶⁰⁸ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, pp. 51-52.
- ⁶⁰⁹ Testimony of Ms. A, Transcript of Proceedings, vol. 54, 10 May 2012, pp. 79-84 and 100-104.
- ⁶¹⁰ Testimony of Ms. A, Transcript of Proceedings, vol. 54, 10 May 2012, pp. 79-84.
- ⁶¹¹ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 80-81.
- ⁶¹² Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 121-123, 125, 130 and 136.
- ⁶¹³ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 80-81.
- ⁶¹⁴ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 82-84.
- ⁶¹⁵ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 100-104.
- ⁶¹⁶ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 103-104.
- ⁶¹⁷ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 81-82.
- ⁶¹⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 39-42.
- ⁶¹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 43-45.
- ⁶²⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 152-153.
- ⁶²¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 153-155.
- ⁶²² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 156-159.
- ⁶²³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 158-159.
- ⁶²⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 108-109.
- ⁶²⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 109-112.
- ⁶²⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 48-49.
- ⁶²⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 48-50.
- ⁶²⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 53-55 and 74-76.
- ⁶²⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 53-55 and 74-76.
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- ⁶³¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 144-146.
- ⁶³² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 87-88.
- ⁶³³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 104-106.
- ⁶³⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 105-106.
- ⁶³⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 104-106.
- ⁶³⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 177-178.
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- ⁶³⁹ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 69.
- ⁶⁴⁰ Testimony of Lt Dunn, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 151-153.
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- ⁶⁴³ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 119-120.
- ⁶⁴⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 534.
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- ⁶⁴⁶ Testimony of MCpl Hillier, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 139-143.
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- ⁶⁴⁸ Testimony of Kirk Lackie, Transcript of Proceedings, vol. 50, 19 September 2012, p. 50-52.
- ⁶⁴⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 59-61.
- ⁶⁵⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 164-165.
- ⁶⁵¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 164-165.
- ⁶⁵² Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 158-159.
- ⁶⁵³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 617-618.
- ⁶⁵⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 617-618.
- ⁶⁵⁵ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 70-72.
- ⁶⁵⁶ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 73-74.
- ⁶⁵⁷ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 106-107.
- ⁶⁵⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 2-4.
- ⁶⁵⁹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 16-24.
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- ⁶⁶³ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 75-77.
- ⁶⁶⁴ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 75-77.
- ⁶⁶⁵ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 75-77.
- ⁶⁶⁶ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 76-77.
- ⁶⁶⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 41-42.
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- ⁶⁷⁰ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, p. 2.
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- ⁶⁷⁶ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 32-33.
- ⁶⁷⁷ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 35-36.
- ⁶⁷⁸ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 59-61.
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- ⁶⁸⁰ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 71-75.
- ⁶⁸¹ Testimony of Dr. Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 75-79.
- ⁶⁸² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 250.
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- ⁶⁸⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 160-161.
- ⁶⁸⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 112-113.
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- ⁶⁸⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 265-266.
- ⁶⁸⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 71.
- ⁶⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 525 [Emphasis added].
- ⁶⁹¹ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 87.
- ⁶⁹² Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 87.
- ⁶⁹³ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 104-107.
- ⁶⁹⁴ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 104-105 and 107-108.
- ⁶⁹⁵ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 106-107.
- ⁶⁹⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 568 [Emphasis added].
- ⁶⁹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 213.
- ⁶⁹⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H.
- ⁶⁹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 222.
- ⁷⁰⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 222.
- ⁷⁰¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 81.
- ⁷⁰² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 81-82.
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- ⁷¹¹ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 40-41.
- ⁷¹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 254.
- ⁷¹³ See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 52-53.
- ⁷¹⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 53.
- ⁷¹⁵ Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 130-143; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 73-74.
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- ⁷¹⁸ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 11-12.
- ⁷¹⁹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 13-14.
- ⁷²⁰ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 14-15.
- ⁷²¹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 20-21.
- ⁷²² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 37-38.
- ⁷²³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 36.
- ⁷²⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 37-38.
- ⁷²⁵ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 79-84.
- ⁷²⁶ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 83-84.
- ⁷²⁷ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 77-78.
- ⁷²⁸ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 73-74 and 76-77.
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- ⁷³⁰ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 174-176.
- ⁷³¹ Exhibit P-5, Collection E, vol. 3, tab 1, doc. 1242.
- ⁷³² Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 46-47.
- ⁷³³ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 66-67; Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April, 2012, pp. 199-201.
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- ⁷³⁵ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 26-28.
- ⁷³⁶ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 53-54.
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- ⁷⁴³ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 107-108.
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- ⁷⁴⁶ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 94-95.
- ⁷⁴⁷ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 38-39.
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- ⁷⁴⁹ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 202-204.
- ⁷⁵⁰ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 205-206.
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- ⁷⁵² Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 222-224.
- ⁷⁵³ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 12-13.
- ⁷⁵⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 254-255 [Emphasis added].
- ⁷⁵⁵ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 11-13.
- ⁷⁵⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 255.
- ⁷⁵⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 253-257.
- ⁷⁵⁸ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 74-75 [Emphasis added].
- ⁷⁵⁹ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 36-37.
- ⁷⁶⁰ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 95-96.
- ⁷⁶¹ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 63-64.
- ⁷⁶² Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 111-112.
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- ⁷⁷⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, p. 51.
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- ⁷⁹⁵ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 88-89.
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- ⁷⁹⁸ Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 40-41; Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 22-23; Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March, 2012, pp. 222-224; Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 64-65; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 74-75; Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 111-112; Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 99-101.
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- ⁸¹³ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 114-116.
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- ⁸¹⁵ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 116-117.
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- ⁸¹⁹ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 53-54.
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- ⁸²² Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 176-177.
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- ⁸²⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 481.
- ⁸²⁶ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 223-224.
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- ⁸³⁵ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 71-72; Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 180-182.
- ⁸³⁶ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 26-27.
- ⁸³⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 48-50.
- ⁸³⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 472.
- ⁸³⁹ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 48-50 and 93.
- ⁸⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 471.
- ⁸⁴¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 496.
- ⁸⁴² Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 236-237.
- ⁸⁴³ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 240-241.
- ⁸⁴⁴ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 240-243.
- ⁸⁴⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 494-496.
- ⁸⁴⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 494-496.
- ⁸⁴⁷ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 287-290.
- ⁸⁴⁸ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 289-290.
- ⁸⁴⁹ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 289-290.
- ⁸⁵⁰ Testimony of Maj Hannah, Transcript of Proceedings, vol. 3, 27 March 2012, pp. 289-290.
- ⁸⁵¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 96-97.
- ⁸⁵² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 93-96.
- ⁸⁵³ Testimony of Sgt Bowden, Transcript of Proceedings, vol. 7, 10 April 2012, pp. 25-27 and 39-43.
- ⁸⁵⁴ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 35.
- ⁸⁵⁵ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 53-54.
- ⁸⁵⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 245.
- ⁸⁵⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.
- ⁸⁵⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 28-29.
- ⁸⁵⁹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 2-5.
- ⁸⁶⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 199-200.
- ⁸⁶¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 198-201.
- ⁸⁶² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 250.
- ⁸⁶³ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 13.
- ⁸⁶⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 193-196.
- ⁸⁶⁵ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 3-5.
- ⁸⁶⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 196-197.
- ⁸⁶⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 24-25.
- ⁸⁶⁸ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 102-104.

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- ⁸⁶⁹ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 103-104.
- ⁸⁷⁰ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 145.
- ⁸⁷¹ Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 145.
- ⁸⁷² Exhibit P-4, Collection D, vol. 13, tab 1, doc. 1128, p. 145.
- ⁸⁷³ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 31-33.
- ⁸⁷⁴ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 32-33.
- ⁸⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 493-495.
- ⁸⁷⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 495.
- ⁸⁷⁷ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 34-35.
- ⁸⁷⁸ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 88-89.
- ⁸⁷⁹ Testimony of Lt Dunn, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 157-158.
- ⁸⁸⁰ Testimony of Maj Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 151-153.
- ⁸⁸¹ Testimony of Mr. Bartlett, Transcript of Proceedings, vol. 35, 18 June 2012, pp. 62-63.
- ⁸⁸² Exhibit P-105, doc. 1382, p. 31.
- ⁸⁸³ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 202-204.
- ⁸⁸⁴ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 202-204.
- ⁸⁸⁵ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 79-80.
- ⁸⁸⁶ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 79-80.
- ⁸⁸⁷ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 146-148.
- ⁸⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 464.
- ⁸⁸⁹ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 170-171.
- ⁸⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 464.
- ⁸⁹¹ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 73-75.
- ⁸⁹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 474-475; Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 62-63.
- ⁸⁹³ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 135-136.
- ⁸⁹⁴ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 135-136.
- ⁸⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 479-480.
- ⁸⁹⁶ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 136-138.
- ⁸⁹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 479-480.
- ⁸⁹⁸ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 136-138.
- ⁸⁹⁹ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 138-140.
- ⁹⁰⁰ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 144-145.
- ⁹⁰¹ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 146-148.
- ⁹⁰² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 493-495.

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- ⁹⁰³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 796.
- ⁹⁰⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 796.
- ⁹⁰⁵ Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 150-153.
- ⁹⁰⁶ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, pp. 106-108.
- ⁹⁰⁷ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, pp. 114-117.
- ⁹⁰⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 796.
- ⁹⁰⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 617-618.
- ⁹¹⁰ Testimony of Maj Volstad, Transcript of Proceedings, vol. 7, 10 April 2012, pp. 118-119.
- ⁹¹¹ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 73-74.
- ⁹¹² Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 78-87.
- ⁹¹³ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 86-87 [Emphasis added].
- ⁹¹⁴ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 107-109.
- ⁹¹⁵ Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 188-191.
- ⁹¹⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 245-248.
- ⁹¹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 249-258.
- ⁹¹⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 114-116.
- ⁹¹⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 114-116.
- ⁹²⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 151.
- ⁹²¹ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, pp. 13-14.
- ⁹²² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 151-153.
- ⁹²³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 76-77.
- ⁹²⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 74-80.
- ⁹²⁵ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 154-155.
- ⁹²⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 151-153.
- ⁹²⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 199-201.
- ⁹²⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 76-77.
- ⁹²⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 76-79.
- ⁹³⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 125-126.
- ⁹³¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 78-79.
- ⁹³² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 74-80.
- ⁹³³ See Chapter 4.4, The 2010 Criminal Negligence Investigation.
- ⁹³⁴ Exhibit P-6, Collection F, vol. 3, tab 1, doc. 1315, pp. 3-4
- ⁹³⁵ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 137-138.
- ⁹³⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 94.

⁹³⁷ The duty of care for criminal negligence is established by the criminal negligence provisions of the *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(a): “Every one is criminally negligent who [...] in doing anything [...] shows wanton or reckless disregard for the lives or safety of other persons.”; and *Criminal Code*, R.S.C. 1985, c. C-46, s. 219(1)(b): “Every one is criminally negligent who [...] in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.” See also Ewaschuck, E.G., *Criminal Pleadings & Practice in Canada* (2d ed.) (Toronto: Canada Law Book, 2013), p. 28-13: “Criminal negligence may be established by acts or omissions (where there is a legal duty) or *both* where the acts and omissions show a wanton or reckless disregard for the lives or safety of others.”

⁹³⁸ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 134-135.

⁹³⁹ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 183-185.

⁹⁴⁰ Testimony of Ms. A., Transcript of Proceedings, vol. 20, 10 May 2012, pp. 40-41.

⁹⁴¹ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 188-189.

⁹⁴² Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 188-189.

⁹⁴³ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 189-190.

⁹⁴⁴ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 191-193.

⁹⁴⁵ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 193-195.

⁹⁴⁶ Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 10-12.

⁹⁴⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 248.

⁹⁴⁸ Exhibit P-6, Collection F, vol. 2, tab 1, doc.1293, pp. 13 and 25-30.

⁹⁴⁹ Exhibit P-6, Collection F, vol. 2, tab 1, doc.1293, p. 37.

⁹⁵⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 274-276.

⁹⁵¹ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 29-32.

⁹⁵² Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 32-34.

⁹⁵³ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 82-84.

⁹⁵⁴ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 89-91.

⁹⁵⁵ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 38-39.

⁹⁵⁶ Exhibit P-132, vol. 1, tab 1, doc. 1399, pp. 4-14.

⁹⁵⁷ Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 188-195; Testimony of Capt Ross, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 10-12.

⁹⁵⁸ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 72-75; Testimony of Ms. Ferdinand, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 124-128.

⁹⁵⁹ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 32-34.

⁹⁶⁰ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 82-84.

⁹⁶¹ Exhibit P-105, doc. 1382, p. 31.

⁹⁶² Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-H, p. 13.

⁹⁶³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 111-115.

⁹⁶⁴ *National Defence Act*, RSC 1985, c N-5, Part III, ss. 55-249.26.

⁹⁶⁵ See Section 4.4, The 2010 Criminal Negligence Investigation.

⁹⁶⁶ Greenspan, Edward L., Rosenberg, Marc, and Heinein, Marie, *2013 Martin's Annual Criminal Code*, (Toronto: Canada Law Book, 2012), pp. 447-449; *R. v. F. (J.)*, [2008] 3 S.C.R. 215 at paras. 7-11.

⁹⁶⁷ See *R. v. Brocklebank*, 1996 CarswellNat 1888, 134 D.L.R. (4th) 377, 106 C.C.C. (3d) 234, 30 W.C.B. (2d) 564, 5 C.M.A.R. 390, paras 18, 32 and 60; Létourneau, Gilles, and Drapeau, Michel, *Canadian Military Law Annotated*, (Toronto: Thomson Carswell, 2006), pp. 660-664. The text adds that QR&O 103.56 defines “negligently” in section 124 of the *National Defence Act* as meaning “that the accused either did something or omitted to do something in a manner which would not have been adopted by a reasonable and capable person in his position in the Service under similar circumstances.”

⁹⁶⁸ See *R. v. F. (J.)*, [2008] 3 S.C.R. 215, paras. 7-11; *R. v. Kazenelson*, 2013 CarswellOnt 1765, 2013 ONCJ 63, 105 W.C.B. (2d) 132 (Ont S.C.J.); *R. v. Brocklebank*, 1996 CarswellNat 1888, 134 D.L.R. (4th) 377, 106 C.C.C. (3d) 234, 30 W.C.B. (2d) 564, 5 C.M.A.R. 390, para 60; *R. v. Creighton*, [1993] 3 S.C.R. 3, pp. 73-74.

⁹⁶⁹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 73-74 and 85.

⁹⁷⁰ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 202.

⁹⁷¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 33-34 and 55-56; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 120; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 29.

⁹⁷² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 180-181; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 33-34, 55-56 and 133-134.

⁹⁷³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 120.

⁹⁷⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 17-19.

⁹⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-265.

⁹⁷⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 53.

⁹⁷⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 215-216.

⁹⁷⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 45-47.

⁹⁷⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 87-88.

⁹⁸⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 88.

⁹⁸¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 88-89.

⁹⁸² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 86-87.

⁹⁸³ See Section 4.1.2, Investigating Negligence.

⁹⁸⁴ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 264 and 274-497; Testimony of Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 73-78 and 81-85; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 41-43, 50-51 and 152-154; Section 4.1.2, Investigating Negligence.

⁹⁸⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-264.

⁹⁸⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 65.

⁹⁸⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 30-31.

⁹⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 208.

⁹⁸⁹ Exhibit P-1, Collection A, vol. 2, tab 1, doc. 001-C, pp. 22-25.

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- ⁹⁹⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 60-61.
- ⁹⁹¹ See, generally, Section 4.1.1, Investigating the Sudden Death; Section 4.1.2, Investigating Negligence.
- ⁹⁹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 50-51.
- ⁹⁹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 48.
- ⁹⁹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 113-114.
- ⁹⁹⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 48.
- ⁹⁹⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 163.
- ⁹⁹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-265; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 16-17.
- ⁹⁹⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 40.
- ⁹⁹⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 67-68.
- ¹⁰⁰⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ¹⁰⁰¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 188-191.
- ¹⁰⁰² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 188-191.
- ¹⁰⁰³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ¹⁰⁰⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 28.
- ¹⁰⁰⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 28-29.
- ¹⁰⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ¹⁰⁰⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 276, 464, 479-480, 584-586 and 617-618.
- ¹⁰⁰⁸ See Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 54-57; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 102 and 273; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 107-108; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 71-72.
- ¹⁰⁰⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ¹⁰¹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 263.
- ¹⁰¹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 264.
- ¹⁰¹² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 135-137.
- ¹⁰¹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 180-182; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 189.
- ¹⁰¹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 258.
- ¹⁰¹⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 61.
- ¹⁰¹⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 142-143.
- ¹⁰¹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 189-190 and 206-207.
- ¹⁰¹⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 18-19.
- ¹⁰¹⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 163-164.

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- ¹⁰²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.
- ¹⁰²¹ Exhibit P-158, tab 1, doc. 1432, p. 44; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 277-279.
- ¹⁰²² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 113-123 and 162-163; Testimony of LCol (ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 42-45; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 113-114.
- ¹⁰²³ Exhibit P-158, tab 1, doc. 1432, pp. 31-38.
- ¹⁰²⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 521.
- ¹⁰²⁵ See Section 4.1, Investigating Negligence.
- ¹⁰²⁶ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 3, p. 1.
- ¹⁰²⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 11-13, 115-116 and 127-129; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 199.
- ¹⁰²⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 14-15 and 116-118; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 199-200.
- ¹⁰²⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 14 and 116-117; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 200.
- ¹⁰³⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 11-16 and 115-118; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 39-41 and 74-75; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 198-200.
- ¹⁰³¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 200.
- ¹⁰³² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 13-14.
- ¹⁰³³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 116.
- ¹⁰³⁴ See, generally, Section 4.1.1 Investigating the Sudden Death; Section 4.1.3 The Investigation Plan.
- ¹⁰³⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 520-521.
- ¹⁰³⁶ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 274-497. See, generally, Section 3.0 Narrative.
- ¹⁰³⁷ See Exhibit P-1, Collection A, vol. 2, tab 7, doc. 001-I, pp. 28-29 and 36; Final Submissions of the Subjects of the Complaint, pp. 64-65.
- ¹⁰³⁸ See Exhibit P-1, Collection A, vol. 2, tab 7, doc. 00-I, p. 2; Section 4.1.2 Investigating Negligence.
- ¹⁰³⁹ See Section 4.1.2, Investigating Negligence.
- ¹⁰⁴⁰ See Section 4.1.2, Investigating Negligence.
- ¹⁰⁴¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 164-166.
- ¹⁰⁴² See Section 4.1.2, Investigating Negligence.
- ¹⁰⁴³ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ¹⁰⁴⁴ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ¹⁰⁴⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 198-200.
- ¹⁰⁴⁶ See Section 4.6 CFNIS Independence and Impartiality.
- ¹⁰⁴⁷ See Section 4.6 CFNIS Independence and Impartiality.

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- ¹⁰⁴⁸ See Section 4.1.2, Investigating Negligence.
- ¹⁰⁴⁹ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 7.
- ¹⁰⁵⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 9-10.
- ¹⁰⁵¹ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 1.
- ¹⁰⁵² Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 14.
- ¹⁰⁵³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 113-116.
- ¹⁰⁵⁴ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 116.
- ¹⁰⁵⁵ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, p. 118.
- ¹⁰⁵⁶ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 7.
- ¹⁰⁵⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 5-6.
- ¹⁰⁵⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 11.
- ¹⁰⁵⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 136.
- ¹⁰⁶⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 625.
- ¹⁰⁶¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 264; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 14.
- ¹⁰⁶² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 265.
- ¹⁰⁶³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 15-16.
- ¹⁰⁶⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 47-117.
- ¹⁰⁶⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97 and 113-114.
- ¹⁰⁶⁶ Exhibit P-150, tab 1, doc. 1429; Exhibit P-158, tab 1, doc. 1432.
- ¹⁰⁶⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 523.
- ¹⁰⁶⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 7; p. 38; pp. 191-192.
- ¹⁰⁶⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 7.
- ¹⁰⁷⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 7-8.
- ¹⁰⁷¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 14-16.
- ¹⁰⁷² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 19-21 and 27.
- ¹⁰⁷³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 16-17 and 24-25.
- ¹⁰⁷⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 41-42.
- ¹⁰⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 96.
- ¹⁰⁷⁶ Exhibit P-149, doc. 1427, pp. 11-68.
- ¹⁰⁷⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 623-624; Exhibit P-158, doc. 1432, p. 37; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 157-160.
- ¹⁰⁷⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 65-66.
- ¹⁰⁷⁹ Exhibit P-1, Collection A, vol. 2, tab 12, doc. 001-Q, p. 1.

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- ¹⁰⁸⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 117.
- ¹⁰⁸¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 13-14.
- ¹⁰⁸² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 13-14.
- ¹⁰⁸³ Testimony of CWO (Ret'd) Watson, vol. 55, 1 October 2012, pp. 11-128.
- ¹⁰⁸⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 17.
- ¹⁰⁸⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 19-20.
- ¹⁰⁸⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 21.
- ¹⁰⁸⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 84-85; pp. 99-100; pp. 156-157.
- ¹⁰⁸⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 18-21.
- ¹⁰⁸⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 257-258.
- ¹⁰⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97.
- ¹⁰⁹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 115; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 107-108.
- ¹⁰⁹² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 107-108.
- ¹⁰⁹³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p 150-152.
- ¹⁰⁹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc 001, pp 113-114.
- ¹⁰⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 113-114.
- ¹⁰⁹⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 115.
- ¹⁰⁹⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 52.
- ¹⁰⁹⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 38-39.
- ¹⁰⁹⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 106-109.
- ¹¹⁰⁰ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 184-185; Testimony of Insp Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 204-205.
- ¹¹⁰¹ Exhibit P-150, tab 1, doc. 1429.
- ¹¹⁰² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 113-123.
- ¹¹⁰³ Exhibit P-150, tab 1, doc. 1429; Exhibit P-158, tab 1, doc. 1432; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ¹¹⁰⁴ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, p. 118.
- ¹¹⁰⁵ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 13.
- ¹¹⁰⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 135; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 209-210.
- ¹¹⁰⁷ Exhibit P-1, Collection A, vol. 2, tab 12, doc. 001-Q, p. 2.
- ¹¹⁰⁸ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 42-45; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 113-114.
- ¹¹⁰⁹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 113-114.

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- ¹¹¹⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 114-115; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 185-186; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 145.
- ¹¹¹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 140-142.
- ¹¹¹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 140.
- ¹¹¹³ Exhibit P-158, tab 1, doc. 1432, pp. 31 and 36.
- ¹¹¹⁴ Exhibit P-158, tab 1, doc. 1432, p. 30.
- ¹¹¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 143.
- ¹¹¹⁶ See: 4.1.2, Investigating Negligence.
- ¹¹¹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 141-142.
- ¹¹¹⁸ See: 4.1.2, Investigating Negligence.
- ¹¹¹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 143-144.
- ¹¹²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 143.
- ¹¹²¹ See: 4.1.5, Recordkeeping and Supervision.
- ¹¹²² Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 121-122.
- ¹¹²³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 120-122.
- ¹¹²⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 186-187.
- ¹¹²⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 187-188.
- ¹¹²⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 188-189.
- ¹¹²⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 190-192.
- ¹¹²⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 192-193.
- ¹¹²⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 118-119.
- ¹¹³⁰ See 4.1.3, The Investigation Plan.
- ¹¹³¹ See 4.1.4, The Concluding Remarks.
- ¹¹³² Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 113-115.
- ¹¹³³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 114-115.
- ¹¹³⁴ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 165-166.
- ¹¹³⁵ See: 4.1.4, The Concluding Remarks.
- ¹¹³⁶ Exhibit P-1, Collection A, vol. 2, tab 12, doc. 001-Q_r, p. 1.
- ¹¹³⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 65-66.
- ¹¹³⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 210-211.
- ¹¹³⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 210-211.
- ¹¹⁴⁰ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 14.
- ¹¹⁴¹ See, generally, Section 4.1.4, The Concluding Remarks.
- ¹¹⁴² Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 2.

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- ¹¹⁴³ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 2.
- ¹¹⁴⁴ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 3.
- ¹¹⁴⁵ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 6.
- ¹¹⁴⁶ Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 2.
- ¹¹⁴⁷ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 14.
- ¹¹⁴⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 116; Exhibit P-147, tab 1, doc. 1422, p. 173.
- ¹¹⁴⁹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 280-282.
- ¹¹⁵⁰ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 7.
- ¹¹⁵¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 171.
- ¹¹⁵² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 157-158.
- ¹¹⁵³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 169.
- ¹¹⁵⁴ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 4.
- ¹¹⁵⁵ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 3.
- ¹¹⁵⁶ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 7.
- ¹¹⁵⁷ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 5.
- ¹¹⁵⁸ Exhibit P-6, Collection F, vol. 1, tab 43, doc. 1190, p. 3.
- ¹¹⁵⁹ Exhibit P-177, doc. 1457, p. 1.
- ¹¹⁶⁰ See generally the scanned images of documents included in Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001
- ¹¹⁶¹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 91.
- ¹¹⁶² Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 118-120; Exhibit P-177, doc. 1457, pp. 1-2..
- ¹¹⁶³ Exhibit P-6, Collection F, vol. 1, tab 37, doc. 1184, p. 2.
- ¹¹⁶⁴ Exhibit P-150, tabs 1 to 3, docs. 1429, 1430, and 1431; Exhibit P-158, tabs 1 and 2, docs. 1432 and 1433.
- ¹¹⁶⁵ Testimony of Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, p. 118.
- ¹¹⁶⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 49; Exhibit P-147, tab 1, doc. 1422, p. 134.
- ¹¹⁶⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 116.
- ¹¹⁶⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 280-281.
- ¹¹⁶⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 104.
- ¹¹⁷⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 93.
- ¹¹⁷¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97.
- ¹¹⁷² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 115.
- ¹¹⁷³ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 1.
- ¹¹⁷⁴ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, p. 1.

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- ¹¹⁷⁵ Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, p. 1.
- ¹¹⁷⁶ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 1.
- ¹¹⁷⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 67.
- ¹¹⁷⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 614.
- ¹¹⁷⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 620.
- ¹¹⁸⁰ Exhibit P-1, Collection A, vol. 2, tab 6, doc. 001-D, p. 1.
- ¹¹⁸¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 115.
- ¹¹⁸² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 310-311.
- ¹¹⁸³ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 85-88.
- ¹¹⁸⁴ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 89.
- ¹¹⁸⁵ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 104-108.
- ¹¹⁸⁶ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, p. 107.
- ¹¹⁸⁷ Exhibit P-1, Collection A, vol. 2, tab 2, doc. 001-D, pp. 100-103; p. 107.
- ¹¹⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 568.
- ¹¹⁸⁹ Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 74-76.
- ¹¹⁹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 590-592.
- ¹¹⁹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 591-592.
- ¹¹⁹² Exhibit P-1, Collection A, vol. 2, tab 3, doc. 001-E, pp. 75 and 79-80.
- ¹¹⁹³ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, p. 35.
- ¹¹⁹⁴ Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 53-54.
- ¹¹⁹⁵ See: 4.1.2, Investigating Negligence.
- ¹¹⁹⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 79-80.
- ¹¹⁹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 621.
- ¹¹⁹⁸ Exhibit P-1, Collection A, vol. 2, tab 7, 001-I, pp. 27-28.
- ¹¹⁹⁹ Exhibit P-1, Collection A, vol. 2, tab 7, 001-I, pp. 4-6.
- ¹²⁰⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 274.
- ¹²⁰¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 141-142.
- ¹²⁰² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 533.
- ¹²⁰³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 566.
- ¹²⁰⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 611.
- ¹²⁰⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 243-244.
- ¹²⁰⁶ See: 4.1.1, Investigating the Sudden Death; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 527-528.
- ¹²⁰⁷ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 86-88.
- ¹²⁰⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 43-45

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- ¹²⁰⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 43.
- ¹²¹⁰ Exhibit P-149, doc. 1427, pp. 11-17. The first File Status Report for this file is included in a collection of CFNIS WR File Status Reports dated March 4, 2008. The explanation may be the date of the 2008 Sudden Death Investigation report was redacted. there was an error when compiling the document, or a page is missing. See Transcript of Proceedings, vol. 48, 14 September 2012, pp. 123-126.
- ¹²¹¹ Exhibit P-149, doc. 1427, p. 17.
- ¹²¹² Exhibit P-149, doc. 1427, pp. 18-26.
- ¹²¹³ Exhibit P-149, doc. 1427, pp. 27-35.
- ¹²¹⁴ Exhibit P-149, doc. 1427, p. 45 [Emphasis added].
- ¹²¹⁵ Exhibit P-149, doc. 1427, pp. 36-46.
- ¹²¹⁶ Exhibit P-149, doc. 1427, pp. 47-68.
- ¹²¹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 122-123.
- ¹²¹⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 64-65.
- ¹²¹⁹ Exhibit P-149, doc. 1427, pp. 27-68.
- ¹²²⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 291-292.
- ¹²²¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 295-296.
- ¹²²² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 78.
- ¹²²³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 295-296.
- ¹²²⁴ Exhibit P-149, doc. 1427, p. 45.
- ¹²²⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p 66.
- ¹²²⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 60.
- ¹²²⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 128-133.
- ¹²²⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 65-67.
- ¹²²⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 52-55.
- ¹²³⁰ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 95-96.
- ¹²³¹ See: Section 4.1.2, Investigating Negligence.
- ¹²³² Exhibit P-1, Collection A, vol. 2, tab 4, doc. 001-F, pp. 53-59; pp. 90-93; pp. 96-101. On May 5, 2008, the CFNIS interviewed MCpl Bowden, who also discussed the abortive suicide watch in detail. See Exhibit P-1, Collection A, vol. 2, tab 5, doc. 001-G, pp. 12-15; pp. 19-38.
- ¹²³³ Exhibit P-149, doc. 1427, p. 45.
- ¹²³⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 175.
- ¹²³⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 181-182.
- ¹²³⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 100.
- ¹²³⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 175.
- ¹²³⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 79-80.
- ¹²³⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp.181-182.

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- ¹²⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 181.
- ¹²⁴¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 99-100.
- ¹²⁴² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 99.
- ¹²⁴³ *Fatality Inquiries Act*, RSA 2000, c F-9.
- ¹²⁴⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 308-309.
- ¹²⁴⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 172-173.
- ¹²⁴⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 212.
- ¹²⁴⁷ Final Submissions of the Subjects of the Complaint, pp. 53-54.
- ¹²⁴⁸ Submissions of Ms. McLaine, Transcript of Proceedings, vol. 62, 9 January 2013, p. 97.
- ¹²⁴⁹ Submissions of Ms. Richards, Transcript of Proceedings, vol. 62, 9 January 2013, pp. 98-99.
- ¹²⁵⁰ See, generally, Section 4.6, CFNIS Independence and Impartiality.
- ¹²⁵¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 178 and 181-182.
- ¹²⁵² *National Defence Act*, RSC 1985, c N-5, s. 273.2 and 273.3.
- ¹²⁵³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 170.
- ¹²⁵⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 31.
- ¹²⁵⁵ *Fatality Inquiries Act*, RSA 2000, c F-9.
- ¹²⁵⁶ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 170.
- ¹²⁵⁷ *R. v. Pugliese*, 1992 CanLII 2781 (ON CA).
- ¹²⁵⁸ *R. v. Wills*, 7 OR (3d) 337 (CA).
- ¹²⁵⁹ *R. v. Caslake*, [1998] 1 SCR 51.
- ¹²⁶⁰ *R. v. Mann*, 2004 SCC 52, [2004] 3 SCR 59 at para 40.
- ¹²⁶¹ *Criminal Code*, RSC 1985, c C-46, s. 487.11; *R. v. Silveira*, [1995] 2 SCR 297 at paras 101-115.
- ¹²⁶² *Criminal Code*, RSC 1985, c C-46, ss. 117.02 and 529.3; *R. v. Silveira*, [1995] 2 SCR 297 at paras 101-115; *Canada (House of Commons) v. Vaid*, 2002 FCA 473, [2003] 1 FC 602 at para 39.
- ¹²⁶³ *R. v. Grant*, [1993] 3 SCR 223 at 242, citing *R. v. Wise*, [1992] 1 SCR 527.
- ¹²⁶⁴ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 21.
- ¹²⁶⁵ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 6(b).
- ¹²⁶⁶ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 9(1).
- ¹²⁶⁷ *Fatality Inquiries Act*, RSA 2000, c F-9, s. 21(1).
- ¹²⁶⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 98-99.
- ¹²⁶⁹ Final Submissions of the Subjects of the Complaint, p. 54.
- ¹²⁷⁰ See: Section 4.1.1, Investigating the Sudden Death.
- ¹²⁷¹ Although the term “exhibits” generally refers to items entered in evidence before courts or tribunals, and the MP policies generally use the term in this manner (see Exhibit P-6, Collection F, vol. 1, tab 41, doc. 1188, p. 5; Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 12-14), both the complainants and the CFNIS members involved in this investigation have used this term to describe the property seized during

the investigation, even though the items were never used in any court proceedings (see Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 161-166; Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 28, p. 5). The CFNIS members often identified the seized items retained for the purposes of the investigation as “exhibits,” while they identified other items turned over to Cpl Langridge’s Regiment as “personal effects” or “personal property” (see Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 161-166, 178-179, 208 and 227). Because the documents and testimony at the hearings generally use the term “exhibits” to describe the property seized by the CFNIS and retained for the purposes of the investigation, this Report also uses the term “exhibits” in this manner.

¹²⁷² Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 28, p. 5.

¹²⁷³ See: Section 4.2, The Suicide Note Left by Cpl Langridge.

¹²⁷⁴ See: Section 4.1.1, Investigating the Sudden Death.

¹²⁷⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 181-182.

¹²⁷⁶ See: Section 4.1.1, Investigating the Sudden Death.

¹²⁷⁷ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714; Testimony of MCpl Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 152-153.

¹²⁷⁸ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189.

¹²⁷⁹ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 2.

¹²⁸⁰ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 12.

¹²⁸¹ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 14.

¹²⁸² Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 13.

¹²⁸³ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 47-52.

¹²⁸⁴ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 12-13.

¹²⁸⁵ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 13.

¹²⁸⁶ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 14.

¹²⁸⁷ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 12-14.

¹²⁸⁸ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 43-45 and 52-54 [Translation]; Testimony of LCol Delaney, Transcript of Proceedings, vol. 16, 25 April 2012, pp. 53-54.

¹²⁸⁹ See: Section 4.1.1, Investigating the Sudden Death.

¹²⁹⁰ See: Section 4.1.1, Investigating the Sudden Death; Section 4.1.2, Investigating Negligence; Section 4.2, The Suicide Note Left by Cpl Langridge.

¹²⁹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.

¹²⁹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 523.

¹²⁹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 1 and 630.

¹²⁹⁴ Exhibit P-1, Collection A, vol. 2, tab 10, doc. 001-Q.

¹²⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 524.

¹²⁹⁶ See: Section 4.1.1, Investigating the Sudden Death.

¹²⁹⁷ See: Section 4.1.2, Investigating Negligence.

¹²⁹⁸ See: Section 4.1.1, Investigating the Sudden Death and Section 4.1.2, Investigating Negligence.

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- ¹²⁹⁹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 89-90.
- ¹³⁰⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 1 and 630.
- ¹³⁰¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 1 and 630.
- ¹³⁰² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 513-515.
- ¹³⁰³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 512-513.
- ¹³⁰⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 512.
- ¹³⁰⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 151-152.
- ¹³⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ¹³⁰⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 218.
- ¹³⁰⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 134-135 and 152; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 36-37.
- ¹³⁰⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 152.
- ¹³¹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ¹³¹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ¹³¹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ¹³¹³ See: Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³¹⁴ See Exhibit P-4, Collection D, vol. 1, tab 89, doc. 086.
- ¹³¹⁵ Exhibit P-1, Collection A, vol. 2, tab 11, doc. 001-P.
- ¹³¹⁶ Exhibit P-1, Collection A, vol. 2, tab 11, doc. 001-P.
- ¹³¹⁷ Exhibit P-1, Collection A, vol. 2, tab 11, doc. 001-P.
- ¹³¹⁸ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 634-714.
- ¹³¹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 109.
- ¹³²⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 109-110.
- ¹³²¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 110.
- ¹³²² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 215.
- ¹³²³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 214-216. See, generally, Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³²⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 220-221.
- ¹³²⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217.
- ¹³²⁶ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³²⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 12; Exhibit P-147, tab 1, doc. 1422, p. 22; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 85-86 [Translation]. See, generally, Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³²⁸ This individual is not the same person as CWO Douglas Ross, the RSM for the LDSH Regiment.
- ¹³²⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 7.
- ¹³³⁰ Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, p. 1.

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- ¹³³¹ Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, p. 2.
- ¹³³² Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, p. 1.
- ¹³³³ Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, pp. 2-3.
- ¹³³⁴ Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, p. 3.
- ¹³³⁵ Exhibit P-5, Collection E, vol. 6, tab 37, doc. 1270, p. 3.
- ¹³³⁶ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261.
- ¹³³⁷ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ¹³³⁸ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261.
- ¹³³⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ¹³⁴⁰ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ¹³⁴¹ See Section 4.1.1, Investigating the Sudden Death; Section 4.1.2, Investigating Negligence; Section 4.1.3, The Investigation Plan; Section 4.1.4, The Concluding Remarks; Section 4.1.5 Recordkeeping and Supervision; Section 4.1.6, Search Warrants.
- ¹³⁴² Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ¹³⁴³ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 2.
- ¹³⁴⁴ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 1-2.
- ¹³⁴⁵ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 2.
- ¹³⁴⁶ See Section 4.1.1, Investigating the Sudden Death.
- ¹³⁴⁷ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 2-6.
- ¹³⁴⁸ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 6-7.
- ¹³⁴⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 6-7.
- ¹³⁵⁰ See Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 3-4. See, generally, Section 4.1.4, The Concluding Remarks; Section 4.1.5, Recordkeeping and Supervision.
- ¹³⁵¹ See Section 4.1.1, Investigating the Sudden Death.
- ¹³⁵² Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 7.
- ¹³⁵³ Exhibit P-148, tab 3, doc. 1428.
- ¹³⁵⁴ See Section 4.1.1, Investigating the Sudden Death.
- ¹³⁵⁵ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 3.
- ¹³⁵⁶ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 2-3.
- ¹³⁵⁷ See, generally, Section 4.1.2, Investigating Negligence; Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹³⁵⁸ See Section 4.1.2, Investigating Negligence.
- ¹³⁵⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ¹³⁶⁰ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 4-5.
- ¹³⁶¹ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³⁶² Section 4.2, The Suicide Note Left by Cpl Langridge.

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- ¹³⁶³ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5.
- ¹³⁶⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ¹³⁶⁵ See Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 6-7.
- ¹³⁶⁶ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 6.
- ¹³⁶⁷ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 6.
- ¹³⁶⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹³⁶⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 161; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 157.
- ¹³⁷⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 157.
- ¹³⁷¹ Testimony of MWO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 184-185.
- ¹³⁷² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 149-150.
- ¹³⁷³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 135-136 and 138-139.
- ¹³⁷⁴ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁷⁵ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁷⁶ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁷⁷ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁷⁸ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁷⁹ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁸⁰ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁸¹ See: 4.1.5, Supervision and Recordkeeping.
- ¹³⁸² See: 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹³⁸³ See: 4.1.1, Investigating the Sudden Death; 4.1.2 Investigating Negligence.
- ¹³⁸⁴ See: 4.1.1, Investigating the Sudden Death.
- ¹³⁸⁵ See: 4.1.1, Investigating the Sudden Death; 4.2 The Suicide Note Left by Cpl Langridge.
- ¹³⁸⁶ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 70-72 [Translation]; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 106-109; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 20.
- ¹³⁸⁷ See: 4.1.1, Investigating the Sudden Death.
- ¹³⁸⁸ See: 4.0, The Subjects of the Complaint: Role, Involvement and Background; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 356-357.
- ¹³⁸⁹ Exhibit P-6, Collection F, vol. 3, tab 8, doc. 1327; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 287.
- ¹³⁹⁰ See Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 175 and 306.
- ¹³⁹¹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.

¹³⁹² See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 139; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 149-151; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 156-158. See also, Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 76.

¹³⁹³ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 197 and 209; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 18-21 and 256-258.

¹³⁹⁴ Final Submissions of the Subjects of the Complaint, pp. 1, 51 and 107.

¹³⁹⁵ Final Submissions of the Subjects of the Complaint, p. 49.

¹³⁹⁶ Final Submissions of the Subjects of the Complaint, pp. 48-49.

¹³⁹⁷ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 139; Testimony of CWO (ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 18-21, 149-151 and 256-258; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 197 and 209; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 156-158. See also, Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 76.

4.2 THE SUICIDE NOTE LEFT BY CPL LANGRIDGE

1. Cpl Stuart Langridge left a suicide note in the room where his body was found. It read:

Sorry but I can't take it anymore. I love you mom, Shaun, James, Mike, Grandma, Aunti, Tom. Please know that I needed to stop the pain. xoxo Stu

PS I don't deserve any kinda fancy funeral just family. Ty.¹

2. The note was seized by CFNIS investigators on March 15, 2008.² No one at the time told Cpl Langridge's parents – nor anyone else in his family – about the contents or even the existence of this note. The Fynes learned about it over 14 months after Cpl Langridge died. They did not learn about it from the CFNIS.

Disclosure of the Suicide Note to the Fynes

3. On May 22, 2009, 14 months after Cpl Langridge had died, Mr. Fynes received a phone call from Maj Bret Parlee, President of the BOI convened by the CF to inquire into Cpl Langridge's death.³ The BOI was unrelated to the CFNIS investigation into the death, which had been concluded much earlier. In May 2009, Maj Parlee's work on the BOI was near completion.⁴ The witness testimony had already been heard, and the preparation of the report was in its final stages.⁵

4. During the telephone conversation, Maj Parlee advised Mr. Fynes "he'd received special permission to provide information to [Mr. Fynes] in regards to a further exhibit."⁶ He then told Mr. Fynes that Cpl Langridge had left a suicide note when he died.⁷ He read the note to Mr. Fynes over the phone.⁸ This was the first time the Fynes learned about Cpl Langridge's suicide note. At the time, no explanation was provided to them as to why the note had not been disclosed previously.

5. The same day, Mr. Fynes wrote to Maj Stewart Parkinson, the Fynes' AO, to tell him about his conversation with Maj Parlee and the information he had revealed. Mr.

Fynes commented: “unbelievable that it took over fourteen months to learn of this.”⁹ This was also the first time Maj Parkinson learned of the existence of the suicide note.¹⁰

6. After his conversation with Mr. Fynes, Maj Parlee reported: “the news was well received on the phone, however, there may be a backlash due to the fact it was not provided to them shortly after the death.”¹¹ In testimony, he explained the conversation was pleasant, as Mr. Fynes always conducted himself in a professional manner.¹² He added he “fully expected him and Mrs. Fynes to be upset, as anyone would be.”¹³ On the whole, he agreed the Fynes’ reaction was very tempered, considering the situation.¹⁴

7. Mrs. Fynes testified about the impact the news had on her:

I was devastated, to be honest. I just had this image of my son sitting there and going through a shopping list of the people who he thought was important, the people who were important in his life who actually would still care about it. Sorry.

And I just thought what a horribly lonely place he was in when he wrote that note, and then nobody even cared enough to think that we might want to see it.¹⁵

8. In addition to the obvious pain and suffering they endured when they discovered their son’s last words had not been communicated to them, the Fynes were also significantly distressed to learn they had been unable to attempt to honour the wishes he had expressed about his funeral.¹⁶ On March 26, 2008, long before anyone was informed about the suicide note, a full military funeral was held for Cpl Langridge. Mr. Fynes testified:

[...] our son’s last request, the last thing he said to us was he wanted to have a small family funeral. His wishes, his last wishes were not honoured because we did not know that...¹⁷

HOW DID THE SUICIDE NOTE COME TO BE DISCLOSED?

9. As Mr. Fynes testified, “had it not been for the Board of Inquiry we would never have known our son had left a suicide note.”¹⁸ Indeed, the CFNIS did not come forward of its own accord to reveal the existence of the note.

10. The note had been seized by the CFNIS on the night Cpl Langridge died.¹⁹ The CFNIS investigation was concluded in June 2008.²⁰ No steps were taken to advise the

Fynes about the note. Approximately six months later, the CF convened the BOI to inquire into Cpl Langridge's death. On January 26, 2009, Maj Parlee wrote to the OC of the CFNIS WR Detachment, Maj Daniel Dandurand, to request a copy of the CFNIS investigation report for the BOI.²¹ A redacted copy of the report was provided on February 3, 2009.²²

11. According to Maj Parlee, the copy of the CFNIS report contained no reference to the suicide note.²³ He testified he learned about the existence of the note subsequently, from a footnote in the Certificate of Death from the province of Alberta.²⁴ He explained he received the Certificate later in the BOI's investigation.²⁵

12. The copy of the CFNIS report received by this Commission did contain references to the suicide note.²⁶ However, as submitted by counsel for the subjects of the complaint, there is no evidence the CFNIS disclosed the entire investigation file to the BOI.²⁷ In fact, Maj Parlee's testimony and the contemporaneous correspondence indicate they did not. The Commission has reviewed the Certificate of the Alberta Chief Medical Examiner and found it was accompanied by an External Examination Form, which contained a reference to the suicide note.²⁸ Maj Parlee appended a copy of this form when he wrote to the CFNIS to request the note.²⁹

13. On March 11, 2009, Maj Parlee wrote to Maj Dandurand:

In the course of conducting the Langridge BOI, I have come across evidence that indicated that there was a suicide note left in Cpl Langridge's room. **The NIS report does not have any record of a suicide note.** Can you confirm that there was or was not a suicide note found in Cpl Langridge's room during the NIS or MP investigation?³⁰
[Emphasis added]

14. Two days later, Maj Dandurand replied: "you're best to call me on this one."³¹ Maj Parlee wrote again, indicating he expected Maj Dandurand would require a formal request and asking to whom it should be addressed.³²

15. Maj Parlee testified his first reaction upon learning the note existed was to request it, as the note was a piece of evidence he believed was relevant to the BOI.³³ He also indicated he felt compassion for the family and hence attempted to provide the note to them.³⁴

16. Maj Parlee recalled having a meeting with Maj Dandurand to discuss the suicide note after their initial exchange of correspondence.³⁵ He stated Maj Dandurand then expressed the view that this particular piece of evidence was not to be released based on CFNIS regulations.³⁶ Maj Dandurand did not mention any ongoing investigation and did not explain why he referred to the suicide note as “evidence.”³⁷

17. On Friday, March 13, 2009, Maj Dandurand wrote to Maj Parlee. He advised him to forward the official request for the suicide note to him and indicated he would need to seek approval from Ottawa.³⁸ He then forwarded Maj Parlee’s initial email to the DPM Police and the CFNIS DCO, indicating: “the subject BOI is looking for additional information above and beyond what we have already provided. Do we have authority to disclose the suicide note?”³⁹ Maj Francis Bolduc, the DCO, asked if this matter could wait until the following week. Maj Dandurand replied it could and commented: “they’re just looking for evidence above and beyond what we normally give to BOIs.”⁴⁰ He added he was seeking approval from the DPM Police for the disclosure and wanted to inform the DCO.⁴¹

18. The following Monday, March 16, 2009, Maj Parlee sent a formal letter addressed to the CFNIS CO, requesting a certified true copy of the suicide note found in Cpl Langridge’s room.⁴² He attached a copy of the External Examination Form from the Alberta ME’s Office and noted the suicide note was referred to in the form.⁴³ In testimony, Maj Parlee explained he understood there was a necessity for Maj Dandurand to determine, through his chain of command, whether they could release the suicide note.⁴⁴ He stated this “took a considerable amount of time.”⁴⁵

19. On April 7, 2009, Maj Parlee sent a follow up email asking whether Maj Dandurand could provide a timeline as to when the copy of the note would be received.⁴⁶ On April 16, Maj Parlee wrote again, asking Maj Dandurand whether there was any word on when he would receive the note.⁴⁷ The same day, Maj Dandurand wrote to the DPM Police in Ottawa, copying Maj Bolduc. He indicated there was a request from the BOI “for a copy of the suicide letter seized” and asked whether the Detachment had the concurrence of the DPM Police to provide it.⁴⁸ A few minutes later, the DPM Police

responded in the affirmative and advised Maj Dandurand to provide the copy to the BOI.⁴⁹

20. In testimony, Maj Dandurand explained he viewed the BOI's request as unusual.⁵⁰ As there had been several requests from BOIs in the Region for actual evidence in the CFNIS holdings, Maj Dandurand was careful in approaching this request.⁵¹ He believed BOIs were entitled to receive the entire investigative file, but thought handing over seized items would be an issue because of the need to maintain continuity.⁵² He assumed a copy of the suicide note would have been scanned into the file and provided to the BOI along with the report.⁵³ He thought this would have been sufficient for the BOI.⁵⁴ He could not explain why Maj Parlee did not have a copy of the note.⁵⁵ He could not explain why sending another copy to the BOI would be an issue, or why authorization was required.⁵⁶

21. Maj Bolduc explained his understanding was Maj Dandurand was requesting authorization to disclose the suicide note to the BOI, in accordance with applicable policies.⁵⁷ The DPM Police was responsible for determining what information could be provided to BOIs.⁵⁸ Maj Bolduc indicated the amount of information provided would depend on what was requested. There was no standard policy about disclosing or not disclosing suicide notes to BOIs.⁵⁹ The general rule was BOIs were entitled to receive all of the information they requested, unless it could prejudice an ongoing police investigation.⁶⁰

22. The BOI received the copy of Cpl Langridge's suicide note on April 17, 2009, just under six weeks after discovering its existence.⁶¹ Maj Dandurand could not recall why it took this long for the copy to be provided.⁶² Another five weeks then passed before the Fynes were advised about the existence of the note. At the time, the CFNIS took no steps to advise them.

23. In testimony, Maj Dandurand indicated he believed the initial communication from Maj Parlee was the first time he became aware of the existence of a suicide note in this file.⁶³ He had assumed command of the Detachment in July 2008, shortly after the investigation into Cpl Langridge's death was concluded.⁶⁴ He testified Maj Parlee's communication did not cause him to review the file.⁶⁵ Instead, he focused on addressing

the BOI's request.⁶⁶ It is not clear whether, at the time, Maj Dandurand was aware the suicide note had not been disclosed to the family.⁶⁷ It does not appear he took any steps to verify whether it had been. He testified Maj Parlee's request did not cause him to question the members involved in the investigation.⁶⁸ He stated the request "did strike me as a little bit odd and I did look into it I believe, but I don't -- I can't recall to what depth I looked into it."⁶⁹

24. Maj Bolduc testified he had not been told by Maj Dandurand or anyone else the suicide note had not been disclosed to the family when he received information about the BOI's request.⁷⁰ Similarly, LCol Gilles Sansterre, the CFNIS CO, noted Maj Dandurand's correspondence with DPM Police and CFNIS HQ about this matter provided no indication the suicide note had never been disclosed to the family.⁷¹ He testified the BOI's request for the suicide note was not brought to his attention at the time, as disclosures to BOIs were routine matters generally looked after by the DCO and not requiring his involvement.⁷²

25. Meanwhile, Maj Parlee, who had had direct discussions with Maj Dandurand about the suicide note, was well aware the family did not know about it. Ten days after receiving the copy of the note, he began to inquire about the process for disclosing the note to the Fynes. On April 27, 2009, he wrote to Maj Serge Côté, an advisor from the DND Administrative Investigation Support Centre (AISC), indicating:

I have obtained a suicide note from the NIS (it was not mentioned in the report that we got from them, although the report may have been severed). **The family has no idea that there was a suicide note...** am I obligated in any way to inform them at this point? If not now, when (and who should be informing them)? It will most certainly be used as evidence in the report.⁷³ [Emphasis added]

26. The next day, Maj Parlee followed up with another e-mail asking Maj Côté whether he had an answer about the suicide note.⁷⁴ In testimony, Maj Parlee explained he was seeking Maj Côté's advice on whether to disclose the suicide note to the family because "it was quite an unusual circumstance."⁷⁵ The following week, Maj Côté wrote back with his advice. He suggested "given the present interaction with the family," Maj Parlee should speak with the BOI's legal advisor, with public affairs, and with the BOI Convening Authority to determine whether to tell the family about the suicide note "as it

may not appease them.”⁷⁶ Since the suicide note was part of the BOI evidence, Maj Côté noted it would be revealed “in due course” when the report was completed.⁷⁷ He added, the family could then be briefed about it after the report had been reviewed by the Convening Authority.⁷⁸ It should be noted that, as of the close of this hearing, the Fynes had still not been briefed officially about the BOI report or provided with a final copy.⁷⁹ Had this advice been followed, they may have remained unaware of their son’s suicide note to this day. However, a different decision prevailed.

27. On May 22, 2009, Maj Parlee called Mr. Fynes and told him about the note. On the same day, he advised Maj Côté that the BOI Convening Authority had authorized him to inform the Fynes about Cpl Langridge’s suicide note.⁸⁰ He reported he had advised the family by telephone, and would be providing them with a copy of the note.⁸¹ In response, Maj Côté expressed concern about giving a copy of the note to the family, since it was part of the evidence before the BOI.⁸² He noted the family was only to get a verbal briefing about the findings in the report, and would be provided a severed copy of the report only after approval by the CDS and with the concurrence of the Convening Authority.⁸³ He added Maj Parlee should consult with his legal advisor first if he still wanted to provide a copy of the note to the family.⁸⁴ Maj Parlee’s response was redacted in the documents produced before this Commission. Following the response, Maj Côté indicated Maj Parlee was “good to go.”⁸⁵

28. In testimony, Maj Parlee could not recall the specifics of his discussions with the Convening Authority about this issue, but was “quite certain” the question of whether to give a copy of the note to the family was discussed.⁸⁶ In a message he wrote during the days that followed the disclosure of the note to the Fynes, he had explained:

[...] Once I actually received the note I informed the Convening Authority who sought advice from the LEGAD before releasing it to [the Fynes].

Technically, we are not obligated to provide the family with any evidence uncovered during the course of the BOI, however, due to the obvious importance to them in this case, the Comd authorized the release of this piece of evidence.⁸⁷

OBTAINING THE ORIGINAL SUICIDE NOTE

29. On May 27, 2009, the copy of Cpl Langridge's suicide note arrived at the Fynes' residence.⁸⁸ Mr. Fynes recalled:

[...] in the first instance when we were apprised of the suicide note they forwarded the – they Puolated the note out to the NIS in Esquimalt. A Captain hand-delivered it to my wife.

I came home from work that night and the Puolator envelope was sitting on our table unopened. My wife couldn't bring herself to open it.

And I have to tell you when we opened that envelope together and I saw that it was a photocopy with an exhibit stamp on it, I was just through the roof.⁸⁹

30. That evening, Mr. Fynes wrote to his AO, Maj Parkinson, to request the original note:

Attached is a copy [of a photocopy] of Stuart's farewell to his family.

That his note was concealed and withheld from us for over fourteen months was cruel, callous and disrespectful.

I expect the "original" to be provided to us immediately. Would you please arrange?⁹⁰
[Emphasis added]

31. Maj Parkinson forwarded the message to Capt Eric Angell, the Adjutant for Cpl Langridge's Regiment, asking him to action Mr. Fynes' request.⁹¹ Capt Angell contacted the CFNIS Detachment to find out how to obtain the original suicide note. On May 28, 2009, WO Ken Ross, the Acting Detachment MWO (chief investigator),⁹² wrote to Capt Angell, copying Maj Dandurand, with what the complainants described as a "shocking statement."⁹³ He advised:

Concerning the family's desire to have the suicide note: The best course of action would be to have the AO to the family, make an ATI request on their behalf.

Should you have any further questions, please feel free to contact me.⁹⁴

32. In response, Capt Angell indicated he was sure WO Ross could "appreciate the sensitive nature of this request."⁹⁵ Capt Angell advised that the family already had a copy of the note and wanted to obtain the original.⁹⁶ As an ATI request would only produce a

copy, he noted this was not a viable option and asked WO Ross whether other avenues could be explored.⁹⁷ In a message, also copied to Maj Dandurand, WO Ross responded:

We appreciate the sensitivity of this matter, however, **the original note is still retained as evidence. I do not foresee the original note being turned over.** That being said, I will make some further inquiries once I am back in the office tomorrow.⁹⁸ [Emphasis added]

33. The next day, Maj Dandurand received authority from the DPM Police in Ottawa to release the original suicide note.⁹⁹ At the time, there were communications about this matter involving the CF Regiment, the Brigade in charge of the Regiment (1 CMBG) and the Area in charge of the Brigade (LFWA). Maj Dandurand advised LFWA the Detachment would be providing the note on the following Monday.¹⁰⁰ LFWA asked him to have WO Ross provide the note as soon as possible to Brigade staff, who would find an appropriate way of delivering it to the family.¹⁰¹ In testimony, the LFWA Chief of Staff, Col Jamie Hammond, commented Maj Dandurand's reaction upon learning about the failure to disclose the suicide note was professional.¹⁰² He noted Maj Dandurand "may have hesitated a little bit because he was worried about evidence and all that sort of stuff," but believed he ultimately came to the right conclusion quickly and obtained authorization to release the original note to the family.¹⁰³

34. WO Ross, for his part, indicated he would coordinate with the evidence custodian the following Monday to release the original note.¹⁰⁴ However, he appeared less than pleased about this development. He wrote to Maj Dandurand:

I was under the impression that the family had made ATI application and subsequently received the note. However, it was Maj Hamilton-Brown [the Brigade G1] who took it upon himself to provide a copy to the family, which obviously wasn't a very good copy at that and I assume was the copy which we provided him? **It would appear that those wishing to do the "right thing" have caused more angst for the family than they have good.**¹⁰⁵ [Emphasis added]

35. The following day, the G1 for the Brigade, Maj Glen Hamilton-Brown, wrote to the LSDH Regiment Adjutant, Capt Angell, indicating he believed the delivery of the original note should be done through the Regiment as the Fynes had requested.¹⁰⁶ On Monday, June 1, 2009, he advised Capt Angell the CFNIS Detachment would be providing him with the original note to deliver to the Fynes.¹⁰⁷ The note was provided to

Capt Angell by WO Ross on the same day.¹⁰⁸ The CFNIS file noted the disposal of the note was authorized by Maj Dandurand, under the authority of the CO for the Regiment, and the note was “returned to Unit Adj at the request of the family.”¹⁰⁹

36. On June 3, 2009, Maj Parkinson delivered the original suicide note to the Fynes.¹¹⁰ Mr. Fynes testified:

And we went back and demanded that we get our son’s suicide note, his last communication to us, and that was delivered shortly thereafter in person by our Assisting Officer who stood in our room and reached it to us and said – **I believe his exact words were: “I have no words.”**¹¹¹ [Emphasis added]

IMMEDIATE REACTIONS

37. After the Fynes received the copy of the note and wrote to their AO to request the original, news of the issue circulated quickly within the CF leadership at the Regiment, Brigade and Area, even reaching the Chief of the Land Staff. Mr. Fynes’ comment indicating withholding the note had been “cruel, callous and disrespectful” was forwarded again and again throughout the CF, giving rise to numerous email discussions about the issue.¹¹² Many expressed shock and disbelief, while others appeared to be scrambling to obtain or provide explanations, and still others were immediately concerned about the public relations impact.

38. Upon learning of the issue, Maj Hamilton-Brown asked the Regiment Adjutant to speak with Maj Parlee and draft a response to the Fynes’ message.¹¹³ Maj Parlee provided his account of the situation, insisting the CFNIS had not informed the BOI about the suicide note nor included it in the redacted investigation report they provided.¹¹⁴ He suggested Public Affairs be “brought back into the loop” to prepare Media Response Lines (MRLs).¹¹⁵ The Chief of Staff to the Brigade Commander, LCol Thomas Bradley, commented about the points to be covered in the response:

Let’s ensure that the legalities of release are also highlighted in the response.

For example, if a person gives a suicide note to a doctor the family never sees it. Important also is that once we got the item, despite having no obligation to do so, the document was released to them.¹¹⁶

39. Capt Angell then provided the following explanation to Maj Parkinson:

The NIS kept the suicide note as evidence during their investigation, LdSH(RC) [the Regiment] did not know it existed. Maj Parlee found out about the note through the course of the BOI investigation, and obtained a copy of the document from the NIS...¹¹⁷ [Emphasis added]

40. When she learned about the issue, Ms. Norma McLeod from Casualty Support in Esquimalt commented:

The first attachment is the suicide letter from the member to his family in which he left specific funeral instructions. Edmonton released this to the family over 14 months later. I will withhold my comments on the matter.

[...] I don't know if you have been following what happened after Cpl Langridge's suicide in Edmonton, but it has been quite horrendous for the family in Victoria. **This is going to explode in the media.** [...] I have attached salient info that I have received to date so that you have some background information. I would like to discuss with you ASAP as urgent intervention is required by you in Edmonton. The family is still asking for things such as medals and a copy of the pers file, etc. We really need to sort this out right now.¹¹⁸ [Emphasis added]

41. In the lengthy message he wrote to respond to some of the issues Ms. McLeod had raised, Maj Hamilton-Brown commented: "The note is a very hot topic for us as we are just as surprised as the Fynes are about some aspects."¹¹⁹

42. Ms. McLeod's message was forwarded throughout the CF.¹²⁰ Ottawa and LFWA staff were advised of the potential for media attention she identified.¹²¹ It was recommended the LFWA Public Affairs Officers' branch be made aware of the situation.¹²² Subsequently, once the news had travelled to even higher levels, the Director of Army Public Affairs (DAPA) was instructed to liaise with LFWA Public Affairs to prepare MRLs "for when this breaks."¹²³

43. When he was advised of the issue, the LFWA Public Affairs Officer (PAO), Maj David Muralt, commented:

This was Cpl Langridge's letter saying goodbye to his family and giving specific instructions for his funeral. A copy of the note was eventually provided by someone here in Edmonton to the family 14 months after his death.¹²⁴

44. Upon receiving the news, the Area Chief of Staff, Col Hammond, immediately enquired:

Are we sure that no-one gave a copy to a member of the family earlier (it is a bit shocking if we did not)?¹²⁵

45. Before this Commission, Col Hammond testified about his reaction when he learned the suicide note had not been disclosed:

I thought it was a bit shocking. Personally I was flabbergasted that the suicide note was not passed to the family within days of knowing we had a suicide note. I think that speaks for itself. To me, it's unforgivable, and the family said it was callous and disrespectful. And I think -- I don't know if everybody in the Canadian Forces, but I think most people in the Canadian Forces would agree with that.¹²⁶

46. In his response to Col Hammond's question, LCol Bradley explained the CFNIS were the only ones with a copy of the suicide note and had not revealed it to the BOI.¹²⁷ He went on:

When we found out we quickly figured that although not mandated to do so, it would clearly be in the families' interest to have this and also so that they wouldn't find out when the BOI documentation was released at the end and really be unhappy.¹²⁸

47. Col Hammond advised the LFWA Commander, BGen Michael Jorgensen, of the situation and noted the Public Affairs Officer (PAO) was preparing "renewed MRLs" to address the issue.¹²⁹ He also brought Maj Dandurand into the conversation, asking him whether the original note could be released "ASAP at this point" and telling him they needed "to find a way to ensure this doesn't happen again (family not aware of its existence for 14 months in case like this)."¹³⁰ He recalled discussing the issue with Maj Dandurand at the time:

[...] I can't remember exactly when, but **I remember having a phone conversation with [Maj] Dandurand and saying come on, this is Keystone Cops. This should not happen.** And that's what I said in the e-mail back to him, that we need to find a way to ensure this doesn't happen again.¹³¹ [Emphasis added]

48. In testimony, Maj Dandurand stated:

I don't recall reading anywhere in an email the reference to Keystone Kops. And the reason why I bring that up is, if I had, that would have definitely soured that relationship.

There was no doubt in my mind that he was very concerned with this and very quickly many opinions on the issue began flying around Western Region, and what I had engaged in a conversation with Colonel Hammond about is, **let's not be so quick to be critical and let's see what's going on here. I wanted people to calm down.** And had he made a reference to Keystone Kops at the time -- I remember exactly where I was when I was

discussing this with him, I was on my front porch and I was on Blackberry, and had he done that, the neighbours would have heard about it.

So, there's no doubt he was upset. [...] And there's no doubt that we were coming at this from two different angles, but we were in agreement that this was not acceptable and we needed to rectify this.¹³² [Emphasis added]

49. In the response he wrote to Col Hammond at the time, Maj Dandurand agreed the family “should have at least been told” but cautioned he would look into the case to find out what happened as he noted it was his experience “everything in these circumstances are not always 100 per cent accurate when first reported.”¹³³

50. There was much confusion within the CF and the CFNIS about who Cpl Langridge’s NOK was, and about whether anyone at all had been told about the suicide note.¹³⁴ Col Dominic McAlea, a JAG Officer in Ottawa who was also advised about the issue, commented to the CLS Chief of Staff: “this may be as much about NIS culture as it is about CF administrative stovepipes.”¹³⁵

51. The confusion and the concern about public relations were not limited to the CF leadership. The CFNIS leadership had similar reactions. On May 30, 2009, Maj Dandurand briefed the CFNIS CO about the issue. He copied the CFNIS PAO, Maj Paule Poulin, on this message and wrote:

We have **a situation arising that may draw media attention**. It is as a result of a BOI into the suicide of one of our soldiers and the parents alledging [*sic*] they were never told about a note. The LFWA staff were up in arms until I told them that perhaps the true unfolding of events were not as initially reported. I will be looking at the report Monday in SAMPIS to determine if anyone, NOK, were told of the letter and also whether the parents were told. They have a copy of the letter; however, they want the original. We will be giving NOK/estate holder and executor the original so long as they want it. **This may turn out to be that the parents are not NOK which may be where the messiness of the situation arose.**

I wanted to give you a heads up in case anything came up over the weekend. Unfortunately, **West coast PAOs with 39 CBG are claiming this is going to “blow up” and have not demonstrated calm** in my reading of their initial reports.¹³⁶ [Emphasis added]

52. Maj Poulin, who had learned about the issue from the LFWA PAO,¹³⁷ reported the information she had obtained, further illustrating the ongoing confusion about what had happened:

Apparently, the soldier still had his ex-common law wife as primary NOK on PEN form at the time. The family apparently was told to go through ATI to obtain the note by an investigator.¹³⁸

53. The preparation of Media Response Lines (MRLs) about the issue soon became an important focus both for the CFNIS and the CF Area and Brigade. MRLs are draft questions and answers, key messages and talking points used by spokespersons to prepare for discussions with the media and to determine what information can be released publicly.¹³⁹ From the moment the Fynes' message about the failure to disclose their son's suicide note began to be circulated, the CFNIS and Area PAOs were in contact to discuss the preparation of the Lines.¹⁴⁰

54. During the following days and weeks, the documentary record revealed there was extensive activity and discussions about coordinating the response to the media and determining the content of the Lines. There were literally hundreds of pages of correspondence and draft MRLs with numerous revisions produced before this Commission for just this short period of time.¹⁴¹ There were also numerous additional discussions and meetings about the matter.¹⁴² It is clear the issue received considerable attention from many different organizations within the CF, including at the highest levels of the CDS and VCDS offices.¹⁴³

55. In addition to the communications between the PAOs for different units and the comments made by the different chains of command on the draft MRLs, there were also many inquiries from the PAOs in their attempt to understand and explain what happened. The CFNIS leadership was involved. The DCO, Maj Bolduc, noted there was much discussion and activity at CFNIS HQ in the immediate aftermath of discovering the failure to disclose the note about "the whole media aspect that was about providing answers, preparing our media lines, replying to journalists."¹⁴⁴ Information was also compiled in preparation for anticipated queries from Parliamentary Affairs and the VCDS office.¹⁴⁵ Maj Poulin made early contact with Maj Dandurand, asking for clarification and a review of the file in order to be able to provide responses.¹⁴⁶ She also sought information from Maj Bolduc and, subsequently, from LCol Sansterre.¹⁴⁷ The CFNIS

participated in the creation of the LFWA MRLs, but also eventually created its own separate MRLs.¹⁴⁸

56. The overall CFNIS approach in its media response was to admit the wrong and focus on positive aspects related to measures taken for the future. Messages from the CFNIS included expressions of regret, statements about procedures having been revised, and statements about the importance to the CFNIS of providing assistance to victims and their families.¹⁴⁹ Limited information was provided about what went wrong. The CFNIS PAO would subsequently use the suicide note incident “as a good teaching example” when briefing a more junior PAO who began working in the office the following year, indicating: “this is how you admit that you are wrong, and it is good to do so.”¹⁵⁰

57. There was strong concern throughout this period, both at the CFNIS and within the CF more generally, about the negative public perception that could result from the failure to disclose the note. When the Brigade Commander, Col K.A. Corbould, initially reviewed the draft LFWA MRLs, he took issue with wording indicating the CFNIS had initially “refused” to release the note.¹⁵¹ He noted this sounded “too much like us and them” and suggested the MRLs be revised to state the CFNIS “could not” release the note.¹⁵² His Chief of Staff, LCol Bradley, suggested:

Let’s look at wording that says something to the effect that [in accordance with] policies in effect the existence of this note and its release were governed under Evidence rules and would not have been released to either the BOI or the family. Recently, in part due to queries from this BOI, this rule has been changed to enable this release of info.

If everyone concurs, this wording **highlights the positive changes that the system has made.**¹⁵³[Emphasis added]

58. During the following weeks, there was further back and forth between Area and the CFNIS when Area “added their two cents” to the CFNIS messages by highlighting the CFNIS’ failure to advise the Regiment or the BOI about the note.¹⁵⁴ In the end, the CFNIS did not take steps to have the messages modified, since they were thought to relate to the BOI and were not inaccurate.¹⁵⁵

59. When the Brigade received a call from reporter David Pugliese on June 12, 2009, and set up an interview, Maj Dandurand expressed concern Mr. Pugliese might be trying

to “back door” the CFNIS by interviewing a CF Commander.¹⁵⁶ He wanted to have the questions about CFNIS issues directed to the CFNIS CO instead.¹⁵⁷ In the end, LCol Sansterre did not participate in the interview, but he did have changes made to the MRLs before it proceeded.¹⁵⁸

60. The interview took place on June 16, 2009, with the LFWA PAO.¹⁵⁹ On June 18, 2009, Mr. Pugliese contacted the CFNIS PAO with follow up questions.¹⁶⁰ In particular, he asked whether “any discipline measures were taken against the investigators” in connection with the failure to disclose the note.¹⁶¹ In response, Maj Poulin “just repeated the line about procedures being amended.”¹⁶² When Mr. Pugliese called a second time to ask again about disciplinary measures, Maj Poulin “spoke about process again.”¹⁶³ When he was advised about this, Maj Dandurand was concerned. He wrote:

Mr. Pugliese’s persistence in asking about disciplinary measures needs to be curbed because it would be completely inappropriate for any actions to be taken against anyone in this case. Believe me, if there was an appropriate disciplinary action [...] to be recommended and taken, I would be the first to say so. I suspect this will be the last of his questions; however, if it is not what are we prepared to say on the matter?¹⁶⁴ [Emphasis added]

61. Following this, media coverage was monitored closely.¹⁶⁵ Maj Poulin noted the CFNIS’ messages about regret, revising procedures and the importance of victim assistance were published.¹⁶⁶

62. When LCol Sansterre contacted Mrs. Fynes shortly after,¹⁶⁷ Maj Poulin was concerned Mrs. Fynes might contact the media again, and immediately prepared an additional line for the MRLs.¹⁶⁸ When the Fynes then requested a copy of the investigation report, Maj Poulin commented it would be “key” to provide the report as soon as possible and added she hoped the report did not end up going to the media.¹⁶⁹ During his subsequent interactions with the Fynes, LCol Sansterre asked Maj Poulin to “screen” one of his responses before he sent it.¹⁷⁰ In testimony, Maj Poulin explained it was not usual for her to be asked for advice about communications with families.¹⁷¹ She believed her input was sought about wording or “the way that things are said” because of the previous media interest about the issue.¹⁷²

63. The next two years saw continued significant activity to coordinate responses to the media every time the issue came in the public spotlight again. Hundreds of additional pages of correspondence and documents were created.¹⁷³ The CFNIS messages about the suicide note were incorporated into CF-wide MRLs created to address all of the issues related to Cpl Langridge's file.¹⁷⁴ They were also repeated in a statement issued by the CDS himself, after Mrs. Fynes held a press conference in October 2010.¹⁷⁵ Throughout this period, the concern about the CF's and the CFNIS' public image continued, and significant time, energy and resources were expended to prepare official responses. By comparison, less energy and fewer resources went into investigating what led to the failure to disclose Cpl Langridge's suicide note.

The Facts: How Did the Failure to Disclose the Suicide Note Occur?

64. Once it was discovered Cpl Langridge's suicide note had not been disclosed to his family for over 14 months, the obvious next step was to find out how this could have happened. During the days, weeks and months that followed the discovery of the failure to disclose the note, the CFNIS and its members provided many different explanations to the public, to other CF members and to the Fynes. Unfortunately, these explanations were not always compatible with each other, or even related to the facts of this case. The source or basis for some of them remains a mystery to this day. In many cases, the explanations were provided before steps were taken to find out what actually occurred.

65. Before this Commission, the Fynes have complained not only about the failure to disclose the suicide note, which they described as "inexcusable,"¹⁷⁶ but also about the CFNIS members having provided inaccurate rationales to explain and justify their actions.¹⁷⁷ The evidence reveals the efforts made by the CFNIS to obtain and provide accurate information about the facts fell far short of what should have been expected under the circumstances. The CFNIS created no record indicating it found out the exact reasons for not disclosing Cpl Langridge's suicide note to the Fynes. No clear explanation was ever provided to the family. What the Commission has learned about

what happened through the witness testimony in this hearing was not compatible with many of the explanations provided previously.

EXPLAINING WHAT HAPPENED

66. Very soon after the failure to disclose the suicide note was discovered, various explanations began to be advanced by CFNIS members.

67. On May 29, 2009, two days after the Fynes' initial message complaining about the failure to disclose the note, Maj Dandurand was in communication with Col Hammond about the issue. In these exchanges, he wrote:

It is worthwhile to note this letter is held as evidence and **it is not routine for us to divulge or release evidence in a case and evidence is held for [several] years.**¹⁷⁸
[Emphasis added]

68. On May 30, 2009, the Chief of the Land Staff (CLS) requested an explanation from the Land Force Provost Marshal (LFPM) about “why the NIS withheld the note from the BOI and the family for some 14 months.”¹⁷⁹ LCol Rod Lander was the LFPM at the time. He testified his role in this case was to gather information from the CFNIS and provide it to the Army Commander, who needed to know what the issues were in order to address any future complaints about how the CF handled the case.¹⁸⁰ When he received the request for an explanation, LCol Lander forwarded it to LCol Sansterre and to the CFPM.¹⁸¹ He asked LCol Sansterre if they could discuss the matter on the following Monday “as the CLS will want an answer, and I want to make sure I have it right.”¹⁸²

69. The following Monday, June 1, 2009, LCol Lander provided the following explanation:

This is the information I have to this point:

The incident occurred 15 Mar 08. The MP Investigation was concluded in July 08. **It appears that the MP investigative team did not reveal the existence of the note to the family as it, in their opinion, would not have added anything to the information already passed during the normal victim services provided, and they felt it may have even had a negative effect.** The fact that the note existed was passed to the BOI with the original documentation provided by the CFNIS. The BOI asked for a copy and were provided one 3 Feb 09 once permission from DPM Police was granted. **The OC of CFNIS Western Region is conducting a detailed Quality Assurance (QA) review of the file and the investigation it represents, which should be concluded by 5 Jun 09. This will include the decision to not reveal the existence of the note to the family by**

the investigative team. The original note is no longer deemed evidence and is in the process of being passed to the family [in accordance with] their request.

This is another incident which indicates to me that the role of MP Victim Services and its interaction with other agencies involved with Casualty Care/Administration is still not well understood by all involved parties, nor is it working particularly well all the time. This will form part of the QA review mentioned above and I will discuss this issue again with the CO CFNIS when he lands in Ottawa.¹⁸³ [Emphasis added]

70. In mid-June 2009, an additional explanation was provided in a revised version of the CFNIS MRLs:

If pressed on whether the suicide note was mentioned during the interview of the mother and stepfather of Cpl Langridge

The mother and stepfather did not ask about a note, and were aware of the coroner's findings into the cause of death. **They did not ask about a note and the investigators did not mention it as the investigation was still ongoing...**¹⁸⁴ [Emphasis added]

71. On June 18, 2009, Maj Dandurand provided yet another explanation. In his message to Maj Poulin about Mr. Pugliese's questions on disciplinary measures, he wrote:

In a nutshell, **the investigator and the case management team did everything in good faith and at no point was the family's well being pushed aside.** As you can appreciate, unless a person goes through an identical situation, **a series of assumptions are made regarding what is in the best interest of the family.** Those assumptions are based on personal experiences in dealing with such matters in the past and **those involved in this particular case, they had many previous investigations of suicide in their repertoire.** We do this constantly when dealing with estates and returning of personal belongings. **There are personal belongings that families of deceased have no reason to be given and we make those careful decisions as and when required.** By returning those items, they only serve to tarnish the remaining image a mother, spouse, loved one has of their deceased family member. [...]

As always, I submit my "two cents" worth for your consideration in dealing with these issues.¹⁸⁵ [Emphasis added]

72. During his first meeting with the Fynes in November 2009, Maj Dandurand provided a different explanation:

First off, **we, at the time, had a policy where we just -- we don't divulge all of these notes,** and you have to appreciate that, at the time, when you're dealing with a death, it's viewed as suspicious.

Now, until such time as we determine that, in fact, we're dealing with suicide as opposed to a suspicious death, we're not going to communicate on that note.¹⁸⁶ [Emphasis added]

73. Another explanation was provided in January 2011. The Fynes had transmitted a series of questions to the CF, including a specific question about the failure to disclose the suicide note. The following statement was included in the answer they received:

The suicide note found with Corporal Langridge was seized as part of the criminal investigation into the sudden death. Upon conclusion of the investigation, **the suicide note was intended to be released to the decedent's parents. However, this was not conducted as expediently as it could have been.**¹⁸⁷ [Emphasis added]

74. Individually, these explanations provided little clarity. Taken together, they made it difficult if not impossible to understand exactly what happened with Cpl Langridge's suicide note and what the reasons were for not disclosing it.

FINDING OUT WHAT HAPPENED

75. LCol Sansterre was advised about the failure to disclose Cpl Langridge's suicide note on May 30, 2009.¹⁸⁸ He testified the first step he took as soon as he learned about it was to "gather the facts" to find out what happened.¹⁸⁹ For this purpose, he ordered a Quality Assurance review of the entire 2008 investigation.¹⁹⁰ He explained:

[...] I asked that a quality assurance review be done on that entire investigation to determine what happened and what could have been done differently and to make sure that if something went wrong, we didn't do that again.¹⁹¹

76. Maj Bolduc was notified of the issue at the same time.¹⁹² He indicated his first reaction was to wait until the facts were verified, to find out "whether it was true that the letter was not given and what the circumstances surrounding it all were."¹⁹³ He explained it was not common or habitual for the CO to order a QA review on a specific file.¹⁹⁴ In this case, the QA analysis was requested as a direct result of the events surrounding the failure to disclose the suicide note.¹⁹⁵ Maj Bolduc also explained the CO asked for the complete file to be reviewed "to see [...] whether there were other things we had not done properly, whether there were other problems besides the suicide note that had not been given to the family."¹⁹⁶ Maj Dandurand, for his part, explained the QA review was designed "to highlight our lessons that we have to learn."¹⁹⁷ He noted it was understood the investigation "was now going to be called into question" as a result of the surfacing of the suicide note, and he explained the CFNIS leadership wanted to ensure they had access

to in-depth knowledge about the case, since this knowledge “was not as fresh in everybody’s mind as what a quality assurance would afford us.”¹⁹⁸

77. In addition to ordering the QA review, LCol Sansterre also testified he had immediate discussions with Maj Dandurand to try to determine why the suicide note had been withheld.¹⁹⁹ In testimony, Maj Bolduc indicated there were numerous discussions about the suicide note at CFNIS HQ at the time “to try to determine, to understand the reasons why it had not been given to [the family].”²⁰⁰ The questions being discussed included: “what happened in that case; why were the parents not informed that a note existed? Why was it not given to them?”²⁰¹ The CFNIS CO was involved in these discussions and also had separate discussions with Maj Dandurand about the issue.²⁰²

78. On June 18, 2009, a little over two weeks after he found out about the note, LCol Sansterre had a telephone conversation with Mrs. Fynes.²⁰³ He had still not received the report for the QA review at the time.²⁰⁴ He told Mrs. Fynes he did not know “how this could have happened” and stated the CFNIS were “going to get to the bottom of it and we’ll figure out what happened.”²⁰⁵

79. During the exchanges immediately following the discovery of the failure to disclose the note, Maj Dandurand had also separately told the LFWA Chief of Staff, Col Hammond, he would look into the matter to find out what happened. On May 29, 2009, he indicated he would “speak with investigators and review the file” and get back to Col Hammond the following week.²⁰⁶ In testimony, Maj Dandurand could not recall what steps were taken in the following days to provide answers to Col Hammond, and could not recall getting back to him “on that specific issue.”²⁰⁷ Col Hammond testified he never received a satisfactory explanation about why the note was not disclosed for 14 months.²⁰⁸ At the time, Maj Dandurand did not speak with the investigators or review the file.²⁰⁹ He explained he relied on WO Ross to gather information and convey it to him.²¹⁰ He expected WO Ross to be “intimately aware of the file” and relied on his input.²¹¹

80. WO Ross had been involved in the early discussions about the Fynes’ request for the original suicide note. At the time, he had suggested they make an ATI request to obtain it. He was then tasked with conducting the QA review requested by LCol

Sansterre.²¹² Maj Dandurand explained QA reviews were generally conducted by the Detachment MWO “due to their years of experience and [...] their ability to be critical” but also because it required taking the person out of the normal activity of the Detachment for a period of five to ten days devoted solely to the review.²¹³ The QA review in this case was ordered shortly after May 30, 2009 and was completed on June 19, 2009.²¹⁴

81. WO Ross was well aware the QA review had been initiated as a result of the failure to disclose the suicide note. When questions were received from the media about the issue during the review, WO Ross was asked for an update and was advised there would be a “media issue” about this.²¹⁵ The report itself specified the QA review was initiated “resultant of a complaint brought forward by Cpl LANGRIDGE’s family who were concerned with the lack of optics of the suicide note and the delay in the delivery of the [subject] suicide note.”²¹⁶ Yet, the QA report provided no information about what actually happened with the suicide note in this case and why it was not disclosed to the Fynes.

82. The report opened with a statement indicating “the totality of the investigation was found to be technically sound” and provided a series of comments about “investigative procedures” and “administrative procedures.”²¹⁷ In total, a little over one page of the seven-page report was devoted to the suicide note. In the comments on investigative procedures, the report noted no steps were taken to compare the handwriting from the note to a known sample of Cpl Langridge’s handwriting or otherwise confirm the authenticity of the note.²¹⁸ However, the report concluded the “scene indicators” and the comments made by the ME at the scene “led the investigators to make the assumption [the note] was drafted by the deceased.”²¹⁹ In one of the comments about administrative procedures, the report also noted there was no mention of the suicide note in the Case Summary for the investigation, indicating reference to this “key element” would have “further supported the manner of death.”²²⁰

83. A separate comment, still in the section devoted to administrative procedures, related directly to the disclosure of the suicide note. It stated:

f. detailed in MCpl Ritco's OF2 text box, at para 61, he articulates that at "1700 hrs, 9 Apr 08, Mr. CAUFIELD (ME) returned call, no need to bring items in, as 10 of the 11 tests have been conducted. There appears to be no evidence to support foul play, therefore at this time it will be classified as suicide." It is at this point consideration by the investigators in consult with the Case Manager, be given to the fact of meeting with the family and providing them with the salient points of the investigation to date and would have presented an opportune time to have the family members review the suicide note to verify the authenticity of the handwriting and possibly give them a copy at that time. If the decision was made not to move forward with any briefings to the family until such time as they received the official report from the ME, the Certificate of Medical Examiner was received 15 May 08, which provided definitive conclusion concerning the manner of death – suicide;²²¹

84. Another comment related to telephone conversations the lead investigator, MCpl Matthew Ritco, had with the Fynes in May 2008, before the investigation was concluded. The report noted, "at no time through the course of either of these conversations was the existence of a suicide note discussed."²²² The following explanation was provided:

In speaking with MCpl Ritco, it was not something that was in the forefront of topic of discussion and that neither Mrs nor Mr FYNES broached the subject or made inquiries of this nature...²²³

85. The concluding section of the report contained three recommendations. One related to the suicide note and simply suggested "a cognizant and informed decision" be made about when to advise the family of the existence of a suicide note, when to allow the family to view the note and when to release the original note to the family.²²⁴

86. The report provided no information about the actual reasons why Cpl Langridge's suicide note was not disclosed in this case. It did not indicate whether this was the result of an oversight or a conscious decision. It did not provide any insight about who was responsible for making decisions about disclosing the note, whether such decisions were made, and if so by whom, when or why. Having received this report, the CFNIS chain of command would have had no further information about what happened with Cpl Langridge's suicide note. In testimony, LCol Sansterre recognized nothing in the QA report explained why the suicide note was not disclosed in this case.²²⁵ He recalled discussing the report with members of the HQ staff, but did not recall any concerns arising out of the report.²²⁶

87. Maj Bolduc testified he was not involved in any attempt to find out why the suicide note was not disclosed and believed the CFNIS CO and the Detachment OC were looking after this aspect. He explained:

À ce moment-là, je me concentrais plutôt à essayer de trouver une façon pour pas que ça se reproduise. **Alors, l'explication de pourquoi que c'est arrivé, je laissais ça entre le commandant du détachement et puis le Colonel Sansterre à gérer.** J'essaie plus de développer le SOP, m'assurer qu'on ne refasse plus ce genre d'erreur-là.

Alors, la discussion du pourquoi, comment c'est arrivé, tout ça, ce n'était pas nécessairement ce qui m'avait été donné comme tâche, mais plutôt pour éviter que ça se reproduise.²²⁷

[TRANSLATION]

At that point, I was more focused on trying to find a way to make sure it didn't happen again. **So the explanation of why it happened, I left that for the detachment commander and Colonel Sansterre to handle between them.** I tried more to develop the SOP, to make sure we didn't make that kind of mistake again.

So the discussion of why and how it happened, all that, it was not necessarily the task I was given[,] that was to avoid it happening again.²²⁸ [Emphasis added]

88. LCol Sansterre testified he did not personally interview the investigators to find out what happened, nor task anyone else to do so.²²⁹ He thought this would have been done during the QA review.²³⁰ However, only one of the members involved in the investigation was contacted during the review.²³¹

89. In testimony, MCpl Ritco recalled being contacted by WO Ross, who was “drafting up his report” at the time and wanted to get clarification before submitting it.²³² The report only mentioned information obtained from MCpl Ritco when discussing the reasons for not mentioning the note during the conversations with the Fynes.²³³ It contained no indication MCpl Ritco (or anyone else) was asked about the reasons for not disclosing the suicide note at any other time during or after the investigation.

90. The case manager, WO Ross Tourout, and the other investigator involved in the seizure of the suicide note, Sgt Jon Bigelow, were not interviewed by WO Ross during the review.²³⁴ The Detachment MWO and Acting OC who had overall responsibility for the supervision of the investigation, MWO Barry Watson, was also not contacted.²³⁵

MWO Watson testified:

[...] I was never consulted when this quality assurance was being conducted. Whether or not I was a member of the unit or a member of a different unit, I was the senior person in place at the time, if they're going to do a quality assurance, then I should have been con -- not consulted, and be spoken to about the conduct of the investigation.²³⁶

91. Maj Dandurand, the Detachment OC, also did not have any discussions with Sgt Bigelow, WO Tourout or MWO Watson about what happened with the suicide note.²³⁷ In fact, these members all testified they were never asked for an explanation by anyone prior to this hearing.²³⁸

92. Maj Dandurand testified he did have a discussion with MCpl Ritco about the suicide note.²³⁹ However, he could not recall when the discussion took place or what its content was.²⁴⁰ No record could be located indicating what explanations he received from MCpl Ritco, if any, about what happened.

93. During the months following the discovery of the failure to disclose the note, Maj Dandurand also did not review the file to find out what happened.²⁴¹ When he did review it months later in preparation for a meeting with the Fynes, his focus was on the redactions done to the file, and he did not do an “intricate delving” into the file or inquire about what the exact process was which led to the suicide note still being held in the evidence room so long after the fact.²⁴²

WHAT HAPPENED?

94. The suicide note was first located by the CFNIS investigators, MCpl Ritco and Sgt Bigelow, on March 15, 2008, the day Cpl Langridge died. They found the note on the desk shortly after they entered the room where Cpl Langridge’s body was found.²⁴³ Sgt Bigelow first transcribed its contents in his notebook.²⁴⁴ The note was then seized and placed in an evidence bag.²⁴⁵ It was treated the same as other exhibits. The investigators wore gloves while handling it.²⁴⁶

95. A copy of the note was made for the Alberta Medical Examiner while the note remained in the evidence bag.²⁴⁷ The ME’s office was satisfied to take only a photocopy of the note and did not require the original.²⁴⁸ At the time, there were no discussions about whether and when to release the note to the family.²⁴⁹ According to the testimony

of the ME investigator present at the scene, the ME's office would have had no objection to a copy of the note being provided to the family at any time, and did not need the CFNIS to retain the original for any period of time.²⁵⁰

96. After the copy was provided to the ME investigator, MCpl Ritco kept the original note.²⁵¹ When he returned to the Detachment that night after processing the scene, he put it in his temporary evidence locker.²⁵² An Evidence Collection log was prepared, and the suicide note was listed as Exhibit number 2.²⁵³

97. MWO Watson, the Detachment MWO and Acting OC for the Detachment, was briefed about the suicide note on the day it was seized.²⁵⁴ WO Tourout, the Case Manager for the investigation, was advised about the note in the following days.²⁵⁵

98. MCpl Ritco testified that in the early days of the investigation, he and WO Tourout discussed whether the suicide note could be released.²⁵⁶ They talked about whether the note had evidentiary value, who was the next-of-kin and to whom the note should go.²⁵⁷ They specifically asked themselves whether the note could be released or if it had to be kept.²⁵⁸ A decision was made not to release the note.²⁵⁹ The factors considered in making the decision included the fact the investigation was in the early stages, the possibility of foul play and the uncertainty surrounding Cpl Langridge's common-law status.²⁶⁰ In testimony, MCpl Ritco explained:

As the lead investigator my stance was this is early on in the investigation, that this potentially could be evidence. Now, if we were to turn over the suicide note, the original copy to the family, we could be giving away potential evidence.²⁶¹

99. At the time, the only options considered were to release the original note to the family or not release it.²⁶² There was no discussion about advising the family of the existence of the note or providing a copy.²⁶³

100. There was no record of this discussion in the investigative file or in MCpl Ritco's notebook.²⁶⁴ Several entries in the notebook documented briefings to WO Tourout or discussions with him. Most included a general mention of the purpose of the discussions but no detail about their contents.²⁶⁵ None referred directly to a discussion about the suicide note, but MCpl Ritco testified he had a clear recollection about it.²⁶⁶ In his

testimony, WO Tourout did not specifically refer to a discussion with MCpl Ritco but confirmed a decision was made not to release the note in the early stages of the investigation. When asked whether the investigative team considered telling the family about the funeral wishes contained in the note, he testified:

It certainly crossed our mind and it's very unfortunate **at that point in time that we couldn't release it** and we feel, obviously we feel bad about that, but as **at that time it was just too soon, in our mind, in our mind in our investigation**, in Sergeant Ritco's investigation.²⁶⁷ [Emphasis added]

101. MWO Watson did not recall being involved in discussions about releasing the suicide note to the family.²⁶⁸ He believed he would have been consulted about this issue.²⁶⁹ He did not recall any issue being brought to his attention during the investigation that raised flags for him.²⁷⁰ He testified he did not have any specific expectation about the disclosure of the note and did not recall those issues coming into his mind at all at the time.²⁷¹ Sgt Bigelow was also not aware of a decision not to disclose the suicide note to the family.²⁷² He explained, because his role in the investigation was circumscribed, he would not necessarily have expected to be advised.²⁷³

102. MS Eric McLaughlin, who was briefly involved in the investigation as a note-taker during a witness interview, testified he was aware of the existence of the suicide note while the investigation was ongoing.²⁷⁴ He did not recall how he learned of it or when.²⁷⁵ He was not involved in any discussions about the note, and was not aware of any steps being taken or decisions being made with respect to disclosing the note to the family.²⁷⁶

103. On March 20, 2008, five days after Cpl Langridge died, MCpl Ritco met with Maj Earl Jared from the Regiment.²⁷⁷ As he was leaving Maj Jared's office, an individual, who identified himself as 2Lt Adam Brown, approached him and indicated he was the AO for Cpl Langridge's common-law spouse.²⁷⁸ He then told MCpl Ritco he "heard that there is a note" and asked if he could tell him about it.²⁷⁹ MCpl Ritco answered he could not say anything as the investigation was ongoing.²⁸⁰ In testimony, MCpl Ritco explained he provided this answer because he did not know who 2Lt Brown was when he

approached him.²⁸¹ Even once his identity was confirmed, MCpl Ritco did not think he should be providing him more information.²⁸² He explained:

[...] until the completion of my investigation, it wasn't -- nothing was revealed. I wasn't going to tell Lieutenant Brown that there was a note even though he was the AO. The same thing [if] Mr. and Mrs. Fynes had an assisting person. I wouldn't tell him, either. If I was going to brief anybody, it would be directly to the family or the next of kin.²⁸³

104. MWO Watson believed MCpl Ritco would have sought guidance about whether to reveal the existence of the suicide note to 2Lt Brown.²⁸⁴ He did not recall being consulted on this point.²⁸⁵ WO Tourout, for his part, testified he was not aware 2Lt Brown had asked about the note.²⁸⁶

105. On April 2, 2008, approximately two weeks after Cpl Langridge's death, MCpl Ritco was contacted by MWO Remi Mainville from the Regiment.²⁸⁷ MWO Mainville was in charge of inventorying and handling Cpl Langridge's personal effects.²⁸⁸ He asked MCpl Ritco to provide him with a list of the items the CFNIS had kept so he could include it in his inventory.²⁸⁹ The next day, MCpl Ritco provided a list of some of the items he retained.²⁹⁰ The list included Cpl Langridge's Blackberry, an AA book, a Bible and family get well cards.²⁹¹ The suicide note was not listed or mentioned. In his message to MWO Mainville, MCpl Ritco advised: "after going [through] my evidence here [are] the only things that I feel that are of a personal effect would be as follows: [...]. Other items do not personal[ly] belong to Cpl LANGRIDGE. Should you require any more information please let me know."²⁹² In testimony, MCpl Ritco explained his reasons for not including the suicide note in the list provided to MWO Mainville:

[A]t the time I felt that it was an ongoing investigation. I was still dealing with a sudden death. I didn't know which way it was going. I didn't think that --although MWO Mainville was looking after his personal effects, I didn't feel that he needed to know that there was a suicide note.²⁹³

106. MWO Watson did not recall being consulted about the decision not to include the note in the list provided to the Regiment.²⁹⁴

107. Shortly before sending the list to MWO Mainville, MCpl Ritco had scanned a copy of the suicide note into the electronic investigation file.²⁹⁵

108. On April 9, 2008, MCpl Ritco took the original suicide note from his evidence locker and placed it in the Evidence Room for the Detachment.²⁹⁶ Prior to this date, he had not taken the note out of his locker at any time.²⁹⁷

109. Nothing more was done with the suicide note until the BOI discovered its existence in March 2009.²⁹⁸ The note was not mentioned again anywhere in the investigative file or in the two investigators' notebooks.²⁹⁹ There was no reference to it in the Investigation Plan, the Case Summary or the Concluding Remarks for the investigation.³⁰⁰ No sample of Cpl Langridge's handwriting was obtained to compare it to the handwriting on the note.³⁰¹ The note was never fingerprinted.³⁰² No other tests were performed to confirm its authenticity.

110. There is no indication the CFNIS members involved intended to contact Cpl Langridge's family at any time to advise them about the note. On April 15, 2008, WO Tourout told MCpl Ritco there was no need to contact Cpl Langridge's mother for the investigation.³⁰³ On May 27, 2008, MCpl Ritco was advised WO Tourout and MWO Watson had determined there was also no need to contact Cpl Langridge's common-law spouse.³⁰⁴ When the Fynes initiated contact, MCpl Ritco had separate telephone conversations with Mrs. and Mr. Fynes on May 5 and May 9, 2008.³⁰⁵ He did not mention the suicide note.

111. MCpl Ritco concluded his investigation on June 2, 2008.³⁰⁶ WO Tourout reviewed the file on June 12, 2008.³⁰⁷ On July 1, 2008, MWO Watson approved the report and officially marked the file as concluded.³⁰⁸ On July 3, 2008, the Acting CO for the CFNIS, LCol Brian Frei, reviewed the investigative file.³⁰⁹ LCol Frei was the DCO for the CFNIS throughout the investigation.³¹⁰ He did not recall being specifically advised about the suicide note during the investigation.³¹¹ When he reviewed the file, he testified he would have seen references to the note being seized and a copy being provided to the ME, and he "wouldn't have thought anything [...] further about the note."³¹² The references to the suicide note found in the file did not raise any flags for him.³¹³ He made no mention of the note in the entry he added to the file after his review.³¹⁴

112. LCol Bud Garrick, the CFNIS CO until June 2008, did not recall whether he was advised about the suicide note in this case.³¹⁵ He also did not recall whether he asked about a note being found at the time.³¹⁶

113. After the investigation was concluded, no immediate steps were taken to dispose of the exhibits seized.

114. On October 23, 2008, MCpl Ritco was contacted about the release of Cpl Langridge's personal effects. Ms. Suzanne Touchette, who worked at the JAG Director of Estates office in Ottawa, sent a message to the Fynes' AO and the President of the Committee of Adjustments (COA), providing authorization to the Regiment to release Cpl Langridge's effects to his executor, Mr. Fynes.³¹⁷ She stated MCpl Ritco, who was also copied on the message, "had informed the COA that approximately 13 items were being held in support of their ongoing investigation."³¹⁸ She asked the recipients to ensure the items were no longer required by the CFNIS and had been returned.³¹⁹ She added it was important to make sure any items still required by the CFNIS for any reason were eventually returned to the executor.³²⁰

115. When he received this message, MCpl Ritco forwarded it to Sgt S.B. Miller at the CFNIS WR Detachment, asking him to provide "guidance regarding the release of Cpl LANGRIDGE's personal effects from our evidence room that we no longer require."³²¹ In response, MCpl Ritco testified he was told the process for the release of the exhibits would be handled "by the senior staff."³²² Prior to this exchange, MCpl Ritco had not been involved in any discussions about holding or releasing the exhibits since the conclusion of the investigation.³²³

116. As a result of MCpl Ritco's inquiries, a letter requesting authority to dispose of the CFNIS evidence was prepared.³²⁴ The letter was dated October 31, 2008, and was addressed to the CO for Cpl Langridge's Regiment.³²⁵ It was signed by MWO Watson.³²⁶ In testimony, MWO Watson explained the request for disposal authority was prepared because the Detachment had received a request for the return of Cpl Langridge's property.³²⁷ He testified that, had this request not been received from the Regiment, the

letter seeking authority to dispose of the exhibits would likely never have been prepared by the Detachment.³²⁸

117. MWO Watson's letter advised the investigation into Cpl Langridge's death was complete, and stated the Regiment CO's authority was requested "to dispose of evidence that was seized during the course of this investigation," in accordance with applicable MP policies.³²⁹ It noted the items listed would be returned to Cpl Langridge's estate once authority was received.³³⁰ Included in the letter was a list of 13 items seized during the investigation.³³¹ The suicide note did not appear in the list.

118. MWO Watson testified he did not send requests for disposal authority routinely.³³² He did not recall who prepared the request in this case.³³³ His normal practice would have been to draft the letter himself and ask the lead investigator or another investigator to draft the list of evidence.³³⁴ MCpl Ritco did not have a clear recollection, but testified he may have compiled the list of items to return.³³⁵ At a minimum, he knew he had input in the preparation of the request and was certain he at least confirmed he "no longer required anything that was in our evidence room in regards to personal effects or seized items."³³⁶

119. On the day the letter was sent, MCpl Ritco added an entry to the file and contacted MWO Mainville at the Regiment to notify him.³³⁷ He advised once approval was granted, the evidence custodian for the Detachment would contact him to make arrangements for him to take possession of Cpl Langridge's effects.³³⁸

120. On January 21, 2009, the Regiment CO, LCol Derek Macaulay, granted authority for the disposal of Cpl Langridge's effects listed in MWO Watson's letter.³³⁹ On January 26, 2009, the items were turned over to MWO Mainville by the Evidence Custodian.³⁴⁰ As it was not listed in the request, the suicide note was not turned over to MWO Mainville.³⁴¹ Nothing further was done with the suicide note until the BOI requested a copy.

TAKING STOCK

121. On the basis of the testimony heard, it is clear the suicide note was initially seized because it was viewed as evidence relevant to the determination of the cause of Cpl Langridge's death.³⁴² While there was no actual plan or intent to test the note when it was seized, or at any other time during the investigation,³⁴³ the CFNIS members involved believed the note had to be seized, handled and retained as an exhibit during the investigation to ensure it would be available for testing if foul play was suspected or if there was question about the cause of death.³⁴⁴ No testing was done because there were no serious concerns about foul play or about the authenticity of the note.³⁴⁵

122. After the seizure of the note and the early determination by MCpl Ritco and WO Tourout that the original could not be released to the family at this stage, nothing further was done with the note.³⁴⁶ As it quickly became increasingly clear Cpl Langridge had indeed committed suicide, the note lost prominence and was eventually forgotten. WO Tourout testified:

Unfortunately, as I testified earlier and, I think, Sergeant Ritco and others before me, **the suicide note was forgotten. It's regrettable.** I know action has been taken within the CFNIS to correct that issue.

I'm sorry. I'm sorry, myself as well as everybody else who has testified. It's unfortunate but it happened.³⁴⁷ [Emphasis added]

123. He explained both he and MCpl Ritco forgot about the note.³⁴⁸ His testimony was not entirely clear as to the precise time when this happened. At times, he appeared to indicate it was at the end of the investigation.³⁴⁹ At other times, he indicated it was earlier. In particular, he explained the investigation's focus moved away from foul play in the very early days and indicated the suicide note was not relevant to the other aspects investigated and was forgotten.³⁵⁰ He also stated it was because the note had been forgotten that there were no discussions about the possibility of concluding the investigation sooner to ensure the family could be advised earlier.³⁵¹

124. From the Commission's review of the file, there is no evidence any of the investigators remembered the note at any time after MCpl Ritco put it in the Evidence Room on April 9, 2008.³⁵² Aside from the entries related to its seizure, not a single entry

in the 714-page investigation file refers to the suicide note. Even the Investigation Plan and the Case Summary (where both LCol Garrick and LCol Frei expected to see a reference to it) did not mention the note.³⁵³ It was not discussed during the interviews, not tested, not referred to and its existence was not disclosed to anyone. MCpl Ritco did not mention the note when he spoke to the Fynes in early May, although during his testimony at the hearing, he indicated he believed he should have done so.³⁵⁴ He provided no explanation for not discussing the note at this time. From the totality of the evidence, it is clear he had forgotten about it by then.

125. During their testimony before this Commission, the members involved in the investigation all appeared to agree the original suicide note had to be retained until the end of the investigation to ensure it was available if testing became necessary.³⁵⁵ However, they expressed different views about whether the existence of the note could have been revealed and a copy provided to the family before the end of the investigation. Some thought the family could and should have been advised about the note right away or very early on, and did not think there was any reason for not telling others, like Ms. A's AO or the Regiment, about the note.³⁵⁶ Others thought the family could only have been notified once foul play was ruled out or the note was no longer required for evidentiary purposes, and did not think the Regiment or anyone else should have been advised.³⁵⁷

126. On several occasions during his testimony, MCpl Ritco referred to the absence of a specific policy about the handling of suicide notes as a reason why he did not think the family could or should have been advised about the note or provided a copy before the end of the investigation.³⁵⁸ His testimony was not entirely clear on this point. On the one hand, he emphasized no policy provided for the specific option of advising the family about the contents of the note without providing the original.³⁵⁹ On the other hand, he stated in the absence of a specific policy, he could make his own determination about disclosing the note in consultation with his chain of command.³⁶⁰ He also stated he thought the note was to be treated like any other piece of evidence because there was no policy.³⁶¹ He could not provide any evidentiary reason for not disclosing the existence of the note to the family.³⁶²

127. Regardless of the views expressed at the time of their testimony about what could or should have been done to advise the family about the note, what is clear from the evidence is none of those factors were actually considered by the members involved in the investigation at the time of the events. The only question considered by MCpl Ritco and WO Tourout was whether the original note could be released. The possibility of advising the family of the contents of the note without releasing the original was not discussed or considered.³⁶³ Sgt Bigelow and MWO Watson were not involved in the discussions, and both testified they did not turn their mind to the issue at all at the time.³⁶⁴ In fact, MWO Watson testified the only reason Cpl Langridge's family was not advised about the note early on was because "it didn't come into my mind to release it to the family like it should have."³⁶⁵

128. The Commission finds the reason the Fynes were not told about Cpl Langridge's suicide note during the investigation is that no one at the CFNIS thought about whether they should be told. It cannot be known what the result would have been if the CFNIS members had considered the issue.

129. As for the original suicide note, it was not provided to the family when the investigation was concluded because, as MCpl Ritco put it, "it fell through the cracks."³⁶⁶

130. MCpl Ritco had assumed the note would be released at the end of the investigation in the normal course.³⁶⁷ He believed there was a process in place for disposing of the exhibits once an investigation was concluded.³⁶⁸ In reality, MWO Watson explained there was no such process, and no one in the Detachment was tasked with ensuring evidence was disposed of when investigations were concluded.³⁶⁹ He noted this was a task "that was overlooked in a lot of investigations" and "should have been delved into more on a regular basis."³⁷⁰ As a result, exhibits seized during the Detachment's investigations often would "just remain in our evidence room."³⁷¹ He testified:

If I can compare it to a smaller detachment [...], their evidence load is pretty low, so they have the ability to go in there and review their evidence and dispose of it, and ask for disposal authority, on a regular basis.

NIS [Western Region] holds an incredibly large amount of evidence. So did we go in there as much as we should have to request disposal on any investigation? No.

There is evidence held on investigations that are years old at CFNIS Western Region.³⁷²

131. In his testimony, Maj Dandurand confirmed the Detachment was “not very efficient at disposing of our evidence in a swift manner” and also testified as a result “it was not uncommon for evidence to be held for several years.”³⁷³ There was a policy requiring the Detachment OC to conduct an annual inspection of the evidence room, which technically would have required going through each piece of evidence to determine if it was still required.³⁷⁴ However, MWO Watson testified this would have been “a year-long project in itself” and indicated he did not carry out any such inspection when he was the Acting OC for the Detachment.³⁷⁵

132. Maj Bolduc also testified about the CFNIS’ practices for disposing of evidence seized. In principle, he explained the evidence custodian should have been put in charge of making determinations about the return of evidence and the Detachment OC should have been responsible to verify files periodically.³⁷⁶ In practice, he indicated some Detachments proceeded more quickly than others with the disposal, and some actually waited in case new information came to light, even where charges were not brought.³⁷⁷ LCol Robert Delaney, who was the CFNIS CO in 2011-2012, testified the time required to dispose of evidence depended on “the operational workload of the detachment.”³⁷⁸

133. When the investigation into Cpl Langridge’s death was concluded in June 2008, the exhibits seized simply remained in the evidence room and nothing was done to return them to anyone. Because no one remembered the suicide note by then, none of the members involved in the investigation followed up to ensure it was provided to the family at the end of the investigation.

134. When steps were taken three months later to return the exhibits because MCpl Ritco happened to be contacted by the Director of Estates, there was an oversight on the part of the investigator who prepared the list of items to be returned – most likely MCpl Ritco – and the note was not included.³⁷⁹ Because it had long been forgotten by then, no one noticed its absence.³⁸⁰

135. On the basis of the evidence heard about the Detachment’s evidence-handling practices, there is every reason to believe, had it not been for the BOI’s intervention, Cpl

Langridge's suicide note would have simply remained in the CFNIS WR evidence room for years, with no one ever being advised about it.

MAKING SENSE OF THE EXPLANATIONS

136. Having ascertained the reasons why Cpl Langridge's suicide note was not disclosed to his family, it is readily apparent the facts are difficult to reconcile with many of the explanations provided about them.

137. First, in the days following the discovery of the failure to disclose the note, Maj Dandurand had written the note was "held as evidence" and explained it was "not routine" for the CFNIS to release evidence as it was generally "held for [several] years."³⁸¹ We know the members involved in the investigation expected the original note would be released immediately at the end of the investigation.³⁸² No one thought it needed to be held for any period of time, much less for several years. MWO Watson did state that in practice, evidence often ended up remaining in the evidence room for years after cases were concluded, but this was the result of lax practices for returning exhibits and not of any policy requirement.³⁸³

138. Maj Dandurand testified he believed the note was still "classified as evidence" at the time he provided his explanation.³⁸⁴ When asked what it was evidence of, he explained:

Simply as a classification not necessarily of anything because thought had been given to whether we should be disposing of it or not at that time.³⁸⁵

139. He indicated his understanding was, if the CFNIS was still holding the suicide note so long after the investigation when all other personal belongings had already been returned, they would have been holding it "only because it was evidence."³⁸⁶ This understanding, as well as his belief evidence was usually held for several years, came from a conversation he had with members of his Detachment who were "experienced in this domain."³⁸⁷ Maj Dandurand had never personally encountered this issue previously.³⁸⁸ He had not had the opportunity to speak with those involved in the investigation before he provided his explanation, but he had discussed the matter with the then Detachment MWO, WO Ross, and they were both of the view the suicide note was

still classified as evidence pursuant to the procedures for evidentiary holdings applicable at the time.³⁸⁹ In testimony, Maj Dandurand recognized that what he then viewed as the “policy” was, in fact, a practice to hold suicide notes as evidence “until such time as they were disposed of,” which would happen “as part of a regular review” of the evidence holdings when the notes would “come to the surface.”³⁹⁰ He also admitted the evidence often ended up being “held for several years” due to the lack of efficient processes for disposing of evidence.³⁹¹ Based on these explanations and on what Maj Dandurand wrote when he was first advised about the failure to disclose the note, it appears the lack of adequate processes for the return of exhibits had become viewed by the Detachment chain of command as a policy requirement or best practice. Regrettably, because it was the way things were done, the members and even the chain of command came to believe it was the way things were supposed to be done.

140. The explanation provided by LCol Lander a few days later focused on the reasons why the existence of the note was not revealed to the Fynes and indicated the investigative team decided not to disclose it because “in their opinion, [it] would not have added anything to the information already passed during the normal victim services provided, and they felt it may have even had a negative effect.”³⁹² This bears no relation whatsoever to the events that occurred. The Fynes received no information – through victim services or otherwise – about the investigation.³⁹³ The only decision made during the investigation was not to release the original note. The members involved never even turned their minds to the possibility of advising the Fynes about the note, let alone did they decide not to do it for the reasons listed.

141. In testimony, MCpl Ritco indicated he had “nothing to do” with the statements made in LCol Lander’s explanation.³⁹⁴ He noted the information available through victim services was never a factor he considered, and indicated he never believed revealing the note could have had a negative effect on the family.³⁹⁵ Sgt Bigelow was also not aware of any determination or consideration of whether revealing the existence of the note would have had a negative effect on the family.³⁹⁶ MWO Watson, who was also unaware of any such determination, wondered where LCol Lander obtained this information.³⁹⁷

142. LCol Lander himself had difficulty making sense of the explanation he provided. He testified:

[...] in my opinion, from what I knew about the case, I don't see why -- especially if the suicide note, as I understand it, was addressed to the family, why they wouldn't have divulged that right away. I didn't get that.

But, again, it was the NIS chain of command to sort out, not mine. My responsibility was to make sure the army commander knew what the issue was.³⁹⁸

143. Since LCol Lander did not have any information about the matter, he had to have obtained the information included in his explanation from the CFNIS. In testimony, he could not recall whom it was he spoke with, but thought it would have been the CFNIS CO or the Operations Officer.³⁹⁹ LCol Sansterre and Maj Dandurand both believed they spoke to LCol Lander at the time, but denied providing the information included in his explanation.⁴⁰⁰ LCol Sansterre testified he had “absolutely no idea where [LCol Lander] would have come up with that information.”⁴⁰¹ The source of LCol Lander’s explanation remains a mystery. It is clear the information he received from the CFNIS was inaccurate or seriously misunderstood, but it cannot be known who provided it. The explanation also included another inaccurate statement indicating information about the existence of the note had been passed to the BOI with the original documentation provided by the CFNIS, which was not in fact the case.

144. The subsequent MRL explanation about the reasons why the note was not mentioned during an interview with the Fynes is also problematic. First, there was no “interview” with the Fynes, only brief telephone conversations with MCpl Ritco when they contacted him. Second, the MRL stated the parents were aware of the coroner’s findings into the cause of death,⁴⁰² which would not have been possible at the time since the ME’s report had not yet been received when MCpl Ritco spoke to them. More importantly, the rest of the explanation, indicating the Fynes did not ask about a note and the investigator did not mention it “as the investigation was still ongoing”⁴⁰³ was not consistent with the explanations provided by MCpl Ritco during the QA review or before this Commission. While, according to WO Ross’ report, MCpl Ritco did mention the Fynes had not asked about the note, he never stated he did not reveal its existence then because the investigation was still ongoing.⁴⁰⁴ On the contrary, his view as conveyed in

his testimony was he should have revealed it.⁴⁰⁵ The reason he did not had nothing to do with the status of the investigation. It was because the note had been forgotten. The CFNIS witnesses could not confirm the source of the information included in this MRL, but agreed it would have been obtained by the PAO from someone at the CFNIS who had knowledge of the file, likely LCol Sansterre, Maj Bolduc or Maj Dandurand.⁴⁰⁶ As to the content of the information, Maj Dandurand did not think it was correct, while LCol Sansterre saw no inaccuracies.⁴⁰⁷

145. The explanation provided by Maj Dandurand two weeks later, when he learned about the questions on disciplinary measures, was surprising. He was adamant the “investigator and the case management team did everything in good faith and at no point was the family’s well being pushed aside.”⁴⁰⁸ He went on to discuss the need to make assumptions in the best interest of the family based on previous experience, noting the members involved in this investigation “had many previous investigations of suicide in their repertoire.”⁴⁰⁹ He discussed decisions about the return of sensitive personal belongings that could cause embarrassment and concluded no disciplinary measures were warranted.⁴¹⁰

146. This explanation did not reflect the facts of the case. The members involved in this investigation did not have extensive experience in conducting suicide or sudden death investigations. In fact, for both the lead investigator and the case manager, this was their first sudden death investigation.⁴¹¹ In testimony, Maj Dandurand acknowledged his statements were based on his own assumptions at the time, as he was unaware of the experience of the members involved.⁴¹² As for the explanation about making assumptions in the best interest of the family, there is no evidence the CFNIS members involved ever considered the possibility of advising the family about the note before providing the original, and their decision not to release the original during the investigation was based on what was viewed as the requirements of the investigation, not the interests of the family. In testimony, Maj Dandurand could not confirm whether he had spoken to MCpl Ritco or anyone involved in the investigation before providing this explanation.⁴¹³ He believed the decisions made about the release of the note were based on what the investigators thought was in the best interest of the family, but he did not recall how he

came to this understanding.⁴¹⁴ He acknowledged the other statements in his message about the return of sensitive or embarrassing items were unrelated to the suicide note or to this specific investigation.⁴¹⁵

147. The explanations provided by Maj Dandurand during his November 2009 meeting with the Fynes, which focused on the existence of a “policy” not to divulge suicide notes, also do not reflect the facts of this case.⁴¹⁶ Whatever the policy may have been,⁴¹⁷ it is clear it had nothing to do with the investigators’ “decision” not to advise the family about the note’s existence and contents. While their views on policies, evidence and the requirements of the investigation may have influenced MCpl Ritco and WO Tourout’s early decision not to release the original note, they never considered the possibility of divulging the note’s existence without releasing the original. As a result, any views they may have held about the policies applicable in this respect could have played no part in what they did. As for MWO Watson, had he turned his mind to the issue, it was his view there was nothing preventing the disclosure of the note and he would have advised the family at an early point in the investigation.⁴¹⁸

148. As for the explanation provided in January 2011, stating the note was intended to be released to the Fynes at the end of the investigation but “this was not conducted as expediently as it could have been,”⁴¹⁹ this is also not an entirely accurate description of what happened. While at least some of the members involved believed the note would be returned at the end of the investigation, by the time the investigation was concluded, it was more than a mere lack of expediency which caused the note not to be returned. The note was omitted when steps were taken to return Cpl Langridge’s personal belongings because it had been forgotten by then, and there is no indication it would ever have been returned if the BOI had not requested a copy and provided it to the Fynes. The source of the information provided in this explanation is unknown. Maj Dandurand, whose Detachment was in charge of passing on the information for inclusion in these responses, testified he was not personally aware of anyone having the intention to release the suicide note at the conclusion of the investigation.⁴²⁰

LEARNING FROM PAST MISTAKES

149. Of all the explanations provided by CFNIS members to the Fynes, the public or other CF members, not a single one contained a complete and accurate reflection of what happened in this case. On the basis of the evidence heard before this Commission, there is no indication this was the result of any intent to misrepresent the facts or mislead. However, there are indications the CFNIS chain of command never did discover why Cpl Langridge's suicide note had not been disclosed. This is the reason why they could not provide consistent explanations.

150. Aside from the explanations examined here, no record was produced before this Commission of any explanations received by the CFNIS chain of command about what happened in this case, much less of any accurate explanation. Most of the CFNIS witnesses who testified before this Commission could not provide an answer.⁴²¹ One witness thought there was probably a "legitimate reason" why the note was not returned right away, but did not know what it was, while others thought it was a mistake.⁴²² But no one knew exactly what happened.

151. Only two members of the chain of command, LCol Sansterre and Maj Dandurand, testified they knew why Cpl Langridge's suicide note had not been disclosed. The explanations they provided were not consistent with each other.

152. Maj Dandurand testified:

I believe -- and this is very hard for me to do, to differentiate between what I know now and what I knew then with respect to this [...]

So, it would have been -- it would have been in around the summer time when I found out -- or when I assessed that the note hadn't been provided and when I asked the investigators -- when I asked people and started searching around, **it was under the explanation of, this was evidence, everything else was returned with the exception of a few articles, but it was the opinion of people that this was still evidence.**⁴²³
[Emphasis added]

153. LCol Sansterre stated:

MR. FREIMAN: [...] Sitting here today, do you know why the suicide note was not turned over?

LCOL SANSTERRE: Yeah, they collected it as evidence and they forgot to give it.

MR. FREIMAN: When did you first hear that it had been collected as evidence and forgotten?

LCOL SANSTERRE: I don't -- I don't know.

MR. FREIMAN: Was it during the course of these proceedings as a result of evidence that we've heard?

LCOL SANSTERRE: I would -- I would have thought it was before that, but I can't be sure.⁴²⁴

154. On the basis of the evidence, it does not appear LCol Sansterre was informed of what happened before this hearing was held. Had he been, the CFNIS and its members would not have continued to provide the inconsistent official explanations seen by the Commission. To the extent that senior leadership of the CFNIS did, in fact, know what happened, it is clear they did not make it known to the members of the organization or of the chain of command. Maj Dandurand, the OC for the Detachment involved, continued to believe the reason for not releasing the note was because it was seen as evidence that needed to be retained. This did not reflect the actual belief of the members involved in the investigation, who all thought the note did not need to be retained after the investigation ended. Instead, it appears to have reflected WO Ross's and Maj Dandurand's own beliefs about applicable evidence policies or procedures.

155. Not having found out what happened in this case, it is difficult to understand how the CFNIS chain of command could take measures to address the issue. Both in the immediate aftermath of the discovery of the failure to disclose Cpl Langridge's suicide note and throughout the ensuing period, up to and including during their testimony before this Commission, members of the CFNIS chain of command insisted their priority was to ensure this did not happen again.⁴²⁵ However, the question arises: how could they fix the problem if they did not know what was broken? Considering the answers they obtained and provided, it is difficult for this Commission to see how they could have been in a

position to be truly certain any measures they put in place would address what went wrong in this case.

156. Further, having endured the pain of learning about their son's suicide note fourteen months after his death and of knowing they had been unable to honour his funeral wishes, the Fynes were entitled to an explanation about how this could have happened. Despite having asked the question many, many times, by the time they testified before this Commission, they still did not know the reasons why their son's suicide note was not disclosed to them.⁴²⁶ Because the CFNIS did not take sufficient steps to find out what happened, the Fynes were not provided the answers they were entitled to receive.

157. Worse, the failure to provide a factual account of what happened, the inconsistent explanations provided and the attempts at justifying what occurred contributed to creating an impression there was an attempt to minimize the seriousness of the problem or even to cover up the issue. This may have contributed to the Fynes' belief that withholding the note was intentional in the first place. In testimony, Mr. Fynes indicated he believed the failure to disclose the suicide note "was a very calculated deception designed to protect the uniform from embarrassment."⁴²⁷ He explained:

The fact that it wasn't even disclosed to the Regiment when they asked why NIS exhibits were being held tells me they were hiding it because it supported that my son had PTSD, he was in pain and he couldn't take the pain anymore. That was the truth of that note and that was part of the cover-up.⁴²⁸

158. The members involved in the investigation denied there was any intent to hide the note and provided numerous, and undoubtedly sincere, apologies for the situation during their testimony.⁴²⁹ MCpl Ritco testified:

[...] So at the end of my investigation, in the end of May, [...] the items should have been returned to the rightful owners.

Obviously, it didn't happen, and, as the lead investigator -- I believe it was 14 months or 15 months before it was returned to the rightful owner, and, as the lead investigator, I have to bear part of the responsibility on that, is that [*sic*] it should have been returned, but it wasn't.

It wasn't that we intentionally tried not to return it. It fell through the cracks. And for that I'm sorry. There's no family that should have to grieve the death of their son, along with

not knowing or not having to know that there -- there was a suicide note written by their son.

We didn't mean to do it. But, at the end of the day, it happened.⁴³⁰

159. The evidence heard before this Commission provides no support for the notion there was any intentional attempt by the CFNIS members to hide the suicide note. The Commission finds the failure to disclose the note was not part of an intentional cover-up. However, the Commission also finds the failure to provide a timely and straightforward explanation to the Fynes about what happened contributed to arousing suspicions and breeding mistrust.

APOLOGIZING

160. The lack of answers and the inconsistent explanations provided to the Fynes also likely contributed to fostering the dispute between the Fynes and the CFNIS about whether there was or was not an apology provided to the Fynes. The Fynes were obviously left with the strong impression there was no apology, or at a minimum that whatever apologies were made were not adequate. The debate continued when this hearing was held.

161. Mrs. Fynes testified:

Q. We understand that at some point you were offered an apology about the suicide note. Can you tell us about that?

A. No, I can't.

Q. To your mind there was no apology?

A. No.⁴³¹

162. Mr. Fynes testified there was a "token apology" made by Maj Dandurand, but added he "then immediately went on to justify their actions, which completely deflated and defeated the purpose of any acknowledgement that they had messed up."⁴³² He maintained Maj Dandurand "admitted this should not have happened" and even provided "an expression of empathy," but did not provide an actual apology.⁴³³ Mr. Fynes insisted no formal apology was presented.⁴³⁴ He testified:

[T]here has never been a formal apology for this from the Chief of Defence or from the chain of command or directly from the NIS. There may have been references in casual conversation.

We have never been given a proper apology for not having received our son's suicide note, for having been deprived of that and why our son's personal property didn't even appear on the Exhibit Lists. It was suppressed. We only learned of it because of the Board of Inquiry.⁴³⁵

163. Mr. Fynes believed CF members were actually prevented from presenting an apology because of applicable regulations.⁴³⁶ About the public statement issued by the CDS in this case, which included a mention indicating the CFPM “deeply regretted the delay in releasing Cpl Langridge’s suicide note,”⁴³⁷ Mr. Fynes said:

If this was an apology, it was made to the media, it was not made to us. It was never communicated directly with us.⁴³⁸

164. In contrast, the CFNIS and its members all maintained there had been numerous apologies presented to the Fynes. In early 2011, responses provided to the Fynes by the CF stated the CFNIS had “formally apologized to the family” for the late disclosure of the note.⁴³⁹ In their closing submissions, counsel for the subjects argue the CFNIS “has repeatedly recognized that failing to provide the suicide note to the family until 14 months after the death in the 2008 investigation was unacceptable.”⁴⁴⁰ They submit both LCol Sansterre and Maj Dandurand apologized to the Fynes, recognized “it was wrong for them to have delayed the handing over of the suicide note” and expressed their regret.⁴⁴¹ They add the CDS also issued a statement apologizing to the Fynes publicly.⁴⁴²

165. On the basis of the evidence heard, the Commission finds there were apologies provided to the Fynes by the CFNIS. When he spoke to Mrs. Fynes on June 18, 2009, LCol Sansterre apologized.⁴⁴³ He testified:

I said, I'm terribly sorry for what happened, I don't know how it happened.

[...] I certainly felt -- I felt terrible about what had happened, and to this day I still feel terrible about what happened. I mean, if we could turn back time, this wouldn't happen. And I know when I spoke to her I said, I'm very sorry, I don't know how this could have happened [...]⁴⁴⁴

166. During his meetings with the Fynes, Maj Dandurand also made statements which were clearly meant to convey expressions of regret and apology. He agreed with Mrs.

Fynes there was no excuse for this and stated he was “not disputing [the Fynes’] anger one bit.”⁴⁴⁵ He also indicated not disclosing the note for over a year after the investigation was concluded was “completely inappropriate.”⁴⁴⁶ He said he would “never stop feeling horrible” about the late disclosure.⁴⁴⁷ He stated the CFNIS could not “make right the wrong” but could only tell the Fynes “it will never happen again,” indicating this was a view he shared with the CFNIS CO, LCol Sansterre.⁴⁴⁸ He told the Fynes:

[...] the fact that the letter took so long, Shaun, Sheila; wrong. Wrong. Okay? It shouldn't have happened.⁴⁴⁹

167. In addition to these direct apologies, there were also public apologies. One occurred in June 2009, when the CFNIS PAO's message during a media interview indicating the CFNIS “regrets the situation” was published,⁴⁵⁰ and there was another in October 2010, when the CDS' public statement indicating the CFPM “deeply regretted” the delay in disclosing the note was released.⁴⁵¹

168. Nevertheless, there are two reasons why it is not surprising the Fynes were not satisfied with these apologies. First, they were not provided at the right time and in the right manner. Second, some of the apologies were not unqualified, but were rather accompanied or followed by statements attempting to justify some of what had occurred.

169. When Cpl Langridge's case began to attract significant media attention in the fall of 2010, questions were asked by the CF chain of command about whether (and when) an apology had been provided to the Fynes for the failure to disclose the suicide note.⁴⁵² The CFPM was provided the following information, which he passed on to his contacts at JAG and VCDS:

Mrs. Fynes received a **face to face personal apology from the [Detachment] Commander (Major) for NIS Western Region**. This apology and explanation of why the delay happened and how the CFNIS would stop recurrence was given **at the time that the original note from Stuart Langridge was provided to her**.⁴⁵³ [Emphasis added]

170. Regrettably, this information was not accurate.⁴⁵⁴ It was provided as a result of confusion and misunderstandings on the part of the CFNIS members tasked with gathering information for the CFPM.⁴⁵⁵ In actual fact, when the Fynes were told by Maj

Parlee about the existence of their son's note, no one from the CFNIS contacted them. It was the BOI President, not the CFNIS, who made arrangements to provide them with a copy of the note. When they requested the original and the issue was brought to the attention of the CFNIS chain of command, the CFNIS took no steps to deliver the note personally or provide a formal apology.⁴⁵⁶ The first contact with the CFNIS occurred three weeks later and was not in person but over the phone, when LCol Sansterre spoke to Mrs. Fynes. Face-to-face contact did not occur until many months later.⁴⁵⁷

171. Even LCol Sansterre's call was not part of any plan to provide a formal apology and would likely not have been perceived as such by the Fynes.⁴⁵⁸ LCol Sansterre did not intend to call the Fynes directly. He was trying to reach their AO to set up a briefing, but ended up speaking with Mrs. Fynes because of a mistake in the contact information provided to him.⁴⁵⁹ At the time, Mrs. Fynes told LCol Sansterre she felt strongly the measures taken by the CFNIS to contact the Fynes were "as a result of the media."⁴⁶⁰ While LCol Sansterre did the right thing in providing an unqualified apology once he was on the phone with Mrs. Fynes, it appears no one at the CFNIS had thought about providing an apology to the family prior to this accidental contact. When the CFNIS PAO was asked during a media interview shortly before LCol Sansterre's call to the Fynes "why the CFNIS never called the family to apologize about not giving them the suicide note," she had no lines about the issue and could not provide an answer.⁴⁶¹ Based on the MRLs she had, she only stated she was aware "the family was interviewed as per the normal process at the beginning of the investigation," which in itself was not even accurate.⁴⁶² Her reports to the chain of command about the questions she was asked, and the ultimate publication in the media article of a statement indicating the CFNIS had "never contacted the family to explain, or apologize," did not lead to further discussions within the chain of command about the need to provide a formal apology to the Fynes.⁴⁶³

172. When face-to-face contact between the Fynes and the CFNIS finally occurred in November 2009, it was in the context of a meeting with Maj Dandurand to discuss the CFNIS investigation into Cpl Langridge's death. The expressions of regret Maj Dandurand provided about the failure to disclose the suicide note during this and subsequent meetings were qualified by other statements which appeared to indicate at

least some of the actions taken in handling the note were justified. In particular, Maj Dandurand indicated a suicide note would never be taken “straight to the parents” but would always need to be kept for a certain period of time after the death.⁴⁶⁴ The views he expressed indicated he believed it was wrong to keep the note for 14 months, but did not believe it had been wrong to keep it initially, even if it meant the Fynes would not have been advised about their son’s funeral wishes.⁴⁶⁵ He specifically stated relying on the wishes expressed in the suicide note before foul play was ruled out would have been dangerous.⁴⁶⁶

173. During a subsequent interview with Maj Parkinson, Maj Dandurand also made the following comments:

MAJ DANDURAND: [...] The issue is there's very much a recognition by the NIS that, you know what, there should have been a review of evidentiary holdings at least at the end of the file, and we would have been able to give it to them at that point. I believe the file was concluded within three months.

At the point where it's determined that foul play is ruled out – [...] we accept and we've changed our practices that, yes, actually, it's at that point.

The part where I think it would have had no bearing on the funeral dealings is that the determination of no foul play had not yet been made at the point of the funeral.

[...]

And we've explained at this [sic] at length, and I'm explaining this now because you do still have contact with Shaun and Sheila Fynes, and, funny enough -- not funny, but oddly enough this still does come up, even though they've had it explained twice to them. [...]

The issue is that, until that determination's made, that's considered non-disclosable evidence, from a police investigation point of view. **It's frustrating for the family perhaps, but had it been foul play, had it been foul play and the note had been falsified – [...] and then they had acted on that for the funeral – [...] that could have been equally traumatic.** Yeah.

[...] But it's kind of...as long as we accept that the circumstances, and I described them. What happened, unacceptable – [...] and we've changed that. That will not happen again.

What they're insinuating, that they should have been told right away --

MAJ PARKINSON: Would never happen.

MAJ DANDURAND: -- I'm not --

MAJ PARKINSON: Highly unlikely.

MAJ DANDURAND: -- entirely sure. **It's not something that we can get pigeonholed into,** that we can get backed into, because it's not healthy for the interest of the

investigation.⁴⁶⁷ [Emphasis added]

174. In their testimony, the Fynes made it clear they did not accept the explanations provided by Maj Dandurand.⁴⁶⁸ They largely viewed them as after-the-fact justifications for the failure to disclose the note.⁴⁶⁹ Mr. Fynes stated from his own review of CFNIS records, he did not believe “there was any legitimate examination of that note beyond finding it and hiding it.”⁴⁷⁰ Mrs. Fynes stated the CFNIS members “were trying to excuse” their failure to disclose the note and commented: “it was a lot of waffling and a lot of excuses.”⁴⁷¹ When they became aware of the comments made to Maj Parkinson from the interview recording, the Fynes took strong offence and viewed the comments as “very disparaging,” which, in turn, caused them to question the sincerity of the expressions of regret and empathy Maj Dandurand had provided when he met with them.⁴⁷² Mrs. Fynes testified:

As he says there, their justification for withholding the note was that they had to investigate foul play. It was deemed a suicide within the first two and a half minutes, I think, after having found Stuart. They were waiting for toxicology which I believe came in around May. Their file was closed in June.

I have read a lot of material about the investigation into Stuart’s death and I have yet to see anything that constitutes even the beginning of an inquiry into could he have been murdered. It just isn’t there. Everyone knew it was a suicide, so I just don’t see anywhere ever there is any justification for that note being withheld for one minute.⁴⁷³

175. In 2011, when the Fynes asked, “Why is it still not understood by the NIS that there was no legitimate justification for suppression and improper retention of a suicide note written by Stuart?”, the following response was initially prepared by the WR Detachment:

This question was posed, answered, and the situation apologized for on two separate occasions with the family. While the letter should have been provided to the family (ie: executor of the estate) at the conclusion of the investigation, following a review of evidence held, it would have only been provided at the time when it was deemed to have no bearing on the investigation (ie: ruling out of foul play or relevance of the note in this regard). **During the interview of the parents, it was clear they had the belief this note should have immediately been provided to them and they did not agree with the explanation provided.**⁴⁷⁴ [Emphasis added]

176. While this response was ultimately not transmitted to the Fynes in this form,⁴⁷⁵ it does provide an indication of the continued disagreement between the CFNIS and the Fynes about exactly what was done wrong and where an apology was needed.

177. Both in their testimony and in the allegations they made before this Commission, the Fynes also maintained one of the “inaccurate rationales” provided to explain or justify CFNIS actions was that the suicide note needed to be kept after the investigation because “there might be an appeal.”⁴⁷⁶ The allegations stated this statement was made during a meeting with CFNIS members.⁴⁷⁷ The transcripts for the three meetings between the Fynes and the CFNIS contain no mention of the possibility of appeals.⁴⁷⁸ The first meeting was not recorded in its entirety.⁴⁷⁹ However, MS McLaughlin, who was present at the meeting, did not believe there was any discussion about a need to keep the suicide note in case of appeals, as this would not apply in this case because no charges were laid.⁴⁸⁰ MCpl David Mitchell, who was present at the subsequent meetings, also did not recall any discussion about this topic during the meetings or during his other interactions with the Fynes.⁴⁸¹ As noted by Mr. Fynes during his testimony, there was a mention of a policy requiring the retention of evidence in the event of an appeal in one of the written responses provided to the Fynes by the CF in 2011.⁴⁸² The reference was included in the response about the reasons for not returning the exhibits seized at the end of the investigation – which technically would include the suicide note – but not in the response specifically related to the failure to disclose the suicide note.⁴⁸³

178. While it does not appear there was any direct reference to the possibility of appeals to justify the failure to disclose Cpl Langridge’s suicide note, it is clear many of the explanations that were provided to the Fynes were not entirely accurate, and some of them did appear focused on justifying at least some of the actions taken by the CFNIS members with respect to the suicide note. As a result, it is not surprising the Fynes were left with the general impression there was more justification than regret being expressed by the CFNIS. The CFNIS’ failure to provide a formal apology to the Fynes immediately upon discovering the issue also did not help.

179. In light of what had happened, the Fynes should have received a more formal and timely apology. First, the CFNIS should have made inquiries to verify whether the note

had been provided to the family as soon as they were contacted by the BOI in early 2009. Immediately upon learning the note had not been disclosed, an official apology should have been provided to the Fynes by the CFPM or his delegate or by the CO for the CFNIS. The CFNIS should have also offered immediately to deliver the original suicide note to the Fynes personally. Finally, immediate measures should have been taken to find out exactly what happened and to provide the necessary explanations to the Fynes. This should have received at least as much attention as was given to the public relations aspect of the matter.

Revising Policies and Procedures

180. In all of the statements prepared for the public, and most of its communications with the Fynes, the CFNIS has consistently maintained that policies and procedures were revised to ensure the failure to disclose the suicide note never happens again. Yet, the evidence heard before this Commission reveals there was no clear and consistent understanding within the CFNIS about what the policies and procedures applicable at the time were, and whether they would have precluded (or required) the disclosure of Cpl Langridge's suicide note. Nor could clear and consistent answers be obtained about exactly what were the revised procedures.

MEDIA RESPONSE LINES AND STATEMENTS

181. All of the MRLs prepared by the CFNIS and other organizations within the CF about the suicide note contained a statement indicating policies or procedures had been changed as a result of the failure to disclose Cpl Langridge's suicide note.

182. In the first MRLs prepared by LFWA after the issue came to light, the following statement was included:

A prior policy dictated that all evidence in an investigation could only be released to the family of the deceased after severance under the Access to Information Act. **This policy has been changed** and a copy of the suicide note was provided to the family.⁴⁸⁴
[Emphasis added]

183. The corrected version of the MRL prepared by the CFNIS PAO contained similar statements, with more detail.⁴⁸⁵ The Background section indicated:

The CFNIS had gathered the note as evidence and initially **could not release it, in accordance with the policies in effect, which prohibited the informal release of such information to family members without going through Access to Information.** Recently, in consultation with Director of Information and Privacy, the family including secondary next-of-kin may request content of CFNIS investigations through their Assisting Officer. Although the documents still have to be severed under Access to Information and Privacy Acts, **there is no longer a requirement for the family to staff official request under Access to Information/Privacy Act.**⁴⁸⁶ [Emphasis added]

184. In the Questions and Answers section, the following statement was included:

At the time of the investigation, **policy dictated that all evidence in an investigation could only be released to the family of the deceased through the Access to Information Act.**⁴⁸⁷ [Emphasis added]

185. Approximately two weeks later, the MRLs were modified at LCol Sansterre's request.⁴⁸⁸ The explanation about the policies applicable was different, but the statement indicating the policies had been changed remained. The relevant portions of the Background section of the LFWA MRLs now read:

The CFNIS had gathered the note as evidence and unfortunately initially did not release a copy of it to the family. **The CFNIS has revised its procedures to ensure such a situation does not happen again.**⁴⁸⁹ [Emphasis added]

186. Access to information policies were discussed separately, in connection with statements about the procedures for access to CFNIS investigation reports, but not in connection with the disclosure of the suicide note.⁴⁹⁰ In the Questions and Answers section, the following information was added:

Q1. Why did it take 14 months for Cpl Langridge's family to receive a copy of his suicide note?

A1. The CFNIS had gathered the note as evidence and unfortunately initially did not release a copy of it to the family. The CFNIS has since revised its procedures to ensure such a situation does not happen again. **A copy of the note should have been provided to the family right away, with the original released to them after the completion of the investigation. The CFNIS regrets the situation and has revised its procedures to ensure that it does not happen again.**

The primary concern of the CFNIS investigators is to assist the victims (in the case of a CF member's death, the family) while preserving the integrity of the investigation.⁴⁹¹

[Emphasis added]

187. In the CFNIS-specific MRLs updated at the same time,⁴⁹² the same lines were included, and one of the “Key Messages” was:

The CFNIS has revised their procedures with respect to the release of such documents as suicide notes to ensure this type of situation does not happen again.⁴⁹³
[Emphasis added]

188. The CFNIS MRLs also provided additional content:

If pressed on usual procedure with regards to suicide notes

A copy of the suicide note should be provided to the family [at] the earliest opportunity, unless this could compromise the integrity of the investigation. The primary concern of the CFNIS investigators is to assist the victims (in the case of CF member’s death, the family) while preserving the integrity of the investigation.⁴⁹⁴ [Emphasis in original]

189. The message about the CFNIS having revised its procedures to ensure this situation did not happen again was included in all subsequent CFNIS and CF MRLs.⁴⁹⁵ It was repeated every time the CFNIS spoke to the media and was quoted in the articles published about the issue.⁴⁹⁶ In October 2010, it formed part of the public statement issued by the CDS about the case.⁴⁹⁷ The relevant portion, which had been previously approved by the CFPM, read:

Furthermore, the Canadian Forces Provost Marshal deeply regrets the delay in releasing Cpl Langridge’s suicide note, and **the Canadian Forces National Investigation Service has since revised its procedures to ensure a situation such as this does not happen again.**⁴⁹⁸ [Emphasis added]

190. When this Commission launched its public interest investigation into this matter in May 2011, the message was again included in the updated MRLs created at the time.⁴⁹⁹

191. The CFNIS and its members also made statements about the revision of policies or procedures in other contexts. When Maj Dandurand met with the Fynes in November 2009, he indicated processes, policies and procedures had been changed:

MAJ DANDURAND: [...] There's one area that you mentioned, right off the bat, and we haven't addressed it yet; the suicide note. Okay?

Suicide note -- Sheila, you said in your interview with Matt, Matt Ritgo [*sic*] that if anything, what you would hope for, is that --

MRS. FYNES: Some change.

MAJ DANDURAND: Some change.

MR. FYNES: Something good to come from this.

MRS. FYNES: Yes.

MAJ DANDURAND: I hope -- I really do hope that you are able to draw some satisfaction from this, **that there has been change as a result of this**. And I'll describe these changes to you. **First off, we, at the time, had a policy where we just -- we don't divulge all of these notes...**⁵⁰⁰ [Emphasis added]

192. During a subsequent meeting held in March 2010, Maj Dandurand told the Fynes all the CFNIS could do about the failure to disclose their son's suicide note was to "make it right for the future, and we have."⁵⁰¹ He stated:

I cannot even come to describe the amount of discussion that occurred surrounding this with respect to right.

What is the next policy move on this? **And now we have it.**⁵⁰² [Emphasis added]

193. In January 2011, the following information was provided to the Fynes by the CFNIS (through Col Gerard Blais) in response to their question about the failure to disclose their son's suicide note:

While the letter should have been provided to the family (ie: executor of the estate) at the conclusion of the investigation, following a review of the evidence held, it would have only been released when it was deemed to have no bearing on the investigation (ie: ruling out of foul play or relevance of the note in this regard). [...]

Clearly, the release of such a note 14 months following the death is not normal practice and the CFNIS has formally apologized to the family for this omission. They have also explained that **this occurrence has led to the revision and "tightening" of the Standing Operating Procedure associated with this topic**. The likelihood of this recurring is even more remote.⁵⁰³ [Emphasis added]

HOW AND WHEN WERE THE PROCEDURES REVISED?

194. LCol Sansterre testified one of the first steps he took upon learning of the failure to disclose Cpl Langridge's suicide note was to direct a CFNIS Standard Operation Procedure (SOP) on sudden death investigations and interactions with family be drafted.⁵⁰⁴ Previously, the CFNIS had no SOP on these topics.⁵⁰⁵ According to LCol Sansterre, the drafting of the SOP would assist in determining the appropriate time for advising families about the existence of suicide notes. He testified:

That's why the SOP was being drafted. When is the best time, and initially, when you initially have a meeting with the family, what type of information do you provide? That goal was get the best practices and detail this SOP.⁵⁰⁶ [Emphasis added]

195. LCol Sansterre tasked the OC for Atlantic Region (OC AR) with the drafting of the SOP in early June 2009.⁵⁰⁷ He was to begin work immediately on gathering information about best practices in other police forces and CFNIS Detachments and preparing the SOP.⁵⁰⁸ On June 22, 2009, he requested input from his colleagues in other Detachments about past experiences and best practices for the conduct of family briefings.⁵⁰⁹ On August 4, 2009, he provided an update and advised a draft would be ready within two weeks.⁵¹⁰ In November 2009, he made a presentation about the issues involved to members of the HQ and Detachments chain of command, but was still working on a draft of the SOP to be sent to CFNIS HQ.⁵¹¹ In early 2010, the draft SOP was still not completed. Sgt Scott Shannon, who worked in the AR at the time, was asked to provide comments and assist with the drafting of an Annex specifically related to family briefings.⁵¹² In April 2010, a revised draft of the SOP was provided to the CFNIS DCO.⁵¹³ The SOP was only finalized in October 2010.⁵¹⁴ By then, more than a year had passed since the discovery of the failure to disclose Cpl Langridge's suicide note.

196. LCol Sansterre testified he was not concerned about the delay in finalizing the SOP, considering the other matters the OC AR had to attend to and the amount of work required to prepare this SOP.⁵¹⁵ The evidence before this Commission indicates the process for drafting an SOP can be lengthy and complex, generally involving research about best practices, legal review and translation.⁵¹⁶ According to LCol Delaney, who replaced LCol Sansterre as the CFNIS CO in April 2011,⁵¹⁷ the time it takes will depend on a number of factors, including the workload of the members involved and the level of priority for the issue.⁵¹⁸ In this case, several drafts were prepared, discussed and circulated.⁵¹⁹

197. The final SOP promulgated in October 2010 was a comprehensive 55-page document which provided guidance about the conduct of sudden death investigations, the processing of death scenes, the collection of evidence, the conduct of neighbourhood canvass and witness interviews, the review of autopsy reports and the conduct of family

briefings.⁵²⁰ A seven-page Annex specifically devoted to these briefings contained detailed lists of points to research, verify, prepare and discuss in meetings with families.⁵²¹ However, there was no reference at all to the disclosure of suicide notes in the SOP or the Annex on family briefings.

198. Some of the points included in the SOP could have been viewed as having an impact on the disclosure of suicide notes. The list of points to be considered in preparing initial family briefings included “return of personal items at the conclusion of the investigation-if possible,” and the items to be covered in the final briefing included scene examination and evidence collected.⁵²² There was also a general direction to ensure information released during the briefings was limited to “investigative processes and not investigative activity especially during ongoing investigations,” which meant the specifics of the investigation were not to be discussed.⁵²³ However, the witnesses who testified before this Commission were unanimous none of these points were meant to address the disclosure of suicide notes, as this topic was simply not covered in the SOP.⁵²⁴

199. It was not until July 2011, over two years after the failure to disclose Cpl Langridge’s suicide note was discovered, that a specific reference to the disclosure of suicide notes was added to the SOP.⁵²⁵ At the time, Maj Bolduc explained an annual review of the SOPs was being conducted when the administrative officer, Capt David Dey, suggested it would be a good idea “to include the passage of a copy of notes from the deceased to the family (in cases determined to be suicide) in SOP 237.”⁵²⁶ Maj Bolduc agreed, particularly since he realized many of the members of the chain of command who had been aware of the issue with the suicide note in this case had moved on or were about to move to different positions.⁵²⁷ Maj Bolduc then immediately proceeded to draft a short paragraph, which was incorporated in the SOP before the end of the month.⁵²⁸ It read:

Any suicide notes found with a deceased person are seized as part of the criminal investigation into the sudden death. **Upon conclusion of the investigation, the suicide note needs to be released to the next of kin (NOK). Furthermore, the NOK should be advised of the existence of any notes as soon as it is practicable to do so, and released to them or to whom it is addressed as soon as it is no longer required for the investigation.**⁵²⁹ [Emphasis added]

200. Since the CFNIS had begun making public statements in June 2009 indicating it had already revised its procedures to ensure the failure to disclose the note did not happen again – and Maj Dandurand made similar statements to the Fynes beginning in November 2009 – the question arises: what revisions to CFNIS procedures were put in place between June 2009 and July 2011?

201. Both LCol Sansterre and LCol Delaney testified verbal directives by the CFNIS CO could be used to advise members of the procedures to follow or to cover any intervening period during the drafting or revising of SOPs.⁵³⁰ LCol Sansterre explained police procedures did not need to be written in order to be communicated to members and enforced.⁵³¹

202. LCol Delaney indicated, as a practical matter, verbal directives would generally be followed up or transmitted by an email “to ensure that the information gets out there in a timely manner,” particularly since the members are often on the road.⁵³² He also testified he would want to capture the contents of any “explicit direction” he gave in a written message, particularly where the direction was “a deviation from what we’re doing currently,” was technical in nature, or was related to a particularly important issue.⁵³³ LCol Sansterre, for his part, testified many procedures were only communicated verbally to the investigators, in particular during training or case management discussions.⁵³⁴

203. The CFNIS records contain no trace of any correspondence, instructions, directive, educational or training materials about the procedure to be followed for the disclosure of suicide notes between June 2009 and July 2011.⁵³⁵ However, LCol Sansterre, Maj Bolduc and Maj Dandurand all testified the issue was discussed extensively, and assured this Commission the members of the Detachments were advised about the problems having occurred in this case and the need to ensure this did not happen again, and were provided instructions about the procedure to follow in future cases.⁵³⁶ In particular, LCol Sansterre testified he addressed the issue in early June 2009 during an OC Conference involving senior personnel and Officers Commanding from CFNIS HQ and all the Detachments.⁵³⁷ He noted this was “very high on the agenda,” as he took the matter very seriously.⁵³⁸ He provided a directive, “effective immediately,” about the handling of suicide notes in future cases:

I directed that **as soon as it was possible, that the family members at least know that it exists, and that they be given either a copy or the actual original as soon as it's possible** to do that.⁵³⁹ [Emphasis added]

204. At the time, LCol Sansterre also told the members suicide notes needed to be released, and families advised, as soon as the notes were “no longer evidence.”⁵⁴⁰ He explained discussions then followed about the appropriate time for advising the family.⁵⁴¹ LCol Sansterre’s own direction was to provide a copy of the note to the family “as soon as it was possible without jeopardizing the investigation.”⁵⁴² However, he did not provide a specific direction about when to release the original or about when to advise the family about the existence of the note, because “every case is completely different.”⁵⁴³

205. Maj Bolduc, for his part, while he recalled many discussions of the issue at HQ and during conference calls and conferences with the OCs, could not specifically recall whether the suicide note was discussed at the June 2009 Conference, nor whether there was a discussion at the Conference of the procedure to follow while awaiting the written SOP.⁵⁴⁴ He also had no specific recollection of the exact directive provided by LCol Sansterre about the handling of suicide notes.⁵⁴⁵ Maj Bolduc did recall discussions about assessing when to turn the note over, or how soon should “as soon as possible” be, once it was determined the note was no longer required for the investigation.⁵⁴⁶ He also recalled numerous discussions where the CO made it clear to all he did not want the failure to disclose the suicide note to happen again.⁵⁴⁷

206. In testimony, LCol Sansterre explained, although he did not put it in writing, the directive he gave about disclosing suicide notes as soon as possible “would have become a procedure” from the moment the issue was discussed at the June 2009 OC Conference.⁵⁴⁸ He added the issue of the disclosure of suicide notes and the directive he gave continued to be discussed in most of the OC conference calls and other OC conferences during the following year.⁵⁴⁹

207. LCol Sansterre explained he relied on the Detachment OCs to understand his instructions and pass them on to their subordinates in the Detachments.⁵⁵⁰ He did not have an expectation those who received his direction would commit it to writing, but thought records would be created in the minutes for the OC Conferences and conference

calls, and added once the SOP was drafted, “it would be clear in the SOP.”⁵⁵¹ As it turns out, the Minutes for the OC Conferences and conference calls contained general references to the drafting of the SOP on family briefings, but no references to the disclosure of suicide notes.⁵⁵² And the SOP itself at first also did not mention the disclosure of suicide notes.

208. In testimony, Maj Bolduc explained he did not think it was necessary to have the procedures to be followed for the disclosure of suicide notes put in writing while the SOP was being revised, or even to include them in the SOP, because the issue had been discussed “inside and out,” the chain of command had “answered the question,” the issue was fresh in everybody’s mind, the “lesson had already been stamped” and everyone “understood the message.”⁵⁵³ He indicated the paragraph he did add to the SOP in July 2011 was generally consistent with the direction already provided and understood by all.⁵⁵⁴ LCol Sansterre was also confident the message had been well understood, and had no concern about the lack of references to the disclosure of suicide notes in the 2010 SOP.⁵⁵⁵ He testified the new SOP was meant to address all aspects of “dealing with families” and was not “an SOP that was specific to suicide notes.”⁵⁵⁶ He explained:

Well, I mean, the SOP itself was not focused on suicide notes. The SOP was focused on sudden death and dealing with families or victims of sudden death. The fact that it wasn't mentioned in here doesn't mean that we didn't pay particular attention to whether there was suicide notes or not.

I see "Return of personal items at the conclusion of investigation." We could have listed it there. Personal items included the individual's watches, maybe, and other items. We could have listed a whole lot of items there, but that would become cumbersome. I know without a doubt that the OCs knew that personal items, personal property, would include any notes left by anybody.⁵⁵⁷

209. At first glance, this is difficult to understand. It was as a direct result of the failure to disclose Cpl Langridge’s suicide note that the CFNIS CO and senior leadership ordered the drafting of an SOP to address the issue of family briefings.⁵⁵⁸ The drafting of this SOP was viewed as one of the measures taken to ensure the failure to disclose the note did not happen again.⁵⁵⁹ Yet, when the SOP adopted over a year later entirely failed to address the issue of the disclosure of suicide notes, the same members of the CFNIS senior leadership testified it was not necessary to address it in any event. To make sense of this, two points must be understood. First, previous policies or procedures were not

viewed by the CFNIS chain of command as having caused the failure to disclose Cpl Langridge's suicide note. Second, the case-by-case monitoring practised by the chain of command in the aftermath of the incident was viewed as the most important and effective measure taken to address the situation, making broad revisions of policy or procedures less pressing or necessary.

210. Despite the discussions about revising procedures, it is clear no one thought Cpl Langridge's suicide note was withheld in this case because of the policies or procedures applicable at the time. While the CFNIS chain of command never did find out exactly what happened, no one believed there was any previous policy or procedure preventing the disclosure of the note for 14 months. LCol Sansterre and Maj Bolduc's testimony was clear on this point. They both indicated the failure to disclose Cpl Langridge's suicide note was a "mistake" made in the case and "not a mistake with the policies."⁵⁶⁰ They also both repeatedly testified it was never a policy, practice or procedure "not to give a suicide note to a family."⁵⁶¹ As a result, LCol Sansterre explained this "wasn't a practice that had to be changed. It was a situation that occurred."⁵⁶²

211. Only Maj Dandurand appeared to believe retaining the suicide note was in line with the policies or practices applicable at the time of the investigation.⁵⁶³ In testimony, he explained he initially thought the applicable policy or appropriate practice was to retain the note as evidence for a lengthy period after the investigation.⁵⁶⁴ For this reason, and based on his discussions with WO Ross during the conduct of the QA review, he was not convinced the Detachment had done "anything wrong" in this case, and was adamant disciplinary measures would have been "completely inappropriate," because he thought there was nothing to suggest the investigators had gone "outside the norm" or wilfully failed to follow normal practices for the handling of evidence.⁵⁶⁵ However, Maj Dandurand's understanding of the applicable policies and practices eventually changed, and he recognized the failure to release Cpl Langridge's suicide note at an earlier time was a "mistake."⁵⁶⁶ Even before he developed this new understanding about the release of the original note, it does appear he was always of the view the failure to disclose the existence of the note was a mistake. Early on, he had written to Col Hammond that he agreed the family "should have at least been told."⁵⁶⁷

212. In order to address what was perceived as the true problem – i.e., to ensure further mistakes were not made – the most important measure put in place was related to case management on a case-by-case basis. Having heard the discussions in the OC Conferences and conference calls about the CO’s displeasure with the failure to disclose Cpl Langridge’s suicide note and his clear direction this should not happen again, it was expected the Detachment OCs, MWOs and case managers would monitor the files closely and manage the cases in order to ensure the disclosure of suicide notes was not unnecessarily delayed.⁵⁶⁸ To ensure this was done, CFNIS HQ decided to get directly involved. LCol Sansterre, either directly or through Maj Bolduc, contacted the Detachment OC every time a new sudden death investigation was opened and asked whether a suicide note was found and what would be done about its disclosure.⁵⁶⁹ This practice continued until December 2011, for as long as Maj Bolduc remained the CFNIS DCO, even if LCol Sansterre had already moved on to a new position in April 2011.⁵⁷⁰ As a result, as LCol Sansterre explained, any CFNIS members tasked to investigate a suicide – whether or not they knew about the Langridge case, the directives issued by the CO or the SOP being drafted and later promulgated – would know about the importance of disclosing suicide notes because of the questions they would be receiving from their chain of command.⁵⁷¹

213. However, as ultimately recognized by Maj Bolduc himself when he added the passage about suicide notes in the SOP, the case monitoring alone could not address the issue permanently. Eventually, the individuals in charge would change, and might not be aware of the issue. Hence, it was necessary to set out the procedure to be followed and to disseminate the knowledge. Most importantly, whether the CFNIS was able to ensure suicide notes were disclosed at the appropriate time would in turn depend on its ability to determine when that was. The CFNIS would then have to ensure the members involved in deciding when to disclose suicide notes in particular cases – or those in charge of monitoring their actions – had a common understanding of how the appropriate time for disclosure should be determined. In this last respect, the evidence before this Commission has shown there were different – and at times inconsistent – views among the members of the CFNIS and its chain of command. It is not clear to what extent this changed after the failure to disclose Cpl Langridge’s suicide note was discovered.

WHAT WERE THE OLD PROCEDURES?

214. The CFNIS members who testified before this Commission all agreed at the time when the investigation into Cpl Langridge's death was conducted, there were no written policies or procedures specifically relating to the disclosure of suicide notes.⁵⁷² There was a general MP policy about evidence handling, which required that evidence be kept "until it is no longer required and/or authority for its disposal has been received."⁵⁷³ The policy set out various waiting periods prior to seeking authority to dispose of exhibits seized where court proceedings were involved, or where the owner of the items could not be identified, and also stated: "physical evidence collected in the course of an investigation and not used as exhibits at a subsequent trial need not be retained with the status of evidence."⁵⁷⁴

215. While the CFNIS members who testified in this hearing were generally aware of this policy, their views on whether and how it would apply to suicide notes varied widely. Some thought the policy would always apply and suicide notes always had to be treated like other evidence,⁵⁷⁵ while others thought the policy would only apply under certain circumstances or for a certain period of time, such as if a suicide note "became evidence," or while a crime was being investigated.⁵⁷⁶ One member commented because of the benefit of releasing them to the family, suicide notes did not necessarily have to be treated like other evidence.⁵⁷⁷ Where the policy was thought to apply – or to apply for a certain period of time – the members had different views about when the note had to be released. Some thought it was at the end of the investigation or once it was decided not to proceed with charges,⁵⁷⁸ while others thought it was at various earlier points, including: when the note "went from being evidence to being information,"⁵⁷⁹ when the information received made it clear the death was a suicide,⁵⁸⁰ when it was determined the note was no longer relevant or necessary for the investigation,⁵⁸¹ when foul play was ruled out,⁵⁸² or when the note no longer had evidentiary value in relation to indications of foul play.⁵⁸³

216. Aside from their views about the applicability of the evidence policies to decisions about the release of original suicide notes, the members also had different understandings about what the practice or procedure was for determining when to disclose the existence and contents of the notes. LCol Garrick, the CFNIS CO at the time,

thought the existence of the note would be disclosed “immediately.”⁵⁸⁴ He thought the contents or copy of the note would also generally be disclosed “right away,” unless the information in the note was relevant to an ongoing investigation.⁵⁸⁵ He did not think the mere fact of not having received official confirmation of the cause of death would have been sufficient to withhold disclosure if the information in the note was not directly relevant to the investigation.⁵⁸⁶ MWO Watson, the Acting Detachment OC at the time, thought the existence and contents of the note could be disclosed within days of the death, even if the original was still being held as evidence.⁵⁸⁷ Maj Bolduc believed the practice was to disclose the existence and contents of suicide notes once it was determined the death was a suicide and the note was no longer necessary for the investigation.⁵⁸⁸ Maj Dandurand and Sgt Bigelow thought the appropriate time was when foul play had been ruled out.⁵⁸⁹ WO Tourout, for his part, testified based on “experience and training,” the appropriate procedure was to disclose the existence and contents of the suicide note only once a “positive determination” about the cause of death had been made.⁵⁹⁰

217. In their testimony, LCol Sansterre and Maj Bolduc both insisted the determination of the appropriate time to disclose or release suicide notes always depended on the particular circumstances of the case, on the experience of the investigators and case managers and on their view of the relevance of the note to the investigation.⁵⁹¹

218. Some of the discrepancies in the members’ views appeared to be related to their understanding of what would be required in order to “rule out foul play.” In their closing submissions, counsel for the subjects of the complaint maintain the CFNIS policy in 2008 “directed foul play could not be ruled out until the ME report was received.”⁵⁹² The Commission has found no documentary evidence or testimony confirming such a policy existed. Based on their testimony, it does appear at least MCpl Ritco and WO Tourout believed foul play was only ruled out in this case at the very end of the investigation.⁵⁹³ However, nothing indicates this was because of any policy in existence at the time.

WHAT WERE THE NEW PROCEDURES?

219. The 2011 SOP provided the existence of suicide notes was to be disclosed “as soon as it is practicable to do so,” and the notes were to be released “as soon as [they were] no longer required for the investigation” or “upon conclusion of the investigation.”⁵⁹⁴ Previously, LCol Sansterre had directed the disclosure be done “as soon as possible without jeopardizing the investigation.”⁵⁹⁵ Maj Bolduc believed the language in the 2011 SOP reflected this same direction.⁵⁹⁶

220. The views about the appropriate time for disclosing suicide notes continued to differ after these new procedures were put in place.

221. Maj Bolduc believed the procedure was to disclose the existence and contents of the note as soon as the possibility of a crime had been eliminated or once it was determined the death was a suicide and the note was no longer required for the investigation.⁵⁹⁷ He also indicated his understanding was the note was to be disclosed once all the circumstances surrounding it had been established and it was determined the disclosure could be done “without prejudicing the investigation.”⁵⁹⁸ According to him, it was always necessary to wait until foul play had been ruled out even before telling the family about the note in order “to protect the integrity of the ongoing criminal investigation.”⁵⁹⁹ In his view, a clear comment by the coroner at the scene indicating everything was consistent with suicide would not be sufficient to lead to the immediate release of the note, as it should only be released “when the investigator is satisfied that there was no foul play.”⁶⁰⁰ His views on when the original suicide note was to be released were less clear. He indicated the general MP policy on evidence handling could still apply where the note was viewed as evidence.⁶⁰¹ He stated his intent in drafting the 2011 SOP paragraph was to provide for the original note to be returned at the end of the investigation, but also said once foul play was ruled out, it was possible it could be released soon after or at the same time as the family was advised about the note.⁶⁰²

222. Maj Dandurand still believed the appropriate time to disclose the note and to release the original was when foul play was ruled out, which in his view required receiving at least informal or preliminary reports from the Coroner’s office about the

cause of death.⁶⁰³ He thought disclosure would not occur immediately upon finding the note, but could take place “within a few weeks of the investigation commencing,” provided foul play – or the involvement or significance of the note in this respect – was ruled out.⁶⁰⁴

223. MS McLaughlin thought the procedure was not to disclose notes when foul play was suspected.⁶⁰⁵ Where there was no suspicion, he thought the note could be disclosed early on, without having to wait for the ME report confirming the cause of death.⁶⁰⁶ He also thought, even where there was suspicion, the determination would mostly depend on whether the disclosure would benefit or hinder the investigation.⁶⁰⁷

224. MCpl Ritco believed that, pursuant to the new procedures, the suicide note had to be disclosed once it was not deemed a “major piece of evidence” or once it was “no longer required” for the investigation.⁶⁰⁸ He believed as long as the possibility of foul play was not ruled out, revealing the existence of a suicide note could pose a risk to the investigation.⁶⁰⁹

225. LCol Sansterre thought the note would be disclosed when it was no longer necessary for the investigation, which he believed would generally be when there was “no suspicion” the note was written by anybody else.⁶¹⁰ He indicated, where there was no suspicion a crime had been committed following a thorough examination of the scene in consultation with the ME, the existence and contents of the note should be disclosed immediately.⁶¹¹ However, in his view, there should be no disclosure “if there is any doubt, any little bit of suspicion.”⁶¹²

226. LCol Delaney, who was the CFNIS CO for over a year after the new procedure was put in place, testified the practice was to advise the family about the note and provide a copy “very quickly.”⁶¹³ He indicated this was generally done before the end of the investigation, while the original note was often retained until the conclusion of the file.⁶¹⁴ He also explained, if the case was “a classic suicide,” the original could be released sooner, but would not be released right away if foul play was suspected.⁶¹⁵ LCol Frei, who became the CFNIS CO in 2012, thought the proper timing for disclosing the existence and contents of the note would depend on a number of factors, including the

contents of the note, the circumstances of the death, whether the note could have evidentiary value and whether its authenticity needed to be investigated.⁶¹⁶ He thought the note would be disclosed earlier where it had no evidentiary content, and believed the intent of the new procedure was to allow for the disclosure to take place before the ME report was received where there was otherwise no suspicion about the circumstances of the death or the authenticity of the note.⁶¹⁷ In his view, the determinations about when to disclose the existence and contents and when to release the original note were completely separate.⁶¹⁸

227. As they had done when discussing the previous practices or procedures, LCol Sansterre and Maj Bolduc both repeatedly insisted the determination of the appropriate time to disclose the note under the new procedures would be very case-specific.⁶¹⁹ Ultimately, it would be for the investigators and their case managers, based on their experience, to determine when the best time was in each case, with oversight by the chain of command and the understanding strong justification would have to be provided for any decision to delay disclosure.⁶²⁰ Maj Bolduc could not provide an estimate of the time it would take for the CFNIS to disclose suicide notes under the new procedures, because the variations were too great.⁶²¹ He insisted there could be no “magic formula” and no fixed timelines, as too narrow a directive would “put obstacles in the way of the investigator’s work” and would prejudice the investigation.⁶²² LCol Frei agreed entirely the determination would be “very case specific.”⁶²³ He thought it would involve the entire investigative team and likely the CO himself as well.⁶²⁴

228. In the end, no clear definition of the terms “as soon as it is practicable” or “as soon as possible” could be provided.⁶²⁵ Different members had different – and at times inconsistent – understandings of what was provided for in the “new” procedure.⁶²⁶

WHAT CHANGED?

229. In light of this evidence, a question arises as to what substantive change, if any, was made when the CFNIS procedures were “revised.” Both before and after the revision, the CFNIS members agreed the appropriate time for disclosing suicide notes depended on

the circumstances of each case and disagreed or had different and inconsistent views about how the determination was to be made.

230. In most cases, the individual members' views about what criteria had to be used to determine when to disclose suicide notes under the old procedures and the new procedures were the same. The revision did not appear to change their opinion about how the appropriate time for disclosure was to be determined. Maj Bolduc thought the appropriate time under the new procedures was once it was determined the death was a suicide and the note was no longer required for the investigation and testified "that was also my understanding of the policies we had before."⁶²⁷ Maj Dandurand thought the appropriate time to disclose the note under both the old and the new procedures was when foul play was ruled out.⁶²⁸ In this respect, he testified the old policy was "exactly the same as the new policy."⁶²⁹

231. LCol Garrick testified the 2011 SOP was not a departure from the practice he would have expected to be followed when he was the CFNIS CO in 2008.⁶³⁰ LCol Sansterre thought the SOP itself was a "new policy" because there was never a written policy on this topic before.⁶³¹ However, he testified:

Would the procedures be different? I don't think so. I think the procedures are what we are detailing now. I don't know of any other suicides where we withheld the note for that long a period of time without advising so.⁶³² [Emphasis added]

232. Maj Dandurand believed what changed was not so much the actual procedures but "the way in which we apply it."⁶³³ He also indicated having a written SOP was a new development, and added the CFNIS' understanding of the process for seizing and disposing of evidence had "evolved."⁶³⁴

233. Maj Bolduc, for his part, explained the main difference was the CFNIS had not previously had this experience with failing to disclose a suicide note.⁶³⁵ Now that this had happened, the lesson was passed on that there had been a mistake and this should not happen again.⁶³⁶

WERE THE STATEMENTS MADE ABOUT THE PROCEDURES ACCURATE?

234. The statement most often made by the CFNIS after the failure to disclose Cpl Langridge's suicide note was discovered – and included in the CDS' public statement on the issue – indicated the CFNIS “has revised its procedures to ensure such a situation does not happen again.”⁶³⁷ LCol Sansterre testified he was “extremely” and “absolutely” satisfied “this was a true and accurate statement.”⁶³⁸ He explained:

I brought it up at every one of those conferences, and that's why I brought these documents with me. **There is a perception that there are people that are lying, whether the CDS or myself, and I take that very seriously.** That's why I came here today outside of my testimony later to say that's not the case.⁶³⁹ [Emphasis added]

235. As the evidence in these proceedings has shown, the substantive understanding of the CFNIS members about the “procedures” for disclosing suicide notes had not really changed, and no new written procedure existed until over two years after the failure to disclose the note was discovered. However, on the basis of the evidence, it is also clear LCol Sansterre and the CFNIS chain of command did believe they had revised the procedures when the public statements were made.

236. In testimony, LCol Sansterre, Maj Bolduc and Maj Dandurand explained the statements about the procedures having been revised were meant to refer to the discussions about the issue and the “practical procedure” or “best practice” reflected in the direction provided by the CO at the time, rather than to any written policies or procedures.⁶⁴⁰ There is no doubt the issue was discussed extensively and the CO made it clear to all he did not want this failure to happen again. Most importantly, as LCol Sansterre testified, in practice, “the procedures were changed from the moment that we knew,” because from this moment on, in every case, the CO got personally involved to ask about suicide notes and their disclosure.⁶⁴¹ This monitoring by HQ, more than the SOP development and any directives or discussions about the appropriate time for disclosure, was what the chain of command viewed as the revision of the procedures. It was the method they chose to ensure the failure to disclose the note would not happen again, and it was the reason they did not see the need to include a specific mention of suicide notes in the first version of the SOP.

237. Further, as explained by LCol Sansterre, although there was not necessarily a change in the substance of the procedures for determining the appropriate time to disclose suicide notes – or even a perception such a change was needed – there certainly was an “emphasis” on making sure the notes were disclosed as soon as possible and this was viewed as the revision of the procedures.⁶⁴² As a result, the Commission finds there was no dishonesty in the public statements made by the CFNIS about revising their procedures.

238. Similarly, although they could have been clearer on this point, the MRLs were not meant to imply the failure to disclose Cpl Langridge’s suicide note had resulted from a problem with the policies rather than from a mistake. While they did not state this directly, LCol Sansterre testified the message the MRLs “very subtly” conveyed when stating the CFNIS had “unfortunately” initially not disclosed the note was that this failure had been the result of a mistake.⁶⁴³ The PAOs did understand this message, and both the LFWA and the CFNIS PAOs transmitted it to the media during interviews.⁶⁴⁴

239. However, there were other statements included in the MRLs and made to the Fynes that created confusion and failed to convey a complete and accurate picture of the situation.

240. First, the statements in the initial versions of the MRLs about access to information policies having prevented the release of the suicide note were clearly not accurate and not related to the facts of this case.⁶⁴⁵ LCol Sansterre, Maj Bolduc and Maj Dandurand all recognized these statements were the result of confusion about the relevant policy area and were “blend[ing] together several issues” and “mixing apples and oranges.”⁶⁴⁶ At the time, Maj Bolduc had expressed doubts about their accuracy and had asked they be verified.⁶⁴⁷ LCol Sansterre had also inquired about the issue.⁶⁴⁸ In the end, the information was not provided to the media because a new version of the MRLs was created at LCol Sansterre’s request before the first interview with the media took place.⁶⁴⁹

241. The statement indicating a copy of the note should have been provided to the family “right away”, which was delivered to the media and published,⁶⁵⁰ is more

problematic. While it was in line with what some of the CFNIS members thought should have been done, it did not represent any consensus within the CFNIS about what would or should be done with suicide notes and hence, would not have been a fair representation of what members of the public could legitimately expect the CFNIS to do in the future. In particular, it was not consistent with the views of the members of the chain of command at the time – LCol Sansterre, Maj Bolduc and Maj Dandurand – who were consulted when the MRL was prepared.⁶⁵¹

242. In testimony, LCol Sansterre noted instead of the words “right away”, it would have been preferable to say, “as soon as we determine that it wouldn’t jeopardize the outcome of the investigation.”⁶⁵² He added, in reality, each time a suicide note was seized by the CFNIS, there were discussions and at times debates “on when is the ‘right away’.”⁶⁵³ Maj Dandurand explained his perspective:

[R]ight away does not, in my mind, necessarily mean upon receipt of the note It's immediately, without delay, transferred to the person to which it's addressed or to the executor of the estate.⁶⁵⁴ [Emphasis added]

243. Instead, Maj Dandurand thought “right away” would mean “within a few weeks of the investigation commencing, provided that foul play has been ruled out.”⁶⁵⁵

244. Maj Bolduc thought “right away” would be “when it is possible to do it and it will not have an impact on the integrity of the investigation.”⁶⁵⁶ He explained the term “right away” was “really the media response, not that was managed but it was at that point, the person who wrote that line thinking it was the thing to do.”⁶⁵⁷ He did not think the words fully or accurately reflected the direction provided by the CO or the procedures to be followed.⁶⁵⁸

245. The language used by Maj Dandurand during his November 2009 meeting with the Fynes also did not present an entirely accurate picture. While his assertion indicating the CFNIS used to have a policy not to divulge suicide notes⁶⁵⁹ was likely the result of his own initial erroneous perceptions about the evidence handling policies applicable, it left the Fynes with the impression the failure to disclose their son’s suicide note was not viewed as a mistake but rather as appropriate behaviour under the policies then in

place.⁶⁶⁰ It also created confusion and further undermined the Fynes' already shattered confidence in the CFNIS. Mr. Fynes testified:

[W]hen I hear a suggestion that there was a policy not to divulge suicide notes I get an absolute chill that other families may have never been told that their loved ones left a note for them if that was indeed a practice within the NIS.⁶⁶¹

246. Finally, the response provided through Col Blais in January 2011 was also not ideal. Its description of what should have been done – releasing the note at the end of the investigation or when foul play or the note's relevance was ruled out – was not clear as to exactly when it was believed the note should have been disclosed.⁶⁶² The lack of consensus within the CFNIS on this point also meant the response would not necessarily be accurate, depending on who was asked to make the determination. More importantly, the response stated the failure to disclose Cpl Langridge's suicide note had led to the "revision and 'tightening' of the [SOP] associated with this topic."⁶⁶³ However, whatever other revision of the procedures may have taken place, it is clear there was no SOP in January 2011 about the disclosure of suicide notes that had been revised or tightened.

247. In testimony, Maj Dandurand indicated he thought the SOP may have been in the process of "being drafted" when this response was provided.⁶⁶⁴ However, the evidence has shown it was not until July 2011 that the SOP paragraph about the disclosure of suicide notes was drafted. In January 2011, there was no plan to add a reference to the SOP then in force.

WERE THE MEASURES TAKEN SUFFICIENT?

248. When the failure to disclose Cpl Langridge's suicide note was discovered, significant amounts of time, energy and resources were invested in preparing the CFNIS and the CF's public response. Hundreds of pages of correspondence and numerous drafts of MRLs were created. Meanwhile, not a single piece of paper or even one electronic communication appears to have been created about the appropriate procedure to follow for the disclosure of suicide notes until a single paragraph was added to the SOP over two years later. Even then, it was done almost as an afterthought, when a suggestion was received from an administrative officer. Previously, the only written document discussing

the issue of the failure to disclose Cpl Langridge's suicide note outside the context of the media response or responses to the Fynes was the QA report about the 2008 investigation.

249. There is no doubt extensive discussions about the issue did take place within the CFNIS chain of command, and the CO became personally involved in monitoring actual cases. However, many issues were left unaddressed.

250. In their testimony, LCol Sansterre and Maj Bolduc made it clear significant reliance would be placed on the experience and assessments of the investigators and case managers with first-hand knowledge of the case when making the determination about the appropriate time to disclose the note.⁶⁶⁵ Indeed, no amount of monitoring by the chain of command could be sufficient if the investigators on the ground did not report the issue in a timely manner and provide the information and preliminary assessments necessary to make the determination. In order to do this, the investigators needed to be aware of the nature and importance of the issue and to have at least some understanding of the factors relevant to making the determination. Yet, very limited steps were taken in this case to make the investigators on whose information these important determinations would ultimately be based aware of the issue and the different considerations at stake.

251. While most of the CFNIS members who testified in this hearing were aware there had been issues with the disclosure of a suicide note in this case,⁶⁶⁶ and were aware of the revised SOP ultimately developed in 2011,⁶⁶⁷ many did not recall being advised about any new directives on this issue before the finalized SOP was circulated.⁶⁶⁸ Some had not even seen the 2011 SOP prior to these proceedings, although they had received instructions in specific cases.⁶⁶⁹ Even Sgt Shannon, who participated in drafting the initial 2010 SOP, was not aware the failure to disclose Cpl Langridge's suicide note had been an important part of the impetus to elaborate the SOP in the first place, and had no knowledge about the applicable CFNIS procedures for the disclosure of suicide notes.⁶⁷⁰

252. Meanwhile, the CFNIS chain of command had ordered a QA analysis of the investigation in order to begin addressing the issue. The report did not reveal what actually caused the failure to disclose the note in this case, but it did discuss the issue. It provided views about when the note should have been disclosed in this case and it

highlighted the need to make “a cognizant and informed decision” about the disclosure of suicide notes.⁶⁷¹ In testimony, LCol Sansterre, Maj Bolduc and Maj Dandurand explained the QA report and its recommendations formed part of the discussions held within CFNIS leadership about developing procedures on the disclosure of suicide notes for the future.⁶⁷² They also explained the report could be used to communicate “lessons learned” to the CFNIS members and Detachments.⁶⁷³ Indeed, while the views it contained about the appropriate time for disclosure did not necessarily correspond to the views ultimately adopted by all members of the chain of command,⁶⁷⁴ circulating the brief report throughout the organization would have been a convenient way to ensure all members were aware there had been an issue, and knew the procedures were being examined by the chain of command.

253. However, the extent to which the report was circulated is not clear. Most of the members involved in the investigation had never seen the report prior to these proceedings and were not aware of the recommendations it contained.⁶⁷⁵ LCol Sansterre recalled the HQ CWO, who was responsible for coordinating with Detachment MWOs, was aware of the report, but neither he nor Maj Bolduc could confirm whether the report was circulated to the Detachments.⁶⁷⁶ Maj Dandurand, for his part, believed within his Detachment, any “lessons learned” from the report were communicated to investigators verbally, through periodic meetings at the Detachment, as well as by ensuring case managers had received the report.⁶⁷⁷

254. In a section entitled “Action Taken to Rectify Procedural Problems Discovered,” the QA report stated:

Resultant of the complaint brought forward by the family of Cpl LANGRIDGE [with respect to] the delay in disclosure of the suicide note; the CFNIS WR Chain of Command has become extremely cognizant of the issue of disclosure of any suicide notes left by the deceased at the scene. Additionally, in depth analysis/discussions have occurred regarding best practices concerning the requirement to engage families of the deceased members in concert with the respective AOs and have in fact ensured that a more proactive approach is being taken [with respect to] ongoing files being investigated by CFNIS WR.

In addition to the foregoing, **a full debrief of the [subject] QA shall be incorporated in a Professional Development day for all investigators and Case Manager (TTBD).** In the interim more stringent monitoring/case managing concerning these types of issues have/will be implemented. Finally, CFNIS WR is anxiously awaiting the proposed new Victim Services Annex, currently being drafted, which upon receipt **will be disseminated**

by means of a PD session.⁶⁷⁸ [Emphasis added]

255. LCol Sansterre testified he had “no doubt that if [WO Ross] wrote it in his recommendations, that training day took place.”⁶⁷⁹ However, Maj Dandurand testified there were no PD days devoted to the report or to the new policy directives for the handling of suicide notes.⁶⁸⁰

256. There is also no indication the issue of the disclosure of suicide notes was incorporated into any training materials for new or existing members. For the period between 2009 and 2011, the CFNIS records were searched, and no educational or training materials discussing the issue were located.⁶⁸¹ The only reference to the issue was found in a presentation Maj Bolduc made to new members of the CFNIS in September 2009.⁶⁸² However, it does not appear the substantive issues were discussed. In testimony, Maj Bolduc recalled he used Cpl Langridge’s case – along with other cases “where we got very bad media coverage about things we had done or things we were said to have made mistakes” – as an example of why it was important to have Quality Assurance programs and to “make sure we do our job properly.”⁶⁸³ He spoke about the media coverage surrounding the failure to disclose the suicide note to convey the message “be sure that if we make mistakes, that is going to make the news a little bit more...” and “there are consequences for everything we do. And we are accountable in all the cases we investigate.”⁶⁸⁴

257. In addition to the insufficient steps taken to make members aware of the issues, it is clear the discussions held also failed to produce the necessary common understanding – even among the members who were aware of them – about the appropriate criteria to use for determining when to disclose suicide notes and about how these criteria should be applied to specific cases. As a result, when they testified before this Commission over three years after the failure to disclose Cpl Langridge’s suicide note was discovered, the members of the CFNIS and its chain of command still had different understandings. If they had to make a determination as of the date of this hearing about when to disclose a suicide note, it is clear they would not all come to the same answer.

258. Further, even the issues the CFNIS witnesses themselves identified during this hearing as still needing to be addressed were not promptly addressed.

259. During his testimony in June 2012, Maj Bolduc explained the paragraph added to the SOP in 2011 might need to be further revised during the July 2012 annual SOP review because it was not entirely clear about who the suicide note should be provided to.⁶⁸⁵ In the initial discussions, LCol Sansterre had directed the note be provided to the NOK, as determined through CF administrative processes.⁶⁸⁶ Initially, the CFNIS advised the AO assigned to the family and waited until a determination was made about who should receive the note prior to providing it.⁶⁸⁷ Subsequently, the CFNIS provided the note directly to the estate, which Maj Bolduc thought was the most appropriate procedure.⁶⁸⁸ He noted that, as a result, there were discussions about the SOP paragraph – which refers to the NOK and the person to whom the note is addressed – and this aspect was being verified.⁶⁸⁹

260. During his testimony in October 2012, LCol Frei noted other issues with the SOP. He explained it was being reviewed “yet again,” this time to provide for greater involvement of the ME or coroner in discussions, to be held on a case-by-case basis, about “how and when” to disclose the contents of suicide notes to family.⁶⁹⁰

261. Yet, in July 2013, the SOP had still not been revised and it remained exactly as updated in July 2011.⁶⁹¹ Considering how long it took to create the SOP and add the paragraph about suicide notes in the first place, this is not entirely surprising.

What Should Have Happened?

262. As could be expected, considering the different views they expressed about the procedures to be followed for the disclosure of suicide notes generally, the CFNIS witnesses who testified before this Commission also had different views about when Cpl Langridge’s suicide note should have been disclosed to his parents. As recognized by counsel for the subjects of the complaint, there was “considerable debate” amongst the CFNIS members about when the note could reasonably have been disclosed.⁶⁹²

263. Some thought the disclosure could have been done at a very early point. LCol Garrick testified he was not aware of any reason in this case preventing the investigators from being able to advise the family about the note right away.⁶⁹³ MWO Watson was of the view a copy of the note should have been provided to the family in the early days, before the funeral was held (March 26, 2008), and the original should have been returned at the end of the investigation.⁶⁹⁴ LCol Sansterre also believed the family should have been made aware of both the existence and contents of the note before the funeral, although the original note might not have been released as quickly.⁶⁹⁵ He explained there was no reason not to disclose the note early on in this case, since the investigators had examined the scene in consultation with the ME and there was no suspicion a crime had been committed.⁶⁹⁶

264. Others had more difficulty pinpointing an exact time. MCpl Ritco testified he believed revealing the existence of the note before foul play was ruled out could have compromised the investigation, and indicated he did not think foul play could be ruled out until he concluded his investigation (end of May 2008).⁶⁹⁷ He stated, as long as foul play remained a possibility, it was also possible the note may have been forged.⁶⁹⁸ He testified:

Potentially, it could be he didn't write it. I'd feel really, really bad if -- and horrible if I had told the family, "Yeah, we found a suicide note, and this is what your son had said", only to find out my investigation had showed that it was foul play and somebody else had written that. Then, I have to go back to the family and say, "You know what, I made a mistake. It wasn't your son's writing. It wasn't your son's suicide note".

So I have to -- as a police officer, it's a judgement call.⁶⁹⁹

265. However, MCpl Ritco also testified he did not think, in hindsight, it would have compromised anything in the investigation to tell the family about the contents of the note while advising them its authenticity had not yet been confirmed.⁷⁰⁰ In the end, he indicated he believed at least if the “new” procedures detailed in the 2011 SOP had applied, he should have disclosed the note to the Fynes and provided them a copy when he had his telephone conversations with them (May 5 and May 9, 2008), and should have released the original at the end of the investigation.⁷⁰¹ He could not identify a specific point in time when the note became “no longer required,” but thought the combination of

all the information he had learned by early May 2008 would have been sufficient to conclude the existence of the note could be disclosed to the family.⁷⁰²

266. Sgt Bigelow, for his part, was initially of the view the appropriate time to disclose the suicide note would have been either when information was received from the ME indicating most tests had been performed and the death would likely be ruled a suicide (April 9, 2008) or once the final ME certificate was received (May 15, 2008).⁷⁰³ Upon further questioning, he indicated it may have been possible to have “some sort of communication to the next of kin” about the funeral wishes contained in the note earlier, particularly in light of the ME’s comments at the scene and the absence of any other indications of foul play.⁷⁰⁴ He did remain steadfast in insisting the aspects of the evidentiary value of the note and whether foul play was ruled out had to be resolved prior to disclosure.⁷⁰⁵

267. Yet others did have a specific time in mind that would have come later in the investigation, after Cpl Langridge’s funeral was held on March 26, 2008. Maj Dandurand believed the appropriate time to disclose the note was once foul play was ruled out which required, in his view, obtaining some information from the ME.⁷⁰⁶ In this case, he believed April 9, 2008, when the preliminary information was received from the ME, would have been the appropriate time.⁷⁰⁷ Maj Dandurand testified that prior to this date, the possibility the suicide note may have been falsified and may not have contained Cpl Langridge’s true wishes was a realistic consideration.⁷⁰⁸ Likely referring to Cpl Langridge’s addiction issues, Maj Dandurand explained, considering Cpl Langridge’s history during the last year of his life, he would not have dismissed the possibility of an untoward situation being staged.⁷⁰⁹ However, he was unable to point to any evidence at all uncovered in this case, during the processing of the scene or after, indicating the death was anything other than a suicide.⁷¹⁰ He was also unable to point to any steps taken by the investigators to rule out or investigate the possibility the death was staged or the suicide note forged.⁷¹¹ He did testify he would have fingerprinted the note and would have had a handwriting analysis done if he was conducting this investigation today.⁷¹²

268. Maj Bolduc was also of the view the “right way” to proceed in this case would have been to release the note when informal confirmation was received from the ME the

death would be ruled a suicide (April 9, 2008).⁷¹³ Similarly, in the QA report, WO Ross had expressed the view the existence and contents of the note should have been disclosed when the information was obtained from the ME (April 9, 2008), although he had added the receipt of the final ME certificate (May 15, 2008) would have also been an appropriate time.⁷¹⁴ WO Tourout, for his part, believed the note could not have been revealed until the cause of death was determined.⁷¹⁵ He explained the investigators had to keep an open mind until it was “proven 100 percent that it’s an actual suicide” and indicated receipt of the ME report (May 15, 2008) would provide confirmation and determine the cause of death.⁷¹⁶

269. Not surprisingly in light of the lack of agreement amongst the CFNIS witnesses, counsel for the subjects of the complaint take the position this Commission should not attempt to determine when Cpl Langridge’s suicide note should have been disclosed in this case. In their closing submissions, they indicate, “this is a dangerous exercise to undertake because it is done from the vantage of hindsight.”⁷¹⁷ It should be noted if the CFNIS members cannot even agree after-the-fact – and on the basis of the most complete knowledge of the case – about when a suicide note should be disclosed, it is difficult to see how they will be able to come to the appropriate determination in ongoing cases where reliance must be placed on imperfect and incomplete knowledge.

270. On the basis of the evidence heard about what the CFNIS investigators knew at the time of the events, the Commission finds the existence and contents of Cpl Langridge’s suicide note should have been disclosed to his family within days if not hours of his death, and certainly before his funeral. In this case, there was simply no indication at all from the scene, the body, or any of the other information available to the investigators on March 15, 2008, giving rise to any suspicion the death was anything other than a suicide.⁷¹⁸

271. As immediately recognized by the ME investigator who attended at the scene, there were no signs of foul play.⁷¹⁹ The information received by the CFNIS investigators during the hours and days that followed further confirmed what was already evident from the scene and the body, as it indicated clearly Cpl Langridge had repeatedly spoken about and attempted suicide during the previous weeks and months.⁷²⁰

272. As pointed out by Mr. Fynes in testimony, the need to investigate or rule out foul play may have been an acceptable justification for not disclosing the note immediately if there had been “a legitimate concern that there was something other than a classic straightforward suicide.”⁷²¹

273. In this case, it is the Commission’s opinion there was no cause for such concern. The evidence gathered by March 19, 2008 overwhelmingly supported the conclusion Cpl Langridge had died as a result of suicide, and there were no contrary indications from any sources.⁷²²

274. Further, the steps taken (or not taken) by the CFNIS members during the investigation were not consistent with the notion that foul play was being actively investigated or that the suicide note was seen as having any evidentiary value.⁷²³ No steps were taken to ascertain whether another person might have been present when Cpl Langridge died or whether the death may have been staged. Very few steps were taken to confirm whether the scene of the death had been disturbed prior to the arrival of the CFNIS, and similarly limited steps were taken to determine Cpl Langridge’s whereabouts during the days immediately preceding his death.⁷²⁴ After March 19, 2008, the investigative steps and witness interviews were not generally even related to the possibility of foul play, as the investigation then focused on the suicide watch issue.⁷²⁵ The suicide note itself was not used for any purpose during the investigation.

275. If the investigators had a real concern the note may not have been written by Cpl Langridge or the death may not have been a suicide – to the point where they felt the note could not be disclosed for these reasons – then they would have had to take immediate steps to have the note analysed to confirm its authenticity. Clearly, there were no such concerns in this case nor any reason for such concerns. To the extent they thought about it at all, the CFNIS members were simply keeping the original note “just in case” information would come to light later making it necessary to have it tested.

276. Since everything is almost always “possible,” the mere abstract possibility of unspecified information casting doubt about the cause of death or the authenticity of the note coming to light at a later time could not constitute an acceptable justification for not

advising the Fynes about their son's suicide note in this case. It may have been acceptable to retain the original note to ensure it was available for testing if new information came to light, but without concrete information indicating there was cause for suspicion, it was not acceptable to keep the Fynes in the dark about their son's last communication.

Could This Happen Again?

277. It seems unlikely there will ever be another case where the CFNIS withholds a suicide note for 14 months. The accumulation of errors and the extreme inattention observed in this case are attributes of the type of situation that can happen only once. For the time being at least, there continues to be heightened awareness within the CFNIS about the importance of disclosing suicide notes, and there is an SOP paragraph directing disclosure as soon as possible and release of the original note at the end of the investigation, at the latest.⁷²⁶ However, the measures in place remain insufficient to prevent the recurrence of one of the most serious impacts endured by the Fynes: the inability to fulfill the funeral wishes their son had expressed in his suicide note.⁷²⁷

278. As has been seen, the members and chain of command of the CFNIS do not share a universal view about when suicide notes should be disclosed and how the determination should be made. In their closing submissions, counsel for the subjects insist "All of the NIS witnesses agreed no policy could dictate the exact time when a note could be provided to the NOK and that this was ultimately [a] matter of **investigatory discretion in each instance.**"⁷²⁸ In the exercise of this "discretion," it does not appear the CFNIS members have received any guidance about whether and how funeral wishes contained in the note should be taken into account. On the basis of the evidence before this Commission, there is cause for concern many CFNIS members would not disclose suicide notes in time to ensure funeral wishes were known before the funeral.

279. As with views about the procedures applicable before and after this case, the CFNIS witnesses' views about the importance of making funeral wishes known varied.

280. In testimony, Maj Bolduc was steadfast in maintaining the note could never be disclosed before foul play was ruled out, regardless of the timing of the funeral and of any funeral wishes in the note.⁷²⁹ He indicated, “it is possible that it will happen quickly, but it is possible that it will take longer than people want.”⁷³⁰ He testified:

Puis je ne veux pas dire qu'on n'a pas de sentiments envers ce que la famille ressent, mais notre objectif c'est vraiment de trouver est-ce qu'il y a un crime qui a été commis, si oui, bien, il faut l'enquêter le crime. Mais si c'est un suicide, **puis on détermine après les funérailles que c'était un suicide, c'est malheureux, mais je pense que l'objectif de la police, c'est vraiment de faire ce travail-là.**⁷³¹

[TRANSLATION]

And I don't want to say that we don't have feelings about what the family is feeling, but our objective is really to find out whether a crime has been committed, and if so, then we have to investigate the crime. But if it was a suicide, and **we determine after the funeral that it was a suicide, that is unfortunate, but I think the objective of the police is really to do that job.**⁷³² [Emphasis added]

281. He noted there are no special rules or procedures providing for early disclosure of funeral instructions, as all would depend solely on whether foul play was suspected.⁷³³ If there were such a suspicion, the information in the note might not be passed on before the funeral.⁷³⁴ Maj Bolduc explained the CFNIS would not “do the family justice” by “run[ning] through the steps too fast” and risk providing information in a manner which would later prevent it from solving the case.⁷³⁵ As an example, he referred to the possibility a person having committed the crime would write a note indicating the deceased wished to be cremated in order to destroy evidence.⁷³⁶

282. Maj Dandurand also testified that whether the note would be disclosed before the funeral would depend on whether foul play was ruled out.⁷³⁷ In the explanations he had provided to the Fynes and to Maj Parkinson, he had hinted the note would rarely, if ever, be disclosed prior to the funeral. He had told the Fynes suicide notes could never be disclosed until foul play had been ruled out, and had specifically commented this might not happen “until well after the funeral.”⁷³⁸ He had described the appropriate procedures as involving preliminary determinations being made by the CFNIS, and the note then being presented to the family for handwriting verification “within weeks” of the death.⁷³⁹ To Maj Parkinson, he had said Cpl Langridge’s suicide note “would have had no bearing on the funeral dealings” because foul play had not yet been ruled out when the funeral

took place.⁷⁴⁰ In testimony, he denied the need to rule out foul play prior to disclosure would make it “highly unlikely,” in practice, for a suicide note to be disclosed prior to the funeral.⁷⁴¹ Instead, he maintained the note could be disclosed before the funeral if the ME provided a “swift return” on the information necessary, depending on when the funeral was held.⁷⁴² However, he also testified receiving information from the ME is necessary in order to rule out foul play, and he admitted he had never seen a case where the ME was able to return the information less than a week after the death, which is generally when funerals are held.⁷⁴³

283. Sgt Bigelow testified he had never received any direction on how to address funeral wishes contained in a suicide note.⁷⁴⁴ He believed there should be “some sort of communication to the next of kin” about funeral wishes in a suicide note, but still thought this could only be done where foul play or the note’s evidentiary value were ruled out.⁷⁴⁵ MCpl Ritco, for his part, insisted the note could not have been disclosed before the funeral in this case. He explained: “I was still right at the [...] beginning of the investigation. I still didn’t know what was going on, whether it was a suicide, whether it was foul play, it was only days afterwards.”⁷⁴⁶ WO Tourout agreed. He indicated it had “certainly crossed [the investigators’] mind” it would have been important for the family to know about the funeral wishes in the note, but was steadfast the note could still not have been released.⁷⁴⁷ He believed the note could not have been released before the funeral even if fingerprinting had confirmed its authenticity. He stated:

[...] it would still have been the same, **it still would have been held as evidence and it wouldn't have undoubtedly [been] determined prior to the funerals.** But again, it's unfortunate and we are sorry for that, but **it just wasn't possible at the time.**⁷⁴⁸
[Emphasis added]

284. MWO Watson, on the contrary, was insistent the note should have been disclosed before the funeral.⁷⁴⁹ About the funeral wishes contained in the note, he testified: “It would have been nice to know and it would have been even better for the family to know that.”⁷⁵⁰ LCol Garrick also thought information about funeral wishes should be disclosed “immediately.”⁷⁵¹ Similarly, LCol Sansterre believed the funeral wishes should have been transmitted to the family in this case.⁷⁵² In general, he thought disclosure of the existence

and contents of suicide notes should be done immediately if no suspicion of foul play existed after the scene examination.⁷⁵³

285. LCol Frei, who was the CFNIS CO when the testimony before this Commission concluded, could not provide specifics about how funeral wishes contained in suicide notes would be addressed. He testified there would be cases where disclosing the note before the funeral would be possible and others where it would not, depending on the “particular circumstances.”⁷⁵⁴

286. On the whole, it is clear that if a suicide note containing funeral wishes is found by the CFNIS in the future, depending on the individual members making the determination and monitoring the case, the note may or may not be disclosed to the family before the funeral.

287. A large part of the problem stems from the different members’ understanding of what level of suspicion would justify withholding disclosure and of what, precisely, the term “ruling out foul play” means. It appears some of the members tend to focus on the need to disprove any potential suspicious circumstances or foul play, whether or not there is any positive reason for suspicion in the first place. As such, they will want to obtain some positive evidence or confirmation the death was indeed a suicide prior to disclosing even the existence of a note. Their default position appears to be not to disclose the note until it is shown disclosure will have no possible impact, and this will in turn happen only once sufficient confirmation has been obtained the death was a suicide. In practice, this type of approach may lead to delayed disclosure. Many of the members involved in this investigation did not believe they had ruled out foul play until the very end of the investigation, even if there was no reason to suspect it in the first place.⁷⁵⁵ For other members, the analysis appears more focused on the reverse question of whether any of the evidence indicates there is reason to suspect foul play may have been involved. Their default position appears to be to disclose the note without needing to disprove all potential scenarios, unless there is a specific reason to believe it should not be disclosed right away.

288. In general, it appears the inclusion of funeral wishes in a suicide note and the timing of the funeral are not viewed by most CFNIS members as important considerations in determining when to disclose the note. No official instruction or direction has been provided in this respect.

289. There will be no true assurances the CFNIS has taken all necessary measures to ensure what happened to the Fynes in this case never happens again until its members develop a common understanding of the appropriate criteria to apply in determining when suicide notes must be disclosed and until knowledge of these criteria is appropriately disseminated throughout the organization, including to the investigators on the ground. While the evidence from the members of other police forces who testified before this Commission has demonstrated it would not be a realistic goal to specify uniform or strict policies dictating the exact time when suicide notes need to be disclosed in all cases – as circumstances can and do vary, and the determinations are more often than not made on the basis of simple common sense⁷⁵⁶ – certain principles do need to be observed by the CFNIS in establishing the appropriate procedures.

290. The default position should always favour early disclosure of the existence and contents of suicide notes. The analysis should then focus on whether there is a reason not to disclose. The determination should be made on the basis of concrete facts and evidence rather than abstract possibilities. Rather than asking whether it has been determined the death was a suicide, the question to ask should be whether there is any actual, realistic reason for suspicion in the case. As appears to be the practice among at least some coroners and MEs, there should be early disclosure in all non-suspicious cases.⁷⁵⁷ Even where realistic suspicion is found to exist, the CFNIS members should remain focused on whether disclosing the existence of the note could harm the investigation. Wherever a realistic harm to the investigation cannot be identified, there should be no reason to withhold disclosure. Where funeral wishes or other time-sensitive information is contained in the note, this should be taken into account in the determination. In such cases, if suspicion does exist and disclosure is delayed as a result, all available measures should be taken to conduct testing of the note immediately. While it may not be possible to obtain absolute confirmation of the note's authenticity prior to the funeral, preliminary

testing such as handwriting comparison could provide at least the necessary indications to determine whether the level of suspicion is sufficient to deprive a family of the opportunity to fulfill what may well be their loved one's last wishes.

291. It should also be noted it is not the role of CFNIS members to protect the family from the potential "harm" that could result from early disclosure of a suicide note if it later turned out the note was not authentic, a rationale invoked on several occasions in testimony before this Commission and in explanations provided to the Fynes. If the CFNIS members believe disclosure cannot hinder the investigation, but nevertheless for one reason or another have doubts about the authenticity of the note – or fear subsequent information may reveal the case to be otherwise than it appears at first – the proper procedure will be to disclose the existence and contents of the note to the family, and to advise them final confirmation of the cause of death or authenticity of the note has not yet been obtained. Under such circumstances, families should be allowed to make their own decisions about whether to honour any wishes contained in the note.

292. Once the family has received a copy of the note, the CFNIS may have reason to retain the original for a certain period of time. The level of suspicion required to justify retaining the original will not be as great as what would be required to justify not telling the family about the note at all. If releasing the original could hinder the investigation – including by making it unavailable for testing or use as evidence if subsequent information revealed this was necessary – there will be justification for not proceeding immediately.

293. Another aspect to address is the process for disposing of evidence. Under the policies and procedures applicable at the time of the investigation into Cpl Langridge's death, the suicide note should, at a minimum, have been returned at the end of the investigation. However, there were no adequate processes in place at the Detachment to ensure evidence was disposed of in a timely manner, and it often ended up being retained for years simply because no one attended to the disposal process. The 2011 SOP does provide clearly for the original note to be released at the end of the investigation at the latest. However, it is not known whether the actual practices of the CFNIS Detachments for disposing of their evidence have improved. Should a suicide note again "fall through

the cracks” during the course of an investigation, or the members not determine it could or should be disclosed, the final safeguard to ensure the family learns of the note at least before a year or more has passed, is to ensure there are adequate processes in place to return items seized when investigations are closed. The history of this case has shown written procedures or instructions are not sufficient. The CFNIS must ensure all of its Detachments have the necessary resources and processes in place for disposing of evidence in a timely manner.

294. Until these issues are addressed properly by the CFNIS, no one, including this Commission, can be certain what happened to Mr. and Mrs. Fynes will never happen again.

¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 163.

² See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2; Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390.

⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.

⁵ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 387.

⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.

⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.

⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.

⁹ Exhibit P-4, Collection D, vol. 12, tab 70, doc. 1097.

¹⁰ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, pp. 37 & 86-87.

¹¹ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390.

¹² Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 229-230.

¹³ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 229-230.

¹⁴ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 230.

¹⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 89-90.

¹⁶ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 89; Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 87; Closing Submission of the Complainants, p. 10. For a discussion of the authority over the planning of the funeral, see Section 4.3, The 2009 PNOK Investigation.

¹⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 5.

¹⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 2-3.

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- ¹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 631-633.
- ²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 521 & 523.
- ²¹ Exhibit P-147, tab 1, doc. 1422, p. 9.
- ²² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 21-22; Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 226.
- ²³ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 115.
- ²⁴ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 115.
- ²⁵ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 115.
- ²⁶ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 151, 163, 164 & 631.
- ²⁷ Reply Submissions of the Subjects of the complaint, p. 8.
- ²⁸ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 259-261.
- ²⁹ Exhibit P-147, tab 2, doc. 1423, p. 22.
- ³⁰ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 104.
- ³¹ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 103.
- ³² Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 103.
- ³³ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 227.
- ³⁴ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 227.
- ³⁵ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 116-117.
- ³⁶ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 117.
- ³⁷ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 117.
- ³⁸ Exhibit P-147, tab 2, doc. 1423, p. 16.
- ³⁹ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 103.
- ⁴⁰ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 102.
- ⁴¹ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 102.
- ⁴² Exhibit P-147, tab 2, doc. 1423, p. 22.
- ⁴³ Exhibit P-147, tab 2, doc. 1423, p. 22.
- ⁴⁴ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 125.
- ⁴⁵ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 125.
- ⁴⁶ Exhibit P-147, tab 2, doc. 1423, p. 20.
- ⁴⁷ Exhibit P-147, tab 2, doc. 1423, p. 26.
- ⁴⁸ Exhibit P-147, tab 1, doc. 1422, p. 11.
- ⁴⁹ Exhibit P-147, tab 1, doc. 1422, p. 11.
- ⁵⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 27.
- ⁵¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 28 & 29.
- ⁵² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 30.
- ⁵³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 28-29.

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- ⁵⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 28.
- ⁵⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 27-29.
- ⁵⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 29.
- ⁵⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 63-64 [Translation]. See also Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 19-20.
- ⁵⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 20.
- ⁵⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 64-65 [Translation].
- ⁶⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 65 [Translation].
- ⁶¹ Exhibit P-147, tab 2, doc. 1423, p. 26.
- ⁶² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 32.
- ⁶³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 27; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 115.
- ⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 18.
- ⁶⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 115.
- ⁶⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 115-116.
- ⁶⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 116.
- ⁶⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 116-117.
- ⁶⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 116-117.
- ⁷⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 62-64 [Translation].
- ⁷¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 51.
- ⁷² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 14-15 & 50-52.
- ⁷³ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 392.
- ⁷⁴ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 391.
- ⁷⁵ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 124-125.
- ⁷⁶ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 391.
- ⁷⁷ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 391.
- ⁷⁸ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 391.
- ⁷⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 92-94; Closing Submissions of the Complainants, p. 78 & Prologue, p. 5.
- ⁸⁰ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390.
- ⁸¹ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390.
- ⁸² Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 389.
- ⁸³ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 389.
- ⁸⁴ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 389.
- ⁸⁵ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 389.
- ⁸⁶ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 128-129.
- ⁸⁷ Exhibit P-5, Collection E, vol. 5, tab 11, doc. 1233, p. 616.

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- ⁸⁸ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15.
- ⁸⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 18.
- ⁹⁰ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15.
- ⁹¹ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15.
- ⁹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 49-50; Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 7.
- ⁹³ Closing Submission of the Complainants, p. 10.
- ⁹⁴ Exhibit P-147, tab 1, doc. 1422, pp. 13-14.
- ⁹⁵ Exhibit P-147, tab 1, doc. 1422, p. 13.
- ⁹⁶ Exhibit P-147, tab 1, doc. 1422, p. 13.
- ⁹⁷ Exhibit P-147, tab 1, doc. 1422, p. 13.
- ⁹⁸ Exhibit P-147, tab 1, doc. 1422, p. 13.
- ⁹⁹ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.
- ¹⁰⁰ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.
- ¹⁰¹ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.
- ¹⁰² Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 96.
- ¹⁰³ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 96.
- ¹⁰⁴ Exhibit P-147, tab 1, doc. 1422, p. 18.
- ¹⁰⁵ Exhibit P-147, tab 1, doc. 1422, p. 18.
- ¹⁰⁶ Exhibit P-5, Collection E, vol. 5, tab 8, doc. 1230, p. 770.
- ¹⁰⁷ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 225.
- ¹⁰⁸ Exhibit P-1, Collection A, vol. 1, tab 1, pp. 631-633.
- ¹⁰⁹ Exhibit P-1, Collection A, vol. 1, tab 1, p. 633.
- ¹¹⁰ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 227.
- ¹¹¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 18.
- ¹¹² Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15.
- ¹¹³ Exhibit P-5, Collection E, vol. 5, tab 11, doc. 1233, pp. 616-617.
- ¹¹⁴ Exhibit P-5, Collection E, vol. 5, tab 11, doc. 1233, p. 616.
- ¹¹⁵ Exhibit P-5, Collection E, vol. 5, tab 11, doc. 1233, p. 616.
- ¹¹⁶ Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, p. 32.
- ¹¹⁷ Exhibit P-4, Collection D, vol. 12, tab 98, doc. 1125.
- ¹¹⁸ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 14.
- ¹¹⁹ Exhibit P-5, Collection E, vol. 5, tab 8, doc. 1230, pp. 766-767.
- ¹²⁰ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 13.
- ¹²¹ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, pp. 12-13.
- ¹²² Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 13.

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- ¹²³ Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, pp. 35-36.
- ¹²⁴ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 11.
- ¹²⁵ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 246-247.
- ¹²⁶ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 63.
- ¹²⁷ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 246.
- ¹²⁸ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 246.
- ¹²⁹ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 245-246.
- ¹³⁰ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 245-246.
- ¹³¹ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 65.
- ¹³² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 123-124.
- ¹³³ Exhibit P-147, tab 1, doc. 1422, p. 16.
- ¹³⁴ See Exhibit P-147, tab 1, doc. 1422, p. 16; Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 244-245; Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, p. 36; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 60.
- ¹³⁵ Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, p. 36.
- ¹³⁶ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 48.
- ¹³⁷ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, p. 137.
- ¹³⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 48; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 11; Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 40-44.
- ¹³⁹ See Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, p. 126; Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, p. 138.
- ¹⁴⁰ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 48; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 11; Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 38 & 40-41.
- ¹⁴¹ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 1-144, 147-163, 171-245, 394-441 & 783-788; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, pp. 3-5 & 11; Exhibit P-5, Collection E, vol. 5, tab 8, doc. 1230, p. 766; Exhibit P-147, tab 1, doc. 1422, pp. 111-113; Exhibit P-92, doc. 1377.
- ¹⁴² See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 78-80, 107-111, 133 & 198; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 3; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, p. 146.
- ¹⁴³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 176-177 & 402; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 166-169.
- ¹⁴⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 78-79 & 83-84 [Translation].
- ¹⁴⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 176-177; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 166-169.
- ¹⁴⁶ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, pp. 3 & 11; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 1, 38, 79, 107-111 & 133; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 137-138 & 146; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 74 & 81.
- ¹⁴⁷ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 137-138, 144-147 & 162-163; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 38, 59-60, 63-67, 106-107, 236-238 & 402.

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- ¹⁴⁸ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 63; Exhibit P-147, tab 1, doc. 1422, pp. 111-113.
- ¹⁴⁹ See Exhibit P-147, tab 1, doc. 1422, pp. 111-113.
- ¹⁵⁰ Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 40 & 51.
- ¹⁵¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 133-134.
- ¹⁵² Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 133-134.
- ¹⁵³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 133.
- ¹⁵⁴ Exhibit P-92, doc. 1377; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 402-403.
- ¹⁵⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 398; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 162-163.
- ¹⁵⁶ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 78-79.
- ¹⁵⁷ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 78-79.
- ¹⁵⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 59-60.
- ¹⁵⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 227.
- ¹⁶⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ¹⁶¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ¹⁶² Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ¹⁶³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ¹⁶⁴ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ¹⁶⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 415, 416, 419-420 & 426-430.
- ¹⁶⁶ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 426-427.
- ¹⁶⁷ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ¹⁶⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 182-184, 198-201 & 701.
- ¹⁶⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 193 & 181.
- ¹⁷⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 171-173.
- ¹⁷¹ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 206-207.
- ¹⁷² Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 205-207.
- ¹⁷³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 246-351, 442-659, 668-672, 680-688, 697-701, 726-732, 735-744, 768-775, 779-781, 796-798 & 808-810; Exhibit P-93, doc. 1378.
- ¹⁷⁴ Exhibit P-93, doc. 1378; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 170-171; 174; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 704-712.
- ¹⁷⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 256-257, 262, 453-454, 535, 542-543 & 737-738.
- ¹⁷⁶ Closing Submissions of the Complainants, p. 9.
- ¹⁷⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 26 & 33.
- ¹⁷⁸ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.
- ¹⁷⁹ Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, pp. 35-36.
- ¹⁸⁰ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 354-355.

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- ¹⁸¹ Exhibit P-147, tab 1, doc. 1422, p. 20.
- ¹⁸² Exhibit P-147, tab 1, doc. 1422, p. 20.
- ¹⁸³ Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, p. 35.
- ¹⁸⁴ Exhibit P-147, tab 1, doc. 1422, p. 112.
- ¹⁸⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ¹⁸⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77.
- ¹⁸⁷ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, p. 6.
- ¹⁸⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 48; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 13.
- ¹⁸⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 43.
- ¹⁹⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 12. See Exhibit P-147, tab 1, doc. 1422, p. 22; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 85-86 [Translation].
- ¹⁹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 28.
- ¹⁹² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 60 [Translation].
- ¹⁹³ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 68-69 [Translation].
- ¹⁹⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 133 [Translation].
- ¹⁹⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 132-133 [Translation].
- ¹⁹⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 55-56 [Translation].
- ¹⁹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 51-52.
- ¹⁹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 50.
- ¹⁹⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 49.
- ²⁰⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 71-72 & 78-79 [Translation].
- ²⁰¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 71-72 [Translation].
- ²⁰² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 71-72 & 78-79 [Translation].
- ²⁰³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 70. See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ²⁰⁴ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 201 & Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ²⁰⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 71.
- ²⁰⁶ Exhibit P-147, tab 1, doc. 1422, p. 16.
- ²⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 61.
- ²⁰⁸ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 64-66 & 71.
- ²⁰⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 61-62.
- ²¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 62.
- ²¹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 62.

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- ²¹² Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 7; Exhibit P-147, tab 1, doc. 1422, pp. 13-14 & 22.
- ²¹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 51.
- ²¹⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 12-13; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 48, 201 & 699; Exhibit P-147, tab 1, doc. 1422, p. 22; Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1.
- ²¹⁵ Exhibit P-147, tab 1, doc. 1422, p. 22.
- ²¹⁶ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 1. See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 29-30.
- ²¹⁷ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261.
- ²¹⁸ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 2.
- ²¹⁹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 2.
- ²²⁰ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 4.
- ²²¹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 4-5.
- ²²² Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5.
- ²²³ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5.
- ²²⁴ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 7.
- ²²⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 48.
- ²²⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 76.
- ²²⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 125-126.
- ²²⁸ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 125-126 [Translation].
- ²²⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 47.
- ²³⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 47.
- ²³¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 161; Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 264; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 149; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 156-157.
- ²³² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 161.
- ²³³ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5.
- ²³⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 264; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 149.
- ²³⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 156-157.
- ²³⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 156-157.
- ²³⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 20-21 & 56-57.
- ²³⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 264; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 149; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 213 & 241.
- ²³⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 20-21, 116 & 132-133.

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- ²⁴⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 21, 116 & 132-133.
- ²⁴¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 131-132.
- ²⁴² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 131-132 & 176-177.
- ²⁴³ Exhibit P-147, tab 1, doc. 1422, pp. 134-135.
- ²⁴⁴ Exhibit P-147, tab 1, doc. 1422, p. 135.
- ²⁴⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 161; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 101; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 69-70.
- ²⁴⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 101.
- ²⁴⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 70.
- ²⁴⁸ Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 41-43
- ²⁴⁹ See Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, p. 42.
- ²⁵⁰ Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 40-43.
- ²⁵¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 161 & Exhibit P-147, tab 1, doc. 1422, p. 136.
- ²⁵² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 632.
- ²⁵³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 164.
- ²⁵⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 7, 37 & 136.
- ²⁵⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 143.
- ²⁵⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 110 & 115-116.
- ²⁵⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 110.
- ²⁵⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 115-116.
- ²⁵⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 111.
- ²⁶⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 111.
- ²⁶¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 116.
- ²⁶² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 117.
- ²⁶³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 117.
- ²⁶⁴ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ²⁶⁵ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 84, 85, 88, 94, 96, 97, 104, 113 & 115.
- ²⁶⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 115-116.
- ²⁶⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 143-144.
- ²⁶⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 37-38 & 212.
- ²⁶⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 37-38 & 212.
- ²⁷⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 250-251.

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- ²⁷¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 39.
- ²⁷² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 265.
- ²⁷³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 265-266.
- ²⁷⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 10-11 & 24-25.
- ²⁷⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 24-25.
- ²⁷⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 25-26.
- ²⁷⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 87.
- ²⁷⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 118-119.
- ²⁷⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 119 & Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 87.
- ²⁸⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 119 & Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 88.
- ²⁸¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 119.
- ²⁸² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 146.
- ²⁸³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 146-147.
- ²⁸⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 230-231.
- ²⁸⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 230-231.
- ²⁸⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 149 & 211.
- ²⁸⁷ Exhibit P-75, tab 1, doc. 1087-J, p. 21.
- ²⁸⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 208; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 121.
- ²⁸⁹ Exhibit P-75, tab 1, doc. 1087-J, p. 21.
- ²⁹⁰ Exhibit P-75, tab 1, doc. 1087-J, p. 21.
- ²⁹¹ Exhibit P-75, tab 1, doc. 1087-J, p. 21.
- ²⁹² Exhibit P-75, tab 1, doc. 1087-J, p. 21.
- ²⁹³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 123-124.
- ²⁹⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 232.
- ²⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 163; Exhibit P-150, tab 1, doc. 1429, p. 3; Exhibit P-158, tab 1, doc. 1432, p. 60.
- ²⁹⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 632.
- ²⁹⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 105.
- ²⁹⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 632-633; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 105-106; Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 104.
- ²⁹⁹ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001; Exhibit P-147, tab 1, doc. 1422, pp. 132-173; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 145-146.
- ³⁰⁰ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-265, 140-144 & 520-521.
- ³⁰¹ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 184.

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- ³⁰² Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 328.
- ³⁰³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97.
- ³⁰⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 115.
- ³⁰⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 254 & 256.
- ³⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 521.
- ³⁰⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 523.
- ³⁰⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 1.
- ³⁰⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 524.
- ³¹⁰ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 73-74.
- ³¹¹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 160-161.
- ³¹² Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 219.
- ³¹³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 161.
- ³¹⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 524.
- ³¹⁵ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 3, 69 & 110.
- ³¹⁶ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 110.
- ³¹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 512-513.
- ³¹⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 512-513.
- ³¹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 512-513.
- ³²⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 512-513.
- ³²¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 512.
- ³²² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 151-152.
- ³²³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 154-155.
- ³²⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 152; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 511.
- ³²⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³²⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³²⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217.
- ³²⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217.
- ³²⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³³⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³³¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³³² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 220-221.
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- ³³⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 218.
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- ³³⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 152.
- ³³⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 511.
- ³³⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 511.
- ³³⁹ Exhibit P-1, Collection A, vol. 2, tab 11, doc. 001-P.
- ³⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 633-642, 644-645, 647-648, 657-658 & 660-662.
- ³⁴¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 631-633; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 223.
- ³⁴² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 90-92; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 140-141; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 119.
- ³⁴³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 70-71; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 142; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 95 & 142; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 186. See also, Investigation Plan: Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-265.
- ³⁴⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 91-92, 95, 102-103 & 141-142; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 70 & 183; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 142 & 144-145; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 38 & 121.
- ³⁴⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 328; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 124.
- ³⁴⁶ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 251; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ³⁴⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 195-196.
- ³⁴⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 207.
- ³⁴⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 145 & 207.
- ³⁵⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 146-147.
- ³⁵¹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 208.
- ³⁵² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 632.
- ³⁵³ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 49; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 161-162. See also Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 140 & 205; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 134-135.
- ³⁵⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 120.
- ³⁵⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 38 & 233-234; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 93-95 & 141-142; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 142 & 144-145.
- ³⁵⁶ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 38-39, 231-232 & 295; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 107.
- ³⁵⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 252-255, 257-262, 274-275 & 321-323; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 142-144, 149 & 211; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September

2012, pp. 89, 108-110, 113-114, 142, 174 & 176-178; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 177-178.

³⁵⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 111-114 & 163.

³⁵⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 112-114.

³⁶⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 216-217.

³⁶¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 113 & 163.

³⁶² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 113.

³⁶³ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 117. See also Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 196-197.

³⁶⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 251-252; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 39-40.

³⁶⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 39-40.

³⁶⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 103-104.

³⁶⁷ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 103-104, 128, 133-135, 152 & 155-156; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 36-37.

³⁶⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 154.

³⁶⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 215-216.

³⁷⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 214.

³⁷¹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 214.

³⁷² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 214-215.

³⁷³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 109-110.

³⁷⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 215.

³⁷⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 215.

³⁷⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 41 [Translation].

³⁷⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 46-47 [Translation].

³⁷⁸ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 50-51.

³⁷⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 36-37; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 134-135 & 152. See also Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217.

³⁸⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 219-220.

³⁸¹ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.

³⁸² See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 103-104, 128, 134-135, 152 & 155-156; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 36-37; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 321; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 144.

³⁸³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 236.

³⁸⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 31.

³⁸⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 31.

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- ³⁸⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 39.
- ³⁸⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 42.
- ³⁸⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 43.
- ³⁸⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 38.
- ³⁹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 73 & 109-110.
- ³⁹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 109-110.
- ³⁹² Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, p. 35.
- ³⁹³ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ³⁹⁴ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 198-199.
- ³⁹⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 197-198.
- ³⁹⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 265-266.
- ³⁹⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 238-240.
- ³⁹⁸ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 357-358.
- ³⁹⁹ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, p. 324.
- ⁴⁰⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 25-26;
Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 48-49.
- ⁴⁰¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 25-26.
- ⁴⁰² Exhibit P-147, tab 1, doc. 1422, p. 112.
- ⁴⁰³ Exhibit P-147, tab 1, doc. 1422, p. 112.
- ⁴⁰⁴ See Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 5.
- ⁴⁰⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 120.
- ⁴⁰⁶ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 198-199; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 88-89.
- ⁴⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 88-89; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 36-37.
- ⁴⁰⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ⁴⁰⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ⁴¹⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ⁴¹¹ See Section 4.0, The Subjects of the Complaint: Role Involvement and Background.
- ⁴¹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 118.
- ⁴¹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 116.
- ⁴¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 117.
- ⁴¹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 119-122 & 125-126.
- ⁴¹⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77.
- ⁴¹⁷ See below, The Change of Policies and Procedures.
- ⁴¹⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 39-40.

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- ⁴¹⁹ Exhibit P-4, Collection D, vol. 1 tab 35, doc. 032, p. 6.
- ⁴²⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 292-293. See, generally, Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ⁴²¹ See, for example, Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 125-126 [Translation]; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 117.
- ⁴²² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 117 & 282; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 84, 179 & 289 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 39, 73 & 107-111; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 69-71 & 73.
- ⁴²³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 131-132.
- ⁴²⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 46-47.
- ⁴²⁵ See Exhibit P-147, tab 1, doc. 1422, p. 111; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 73-74; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 72-73, 81, 84 & 92-94 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 76.
- ⁴²⁶ See Section 4.5.3, CFNIS Interactions with the Fynes, The November 2009 Briefing; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 56.
- ⁴²⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 14.
- ⁴²⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 13.
- ⁴²⁹ See Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 195-196; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 134-135; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 192; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 235.
- ⁴³⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 103-104.
- ⁴³¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 73.
- ⁴³² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 17. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 196 & Exhibit P-4, Collection D, vol. 1 tab 35, doc. 032, p. 6.
- ⁴³³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 198, 201 & 230-231.
- ⁴³⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 17.
- ⁴³⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 199-200. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 231-232.
- ⁴³⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 230.
- ⁴³⁷ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 257.
- ⁴³⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 99-100.
- ⁴³⁹ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, p. 6.
- ⁴⁴⁰ Final Submissions of the Subjects of the complaint, p. 65.
- ⁴⁴¹ Final Submissions of the Subjects of the complaint, p. 66.
- ⁴⁴² Final Submissions of the Subjects of the complaint, p. 67.
- ⁴⁴³ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.

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- ⁴⁴⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 70-71.
- ⁴⁴⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 89 & 94.
- ⁴⁴⁶ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 162.
- ⁴⁴⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 171.
- ⁴⁴⁸ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 163.
- ⁴⁴⁹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 165.
- ⁴⁵⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 60, 203, 429 & 737-739; Exhibit P-147, tab 1, doc. 1422, pp. 111-113.
- ⁴⁵¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 257.
- ⁴⁵² See Exhibit P-119, doc. 1396, pp. 85-86; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 444 & 446.
- ⁴⁵³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 557.
- ⁴⁵⁴ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 63 & 66-68; Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ⁴⁵⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 120-122 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 69.
- ⁴⁵⁶, generally, Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ⁴⁵⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 63 & 66-68.
- ⁴⁵⁸ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 73-74.
- ⁴⁵⁹ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ⁴⁶⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 200.
- ⁴⁶¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ⁴⁶² Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 203.
- ⁴⁶³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 203 & 429.
- ⁴⁶⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 161-163; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77 & 93-94.
- ⁴⁶⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 77 & 93-94.
- ⁴⁶⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 94.
- ⁴⁶⁷ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 44-47.
- ⁴⁶⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 4 & 12-13; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 67-68.
- ⁴⁶⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 73.
- ⁴⁷⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 13.
- ⁴⁷¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 67-68.
- ⁴⁷² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 12 & 230; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 68.
- ⁴⁷³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 72-73.
- ⁴⁷⁴ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 34.

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- ⁴⁷⁵ See Section 4.6, CFNIS Independence and Impartiality; Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ⁴⁷⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 68; Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33(a).
- ⁴⁷⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33(a).
- ⁴⁷⁸ See Exhibit P-2, Collection B, vol. 2, tabs 1 & 2, docs 1087-B & 1087-C; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.
- ⁴⁷⁹ See Section 4.3, The 2009 PNOK Investigation.
- ⁴⁸⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 62-63.
- ⁴⁸¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 192-193.
- ⁴⁸² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 160.
- ⁴⁸³ See Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, pp. 4-6.
- ⁴⁸⁴ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 4.
- ⁴⁸⁵ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 91-95. See also Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, p. 55.
- ⁴⁸⁶ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 92.
- ⁴⁸⁷ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 5.
- ⁴⁸⁸ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 59-60.
- ⁴⁸⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 59-60.
- ⁴⁹⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 59-60.
- ⁴⁹¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 60.
- ⁴⁹² Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 236-237. See Exhibit P-147, tab 1, doc. 1422, pp. 111-113.
- ⁴⁹³ Exhibit P-147, tab 1, doc. 1422, p. 111.
- ⁴⁹⁴ Exhibit P-147, tab 1, doc. 1422, p. 112.
- ⁴⁹⁵ See Exhibit P-92, doc. 1377; Exhibit P-93, doc. 1378; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 508-509 & 699-701; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 170-171.
- ⁴⁹⁶ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 426-430; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 170-171 & 174.
- ⁴⁹⁷ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 256-257, 262, 453-454, 488 & 738.
- ⁴⁹⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 542. See also Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 256-257, 262 & 535.
- ⁴⁹⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 704-712.
- ⁵⁰⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 76. See also pp. 90, 93 & 96.
- ⁵⁰¹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 166.
- ⁵⁰² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 166-167.
- ⁵⁰³ Exhibit P-4, Collection D, vol. 1 tab 35, doc. 032, p. 5-6.
- ⁵⁰⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 5-6, 12 & 43.

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- ⁵⁰⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 12.
- ⁵⁰⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 45.
- ⁵⁰⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 12-13 & 16; Exhibit P-59, doc. 1356, p. 4.
- ⁵⁰⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 12-13, 16 & 22; Exhibit P-59, doc. 1356, p. 4.
- ⁵⁰⁹ Exhibit P-57, doc. 1354.
- ⁵¹⁰ Exhibit P-58, doc. 1355, p. 1.
- ⁵¹¹ Exhibit P-119, doc. 1396, pp. 2-3.
- ⁵¹² See Exhibit P-119, doc. 1396, pp. 167-168 & 143-150; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 76-77.
- ⁵¹³ Exhibit P-119, p. 159.
- ⁵¹⁴ Exhibit P-5, Collection E, vol. 6, tab 48, doc. 1281. See also, Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B.
- ⁵¹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 23-25.
- ⁵¹⁶ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 39-41.
- ⁵¹⁷ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 4.
- ⁵¹⁸ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 40-41.
- ⁵¹⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 144-146 [Translation].
- ⁵²⁰ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B.
- ⁵²¹ Exhibit P-5, Collection E, vol. 6, tab 48, doc. 1281, pp. 6-7, s. 20-21; Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 46-51. LCol Sansterre testified the Annex was already included in the October 2010 version of the SOP: Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 25-26.
- ⁵²² Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 48 & 50.
- ⁵²³ Exhibit P-5, Collection E, vol. 6, tab 48, doc. 1281, p. 7, s. 21; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 150 [Translation].
- ⁵²⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 83; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 151-152 [Translation]; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 78.
- ⁵²⁵ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁵²⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 153 [Translation]; Exhibit P-119, p. 193.
- ⁵²⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 153-155 [Translation].
- ⁵²⁸ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 155-156 [Translation]; Exhibit P-119, doc. 1396, pp. 191-193; Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁵²⁹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁵³⁰ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 37-38 & 41-43; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 7-8.
- ⁵³¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 8-9 & 11.

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- ⁵³² Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 41-43.
- ⁵³³ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 34-39.
- ⁵³⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 8, 39, 42 & 88-89.
- ⁵³⁵ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 62-65.
- ⁵³⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 37-38, 43-44, 49 & 73; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 14, 71-73, 81-85, 87, 89-91 & 95-96 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 97-98.
- ⁵³⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 12-13, 15-17 & 43-44; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 14 [Translation]. See also Exhibit P-59, doc. 1356, p. 3.
- ⁵³⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 16-17.
- ⁵³⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 44. See also pp. 37, 43 & 49.
- ⁵⁴⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 17.
- ⁵⁴¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 17.
- ⁵⁴² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 44-45 & 83-84.
- ⁵⁴³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 44-45.
- ⁵⁴⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 14, 71-73, 81-84, 87, 90-91 & 94-95 [Translation].
- ⁵⁴⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 88-89 [Translation].
- ⁵⁴⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 82 [Translation].
- ⁵⁴⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 71-73, 81, 87 & 89 [Translation].
- ⁵⁴⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 35-36 & 69.
- ⁵⁴⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 20, 50 & 61-62.
- ⁵⁵⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 40, 52-54 & 56-57.
- ⁵⁵¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 42 & 52-55.
- ⁵⁵² See Exhibit P-59, doc. 1356, pp. 3-10; Exhibit P-58, doc. 1355; Exhibit P-119, doc. 1396, pp. 1-6; Exhibit P-119, doc. 1396, pp. 7-16; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 19, 21-22, & 55-56.
- ⁵⁵³ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 87-88, 151-152 & 155 [Translation].
- ⁵⁵⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 164 [Translation].
- ⁵⁵⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 27.
- ⁵⁵⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 70.
- ⁵⁵⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 26-27.
- ⁵⁵⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 97-98; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 72-73 & 81-83 [Translation].

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- ⁵⁵⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 84 & 90-94 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 97-98.
- ⁵⁶⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 84, 179 & 289 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 69-71 & 73.
- ⁵⁶¹ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 37, 39-40, 54, 69; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 81, 97-98 & 151 [Translation].
- ⁵⁶² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 69.
- ⁵⁶³ See Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.
- ⁵⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 31, 42, 73 & 109-110.
- ⁵⁶⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 126-128; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ⁵⁶⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 39, 73 & 107-111.
- ⁵⁶⁷ Exhibit P-147, tab 1, doc. 1422, p. 16.
- ⁵⁶⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 52-53 & 89-90; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 136-137.
- ⁵⁶⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 25, 36-37, 40-41, 50, 56, 74 & 79; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 87, 89 & 117-119 [Translation].
- ⁵⁷⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 3-4 & 89-90 [Translation].
- ⁵⁷¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 56.
- ⁵⁷² See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 112-113 & 163; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 253; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 140-141; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 235; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 65-66; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 49-50; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 109; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 54; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 66-67; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 55-56; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 97-98 [Translation].
- ⁵⁷³ Exhibit P-6, Collection F, vol. 1, tab 41, doc. 1188, p. 5, s. 13.
- ⁵⁷⁴ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, p. 12-14, s. 28, 29(a) & 31. See also Exhibit P-53, doc. 1350, p. 6.
- ⁵⁷⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 163; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 55-56; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 31, 39, 42, 73 & 109-113.
- ⁵⁷⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 40-41, 98 & 100-101 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 40-42; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 50-52.

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- ⁵⁷⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 237.
- ⁵⁷⁸ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 48-50 & 55-56; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 235-237; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 163-164 & 175; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 40-41 & 101-102 [Translation].
- ⁵⁷⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 42.
- ⁵⁸⁰ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 50-52; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 101 & 105 [Translation].
- ⁵⁸¹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 165-166 & 172-173; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 101 & 105 [Translation].
- ⁵⁸² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 31, 39, 42, 73 & 109-113; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 252-255 & 257-260.
- ⁵⁸³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 252-255 & 257-260.
- ⁵⁸⁴ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 52-54.
- ⁵⁸⁵ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 52-53.
- ⁵⁸⁶ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 53.
- ⁵⁸⁷ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 39-40, 233 & 295.
- ⁵⁸⁸ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 101 & 105 [Translation].
- ⁵⁸⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 31, 39, 42, 73 & 109-113; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 252-255 & 257-260.
- ⁵⁹⁰ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 141-142 & 146.
- ⁵⁹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 66-67; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 97-98 & 101 [Translation].
- ⁵⁹² Final Submissions of the Subjects of the complaint, pp. 65-66.
- ⁵⁹³ See, generally, Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁵⁹⁴ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁵⁹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 44-45 & 83-84.
- ⁵⁹⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 164 [Translation].
- ⁵⁹⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 81-82, 103-105, 107-108 & 162-163 [Translation].
- ⁵⁹⁸ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 182 [Translation].
- ⁵⁹⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 107-108 [Translation].
- ⁶⁰⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 251 [Translation].
- ⁶⁰¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 105-106 [Translation].

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- ⁶⁰² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 107-109 & 162 [Translation].
- ⁶⁰³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 96-97.
- ⁶⁰⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 102-103.
- ⁶⁰⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 67-69.
- ⁶⁰⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 70.
- ⁶⁰⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 69.
- ⁶⁰⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 175 & 177-178.
- ⁶⁰⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 177-178.
- ⁶¹⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 31-32.
- ⁶¹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 33-35.
- ⁶¹² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 35-36.
- ⁶¹³ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 58 & 60.
- ⁶¹⁴ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 59-60.
- ⁶¹⁵ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 59.
- ⁶¹⁶ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 173-175 & 183-184.
- ⁶¹⁷ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 174-177.
- ⁶¹⁸ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 173-174.
- ⁶¹⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 46; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 31-32; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 95-96 & 103-104 [Translation].
- ⁶²⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 45-46; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 32-33; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 104 & 165 [Translation].
- ⁶²¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 111-112 [Translation].
- ⁶²² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 95-96 & 111-112 [Translation].
- ⁶²³ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 173. See also Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 70-71.
- ⁶²⁴ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 178.
- ⁶²⁵ See Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 176.
- ⁶²⁶ See Closing Submissions of the Complainants, p. 11.
- ⁶²⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 105 [Translation].
- ⁶²⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 112-113.
- ⁶²⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 111-112.
- ⁶³⁰ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 55.
- ⁶³¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 65.
- ⁶³² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 65. See also Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 25.

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- ⁶³³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 113.
- ⁶³⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 112-113.
- ⁶³⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 105-106 [Translation].
- ⁶³⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 105-106 [Translation].
- ⁶³⁷ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 59-60, 218, 256-257, 262, 426-430, 535 & 542.
- ⁶³⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 35-37.
- ⁶³⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 41.
- ⁶⁴⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 37 & 41; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 178-181 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 76, 94-97 & 100.
- ⁶⁴¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 36-37.
- ⁶⁴² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 71-72.
- ⁶⁴³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 59-61.
- ⁶⁴⁴ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 218; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 157-158; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 429.
- ⁶⁴⁵ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 4; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, pp. 3-4.
- ⁶⁴⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 62-64; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 171-173 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 72-75, 81-83 & 85. See also Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, p. 192.
- ⁶⁴⁷ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 106; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 176-177 [Translation].
- ⁶⁴⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 63.
- ⁶⁴⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 63.
- ⁶⁵⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 429.
- ⁶⁵¹ See Exhibit P-147, tab 1, doc. 1422, p. 113: the members consulted were LCol Sansterre, Maj Bolduc and Maj Dandurand.
- ⁶⁵² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 28-29.
- ⁶⁵³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 30.
- ⁶⁵⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 102-103.
- ⁶⁵⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 102-103.
- ⁶⁵⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 183 [Translation].
- ⁶⁵⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 182 [Translation].
- ⁶⁵⁸ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 182-183 [Translation].
- ⁶⁵⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77.
- ⁶⁶⁰ See, generally, Section 4.5.3, The November 2009 Briefing.
- ⁶⁶¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 4-5.

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- ⁶⁶² See Exhibit P-4, Collection D, vol. 1 tab 35, doc. 032, p. 5.
- ⁶⁶³ Exhibit P-4, Collection D, vol. 1 tab 35, doc. 032, p. 6.
- ⁶⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 6-7.
- ⁶⁶⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 45-46; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 32-33; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 104 & 165 [Translation].
- ⁶⁶⁶ See Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 21; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 104; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 213.
- ⁶⁶⁷ See Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 164-165; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 266-267; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 112 & 170.
- ⁶⁶⁸ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 267 & 269-270; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 88; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 112 & 170-171; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 26; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 240-241.
- ⁶⁶⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 26, 28, 30-31 & 67.
- ⁶⁷⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 78 & 86-88.
- ⁶⁷¹ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 4-5 & 7.
- ⁶⁷² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 28-29; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 71-72, 83 & 140-141 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 134-136.
- ⁶⁷³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 76; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 129-131 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 134-136.
- ⁶⁷⁴ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 48; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 135-136 [Translation].
- ⁶⁷⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 184-185, 272-274 & 315; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 149-150. However, see Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 33-34.
- ⁶⁷⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 130-131 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 76-77.
- ⁶⁷⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 137-138.
- ⁶⁷⁸ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, p. 6.
- ⁶⁷⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 32-33.
- ⁶⁸⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 135-136 & 138-139.
- ⁶⁸¹ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 62-65.
- ⁶⁸² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 84-85 & 165-168 [Translation]; Exhibit P-119, pp. 35-45.

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- ⁶⁸³ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 85 & 167 [Translation].
- ⁶⁸⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 167 [Translation].
- ⁶⁸⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 113 [Translation].
- ⁶⁸⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 47-48 & 87.
- ⁶⁸⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 103 [Translation].
- ⁶⁸⁸ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 103, 113-114 & 162-164 [Translation].
- ⁶⁸⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 113 [Translation]; Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁶⁹⁰ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 167-168.
- ⁶⁹¹ Exhibit P-183, tab 1, doc. 1461, p. 2.
- ⁶⁹² Final Submissions of the Subjects of the complaint, p. 66.
- ⁶⁹³ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 107.
- ⁶⁹⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 38-39, 125, 213 & 295.
- ⁶⁹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 33-35. See also p. 48.
- ⁶⁹⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 34-35.
- ⁶⁹⁷ See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 88-89, 113-114 & 142; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 177-178.
- ⁶⁹⁸ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 109-110.
- ⁶⁹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 108.
- ⁷⁰⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 111-112.
- ⁷⁰¹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 174, 176 & 178.
- ⁷⁰² Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 177-178.
- ⁷⁰³ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 274-275 & 322-323; Exhibit P-1, Collection A, doc. 001, pp. 235 & 258.
- ⁷⁰⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 323-324.
- ⁷⁰⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 274-275 & 323-324.
- ⁷⁰⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 157-159.
- ⁷⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 107-108, 159 & 167.
- ⁷⁰⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 168.
- ⁷⁰⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 168.
- ⁷¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 168-173.
- ⁷¹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 168-173. See, generally, Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷¹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 170.

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- ⁷¹³ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 136-137 [Translation].
- ⁷¹⁴ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 4-5.
- ⁷¹⁵ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 142 & 144.
- ⁷¹⁶ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 18 & 48.
- ⁷¹⁷ Final Submissions of the Subjects of the complaint, p. 66.
- ⁷¹⁸ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷¹⁹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷²⁰ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷²¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 12-13. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 4.
- ⁷²² See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷²³ See Closing Submission of the Complainants, pp. 9-10.
- ⁷²⁴ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁷²⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death. Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ⁷²⁶ See Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15, s. 21.
- ⁷²⁷ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 89; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 5; Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 87; Closing Submission of the Complainants, p. 10.
- ⁷²⁸ Final Submissions of the Subjects of the complaint, p. 68 [Emphasis added].
- ⁷²⁹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 137-138 [Translation].
- ⁷³⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 251-252 [Translation].
- ⁷³¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 138.
- ⁷³² Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 138 [Translation].
- ⁷³³ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 109-111 [Translation].
- ⁷³⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 109 [Translation].
- ⁷³⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 110-111 [Translation].
- ⁷³⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 109 [Translation].
- ⁷³⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 157-161, 164 & 167.
- ⁷³⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 93-94.
- ⁷³⁹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 164.
- ⁷⁴⁰ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 44-47.
- ⁷⁴¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 161 & 167.
- ⁷⁴² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 161.
- ⁷⁴³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 157-159, 162 & 167.
- ⁷⁴⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 271.

⁷⁴⁵ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 274-275 & 323-324.

⁷⁴⁶ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 176.

⁷⁴⁷ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 143-144.

⁷⁴⁸ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 144.

⁷⁴⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 295.

⁷⁵⁰ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 295.

⁷⁵¹ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 52-54.

⁷⁵² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 33-34.

⁷⁵³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 34-35.

⁷⁵⁴ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, p. 177.

⁷⁵⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

⁷⁵⁶ See, generally, Testimony of Det Insp Olinyk, Insp Fitzpatrick and S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 178-181, 184-186, 191-208 & 255-264.

⁷⁵⁷ See Testimony of Insp Fitzpatrick, Transcript of Proceedings, vol. 44, 10 September 2012, p. 264; Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 40-43.

4.3 THE 2009 PNOK INVESTIGATION

Introduction

1. One significant portion of the Fynes' overall complaints to the MPCC involves their dissatisfaction with the 2009 investigation. The genesis of this investigation was the Fynes' unhappiness with the decision to grant Ms. A decision-making authority with respect to Cpl Stuart Langridge's funeral. The Fynes felt that, as a result of the PEN form completed by Cpl Langridge, which named them as primary and secondary next-of-kin (NOK),¹ the regiment should instead have recognized their entitlement to make funeral decisions.

2. The Fynes have two different types of complaints regarding this matter. The first involves their underlying dissatisfaction with the conduct of the CF, which, in their view, improperly gave this authority to Ms. A. This dissatisfaction led to their complaint to the CFNIS alleging the CF members involved were negligent in appointing Ms. A as the primary next-of-kin (PNOK) and therefore guilty of a service offence. The second aspect of their dissatisfaction regarding this matter involves the manner in which the CFNIS conducted its investigation into their complaint. This second aspect constitutes their complaint to this Commission alleging various defects and inadequacies in the 2009 investigation.

3. While related, the Fynes' complaints to this Commission about the 2009 investigation are distinct from their complaints about the CF's actual decisions about the PNOK and the authority to make funeral planning decisions. This report attempts to respond directly only to the Fynes' complaint to this Commission that the CFNIS investigation was inadequate. To assess this issue it is necessary to look at the nature of the Fynes' complaint to the CFNIS about what became known as the "PNOK decision" made by the CF regiment.

4. The Commission has reviewed documents and testimony relating to the PNOK issue and looked into the relevant law. While the Commission concludes the underlying issue of who is entitled to plan a military funeral is one of considerable legal complexity, it also concludes the CFNIS investigation into the Fynes' complaint was wholly inadequate. This chapter addresses the following elements that compromised the 2009 investigation:

- Improper interpretation of the complaints;
- Weak planning;
- Lack of focus;
- Insufficient supervision;
- Failure to interview potential key witnesses;
- Failure to seek outside legal advice;
- Poor recordkeeping; and
- Poor decision-making.

The Complaint

THE OMBUDSMAN INVESTIGATOR'S COMPLAINT

5. The issues forming the basis of the 2009 investigation first came to the attention of the CFNIS on November 17, 2009, when Lt(N) Michael Amirault of the CFNIS Central Region was contacted by Patrick Martel, an investigator from the CF Ombudsman's Office.² Mr. Martel told Lt(N) Amirault he had received a complaint from Shaun and Sheila Fynes that LDSH had represented Ms. A as the common-law spouse of Cpl Langridge at the time of his death and, as a result, she became entitled to certain rights and benefits³ including authority to plan Cpl Langridge's funeral.⁴ Mr. Martel suggested there was a possibility a service offence may have been committed in the determination of Cpl Langridge's PNOK.⁵ Lt(N) Amirault conveyed this information to Maj Daniel Dandurand in a phone call that same day.⁶ He also forwarded the documentation provided by the Ombudsman's Office supporting the allegations with respect to what Maj Dandurand described as "the PNOK issue."⁷ Mr. Martel was

contacted by the CFNIS WR on December 4, 2009, to set up a time to meet. At that time, he faxed additional documents to Maj Dandurand in support of the allegations.⁸

Following this, Maj Dandurand and MS Eric McLaughlin met the Ombudsman's investigators Mr. Martel and Phillippe Joly on December 18, 2009. During that meeting, Mr. Martel provided further documentation in support of the allegations, which MS McLaughlin catalogued in the General Occurrence (GO) file.⁹

6. In the initial stages of the investigation, the complaints were characterized by the CFNIS as having originated with the Ombudsman. The tasking of MS McLaughlin by WO Blair Hart on December 7, 2009, states MS McLaughlin will "conduct an investigative assessment into the Ombudsman's complaint."¹⁰ The File Status Report from December 10, 2009, similarly states, "An allegation has been brought forward by the CF Ombudsman."¹¹

7. On February 12, 2010, Maj Dandurand decided the CFNIS would conduct an investigation into the allegations of negligent performance of duty following the "review of the documentation provided to the CFNIS WR investigators by the CF Ombudsman's office."¹² In a phone call on the same day, Maj Dandurand notified Mr. Fynes of the investigation and advised him, "Investigators from CFNIS WR met with Ombudsman investigators who provided documentation leading CFNIS to initiate this investigation."¹³ In his meeting with the Fynes on March 3, 2010, Maj Dandurand explained the Ombudsman's office was looking at many issues and had brought the allegation concerning the PNOK to the attention of the CFNIS, which is why the CFNIS was speaking with them.¹⁴ Indeed, during his initial conversations with Lt(N) Amirault, Mr. Martel stated he had yet to notify the Fynes he was speaking to the CFNIS.¹⁵

8. In some respects the CFNIS members treated the Ombudsman as the complainant. MCpl David Mitchell contacted Mr. Martel on February 18, 2010, shortly after being assigned to the file, to advise him of the change in personnel and to gather further information on the allegations.¹⁶ The CFNIS committed at that time to keep Mr. Martel informed regarding what was transpiring in the investigation and to contact him for more information as the need arose.¹⁷ In other respects, the investigators did not treat the

Ombudsman as the complainant. After MCpl Mitchell's initial contact they did not contact Mr. Martel again, nor keep him informed about the investigation.¹⁸ The CFNIS did not advise Mr. Martel of the conclusion of the investigation or provide him with a final briefing letter on the investigation.¹⁹

THE FYNES' COMPLAINT

9. On November 28, 2009, the Fynes met with Maj Dandurand and MS McLaughlin. The intended purpose of the meeting was to provide the Fynes with a briefing on the 2008 investigation.²⁰ While Maj Dandurand had received the documents from the Ombudsman's investigator prior to the meeting, he had not reviewed them in detail. MS McLaughlin did not believe he was aware of all of the initial information from the Ombudsman's investigator at the time of the meeting with the Fynes.²¹

10. The Fynes did raise issues at the meeting relevant to the subject matter in the documentation provided to the CFNIS by Mr. Martel. They specifically expressed concerns they had had no decision-making authority over Cpl Langridge's funeral even though they had been named as PNOK and SNOK on his PEN form.²² They also alleged Ms. A was not Cpl Langridge's common-law spouse at the time of his death. In their view, it should have been Mrs. Fynes who was entitled to dispose of Cpl Langridge's remains.²³

11. It is difficult to know the extent of the discussion about these issues because at least an hour of the interview was not audio recorded.²⁴ The transcripts of the recorded portions of the interview relevant to these allegations are relatively short and comprise only a few pages of text.²⁵

12. The allegation concerning the PNOK issue is reflected in MS McLaughlin's complaint synopsis²⁶ written on January 12, 2010, a month and a half after the meeting with the Fynes.²⁷ The complaint synopsis is a summary of the November 2009 meeting with the Fynes and it does not refer to the Ombudsman Investigator's complaint. As such, it tends to indicate the Fynes were viewed as the complainants.

13. In the synopsis, MS McLaughlin states he has been tasked with conducting an investigation into the allegation the LDSH Adjutant was negligent by failing to appoint Mrs. Fynes as NOK. Maj Dandurand's notebook entry for the meeting similarly reflects the allegations concerning the determination of the PNOK and indicates the CFNIS would investigate the allegations.²⁸

14. The Fynes were not contacted again by the CFNIS about the 2009 investigation until February 12, 2010, when Mr. Fynes was contacted by Maj Dandurand who advised him of the departure of MS McLaughlin and told him the CFNIS would be investigating the PNOK allegation.²⁹ The Fynes heard nothing further from the CFNIS about their allegations until their March 3, 2010, interview, which was intended as an opportunity for the Fynes to supply information regarding their PNOK complaint.

WHO WAS THE COMPLAINANT?

15. The CFNIS did not keep a clear record of who was officially viewed as the complainant and whose allegations were being investigated. The Fynes would eventually complain the written briefing they received at the end of the investigation failed to recognize that the PNOK issue had also been brought to the CFNIS's attention by the Ombudsman's Office, and not just by the Fynes.³⁰

16. In their testimony, the CFNIS members involved in the investigation explained they regarded the Ombudsman as a third party complainant or a conduit for the Fynes' complaint to come to the CFNIS.³¹ MS McLaughlin described the Ombudsman's Office as "the investigative body that initially was looking into [the allegations] for the Fynes."³²

17. Maj Dandurand testified the initial notations in the file identifying the Ombudsman as the complainant should not be viewed as determinative of who was, in fact, viewed and treated as complainants by the investigators.³³ He believed nothing turned on this fact.³⁴ To some extent, this may be true.

18. The Ombudsman's investigator did bring the allegation concerning Ms. A's entitlement to certain benefits to the attention of the CFNIS in the first instance. The issue

was then discussed by the Fynes in their meeting with Maj Dandurand and MS McLaughlin and was more fully expanded on in the subsequent meeting with the Ombudsman's investigators. The launch of the investigation seems to have been primarily premised on the information and documents received from the Ombudsman, as comparatively little information was given to the CFNIS by the Fynes about the issues under investigation prior to March 2010.

19. At the same time, the Fynes clearly had a vested interest in the outcome of the investigation. They brought the complaint to the attention of the Ombudsman's investigator who, on his own initiative, took it to the CFNIS.³⁵ Most of the information Mr. Martel passed on to the CFNIS originated from the Fynes or their Assisting Officer Maj Stewart Parkinson.³⁶

20. The lack of clarity in the file notations about the identity of the complainant likely had little practical impact on the actual investigation since the allegations were largely the same. However, proper recordkeeping by MP is always important. As certain entitlements are attached to the status of a complainant,³⁷ it would have been preferable for the CFNIS to establish a clear identity for the complainant in the investigative file.

21. The initial confusion surrounding the identification of the complainant only intensified as the investigation progressed and the CFNIS members sought to understand the issues at stake.

The Investigative Assessment

PURPOSE OF AN INVESTIGATIVE ASSESSMENT

22. Prior to launching an investigation, the CFNIS often carries out an investigative assessment of the allegations (also referred to as the "preliminary investigation") to determine whether there are sufficient grounds to proceed with a full criminal investigation.³⁸ An assessment entails conducting initial steps for an investigation, including file research and/or preliminary interviews, to determine whether the complaint

may involve the commission of a service or criminal offence.³⁹ An assessment is not necessarily completed in every investigation and each completed assessment varies in length and complexity.⁴⁰ There are several possible outcomes of an assessment:

- The evidence supports the belief an offence may have been committed, in which case a complete and thorough investigation is conducted;
- There is no evidence an offence has been committed, in which case the investigation is concluded at that stage; or
- Advice of a technical or subject matter expert is sought; or, the complaint is turned over to another body (for example, an internal CF administrative body).⁴¹

INVESTIGATIVE ASSESSMENT OF THE 2009 COMPLAINT

23. There is inconsistency in the 2009 GO file about whether the first step in pursuing the allegations was an investigative assessment, and, if so, when this was completed. Both the complaint synopsis completed on January 12, 2010,⁴² and Maj Dandurand's notes of the meeting with the Fynes on November 28, 2009,⁴³ indicate an investigation was being launched. Maj Dandurand's notebook entry following the meeting with the Ombudsman's investigators on December 18, 2009, reflects his "assessment that enough suspicion exists to merit an investigation."⁴⁴ This suggests that, at some point in December, the investigators believed no further investigative assessment was necessary before launching an investigation. On the other hand, the initial tasking of MS McLaughlin dated December 7, 2009, indicates an investigative assessment was to be undertaken as a first step.⁴⁵ MS McLaughlin confirmed this in testimony.⁴⁶ The results of the investigative assessment were recorded in the GO file by Maj Dandurand in February 2010.⁴⁷

24. It appears any investigative assessment conducted was based almost entirely on information received from the Ombudsman's investigator, both at his initial meetings with the CFNIS and in the documentation he provided. Other than a few comments by the Fynes in their November 28, 2009, meeting with Maj Dandurand and MS McLaughlin, the Fynes did not provide any substantive information on the allegations prior to the assessment being recorded as completed.

25. Mr. Martel provided the CFNIS with three batches of documents he felt were relevant to the allegations he had brought to the CFNIS: one batch on November 17, 2009;⁴⁸ a second on December 4, 2009;⁴⁹ and a third on December 18, 2009.⁵⁰ The documents were catalogued by MS McLaughlin and scanned into the GO file by investigators.⁵¹ The documents received from Mr. Martel comprised approximately 175 pages.⁵² They included a copy of Cpl Langridge's completed and valid PEN form from 2006 naming the Fynes as his primary and secondary NOK;⁵³ extracts from military policy, procedures and guides regarding the recognition of common-law partnerships, casualty coordination and the personal emergency notification;⁵⁴ and the military statutory declaration of the common-law relationship of Cpl Langridge and Ms. A.⁵⁵

26. In addition to receiving the documents, MS McLaughlin and Maj Dandurand met with the Ombudsman's investigators on December 18, 2009. Despite reference in Maj Dandurand's notebook to MS McLaughlin as the "primary note taker" for the meeting,⁵⁶ no minutes exist of the meeting. Maj Dandurand made brief notes in his notebook, likely after the meeting.⁵⁷ But there are no contemporaneous notes, audio recording, video recording or transcript of the meeting.

27. The December 18, 2009, meeting lasted approximately two and a half hours.⁵⁸ Mr. Martel reviewed extensive documentation with Maj Dandurand and MS McLaughlin.⁵⁹ Maj Dandurand testified Mr. Martel pointed out areas of the Code of Service Discipline worthy of consideration by the CFNIS in addition to the document review. Mr. Martel also provided a list of individuals involved.⁶⁰ As well, they discussed how Cpl Langridge's marital status at the time of his death affected the determination of his NOK.⁶¹

28. After the meeting with the Ombudsman's investigators, MS McLaughlin and Maj Dandurand met to discuss what to do with all the information they had received to date on the allegation.⁶² MS McLaughlin testified the next step in the investigative assessment would have been to secure copies of the documents actually used in making the NOK decision as well as assessing the documents already provided.⁶³ He then would have tried to determine if there was some validity to the complaint.⁶⁴

29. MS McLaughlin did not have the opportunity to complete the steps he identified because he was deployed to Haiti in mid-January 2010.⁶⁵ At that time, he had catalogued all the documents received from Mr. Martel⁶⁶ but had not read any of them. He had simply organized the documents by title for the purpose of drafting a list.⁶⁷ He testified his goal in cataloguing the documents was to make sense of what had been given by the Ombudsman's investigator, not to determine how the material provided would impact the investigation.⁶⁸ As well, MS McLaughlin had not read the 2008 GO file or other relevant documents.⁶⁹

30. MS McLaughlin stated, with respect to the interviews with the Fynes and the Ombudsman's investigators, he had summarized what had been told to the CFNIS during the meetings.⁷⁰ Presumably this refers to two documents in the GO file – the synopsis of the Fynes' complaint as well as the short synopsis of the information obtained from the meeting with Mr. Martel and Mr. Joly.⁷¹ MS McLaughlin had not come to any preliminary conclusions prior to leaving the file, but he stated he had an understanding of what needed to be investigated.⁷²

31. Like MCpl Mitchell, who subsequently took his place on the investigation, MS McLaughlin never did identify as significant the issues of who was entitled to make decisions about a military funeral nor of the role of the PEN form in identifying such person.

32. For a period of about a month after the departure of MS McLaughlin, Maj Dandurand was the only investigator assigned to the investigation. During that time, there was nothing on the file to indicate Maj Dandurand did any work on the investigation.

33. Nevertheless, on February 17, 2010, Maj Dandurand recorded the outcome of the investigative assessment in the GO file.⁷³ The entry is backdated to February 12, 2010,⁷⁴ presumably the date the decision regarding the assessment was reached. Maj Dandurand's entry reads:

Following a review of the documentation provided to the CFNIS WR investigators by the CF Ombudsman's office, it is determined that CFNIS will conduct an investigation into allegations of Negligence in the Performance of Duties. The specifics of the allegation centre on the Chain of Command's decision that Cpl Langridge's spouse and not his

parents were the Primary Next of Kin [...] Maj Dandurand, OC CFNIS WR, will assume responsibility as lead investigator.⁷⁵

34. He also advised Mr. Fynes in a telephone call on February 12, 2010, of the decision to proceed with the investigation and the assignment of MCpl Mitchell to replace MS McLaughlin.⁷⁶

35. Maj Dandurand's GO file entry specifically states a review of the documents from Mr. Martel led to the decision to initiate a full investigation. However, it is unclear whether any CFNIS investigator had actually read the documents prior to the decision to launch the investigation and, if so, when. MS McLaughlin had not reviewed the documents before leaving the file. MCpl Mitchell did review the documents and did discuss some of the documents with Maj Dandurand, but it is uncertain when this occurred.⁷⁷ It may have happened during their first meeting on February 12, 2010, though there is no record of any document review.⁷⁸ It is unlikely MCpl Mitchell had time to review all of the documents prior to the February 12, 2010 assessment, considering the number of documents involved and the fact he began working on this file on February 12th.⁷⁹

36. Maj Dandurand, for his part, could not recall reading the first batch of documents in great detail, but stated it was not uncommon for him to open the envelope containing the documents and leaf through them.⁸⁰ There is no evidence in the GO file he read the other two batches of documents from Mr. Martel before writing the investigative assessment.

37. Some of the documents were reviewed in the meeting with Mr. Martel, but the step of CFNIS investigators independently reading, understanding and identifying important documents does not appear to have been taken as part of the investigative assessment. In fact, it seems likely very few of the documents had actually been read by anyone prior to the assessment being recorded as completed.

38. Maj Dandurand's approach in documenting the process and outcome of the investigative assessment is in sharp contrast with the investigative assessment performed by Sgt Scott Shannon when he took over as lead investigator on the file in September

2010.⁸¹ Sgt Shannon's assessment is very detailed and comprehensive and contains a timeline of significant events, as well as the identification of significant policies, regulations and documents. It also contains notes on the specific steps Sgt Shannon undertook to complete the assessment.⁸² This variance in the execution and documentation of the two assessments clearly highlights the lack of attention devoted to the completion of the initial investigative assessment of the 2009 complaint.

The Mitchell Investigation

39. MCpl Mitchell was assigned to the 2009 investigation in mid-February 2010, after the deployment of MS McLaughlin.⁸³ Because MCpl Mitchell was an intern at the time, Maj Dandurand was designated as the lead investigator.⁸⁴ In practical terms, this meant MCpl Mitchell was to do the legwork on the file,⁸⁵ while Maj Dandurand would provide oversight and direction as the file progressed.⁸⁶ MCpl Mitchell completed his internship as a CFNIS investigator in late March 2010.⁸⁷

UNDERSTANDING OF THE ISSUE IN THE ALLEGATION

40. In commencing the investigation, both MCpl Mitchell and Maj Dandurand overlooked a vital step in their understanding of the issue to be investigated. The focus of the Fynes' frustration with the PNOK process was that, although Ms. A had not been named on the PEN form,⁸⁸ she was recognized as PNOK by the Regiment and given final decision-making authority for Cpl Langridge's funeral.⁸⁹

41. In investigating this issue, a logical first step would have been to examine whether it was Ms. A, the Fynes or someone else (for example, the executor of Cpl Langridge's will) who was entitled to have final decision-making authority for the funeral. The investigation needed to determine whether the PEN form afforded the Fynes any rights with respect to the funeral or whether other documentation, legislation or CF orders might have indicated who was entitled to make funeral decisions. A legal opinion would have been helpful to understand these issues, and to determine who could legally be granted authority to make the funeral decisions and how the determination could be

made. If the Fynes were correct about their entitlement to make decisions regarding the funeral, a logical next step would have been to determine who made the decision that Ms. A was entitled to plan the funeral and why.

42. Instead of adopting this approach, MCpl Mitchell and Maj Dandurand simply assumed the Fynes, as the PNOK and SNOK named on the PEN form, were entitled to decision-making authority for the funeral. As a result, the initial focus of the investigation was solely on the question of who had made the PNOK determination at a meeting involving senior LdSH officers and the Assisting Officers assigned to the Fynes and to Ms. A held two days after Cpl Langridge's death (the "casualty coordination meeting").⁹⁰ MCpl Mitchell stated his task was to determine who at that meeting made the decision Ms. A was Cpl Langridge's NOK, on the basis of what information this decision was made and how it was justified.⁹¹ He was focused on the decision-makers and their actions because he thought identifying them would allow him to determine whether a service offence had been committed.⁹²

43. However, if the initial assumption was incorrect that the PEN form was determinative of who was entitled to plan the funeral (which turned out to be the case), then the investigative steps based on this assumption would be unlikely to assist in resolving the complaint unless the assumption was revisited along the way.

44. MCpl Mitchell's investigation was interrupted part way, before it could come to any conclusions.⁹³ Neither MCpl Mitchell nor Maj Dandurand revisited their assumption about the impact of the PEN form.

INVESTIGATION PLAN

45. One of MCpl Mitchell's first tasks was to prepare an investigation plan (IP).⁹⁴ As listed in his IP, a primary task was to "determine who made the NOK decision."⁹⁵

46. MCpl Mitchell's IP listed the interviews he intended to conduct.⁹⁶ He listed Maj Parkinson, the AO for the Fynes, to corroborate the Fynes' story.⁹⁷ He also planned to interview 2Lt Adam Brown, the AO for Ms. A, because he had attended the casualty coordination meeting.⁹⁸ He listed Capt Mark Lubiniecki (the Unit Adjutant) and LCol

Pascal Demers (the CO LDSH) as interviewees because he believed they had been in attendance at the casualty coordination meeting.⁹⁹ He intended to interview everyone who was at the casualty coordination meeting to get a clear picture of what happened during the meeting.¹⁰⁰ He also wanted to interview Ms. A to clarify her marital status with Cpl Langridge.¹⁰¹ MCpl Mitchell testified he had also considered, but not listed, many more interviews, including: MCpl William Fitzpatrick (the Stables NCO who had found additional paperwork for Cpl Langridge after his death); MCpl Dianne Birt (a HQ squadron clerk who had reportedly been involved in discussions about Cpl Langridge's common law paperwork and possible intent to dissolve the common law relationship); Mr. Dirk Velthuisen (the funeral director present when Ms. A and Regiment members attended at the funeral home); and Cpl Jon Rohmer (a friend of Cpl Langridge, also present at the funeral home).¹⁰²

47. MCpl Mitchell also listed in his IP the task of obtaining all relevant documentation.¹⁰³ However, other than the BOI report specifically,¹⁰⁴ the IP did not identify what documents or sorts of documents were considered to be relevant.

WITNESS INTERVIEWS

48. The interviews conducted by MCpl Mitchell, in line with his IP and his general approach to the issues, all appeared to be focused on identifying the decision-maker or decision-makers involved in naming Ms. A as PNOK.

Maj Parkinson interview

49. The first interview was with Maj Parkinson,¹⁰⁵ who explained he was told the Fynes were PNOK and SNOK for Cpl Langridge in his initial tasking as AO.¹⁰⁶ However, in later conversations with 2Lt Brown, Capt Lubiniecki and Maj Earl Jared, he was informed Ms. A was the PNOK.¹⁰⁷ Maj Parkinson described the Fynes' reaction to being told they were not Cpl Langridge's NOK as being "crushed like a grape."¹⁰⁸

50. Maj Parkinson also provided Maj Dandurand and MCpl Mitchell with information on who made the decision about the PNOK.¹⁰⁹ Specifically, he identified the position of the person who made the PNOK decision.¹¹⁰ In his oral testimony, MCpl Mitchell stated

Maj Keith Reichert was the AJAG for the regiment and had been identified as the decision-maker by either Maj Parkinson or Capt (formerly 2Lt) Brown.¹¹¹ This was further confirmed by Maj Parkinson when he testified the source of the NOK decision was the AJAG.¹¹² However, this reference, along with several others, was redacted by counsel for DND in the interview transcript for Maj Parkinson's interview with the CFNIS that was made available for the Public Interest Hearing.¹¹³

Capt Brown interview

51. The second interview was with Capt Brown, who had been the AO for Ms. A,¹¹⁴ and had attended the casualty coordination meeting.¹¹⁵ He identified several of the other participants in the meeting including Maj Trevor Cadieu, Maj Jared, Capt Lubiniecki and the Regimental Quartermaster, MWO Remi Mainville. There was an additional participant whose name was redacted from the transcripts by counsel for DND,¹¹⁶ but identified by MCpl Mitchell in his testimony as the AJAG, Maj Reichert.¹¹⁷ Capt Brown said he asked during the meeting who would have ultimate say for funeral arrangements and he was told, "for the funeral it was [Cpl Langridge's] common-law wife."¹¹⁸ Capt Brown recalled there was no discussion about the basis for that decision at the meeting and no one asked for justification.¹¹⁹ Capt Brown further stated, it had been stressed there should be an attempt to make decisions regarding the funeral collectively between the Fynes and Ms. A.¹²⁰ He also mentioned Cpl Langridge's will had not yet been found and a copy was not at the meeting.¹²¹

WO (Ret'd) Doucette interview

52. The third interview conducted was with WO (Ret'd) Caroline Doucette, the chief clerk at LDSH at the time of Cpl Langridge's death. She had little information to provide concerning the casualty coordination meeting, which she had not attended.¹²² She had been on leave when the information was assembled from Cpl Langridge's personnel file and given to Capt Lubiniecki.¹²³ She had no knowledge of who made the decision that Ms. A should be the PNOK or how the decision was made.¹²⁴ MCpl Mitchell did not ask WO (Ret'd) Doucette about her email communication in December 2008 with the then Adjutant, Capt Eric Angell, in which she said the PEN form had always stated the Fynes

were the PNOK and SNOK. MCpl Mitchell was in possession of the email¹²⁵ and he stated in testimony he considered the email to be significant.¹²⁶

INCOMPLETE AND INADEQUATE DOCUMENT REVIEW

53. While the purpose of MCpl Mitchell's interviews – both completed and proposed – is relatively clear, the purpose of the document review he conducted is less so.

54. When MCpl Mitchell became involved in this investigation, the GO file included only the documents received from the Ombudsman's investigator.¹²⁷ In accordance with his IP,¹²⁸ MCpl Mitchell obtained a copy of the more than 100-page BOI report from Land Force Western Area (LFWA).¹²⁹ Maj Dandurand stated in his testimony the BOI report was, in his view, relevant to the investigation to provide background information on Cpl Langridge's life.¹³⁰ In fact, the report provided no information relevant to the NOK allegation and MCpl Mitchell himself did not think it was relevant to the 2009 investigation.¹³¹

55. MCpl Mitchell also requested from LFWA the Summary Investigation (SI) into the administrative actions taken by the Unit after Cpl Langridge's death.¹³² MCpl Mitchell received the annexes to the SI, which comprised over 575 pages and contained the questions asked of witnesses and their responses, as well as all the documentary evidence collected as part of the SI.¹³³ Missing from the GO file is a copy of the SI report itself, though it appears MCpl Mitchell did receive it.¹³⁴ Also missing are the references, which do not appear to have been obtained by MCpl Mitchell.¹³⁵ The references contain a collection of 41 policy documents, some related to the PNOK allegation,¹³⁶ the vast majority of which were not already part of the GO file.

56. MCpl Mitchell did not ask for Cpl Langridge's complete personnel file, which may have contained other forms relevant to the PNOK determination. Even with the file, he would not have had any way of becoming aware of yet another PEN form completed by Cpl Langridge as part of a Primary Leadership Qualification (PLQ) course he took in March 2007. This form, designating Ms. A as the PNOK,¹³⁷ as a matter of course would have been retained separately from the personnel file, in a different geographic location.

This form post-dated the PEN form that formed the basis for the PNOK allegations. MCpl Mitchell stated in his testimony this document would have been relevant and something he would have explored.¹³⁸

57. MCpl Mitchell did not obtain or review the 2008 GO file, other than the excerpts contained in the documents received from the Ombudsman.¹³⁹ As a result, relevant materials contained in the 2008 file – such as a note by Capt Lubiniecki written prior to the casualty coordination meeting asking whether Cpl Langridge had a will,¹⁴⁰ and officer notes reporting a March 15, 2008, conversation where Capt Lubiniecki told the MP he was aware Cpl Langridge and his spouse “had separated for some time”¹⁴¹ – were never considered during the PNOK investigation.

58. MCpl Mitchell testified he reviewed all the material in the 2009 file – both the material received from the Ombudsman¹⁴² and the documents he had collected.¹⁴³ However, he did not make any notes nor otherwise identify any documents or information he considered relevant in this material. For example, as part of the SI annexes, MCpl Mitchell had obtained a copy of the Supplementary Death Benefits (SDB) form¹⁴⁴ and Cpl Langridge’s will,¹⁴⁵ as well as emails between the chain of command both immediately before and shortly after the casualty coordination meeting,¹⁴⁶ but it is not known if or how these were used by MCpl Mitchell.

59. MCpl Mitchell also reviewed additional documents not scanned into the file. As a result, it is uncertain exactly what documents were obtained and reviewed during the investigation. For example, MCpl Mitchell conducted policy research on July 16, 2010, but the documents he lists in his GO file entry, namely the Casualty Notification Manuals and CFAO 24-1, do not form part of the file.¹⁴⁷ In his testimony, he identified these documents as relevant and significant.¹⁴⁸ As well, MCpl Mitchell stated he likely reviewed other policy documents referenced in the Casualty Notification Manuals, but there is no list of these documents, and they are not scanned into the file.¹⁴⁹

60. The overall result of the incomplete recordkeeping for this part of the investigation was that a new investigator starting work on the file or even a supervisor reviewing the investigation would not have known what documents were obtained, what

documents were reviewed, and what documents were considered relevant. MCpl Mitchell candidly acknowledged policy review was not his strength.¹⁵⁰ Nevertheless, it may have been helpful to other investigators who worked on the file to have a better sense of what documents had been reviewed, and which, at least in the opinion of MCpl Mitchell, were worthy of further consideration. It appears MCpl Mitchell did not receive further assistance and guidance from his own supervisors in this respect.

STATUS OF THE INVESTIGATION IN SEPTEMBER 2010

61. MCpl Mitchell left the investigation in September 2010.¹⁵¹ By then, he had obtained information about who had attended the casualty coordination meeting¹⁵² and had learned there was no copy of Cpl Langridge's will at the meeting.¹⁵³

62. However, the actual issue MCpl Mitchell had set out to investigate remained outstanding. He had gathered some evidence on the issue of the PNOK decision,¹⁵⁴ but he testified he had not reached a conclusion about who ultimately had made the decision.¹⁵⁵

63. In addition, some issues had not been examined, as they were not part of what Maj Dandurand and MCpl Mitchell understood to require investigation. MCpl Mitchell had not come to a conclusion as to who was entitled to make decisions concerning Cpl Langridge's funeral, how the PNOK decision should have been made or how the decision was made.¹⁵⁶ The meaning of the term "PNOK" was not properly resolved, nor was the purpose of the PEN form understood. No legal opinion was sought about any of these issues. The issue of whether Cpl Langridge had been in a common-law relationship at the time of his death also remained an open question.¹⁵⁷

64. Overall, after six months of investigation, little had been uncovered that could substantiate or refute the complaint. Despite any shortcomings in his investigation, the Commission was impressed by MCpl Mitchell's forthright testimony, and it was clear from the evidence he made an honest effort to carry out the tasks assigned to him. However, he received little help or guidance from anyone in his chain of command.

SUPERVISION OF THE MITCHELL INVESTIGATION

65. Although he was formally in charge of the investigation, at least while MCpl Mitchell was on his internship, and was to provide direction to MCpl Mitchell, Maj Dandurand's involvement in actual investigative activity was limited to attending the meetings with the Fynes¹⁵⁸ and the interview with Maj Parkinson.¹⁵⁹ He met with MCpl Mitchell when he was assigned to the file,¹⁶⁰ met with him to discuss the documents received from the Ombudsman¹⁶¹ and again to brainstorm a list of potential witnesses to be interviewed.¹⁶² There is no evidence he took any steps to ensure the issues to be investigated were properly identified and that legal advice was sought where necessary. In terms of contributions by other supervisors to the investigation, WO Hart reviewed MCpl Mitchell's investigation plan,¹⁶³ and MCpl Mitchell's notebook was reviewed by WO Sean Bonneteau.¹⁶⁴ While these supervisors testified they discussed ongoing investigations with investigators throughout the course of each week,¹⁶⁵ and MCpl Mitchell stated he had an open door with Maj Dandurand,¹⁶⁶ there is no record of the supervisors providing any additional direction or input to MCpl Mitchell, despite his situation as a new member of the CFNIS.

The Shannon Investigation

66. Sgt Shannon officially became the lead investigator on the 2009 investigation on September 7, 2010, following MCpl Mitchell's departure.¹⁶⁷ Maj Dandurand maintained a limited supervisory role on the file, despite being the only investigator with continuous involvement from the outset of the investigation in November 2009. Sgt Shannon did not discuss the investigation with Maj Dandurand until November 2010, almost two months into his tenure as lead investigator.¹⁶⁸ Sgt Shannon also did not discuss the investigation with MCpl Mitchell prior to his departure.¹⁶⁹ Rather, Sgt Shannon's entire initial understanding resulted from his own review of the file as it existed on SAMPIS.¹⁷⁰ Sgt Shannon began the investigation fresh.¹⁷¹

SGT SHANNON'S APPROACH

67. Sgt Shannon adopted a very literal approach to the complaint. As reflected in his investigation plan, he was investigating an allegation that Capt Lubiniecki had designated the incorrect NOK.¹⁷² This is all Sgt Shannon attempted to investigate – who was the proper PNOK. He was quite clear he was not investigating the allegation as to who had authority to make funeral decisions.¹⁷³

Personal Emergency Notification form

68. Given the Fynes' emphasis on the PEN form, an obvious place to begin the analysis of whether the Fynes were Cpl Langridge's PNOK and SNOK would seem to be to examine that form. The Fynes and previous investigators had simply assumed that the PNOK and SNOK, as named on the PEN form signed September 26, 2006,¹⁷⁴ were entitled to be recognized as NOK by the regiment and therefore to plan the funeral.

69. Sgt Shannon examined the PEN form and the attached instructions. The form states at the bottom, "This is not a legal document"¹⁷⁵ presumably meaning the PEN does not create any rights in and of itself. It simply identifies individuals to be contacted in an emergency.¹⁷⁶ Sgt Shannon also consulted CFAO 26-18 which specifically addresses personal emergency notification.¹⁷⁷ The order confirms "the purpose of the PEN is to ensure that when a member dies, is injured, becomes seriously ill or is reported missing, the appropriate persons are notified."¹⁷⁸ It also states the term "next of kin" as used in the order is not a legal term and should not be confused with heir-at-law.¹⁷⁹

70. Sgt Shannon concluded the PEN form had no legal effect in terms of entitlement to the status of PNOK and was only relevant to the issue of notification in case of death or serious injury.¹⁸⁰

Alternative definitions of NOK

71. Having rejected the utility of the PEN form in determining PNOK, Sgt Shannon relied instead on his own research to determine the proper PNOK. In researching the issue, Sgt Shannon looked at the definition set out in CFAO 26-18 as well as in the

instructions accompanying the PEN form.¹⁸¹ As well, Sgt Shannon looked at the CO and AO guides containing examples of who can be considered NOK.¹⁸² Sgt Shannon rejected all of these definitions. He dismissed the definitions in the PEN form and CFAO 26-18 because he saw them as merely “suggestions on the manner in which next of kin should be selected for the purpose of that form.”¹⁸³ Similarly, the definitions in the CO and AO guides were rejected as being too flexible and not providing a definitive method of determining NOK.¹⁸⁴

72. Sgt Shannon did not identify any other definitions of PNOK in the military orders or instructions he consulted. In his investigative assessment, Sgt Shannon proclaimed he had “conducted a formal review of **all** relevant Canadian Forces policies, regulations and documents that pertain to the subject matter of this investigation.”¹⁸⁵ In testimony, he stated categorically:

There is no such thing in any other body of law as primary next of kin and secondary next of kin except in the Canadian Forces Administrative Order [CFAO] related to the PEN form. [...] I was not able to identify any other legal reference [to] the term ‘primary next of kin’ and ‘secondary next of kin.’¹⁸⁶

73. Sgt Shannon’s research into the meaning of PNOK also included sources external to the CF and military law, and incorporated other federal statutes as well as provincial law. Sgt Shannon described his research as being based on “all available bodies of law.”¹⁸⁷ In his testimony, he stated he was not able to find a “conclusive one-page document that the Government of Canada or any province has come up with a bona fide list or set of rules that defines NOK.”¹⁸⁸

74. Sgt Shannon testified he researched the common law and civil law (specifically, the law of torts).¹⁸⁹ From this research he “was able to determine that there is no definitive rule or process in defining NOK.”¹⁹⁰

75. Having concluded there was no legal definition of PNOK or NOK, Sgt Shannon turned to a completely different source – societal customs. From his research, he determined the process for defining NOK relied heavily on such customs.¹⁹¹ He said the customs of society dictate the spouse is the person responsible in situations when a

member of someone's family is in difficulty or requires assistance.¹⁹² The spouse is the person who should make any decisions or take responsibility for the individual.¹⁹³ In his testimony, Sgt Shannon explained:

Our society determines who the family representative would be, which is the spouse based on our customs. If you go and speak to a married person they have a spouse. If you have issues with that family and something happens to the husband you're not going to go and try to find his parents. The spouse is right there.¹⁹⁴

76. In arriving at this conclusion, Sgt Shannon did not rely on any external resource. He believed his own personal assessment of societal customs to be an adequate basis for answering a legal question.¹⁹⁵ He did state in testimony it is ultimately up to a judge to make "that legal determination" if there is any conflict about who is NOK because there is no substantive definition or process for determining NOK.¹⁹⁶ However, for the purpose of this investigation, Sgt Shannon relied exclusively on his own interpretation of societal customs.

77. Sgt Shannon stated such customs depend on how society defines family. As an example, in a primarily Anglo-Saxon Christian society, family would be spouse, parents, brothers, sisters, stepsisters, stepbrothers, etc. Other cultures in present day Canada accept only a male as the NOK.¹⁹⁷ He agreed, regardless of which community is being examined, NOK can comprise more than one individual.¹⁹⁸ However, he believed the spouse would take precedence as NOK in 99 percent of cultures within Canada.¹⁹⁹

78. In his opinion, the customary understanding of "spouse" includes "common-law spouse." In this situation, hence, there is no difference between those who are legally married and those who complete a CF common law statutory declaration.²⁰⁰ In either case, no other family member takes precedence over the spouse.²⁰¹

79. Sgt Shannon believed a common-law spouse is equivalent to a spouse, which is equivalent to NOK.²⁰² Using this formulation for the meaning of NOK, the only issue under investigation necessarily became whether Cpl Langridge and Ms. A were in a common-law relationship, as the military defined it, at the time of Cpl Langridge's death.²⁰³ If so, then Ms. A was properly Cpl Langridge's PNOK. Sgt Shannon saw no

difference between alleging the NOK had been improperly designated and alleging the common-law spouse had been improperly identified.²⁰⁴

Marital status of Cpl Langridge and Ms. A

80. In addressing the issue of Cpl Langridge's marital status, Sgt Shannon considered only whether a common-law relationship existed based on military rules and regulations.²⁰⁵ In his investigative assessment,²⁰⁶ Sgt Shannon identified the policy and regulations relevant to the issue of Cpl Langridge's common-law status at the time of his death. He identified two different orders stipulating when a common-law relationship was no longer deemed to be valid by the CF. The first states the relationship will be considered terminated when there has been a three-month period of separation between the CF member and the common-law spouse, and imposes an obligation on the CF member to advise the CO when the relationship no longer meets the conditions for recognition by the CF.²⁰⁷ Sgt Shannon also identified a second Instruction, stating the only method of terminating a common-law relationship was for the CF member to advise the CO in writing using a specified form.²⁰⁸ Both of these provisions existed at the time of Cpl Langridge's death, so, at that time, a common-law relationship could have been ended by either set of actions.²⁰⁹ Sgt Shannon was satisfied that Cpl Langridge continued to be in a common-law relationship with Ms. A at the time of his death because they had not been separated for three months, nor had Cpl Langridge filed any paperwork advising the CO of the end of the relationship.

81. Sgt Shannon found "the record is quite clear"²¹⁰ that Cpl Langridge and Ms. A had a temporary separation at the time of his death but had not been separated for more than three months.²¹¹ Sgt Shannon determined the date of separation primarily based on one document, described by him as a statutory declaration of the landlord stating Cpl Langridge and Ms. A ceased to have co-financial responsibility for their joint residence on February 11, 2008.²¹² He considered financial responsibility for a residence in which the couple had lived to be evidence of continuing cohabitation.²¹³ Since February 11, 2008 was within three months of the date of Cpl Langridge's death on March 15, 2008, he concluded Cpl Langridge and Ms. A had not been separated for a period of three

months or greater as required by the CF Order.²¹⁴ It was not of concern to him whether Cpl Langridge or Ms. A had actually been living in the residence until February 11, 2008. He believed this was legally their joint residence until the day they mutually ceased being responsible for their shared property.²¹⁵ For him, this fact, along with the fact their personal effects were located in the residence, was enough to establish the continuation of the common-law relationship within three months of Cpl Langridge's death.²¹⁶

82. By establishing that Cpl Langridge and Ms. A were in a common-law relationship at the time of his death, Sgt Shannon believed he had determined who the PNOK was. He had answered the allegation as he had interpreted it.

“New” allegation by Mrs. Fynes – lack of involvement in funeral planning

83. Well into his investigation, Sgt Shannon added on his own accord an allegation concerning the Fynes' role in the funeral. He testified:

[...] However, I will add that the November [2010] press conference by Mrs. Fynes she made a public allegation that the Canadian Forces allowed other members to plan her son's funeral. Upon hearing that public allegation, I expanded the scope of my investigation and I incorporated that new allegation into my investigation.²¹⁷

84. This “new” allegation specifically addressed the Fynes' concern about Ms. A's role in planning the funeral.²¹⁸ Sgt Shannon understood Mrs. Fynes to be complaining she had not been involved in the planning of her son's funeral.²¹⁹

85. Of note, this particular allegation is not mentioned in Sgt Shannon's investigation plan,²²⁰ investigative assessment²²¹ or in his PowerPoint presentation to the chain of command at the conclusion of the file.²²² He testified, by the time he prepared the presentation, he had already determined to his own satisfaction that this allegation was not founded, so there was no need to address it.²²³ In fact, the first mention of this specific allegation being part of Sgt Shannon's investigation came during his testimony. It is unusual to investigate an allegation without making note of it anywhere in the file and without recording any conclusions. It is also perplexing an investigation of “new” allegations would be attempted on the basis of a press conference without ever contacting the person making the allegation.

86. Sgt Shannon testified Mrs. Fynes had communicated with Ms. A, both by phone and through her AO, to make decisions concerning the funeral prior to the regiment recognizing Ms. A's decision-making authority over the funeral. Sgt Shannon interpreted this as Mrs. Fynes having "made statements that she was going to be co-planning the funeral with [Ms. A]."²²⁴ He stated Mrs. Fynes had, on the first day after Cpl Langridge's death, made the same decision as the regiment about who could give instructions regarding the funeral.²²⁵ It was his opinion Ms. A, because she was the spouse, received communications from Mrs. Fynes and an agreement was reached concerning how the funeral service would transpire.²²⁶ He explained:

If you look at the totality of the circumstances in this case, Mrs. Fynes, on the very first day, when she became aware that her son had passed, provided her wishes on what would happen at the funeral through her assisting officer to [Ms. A] as the next of kin. So even before she was advised of that decision by the Canadian Forces, she had instinctively realized that her son's spouse would be the person that would be dealing with these matters. That is the only logical assumption that you can draw from the fact that she identified her wishes and communicated them in a diplomatic and polite manner to the spouse of her son.²²⁷

87. Sgt Shannon was also of the opinion the Fynes had a significant input into the funeral and, in his view, all the wishes of the Fynes concerning the funeral were accommodated by Ms. A.

The record is also very clear, the documentary record, especially the personal notes of the Assisting Officer of Mrs. Fynes, **that there is not one wish of Mrs. Fynes in regards to the final remembrance of her son that was not agreed to by [Ms. A].** [Ms. A] then communicated the wishes of the family to the Regiment through her Assisting Officer. The Regiment responded to those wishes.²²⁸ [Emphasis added]

88. On the narrow question of the Fynes' involvement in funeral planning, Sgt Shannon concluded there was no basis for the allegation they had been excluded.²²⁹

PROBLEMS WITH SGT SHANNON'S INVESTIGATION

Misunderstanding of the allegation

89. During their respective interviews with the CFNIS, the Fynes and the Ombudsman's investigators raised many different issues. However, the issue to be investigated, as identified by Maj Dandurand in the investigative assessment, was the

decision confirming Ms. A and not the Fynes as Cpl Langridge's PNOK.²³⁰ There was no explicit definition of the terms "primary next of kin" and "next of kin" when the complaint was formulated, nor was there a test of the connection between being recognized as PNOK and the ability to plan the funeral. Yet, it seems likely that all those involved in the investigation prior to Sgt Shannon shared the belief the person recognized as PNOK was entitled to plan the CF member's funeral.²³¹ The terms NOK and PNOK had been used by the investigators, the regiment and the complainants to mean the individual who had final decision-making authority over the funeral.

90. The Fynes were upset about the designation of PNOK because of the consequences it had on funeral planning.²³² In their second interview with the CFNIS, Mrs. Fynes explained the issue in this way, "When we went to the funeral, because she [Ms. A] was the primary next of kin, and she got to call the shots, she closed the casket, she arrived... she chose everything."²³³ The Ombudsman's investigators and Maj Dandurand confirmed there was discussion in their meeting about who the appropriate PNOK for the purposes of funeral planning would have been.²³⁴

91. Members of the chain of command of the regiment established in their testimony that in their view "the next of kin is entitled to plan and coordinate the funeral"²³⁵ and the implications of the NOK decision "are significant in terms of having influence over funeral proceedings."²³⁶ This understanding of the role of the PNOK is supported in the QR&Os, which state a military funeral will be accorded to a deceased member of the CF where the next of kin so desires.²³⁷ As a result of the regiment's recognition of Ms. A as PNOK, members of the chain of command testified the regiment would have defaulted to the wishes of Ms. A had there been a discrepancy between what the Fynes and Ms. A had wanted at the funeral.²³⁸

92. The CFNIS, at least prior to Sgt Shannon's involvement, also had this understanding of the role of the PNOK. The initial complaint found in the investigation file states Ms. A had been appointed as NOK and "this decision denied the Fynes the right to make arrangements for their son's funeral."²³⁹ MCpl Mitchell explained his understanding of PNOK as "the person best suited in order to ensure that what I want

done as regards to funeral or estate.”²⁴⁰ MS McLaughlin was a little more circumspect about the exact role of the NOK, stating he did not know the consequences of being named NOK,²⁴¹ though the result in this case had been to allow Ms. A to make the funeral arrangements.²⁴² Maj Dandurand also believed one consequence of the NOK designation was to allow Ms. A to make decisions about the funeral.²⁴³ Maj Dandurand described the NOK decision as the decision from which everything else flowed, including the ability to plan the funeral.²⁴⁴ In fact, Maj Dandurand had not even asked for the meaning of “next of kin” with respect to funeral planning to be determined given that, for him, the consequences of the PNOK decision seemed so obvious in this case.²⁴⁵ Up until this point in the investigation, no investigator had seriously questioned the connection between the PNOK and funeral planning. It was also clear funeral planning was the issue of concern for the complainants.

93. However, the essence of the allegation is not reflected in the GO file. While the initial complaint synopsis does include the allegation that Ms. A’s appointment as NOK “denied the Fynes the right to make arrangements for their son’s funeral,”²⁴⁶ the subsequent summary of the meeting with the Ombudsman’s investigators,²⁴⁷ the investigative assessment prepared by Maj Dandurand²⁴⁸ and MCpl Mitchell’s investigation plan²⁴⁹ all refer only to investigating possible negligence in the making of the PNOK decision. The Fynes’ allegation concerning who was entitled to plan the funeral was not included.

94. Sgt Shannon’s understanding of the allegations came from his review of documents relevant to the investigation. However, if the allegation concerning funeral planning was implied but not specifically stated, Sgt Shannon could not readily have been able to determine what should have been under investigation. Despite this, it was Sgt Shannon’s responsibility, as the new lead investigator, to clarify what should have been under investigation.

95. Sgt Shannon informed himself about the file only by conducting what he considered to be a thorough review of its contents. While he insisted he was required, as part of the file handover process, to read all the documentation on the file and that he had

done so,²⁵⁰ there were some notable exceptions to his purported comprehensive file review. This may have contributed to his imperfect understanding of the allegations.

96. Sgt Shannon testified he was required to review all the material on the file including all audio and video recordings.²⁵¹ However, he did not review recordings of the three interviews with the Fynes.²⁵² Instead, he simply reviewed interview summaries and notes.²⁵³ Notably, from the second and third interviews with the Fynes, there are over five hours of audiotape comprising 360 pages of transcripts.²⁵⁴ Yet there are only four pages of summaries for these interviews in the GO file.²⁵⁵ The written summaries are far less comprehensive than the audio recordings; many specifics are not included and would not have been known to Sgt Shannon. All audio recordings should have been reviewed to ensure the Fynes' actual allegations were understood. In addition, consideration should have been given to conducting a fresh interview with the Fynes.

97. No audio recording or contemporaneous notes existed for the December 2009 meeting with the Ombudsman's investigators, so Sgt Shannon could not have reviewed a complete account of what occurred at that meeting. However, it would have been possible to contact Mr. Martel to discuss the allegations made during his meeting with the CFNIS, or to discuss it with the CFNIS members who were present. Instead, the decision was made not to contact Mr. Martel who, at least on paper, was identified as the complainant.

98. Sgt Shannon did not meet with Maj Dandurand until some two months into his investigation,²⁵⁶ at a briefing Sgt Shannon provided to the command team sometime after he had already reached conclusions about the allegations. Sgt Shannon testified he was of the firm belief, when he began the meeting, he "had failed to cross the threshold of a mere suspicion that any individual of the Canadian Forces had committed any offence defined by the *Criminal Code of Canada* or by the Code of Service Discipline."²⁵⁷ While he testified he kept an open mind and was inquisitive,²⁵⁸ it is questionable whether this meeting had any impact on Sgt Shannon's understanding of the allegations. The conclusions reached in the investigation suggest it did not.

99. Rather than seeking out primary sources to clarify or verify his understanding of the allegation, Sgt Shannon relied on his own reading of relevant documents to form his

understanding of the allegations. He framed the issue under investigation simply as determining whether Ms. A, as the common-law spouse of Cpl Langridge, was his NOK at the time of his death.²⁵⁹ Admittedly, the Fynes themselves often expressed their complaint simply in terms of PNOK status. However, the fact remains the essence of the complaint was about funeral planning and that should have been the focus of the investigation.

100. The allegation concerning who was entitled to plan the funeral was not considered. It does not matter if the common-law spouse was the equivalent of PNOK, if the PNOK was not entitled to plan the funeral. However, no one ever asked if the PNOK was entitled to plan the funeral. The link between the PNOK and the authority to plan the funeral was never made. Nor was it considered important. Maj Dandurand testified that at the time he viewed the ultimate question as what factors went into the CO's decision as to who was the NOK.²⁶⁰ However, if the PNOK does not have the authority to plan the funeral, then determining who is the PNOK is not responsive to the allegation made by the Fynes and the Ombudsman's investigator. There was no analysis completed about whether Ms. A was the correct person to plan the funeral and whether the regiment was negligent in recognizing that entitlement.

101. The addition of the "new" allegation by Sgt Shannon also reflected his misunderstanding of the Fynes' primary concern. Sgt Shannon's formulation of the "new" allegation still did not address the central issue of who was entitled to plan the funeral. Sgt Shannon focused narrowly on whether the Fynes had any input into the funeral, not on whether they had been deprived of their rightful decision-making authority in the matter. This was an inadequate understanding of the actual allegations made by the complainants and the issues in need of investigation.

Incomplete and faulty legal analysis

102. The investigation of the issue of who was entitled to plan Cpl Langridge's funeral was a legally complex one. Meticulous research should have been conducted to find all the relevant CF orders, policies and directives potentially applicable to the issue of funeral planning and the recognition of common-law relationships. In addition, research

should have been done on whether any provincial or federal law existed on either of these issues. A careful analysis had to be conducted to determine what law applied in the circumstances. This type of detailed evaluation of the PNOK allegation required the specialized training of a lawyer. However despite his lack of training, Sgt Shannon undertook the legal analysis himself.

103. It is the Commission's opinion Sgt Shannon's purported comprehensive review of the relevant law was incomplete and incoherent. He missed a number of relevant CF orders and policies, in part because he did not recognize the relevance of regulations dealing with funerals. He also improperly dismissed the relevance of provincial law by focusing on the general principle that the military has no duty to enforce provincial law and the CFNIS has no power to investigate breaches of provincial law.

104. Sgt Shannon's central thesis in the investigation – that common-law status was the equivalent of NOK – is likely not supportable in law. This central assumption, around which his investigation was based, was never tested by legal counsel. If it was incorrect to conclude that a common-law spouse, as defined by the CF, and PNOK are equivalent, then the entire investigation was faulty.

Incomplete understanding of the PEN form

105. Sgt Shannon's investigation began with the PEN form. While he was convinced the purpose of the form was straightforward and easy to determine,²⁶¹ a careful review shows there are conflicting messages about the status of the PNOK as named on the PEN form.

106. Sgt Shannon failed to identify the anomalies in the PEN form. The form is not clear. It allows for separate identification of the PNOK and SNOK, and the personal emergency notification contact,²⁶² but it does not describe the purpose or role of the NOK. If the form was primarily for the purpose of emergency notification, why identify the PNOK and SNOK on it at all? Why designate the NOKs on the form if they have no status?

107. Sgt Shannon also failed to identify as relevant the portion of CFAO 26-18 stating, “The person designated as PEN contact or NOK should be capable of making decisions in an emergency, **especially in respect of funeral and burial.**”²⁶³ Clearly, in this order it was assumed funeral arrangements would be the purview of the PNOK or PEN contact as designated on the PEN form.

108. Given this lack of clarity, CF members can be excused for not having as clear an understanding of the PEN form as Sgt Shannon had developed. There was a widespread understanding that the PNOK, as named on the PEN form, were entitled to plan a deceased member’s funeral. This understanding was even shared by members of the CFNIS,²⁶⁴ in particular Maj Dandurand, who had believed throughout his entire career that the PNOK as named on his PEN form would have an impact on things “such as planning of my funeral, should anything untoward happen.”²⁶⁵ For this reason, it seems at least plausible the PEN form could be of some value in determining the intentions of Cpl Langridge concerning who would have decision-making authority over his funeral.

109. Sgt Shannon did not account for the anomalies in the PEN form and in CFAO 26-18 indicating the NOK do have a role different from the emergency contact and, specifically, some responsibility with respect to funeral and burial arrangements. As a result, his analysis of the PEN form was incomplete. Assistance from legal counsel should have been sought in developing a complete analysis of the PEN form.

Failure to seek legal advice on PNOK research

110. The Commission is of the opinion Sgt Shannon should have sought legal advice to ensure the research he conducted concerning the role of the NOK was complete. Despite his assertions to the contrary, Sgt Shannon did miss identifying some CF orders containing a definition of PNOK. For example, Sgt Shannon did not identify CFAO 24-5 on “Funerals, Burials and Graves Registration” which provides a definition of NOK to be used in connection with that order.²⁶⁶ DAOD 7011-0 on service estates and personal belongings also supplies a definition of NOK.²⁶⁷ It may be that PNOK is a particular term of art within the military legal context. Sgt Shannon sought no legal advice to confirm that the PNOK definitions in military orders could all be safely ignored or to verify

whether his conclusions concerning the utility of the definitions of PNOK contained in military orders were supportable.

111. The exact sources consulted in the investigation are not listed in the GO file and it is not known which specific pieces of federal legislation, provincial legislation or case law were accessed for Sgt Shannon's research. It is, therefore, not known whether, in the course of this research, Sgt Shannon became aware of *Fasken v. Fasken*,²⁶⁸ a 1953 Supreme Court of Canada case that considered the meaning of the term "next of kin." That case, the Court's most recent statement on this subject, suggests that at common law, and in the absence of statutory provisions to the contrary, blood ties are determinative of status as next of kin and, if there are no children, surviving parents constitute next of kin, even if there are living siblings.

Lack of recognition of the role of the executor in funeral planning

112. Significantly, while acknowledging the executor had an important role to play after the death of an individual, Sgt Shannon completely dismissed the role of executor as relevant to his investigation because he was not investigating who was in charge of planning the funeral.²⁶⁹ He failed to consider CF orders and policy concerning the executor as well as those relevant to the issue of funeral planning. Notably, in testimony Sgt Shannon acknowledged missing DAOD 7011-1 in his research.²⁷⁰ This is a substantial omission given that the text of the order reads, "**The executor or liquidator of the succession named in a will is, subject to provincial law, entitled to the custody of the remains. The executor or liquidator of the succession is not necessarily the deceased's NOK.**"²⁷¹ The Casualty Admin Guide also refers to the role of the executor, stating "the Assisting Officer with the assistance of the chaplain, **will discuss with the Estate Executor with respect [sic] to interment.**"²⁷²

113. Contrary to the belief of the regiment, the Fynes, and the earlier investigators, these directives suggest the PNOK was **not** entitled to make decisions about interment of Cpl Langridge's remains. However, other CF policy documents suggest the NOK are entitled to plan the funeral and still others suggest there is a role in funeral planning for both the NOK and the executor.²⁷³ However, because Sgt Shannon's research was

incomplete, and he did not understand the allegations centred on funeral planning, he did not consider how this variety of CF policies fit together.

114. Interestingly, the question of the role of executor did surface in the investigation, but not as a result of any research or legal conclusions reached by Sgt Shannon. Rather, it was raised as an issue at the CFNIS command team meeting in early November 2010. As a result of the meeting, Sgt Shannon was asked to investigate “the role of the Executor of a CF Will in the planning process of a funeral of a CF member” in the follow up interviews with the subject matter experts, Sgt Carole Pelletier and LCdr Charles Gendron.²⁷⁴ MS Tania Gazzellone, who assisted Sgt Shannon in conducting the interviews, did ask questions with respect to the role of the executor, and both experts thought the executor would play some role in funeral planning.²⁷⁵ However, given a hypothetical situation very similar to Cpl Langridge’s, the subject matter experts advised such matters were best addressed to the JAG.²⁷⁶ Apparently, Sgt Shannon did not feel it was necessary to act on that advice.

Applicability of provincial law

115. Sgt Shannon rejected the applicability of provincial law to the issues under investigation. Specifically, he rejected the use of provincial law as a potential basis for establishing a breach of a military duty, a necessary element for the Code of Service Conduct offence of negligent performance of a military duty.²⁷⁷ In his assessment, he had “no jurisdiction or interest in provincial law and it has no bearing on the actions or conduct of members of the Canadian Forces.”²⁷⁸ While Sgt Shannon agreed part of the Fynes’ allegation was that a decision concerning the appointment of PNOK had been made without reference to provincial statutes, he testified it would not be appropriate to hold the potential suspects up to the standard of knowing and having to abide by provincial statutes.²⁷⁹ He stated he was very clear and concise in identifying the military rules, regulations and orders applicable to this case and in concluding the provincial statutes could not be the basis for imposing a duty related to military operations.²⁸⁰

116. The assertion provincial law was not relevant to the investigation is questionable. Under the *Constitution Act 1867*, matters of property, wills and estates, as well as marital

status, all fall under provincial legislative jurisdiction.²⁸¹ *Prima facie*, therefore, provincial legislation and case law interpreting the common law may be potentially relevant, if not determinative, with respect to those issues. Valid federal (including military) law will prevail over valid provincial law in cases of conflict. However, whether there is a conflict, whether the respective laws are validly enacted from a constitutional point of view, and whether any apparently conflicting laws can be reconciled, are all subtle and complex legal questions. The categorical statement in the final briefing letter to the Fynes that “the investigation did not consider any provincial legislation as a source of reference owing to the fact the NDA hold[s] legal precedence over provincial legislation”²⁸² is based on a great over-simplification.

117. The Fynes had raised the issue of the relevance of provincial law to the funeral planning allegation in their discussions with the CFNIS.²⁸³ The Ombudsman’s investigator had provided copies of what was believed to be relevant provincial legislation to the CFNIS.²⁸⁴ Provincial law should not have been dismissed out of hand.

118. Sgt Shannon’s rejection of provincial law meant he did not consider two potentially relevant pieces of Alberta legislation – the *Funeral Services Act*²⁸⁵ and the *Adult Interdependent Relationship Act*.²⁸⁶ The *Funeral Services Act* is the provincial statute concerning the disposition of human remains in Alberta. While there is nothing in the legislation concerning who is entitled to plan the deceased’s funeral, the regulation does contain direction concerning who is entitled to dispose of the remains of the deceased. The first person with the right to dispose of the remains is the personal representative designated in the will of the deceased.²⁸⁷ The term “personal representative” is neither defined in the Act nor in the regulation but most likely refers to the executor as named in the will. Mr. Fynes was eventually recognized by the CF to be Cpl Langridge’s executor.²⁸⁸ This legislation, and this section in particular, were brought to the attention of the CFNIS early in the investigation and included in the documents received from the Ombudsman.²⁸⁹

119. The *Adult Interdependent Relationship Act* defines the entitlement to status as adult interdependent partners for residents of Alberta.²⁹⁰ Though different language is

used, “interdependent partner” appears to be another term for “common-law spouse.” Under the provisions of the Act, Ms. A and Cpl Langridge were not interdependent partners, not having fulfilled any of the necessary pre-conditions (living together for a period of three years, having children or having entered into an adult interdependent agreement under the Act).²⁹¹ According to the Fynes, if Ms. A was not Cpl Langridge’s interdependent partner under the provincial legislative scheme, she was not his spouse.²⁹² If the Fynes were correct, even with Sgt Shannon’s conclusion that NOK equals spouse equals common-law spouse, Ms. A could not be his PNOK.

Failure to investigate who in the Chain of Command made the PNOK decision

120. Sgt Shannon’s failure to investigate the issue of who named or recognized Ms. A as PNOK was the result of his faulty conclusion that she was clearly the correct NOK and also his opinion Cpl Langridge himself determined his NOK simply by entering into a common-law arrangement.²⁹³

121. Sgt Shannon testified the military relies on administrative documents completed by members to disclose the individual family circumstances of each member.²⁹⁴ In this case, Cpl Langridge had completed a CF common-law statutory declaration with Ms. A in December 2007. Since it was Sgt Shannon’s thesis that PNOK was the equivalent of spouse and common-law spouse, he concluded the military had no role to play in placing Ms. A in a position where she could exercise the duties, privileges and responsibilities associated with PNOK. It was his opinion Cpl Langridge had already made such a determination²⁹⁵ and all the military did was support those wishes.²⁹⁶ Thus, Sgt Shannon did not find it relevant to his investigation to determine who in the regiment actually made the decision regarding PNOK or how the decision was made.

122. This conclusion is difficult to understand and involves a measure of circular reasoning. For Sgt Shannon, the only relevant decision was Cpl Langridge’s decision to enter into a common-law relationship with Ms. A. This decision led to Ms. A being his PNOK. However, this line of reasoning seems to ignore that the relevant “decision” was the decision to recognize Ms. A as PNOK, not the decision of Cpl Langridge to make Ms. A his common-law spouse. Someone in the military had to decide whether Cpl

Langridge's declaration of common-law did indeed make Ms. A his PNOK. Someone had to recognize Ms. A's entitlement to PNOK status in order for the status to be meaningful.

123. It would seem precisely such a decision was conveyed in the email sent by LCol Demers prior to the casualty coordination meeting on March 17, 2009, stating "given the docs on file, it seems [Ms. A] is PNOK, so we need to follow her wishes."²⁹⁷ Sgt Shannon testified this was not a decision about who was PNOK, but a direction from the CO.²⁹⁸ Whether it was a direction or decision, this email clearly seems to constitute evidence relevant to determining who in the regiment had made the PNOK decision. However, Sgt Shannon completed his inquiry into the matter with the conclusion the PNOK decision was Cpl Langridge's alone.

Failure to interview key players

124. Having attributed the PNOK decision to Cpl Langridge, Sgt Shannon failed to interview the key players in the actual decision-making process. In his investigation plan, Sgt Shannon identified four interviews to be conducted concerning the NOK allegation – Maj Cadieu, LCol Demers, Maj Reichert and Capt Lubiniecki.²⁹⁹ With the exception of Maj Reichert, Sgt Shannon considered each of these officers to be suspects in his investigation.³⁰⁰ However, Sgt Shannon interviewed none of them.

125. In his testimony, he stated the "reasonable suspicion model" led to his decision not to interview anyone identified as a suspect.³⁰¹ He explained that, to invoke his authority and power as a police officer, he must have a reasonable suspicion the individuals to be interviewed had committed a crime. Since at no time did he establish a reasonable belief an offence had occurred, he did not interview anyone identified as a suspect.³⁰²

126. This logic is flawed. Sgt Shannon concluded the officers identified as potential suspects did not need to be troubled with interviews because he did not believe they had a role in any possible offence. However, interviewing these officers may have clarified if they did in fact have a role or useful information that would have cleared up any errors of

fact about what occurred at the casualty coordination meeting and how the PNOK decision was made.

127. Furthermore, Sgt Shannon's interpretation of his authority to interview suspects was not one shared by other members of the CFNIS. MCpl Mitchell was prepared to interview all those who had attended the casualty coordination meeting, including identified suspects.³⁰³ When he learned, during the course of his interview with Capt Brown, that Capt Brown had attended the casualty coordination meeting, he administered a caution.³⁰⁴ Sgt Shannon could have proceeded in the same manner when interviewing other subjects.

128. As interviews with police are always voluntary in any event, there was no issue about Sgt Shannon not being able to exercise his "authority" absent sufficient suspicion.

129. Sgt Shannon could have relied on factual evidence gathered from interviews as well as factual evidence gathered from documents. However, with the exception of two interviews with subject matter experts, Sgt Shannon's entire investigation focused on a review of documents. He chose not to interview the witnesses identified in his investigation plan because he viewed the records and documents to be much more accurate than witness interviews taking place years after the events occurred.³⁰⁵ It was Sgt Shannon's belief, in this particular case, the documents spoke louder than words³⁰⁶ and, while the witnesses provided many different versions of events, the documents eliminated the "static."³⁰⁷ According to Sgt Shannon, the information in the documents was very black and white and explained the story so there could be no contesting what had happened.³⁰⁸ Sgt Shannon assumed the documents made it obvious who did what and when. He rejected witness interviews as a potentially valuable source of information, even though significant and otherwise unavailable information could have been gained from speaking to some of those involved in the events under consideration.

Insufficient investigation of the status of the common-law relationship

130. Regarding his investigation of whether Cpl Langridge was in a common-law relationship at the date of his death, Sgt Shannon would have benefitted from conducting

interviews with fact witnesses prior to reaching his conclusion there was evidence of cohabitation. There were many interviews that could and should have been undertaken. Sgt Shannon did not interview Ms. A, even though it seems entirely likely an interview with her would have yielded important information on the status of her relationship with Cpl Langridge at the time of his death, and when (or even if) they had ceased to cohabit. A brief interview with Mrs. Fynes could have been useful in confirming when she helped move Cpl Langridge out of his joint accommodation with Ms. A. Sgt Shannon rejected the need to interview Mrs. Fynes because she had already been interviewed several times,³⁰⁹ though not on the topic of Cpl Langridge's marital status. Likewise, an interview with Padre William Hubbard, who helped move Cpl Langridge's belongings out of his and Ms. A's shared residence, may have proven useful.³¹⁰

131. Sgt Shannon relied only on prepared summaries of interviews with the Fynes.³¹¹ As a result, he missed information the Fynes gave concerning the status of Cpl Langridge's common-law relationship with Ms. A. The audio tapes contained a number of potentially relevant allegations by Mrs. Fynes, notably: the chain of command was aware Cpl Langridge and Ms. A had broken up because they had made a verbal declaration before Maj Jared;³¹² Ms. A had asked for a restraining order on Cpl Langridge;³¹³ Veterans Affairs had deemed Cpl Langridge to be single at the time of his death;³¹⁴ and the relationship had ended when Cpl Langridge left the residential treatment centre in early January 2008.³¹⁵ None of this information appeared in the summaries prepared by MCpl Mitchell, but all of it might have been relevant to the issue of Cpl Langridge's cohabitation with Ms. A.

132. Sgt Shannon found there was no statutory declaration ending the common-law relationship as per CF policy in the unsigned documents found behind the filing cabinet after Cpl Langridge's death (discussed in more detail below). To Sgt Shannon, the absence of this document meant Cpl Langridge had not been contemplating ending his relationship with Ms. A.³¹⁶

133. However, there was evidence to suggest such a document may have existed. In her interview with MCpl Mitchell as part of this investigation, WO (Ret'd) Doucette said

that after Christmas 2008, MCpl Fitzpatrick had told MCpl Birt Cpl Langridge wanted to dissolve his common-law relationship and, as a result, MCpl Birt put together a package containing the necessary forms and gave it to MCpl Fitzpatrick for Cpl Langridge.³¹⁷ In testimony, MCpl Fitzpatrick confirmed Cpl Langridge had told him he and Ms. A had split up and MCpl Fitzpatrick provided him with blank forms to update. It is not clear from his testimony if the dissolution form was included, but he did provide Cpl Langridge with a package of forms.³¹⁸ Four partially completed forms, not including the form dissolving the common-law relationship, were found by MCpl Fitzpatrick behind his filing cabinet after Cpl Langridge died. While the forms should have been returned to the clerk,³¹⁹ MCpl Fitzpatrick stated Cpl Langridge also had the option of returning the completed forms directly to him or someone he knew in the office because Cpl Langridge was transferred to the Regimental Quarter Master's shop from MCpl Fitzpatrick's office shortly after receiving the forms.³²⁰

134. Sgt Shannon simply accepted that since no form had been found, none existed. He did not investigate further. It is entirely possible Cpl Langridge decided not to formally end his relationship with Ms. A, and therefore never completed a dissolution form. However, in all the other forms found, Cpl Langridge had indicated the benefits were to be given to his parents. Given the importance of the dissolution form to the whole issue of Cpl Langridge's common-law status, Sgt Shannon should arguably have undertaken some effort to satisfy himself no such form existed. This could have included reviewing the interview of WO (Ret'd) Doucette³²¹ and interviewing MCpls Birt and Fitzpatrick.

135. Sgt Shannon could have spoken to members of the regiment concerning where Cpl Langridge's original will was found as it was not discovered for the first few days after his death.³²² Given the CFNIS and the regiment had both misplaced important documents in this and the 2008 investigation, it would have been prudent for Sgt Shannon to investigate to ensure no dissolution form existed.

136. Ultimately, it may be Sgt Shannon was correct in his conclusion that under military law a common-law relationship still existed at the time of Cpl Langridge's death. The CF requirements necessary to terminate the relationship may not have been met.

However, in arriving at that conclusion, Sgt Shannon ignored many sources of relevant evidence. His factual inquiry into the common-law relationship was cursory. While Sgt Shannon's conclusion may have been correct, it was supported by incomplete evidence.

Inadequate investigation of the Fynes' intentions for funeral planning

137. Similarly, Sgt Shannon did not conduct a thorough factual investigation of the Fynes' involvement in funeral planning. His conclusions were based on very significant assumptions about Mrs. Fynes' intentions regarding Cpl Langridge's funeral and about her actual role in making decisions about the funeral and the disposition of Cpl Langridge's body. These assumptions were without basis in anything the Fynes had said and unsupported by the facts.

138. It is difficult to understand how Sgt Shannon could possibly know what Mrs. Fynes' intentions were concerning who would plan the funeral since he had never talked to her about her involvement in the funeral planning or listened to the interviews conducted with the Fynes by the CFNIS. The Fynes had never expressed any intention that Ms. A should be the one to plan the funeral. Rather they acquiesced to what they understood to be Ms. A's authority to plan the funeral when they were told the regiment had recognized her as PNOK. They felt they had no choice in who planned the funeral.³²³

139. Furthermore, Sgt Shannon's interpretation of the facts concerning Mrs. Fynes' intentions for funeral planning is questionable. For example, the telephone call from Mrs. Fynes to Ms. A in the days following Cpl Langridge's death was likely not viewed by Mrs. Fynes (or Ms. A for that matter) as Mrs. Fynes agreeing with Ms. A's authority to plan the funeral. Indeed the phone call was motivated, at least in part, by a desire of the Fynes to reassure Ms. A that Cpl Langridge's debts would be paid.³²⁴

140. Sgt Shannon was also not correct that all of the Fynes' wishes concerning the funeral were met. They clearly conceded to Ms. A several matters of importance. The most significant concessions involved negotiations concerning the flag to be placed on Cpl Langridge's casket and whether his remains would be buried or cremated. The Fynes had wanted the regimental flag to be used.³²⁵ In communications between the AOs, Ms.

A's preference for cremation had been conveyed. However, Ms. A was willing to budge on cremation if the Canadian flag was used on the casket instead.³²⁶ Since the issue of how the remains would be disposed was an emotional one for Mrs. Fynes,³²⁷ she agreed with Ms. A's request in order to avoid having Cpl Langridge's remains cremated.³²⁸ When the flag was removed from the casket at the funeral, it was presented to Ms. A.³²⁹ The Fynes felt strongly they should have received it.³³⁰ Ms. A also had a viewing of the body prior to the funeral, which the Fynes would not have had³³¹ and Ms. A closed the casket.³³²

141. The evidence shows Mrs. Fynes compromised on issues about which she felt very strongly. These facts would have been available to Sgt Shannon had he met with the Fynes to discuss the allegations, reviewed their previous interviews, and thoroughly reviewed the documents which were part of the GO file.

Conclusion Regarding the Investigation of the PNOK Complaint

142. In the end, the command team agreed with the conclusions Sgt Shannon had reached on the file.³³³ They were satisfied with his investigation and analysis of the allegations and were confident Sgt Shannon had come to proper conclusions.³³⁴ WO Hart summed it up, in responding to the Fynes' allegation to the MPCC that both the 2009 and 2010 investigations were inadequate and failed to address the issues to be investigated:

I am fully satisfied that these investigations were conducted thoroughly. There are always going to be difference [*sic*] in opinion from people as to what they want to see done. However, when we looked at this file, when we looked at the circumstances around here, these matters in a neutral way, not looking to cast blame one side or another and view them on the face as the allegations that were made, I'm comfortable with how these investigations played out. I have no reservations about it at all.³³⁵

143. Sgt Shannon and the command team were completely confident in reaching the conclusion the investigation should be closed and no charges were to be laid. Even if this conclusion was correct, fundamental errors were made in the handling of the investigation.

144. While Sgt Shannon correctly identified the need to examine assumptions concerning the use of the PEN form made by the previous investigators and the complainants, he failed to identify the central issue of the complaint. Rather, he focused his investigation very narrowly on whether Ms. A was Cpl Langridge's common-law spouse at the time of his death. The entitlements associated with being recognized as PNOK, particularly whether this included the entitlement to plan the funeral, were not investigated. Though they did not state their complaint particularly clearly and though they based the complaint on the assumption the PEN form was central to the determination of the issue, the Fynes were ultimately concerned the role of planning the funeral had been given to someone who was not entitled.

145. After the investigation was well under way, Sgt Shannon did consider the additional allegation about funeral planning. The investigation of this allegation focused only on the Fynes' participation in funeral planning, and still missed the central issue of who was entitled to plan the funeral.

146. As a result of not understanding the complaint, relevant questions were not asked in the investigation. The role of the executor was not considered to be relevant to the issues being investigated. Nor was the identity of the person or persons who actually made the PNOK decision. Neither issue formed part of the investigation.

147. Understanding the complaint and the full range of questions that needed to be investigated was a difficult and complex task. However, it would have been important to properly identify the allegation concerning who was entitled to plan Cpl Langridge's funeral.

148. A fundamental flaw in the investigation was the failure to seek legal advice.³³⁶ Once the core of the allegation had been identified, it should have been apparent legal advice was required. The issues of who can be recognized as PNOK, the entitlements associated with that status, as well as who is entitled to plan the funeral are all complex legal questions involving the interplay of multiple military orders and policies as well as consideration of provincial and possibly case law. Those issues required legal input.

149. Instead, all the analysis done was by Sgt Shannon. Even without legal training, Sgt Shannon was convinced he had the experience and expertise necessary to be able to draw legal conclusions with respect to the investigation.³³⁷ He testified:

I made the determination not to consult legal aid or legal advice because I didn't believe it was necessary. I believed my assessment of the wording of the orders and the regulations was accurate and logical and clearly articulated and then my articulation of those were supported by the in-depth review by Major Dandurand, [and] the command team.³³⁸

150. Legal advice was available had the investigators requested it. MCpl Mitchell had sought and obtained a legal opinion on the 2010 investigation.³³⁹ There was a dedicated JAG officer in the office of the CO CFNIS who was available to provide opinions and answer questions concerning cases.³⁴⁰ Maj Dandurand confirmed investigators were aware of these resources and, if they believed they were delving into areas outside of their expertise, they would not have hesitated to access the available resources.³⁴¹ No acceptable justification was provided for the failure to seek legal advice in this case.

151. The investigation also suffered from other shortcomings. In conducting the investigation about the common-law relationship and the input the Fynes had into funeral planning, there was a failure to conduct interviews with fact witnesses. Assumptions were made that were not supportable on the actual facts.

152. Ultimately, it may well be that Sgt Shannon was correct there was no conduct of members of the CF amounting to a service offence. However, this outcome was not because Ms. A was the correct PNOK. Rather, the underlying military law on PNOK and funeral planning and its interplay with provincial law may have been so murky and complex that a decision-maker coming to a wrong conclusion could not be seen as negligent in the performance of a military duty.

153. To the extent the CF decision-makers took legal advice in making the decision, then even if the decision was arguably wrong in law, it is unlikely it would constitute a service offence since acting on legal advice might well negate negligence. On the other hand, if a legal advisor determined Ms. A should be given decision-making authority over the funeral, he or she might have been guilty of negligent performance of their military

duty in the provision of that advice. This possibility was never appreciated, let alone pursued.

154. The fact there might not have been grounds to lay a charge with respect to the decision to name Ms. A as PNOK and to give her authority over the funeral does not absolve those who carried out the investigation of responsibility for the substandard way in which the investigation was carried out. The Fynes' complaint against the chain of command may not have been sustainable at law, but their allegation against the CFNIS for the way their complaint was investigated is well-founded.

Additional Complaints to the CFNIS

155. In addition to the general complaint about Ms. A being recognized as Cpl Langridge's PNOK, and the impact of that recognition on decision-making related to Cpl Langridge's funeral, the Fynes raised with the CFNIS three additional concerns that could support criminal or service offence charges:

- (1) Potential offences committed by Ms. A and by the two CF members who accompanied her during her visit to the funeral director, including conduct that may have amounted to fraud in the form of providing false information for the purpose of obtaining benefits;³⁴²
- (2) Potential criminal conduct or service offences associated with Cpl Langridge's misplaced paperwork found after his death but prior to his funeral;³⁴³ and
- (3) An allegation that a JAG officer gave an opinion about the status of the relationship between Cpl Langridge and Ms. A based on an outdated policy document.³⁴⁴

156. The Fynes' complaint to the MPCC alleges the CFNIS failed to properly address issues requiring investigation and failed to investigate issues specifically brought to their attention.³⁴⁵

157. The Fynes were correct to believe these allegations were given, at best, cursory attention. Given Sgt Shannon's conclusion Ms. A was properly Cpl Langridge's PNOK,

this is not surprising. It may be none of these additional complaints to the CFNIS was capable of supporting criminal or service offence charges. That result does not justify a failure by the CFNIS to inform the Fynes in a timely manner of the basis for a decision not to investigate the first two additional allegations nor, for the third allegation, does it excuse a failure to ensure the complaint was properly analyzed, which in fact corresponded to the essence of the Fynes' concerns.

THE REGISTRATION OF DEATH

158. From the time they received the first Proof of Death Certificate, the Fynes were consistent in raising concerns with the CF about the Registration of Death for Cpl Langridge.³⁴⁶ When given a Proof of Death certificate following the interment, the Fynes complained the information on that form concerning Cpl Langridge's residence, marital status and NOK was all incorrect.³⁴⁷ Some changes were made to subsequent Proof of Death certificates by the funeral director after consultation with Capt Brown.³⁴⁸ The Fynes believed that Mr. Fynes, in his capacity as executor, could not proceed to deal with the administration of Cpl Langridge's estate as a result of inaccuracies in the Registration of Death Certificate.³⁴⁹ The Fynes also complained it was disrespectful for Cpl Langridge to have been buried while paperwork was incorrect.³⁵⁰ Because of their intense concern about this issue, they eventually sought and obtained an *ex parte* order amending the Registration of Death to remove the designation of Ms. A as Cpl Langridge's common-law spouse, to change the permanent residence address, and to change the identity of the informant for the information contained in the Registration of Death from Ms. A to Mrs. Fynes.³⁵¹

159. With respect to the Registration of Death Certificate, the Fynes alleged the CF had played a role in providing inaccurate information to the funeral director (or allowing it to be provided). Specifically, they claimed Ms. A provided false information and the two CF members accompanying her just stood by while she said things that were "clearly and obviously untrue."³⁵² They claimed offences may have been committed by Ms. A when she gave incorrect information,³⁵³ and offences may also have been committed by the two CF members in attendance when the information was given.³⁵⁴ They maintained,

had Mr. Fynes been sent to the funeral home instead of Ms. A, the issues concerning the Registration of Death would have been avoided.³⁵⁵ In addition, there was some suggestion by the Fynes that Ms. A had provided incorrect information, particularly with respect to her marital status, to support her eligibility for monetary benefits as a result of Cpl Langridge's death.³⁵⁶ They also alleged the funeral director had attempted to provide them with a copy of the first, and as it turned out, inaccurate Proof of Death certificate at the funeral, but was stopped by someone in uniform and told not to provide it until after the Fynes had returned to Victoria.³⁵⁷

MISPLACED PAPERWORK

160. The Fynes raised separate concerns with the CFNIS about the administrative documents relating to Cpl Langridge, which were found behind MCpl Fitzpatrick's filing cabinet after Cpl Langridge's death. There were four documents: a will;³⁵⁸ a Designation of Memorial Cross Recipients form;³⁵⁹ a Personal Emergency Notification form;³⁶⁰ and a Supplementary Death Benefits form.³⁶¹ Each document related to the administration of Cpl Langridge's affairs after his death. While none of the documents was fully completed, each named the Fynes as the intended recipients of the particular benefits or responsibilities being conferred. Of particular importance was the will found behind the filing cabinet, in which Cpl Langridge had changed the executor from his friend David White to his stepfather, Shaun Fynes. The CF eventually deemed this will to be valid under provisions in the *Alberta Wills Act*,³⁶² but Mr. Fynes was not advised there was any change in the estate executor until almost two months after the second will was found.³⁶³

161. The Fynes alleged the explanations of how and where the documents were found did not "even pass the giggle test,"³⁶⁴ perhaps suggesting they believed the documents had been deliberately suppressed for some reason related to the PNOK decision, but certainly alleging some misconduct in connection with their initial disappearance and subsequent discovery.³⁶⁵

NO INVESTIGATION OF THESE TWO ISSUES

162. Neither the Registration of Death nor the misplaced paperwork allegations were investigated as part of the 2009 investigation. The allegations did not form part of the synopsis of the initial complaint, of either investigative assessment, of either MCpl Mitchell's or Sgt Shannon's investigative plans, nor of the concluding PowerPoint presentation. There are brief references to both issues in the GO file in the context of notes regarding a phone call with the Ombudsman's investigator,³⁶⁶ and some documents from the Ombudsman's investigator which are included in the file.³⁶⁷ There is also mention of the Registration of Death issue as part of the complainants' statement.³⁶⁸ In contrast, the issues were discussed at some length by the Fynes and the CFNIS on multiple occasions during the course of the investigation³⁶⁹ and were brought to the attention of the CFNIS by both the Ombudsman's investigator³⁷⁰ and Maj Parkinson.³⁷¹ The CFNIS investigators should have been aware of these issues.

163. It may be the allegations were not part of the investigation because they were viewed simply as consequences of the PNOK decision. Both the Fynes and the investigators had identified the NOK decision as the "nexus" because "so much was hinging on that one decision on the administrative side."³⁷² Maj Dandurand explained the issues under investigation this way:

My interpretation of what it was we were going to investigate was the negligent performance of duty with respect to the primary - - determination of primary next of kin, which from there, at the time, our understanding was everything else was a consequence thereof.³⁷³

164. Since the investigation reached the conclusion that Ms. A was the correct PNOK and therefore no error had been made in her appointment, it appears the investigators concluded there was no need to investigate the other follow-on allegations.

165. During initial interviews with the Fynes, Maj Dandurand stated other agencies and administrative processes were dealing with the full range of their administrative concerns. He suggested the Ombudsman's office,³⁷⁴ the BOI, and the SI³⁷⁵ were looking into the full spectrum of issues. He used the analogy with the Fynes that the CFNIS was

only investigating about five centimetres of the metre stick of issues they had raised.³⁷⁶ However, he did assure them the CFNIS would investigate any criminal issues.³⁷⁷

166. In testimony, the investigators raised other reasons for not investigating these particular allegations. Sgt Shannon dismissed the death certificate issue because, in his view, there was no causal relationship between CF members' actions and the effective operations of the CF, a necessary element to found a service offence.³⁷⁸ With respect to the misplaced paperwork, MS McLaughlin stated he would not have pursued the issue because MCpl Fitzpatrick did not deliberately misplace the documents and therefore he did not see any indication that a service offence had been committed.³⁷⁹ Sgt Shannon did not consider the misplaced documents to be relevant because they were not fully completed and, in his view, none affected the status of Cpl Langridge's common-law relationship.³⁸⁰ MCpl Mitchell, it should be noted, did conduct some preliminary investigation into both issues, asking questions concerning both the death certificate issue and the misplaced paperwork during the witness interviews he conducted.³⁸¹

167. It would appear failure by the CFNIS to investigate and reach conclusions about the allegations concerning the death certificate and the misplaced paperwork was in large part a consequence of the flawed investigation into the PNOK issue. Had the issue been understood as relating to funeral planning, the Fynes' additional allegations would have been a more obvious component of the overall investigation. Issues concerning the information Ms. A provided for the Registration of Death arose because the CF designated Ms. A to attend at the funeral home, accompanied by CF members, to make decisions about the funeral. The facts concerning the misplaced documents may not have been investigated, in part because the documents were not viewed as relevant, but the contents of the new will would have had a direct impact on funeral planning, while other documents may well have been evidence of Cpl Langridge's intentions regarding who should make decisions about his funeral.

THE QUESTION OF JURISDICTION

168. The investigators also justified the failure to investigate the additional allegations by stating they were beyond the jurisdiction of the CFNIS.³⁸² While this may be true for

some of the allegations, the allegations related to the CF's role in assisting in the provision of any alleged misinformation would appear, at least *prima facie*, to fall within the potential scope of CFNIS jurisdiction. If allegations do fall outside of the mandate or jurisdiction of the CFNIS, the complainants should be informed of that fact. Maj Dandurand did advise the Fynes during their final interview that, for the investigation to come to a timely conclusion, the investigation was staying focused on the allegation of negligence.³⁸³ However, the Fynes were never informed there would be no investigation of the death certificate and misplaced documents allegations. Sgt Shannon noted, with respect to the allegations concerning the death certificate, if he were the one receiving the complaint, he would have advised the Fynes to contact the Edmonton Police Service.³⁸⁴ When dealing with these types of allegations by a complainant, Sgt Shannon suggested the following course of action:

[...] in many situations the police receive reports from citizens, and right from the very, very initial contact, it is clear that what the citizen is reporting to the police is not a crime, or it is not a matter that is within the purview of the police. Then it is incumbent on the professionalism of the police officer to advise the citizen, and then to provide potential avenues where that person can gain the assistance that they require.³⁸⁵

169. If the CFNIS was not going to investigate allegations beyond the PNOK issue, the Fynes ought to have been clearly informed. In the case of the issues concerning Ms. A and the death certificate, being so informed may have allowed them to pursue the matter in a different, perhaps more appropriate, forum.

170. The CFNIS should not rely on other agencies or processes to investigate or resolve issues properly falling within its jurisdiction or mandate. The CFNIS should determine independently whether an allegation merits criminal investigation of issues or persons within its jurisdiction, regardless of other investigations being conducted and their results.

171. The issue of the potential involvement of CF members in providing incorrect information for the death certificate and the issue of the misplaced documents were reviewed as part of the SI into administrative matters. However, this did not relieve the CFNIS from the obligation to conduct its own investigation into any criminal aspects of

these complaints or from a requirement to inform the Fynes in a timely manner of the reasons for any decision not to investigate.

ISSUE OF JAG LEGAL ADVICE ON CPL LANGRIDGE'S MARITAL STATUS

172. Almost at the outset of the 2009 investigation, there was a complaint concerning a decision allegedly made in a letter from LCol Bruce King, a senior JAG officer, regarding Cpl Langridge's marital status. As recorded in the investigative file, the complaint synopsis reads:

Lastly, [the Fynes] were concerned with a decision rendered by a JAG officer which formally advised that Cpl Langridge and [Ms. A] were in fact still in a common-law relationship at the time of death. The Fynes believe that the JAG officer quoted a repealed policy when rendering his decision.³⁸⁶

173. On its face, this complaint has several obvious defects. LCol King's involvement with the Fynes matter did not begin until the convening of the BOI, for which LCol King acted as legal advisor.³⁸⁷ The discussions that affected the CF's recognition of Ms. A as Cpl Langridge's common-law spouse occurred many months before the BOI was convened. LCol King did write a letter to the Fynes' lawyer, in part, as a response to the Fynes' allegations about the consequences to them of the inaccurate information in the proof of death certificate. The letter, however, was dated March 20, 2009,³⁸⁸ more than a year after the military's decision to recognize Ms. A as Cpl Langridge's PNOK. The March 2009 letter is clearly marked "without prejudice," indicating it was sent in the context of potential settlement discussions. As such, based on "settlement privilege," neither the letter nor its contents could be relied upon for any purpose outside of settlement discussions.

174. It is difficult to see how LCol King's letter could be characterized as a decision about Cpl Langridge's common-law status or how, in view of the timing, any such decision could be factually linked to any consequences suffered by the Fynes.

175. Aside from these incongruities, there may be reason to question the accuracy of the formal complaint as recorded in the GO file. No mention is made in the initial record of the identity of the JAG officer involved nor, more importantly, of when the alleged

incorrect legal opinion was given or in what context.³⁸⁹ Following the CFNIS meeting with the Ombudsman’s investigator, the complaint was refined to identify a specific JAG officer – LCol King – and also to identify a letter from LCol King to the Fynes’ lawyer as a “copy of the decision rendered by LCol King [with respect to] Cpl LANGRIDGES’S [sic] common law status.”³⁹⁰

176. It is not possible to know precisely what complaint about the JAG officer the Fynes made directly to the CFNIS. The only discussion of the issue between the Fynes and the CFNIS was not recorded. That discussion took place in the context of a lengthy conversation following the Fynes’ first interview with the CFNIS, but the parties to the discussion had left the room where the interview was taking place and the recording device had been turned off. MS McLaughlin testified that, in the unrecorded discussion, the Fynes did not give any names nor was there any other real information other than the fact a JAG officer had quoted a repealed policy.³⁹¹

177. Maj Dandurand explained in his testimony that the issue galvanized for him after the meeting with the Ombudsman,³⁹² and he understood the issue under investigation was whether bad advice had been provided by a legal officer (assumed to be LCol King) during the casualty coordination meeting or to the CO.³⁹³ He thought it was as a result of this advice that the PNOK decision was made, and the Fynes were denied final decision-making authority over Cpl Langridge’s funeral. This seems to be a reasonable understanding of the complaint given the Fynes’ concern with the funeral planning issue.

178. Maj Dandurand’s understanding of the nature of the Fynes’ complaint makes a good deal more sense than the formal complaint as recorded in the GO file. There was a casualty coordination meeting. A JAG officer (not LCol King) was in attendance.³⁹⁴ Legal advice was presumably given.³⁹⁵ Following that meeting, the decision to recognize Ms. A as PNOK was ratified.³⁹⁶ This series of facts appears to leave open the possibility that there might have been a plausible case for a charge of negligent discharge of a military duty by the person providing the legal advice. If the legal advice was the basis for the PNOK decision, if it was incorrect and caused harm to the Fynes, and if it was found to fall markedly below the standard to be expected by a legal officer in the

circumstances, it is possible an offence could have been made out. However, no such investigation was ever carried out, making it impossible to speculate further about any such possible charge.

179. As noted by Maj Dandurand in his testimony, when a complaint comes to the attention of a member of the CFNIS, that person should “at the least validate whether the individual is formally complaining. We pose the question: Is this what you’re complaining about?”³⁹⁷ This seems like sensible advice, especially when facts about a case raise questions as to whether the complaint as formulated makes any sense. In this investigation, the investigators did not seem to appreciate the importance of this basic step. Instead, the initial investigators seem to have relied on information coming from the Ombudsman’s investigator to clarify the complaint³⁹⁸ rather than attempting to verify the allegation with the Fynes, in circumstances where, as far as the CFNIS was concerned, the Ombudsman was not the true complainant.

180. At all times, the investigation appears to have relied exclusively on the formal complaint as set out in the GO file. Sgt Shannon’s approach to his investigative task was extremely literal. Sgt. Shannon seems to have never asked how a letter written many months after Ms. A’s status as Cpl Langridge’s common-law spouse was recognized by the CF – a letter expressly stating that it was written “without prejudice” – could be construed as constituting a decision as to her marital status. Instead, he simply investigated the issue of whether the policy upon which this “decision” was allegedly based was repealed at the material time.³⁹⁹ Having determined the order had not been repealed as of the date of Cpl Langridge’s death,⁴⁰⁰ Sgt Shannon took no further investigative steps, simply concluding the allegation against LCol King was unfounded.

181. None of the investigators on the file conducted an investigation into the actual focus of the complaint, namely, the legal advice that led to the PNOK decision.

182. Given the incongruities in the formal complaint, some effort should have been made to ensure the complaint being investigated was an accurate reflection of the actual issues troubling the Fynes and of the issues actually raised on the facts. It would also

have been useful if the investigators sought legal advice regarding the meaning and consequences of the March 2009 letter.

CONCLUSION REGARDING THE INVESTIGATION INTO THE ADDITIONAL COMPLAINTS

183. In the course of conducting the 2009 investigation, the CFNIS did not investigate several of the major allegations brought forward by the Fynes. Had there been better clarity in the GO file itself and among investigators as to the importance of the funeral planning issue, the additional concerns raised by the Fynes might have been the subject of a more appropriate investigation. Seemingly incongruous complaints should have been clarified with the Fynes before being dismissed with only superficial investigation. If a decision had been made that certain issues were not going to be investigated, this ought to have been communicated clearly to the Fynes.

Supervision and Recordkeeping

THE IMPORTANCE OF SUPERVISION TO AN INVESTIGATION

184. Supervision is an integral part of managing an investigation to a successful conclusion. In any investigation, leadership and oversight are required to ensure that the complainant's concerns are fully and appropriately investigated. In this case, the supervisors took a hands-off approach. Supervisors may have spoken to investigators and checked SAMPIS regularly, but they allowed the investigators to proceed with the investigation as they saw fit with limited supervisory direction. While such a supervisory approach may be appropriate in certain circumstances, it was not appropriate for this investigation. A complex set of allegations and facts, the lack of continuity on the file and poor recordkeeping required more, rather than less, oversight and control. The central role of the supervisor is to be knowledgeable about the details of the investigation, to give input, and to provide direction.

RESPONSIBILITY FOR SUPERVISION OF THE INVESTIGATION

185. Investigators were supervised initially by the Operations WO who acted as the de facto Case Manager.⁴⁰¹ WO Hart was in this position at the outset of the investigation up to July 2010, during the period MS McLaughlin and MCpl Mitchell worked on the file. WO Bonneteau assumed the position in the summer of 2010 shortly before Sgt Shannon became the lead investigator.⁴⁰²

186. The Operations WO assigned investigators to files and provided the OC updates on investigations in weekly status reports and, in person, at briefings with the command team.⁴⁰³ It was also the responsibility of the Operations WO to review and oversee the course of investigations to ensure they were being conducted in a timely and proper manner.⁴⁰⁴

187. The Operations WO relied, in part, on informal discussion with the investigators to monitor activity in the investigation. During the course of the investigation, both WO Hart and WO Bonneteau regularly spoke with investigators to discuss where things stood and what they were anticipating as their next course of action.⁴⁰⁵ If there were questions about what was being done, the supervisor would speak to the investigator.⁴⁰⁶

188. Supervisors also relied on the SAMPIS entries made by the investigators to monitor and oversee the file.⁴⁰⁷ Supervisors had complete access to SAMPIS and could enter the system at any time and check the file for information or review it from a quality assurance perspective.⁴⁰⁸ WO Bonneteau testified his initial understanding of the investigation came from reading and reviewing the file.⁴⁰⁹ He also reviewed every ongoing file daily to ensure activity was continuing.⁴¹⁰

189. The OC of the detachment throughout the course of the 2009 investigation was Maj Dandurand. While day-to-day activity did not necessarily come to his attention,⁴¹¹ he would be made aware of critical or unanticipated developments.⁴¹² Maj Dandurand, like the Operations WO, relied on informal daily meetings with members of his command team to stay up-to-date on files.⁴¹³ The Operations WO and the command team would sit down weekly with the OC and report on ongoing investigations.⁴¹⁴ The OC was

responsible for taking the information and briefing the chain of command on significant developments.⁴¹⁵

190. Maj Dandurand testified command does not generally operate in a strictly linear fashion within the CFNIS and the MP. While orders come down the chain of command, “there is a recognition that command is done by [the] team.”⁴¹⁶ Nevertheless, Maj Dandurand, as the OC, had ultimate accountability for the conduct of all investigations and the responsibility to evaluate whether the steps taken in an investigation were reasonable.⁴¹⁷ The final decision to close an investigation also rested with the OC.⁴¹⁸

191. The investigators expected oversight and expected to have their work reviewed and checked by the supervisory team.⁴¹⁹ As MCpl Mitchell noted:

The decisions that we make are always – I wouldn’t say second guessed, but checked and solidified throughout our chain of command...Files are reviewed all the time. They are constantly reviewed by the case manager – sorry, the team leader and the case manager should be reviewing the files from beginning to end.⁴²⁰

192. The role of the command team was to analyze the investigators’ actions and to provide direction.⁴²¹ As noted by LCol Gilles Sansterre, the CO CFNIS, it is the supervisors who should provide leadership and guide the conduct of the investigation.⁴²²

PASSIVE INVOLVEMENT OF SUPERVISORS

193. While there was an expectation of supervisory engagement in investigations, the role assumed by the supervisors in this case was not one of ongoing evaluation of the investigation, but rather of somewhat detached observation. Neither WO Hart nor WO Bonneteau liked to micro-manage investigations.⁴²³ As WO Hart explained in his testimony:

The investigator is the individual who is tasked to conduct the investigation. That is the individual who gets down into, as you say, the nitty-gritty. It is my job just to oversee, from a more global perspective, what they are doing, and to follow the flow of the investigation, to make sure that it’s being conducted. [...] The investigators, when they are initially tasked, will have the job to take a look at the complaint and to draft their initial investigation plan. Once the initial invest plan is drafted, we will review it to make sure that they have a handle on what it is that is expected of them, and then, from that point on, they are allowed to proceed with their investigations.⁴²⁴

194. In practical terms, supervisors do not task the investigators with every step in the investigation, nor do they reinvestigate allegations.⁴²⁵ As WO Bonneteau noted in his testimony, it was not the role of the Operations WO to “hold the hand of every investigator,” or else files would never be completed.⁴²⁶ More direction would be given to an intern, but an experienced investigator such as Sgt Shannon would simply be allowed to do his job.⁴²⁷

195. Maj Dandurand had a unique role in the supervision of this investigation. At the outset, he was not only the OC of the detachment but also an investigator on the file. Initially, his participation in the investigation was very important, but after May 2010, his involvement, whether investigatory or supervisory, became much more limited. After that point in time, he participated in the command team briefing in early November 2010, the concluding PowerPoint presentation in February 2011, and he reviewed the file and signed the concluding letter sent to the Fynes in May 2011. While he was kept up to date on critical developments in the investigation, he did state that, after an initial briefing, “the investigators have their understanding and the benefit of the totality of the group’s experience in pursuing these investigations and then they go and do their work.”⁴²⁸ Maj Dandurand could have served as “the continuity stream for this file,”⁴²⁹ a useful role given the personnel turnover in the investigation. But, for a number of reasons, his contributions to the investigation were very limited during the last year the file was active.

196. It is important to note a more hands-off approach to oversight of investigations is not necessarily unreasonable. It does allow experienced investigators to get on with the job of actually conducting the investigation and demonstrates confidence in the investigators’ abilities. Although such a supervisory approach was popular in the CFNIS WR Detachment command team, in this case it was not appropriate. This investigation required a more substantive review of the material under investigation. The allegations were very complicated and any serious review of the conclusions reached by the investigators required an understanding of the allegations and what needed to be done to fully investigate them.

197. On the whole, because of the lack of guidance and oversight from the supervisors, the allegations were never properly understood or identified, relevant facts were not uncovered, appropriate legal advice was not sought and conclusions were not appropriately questioned.

Failure to understand the allegation and the issues under investigation

198. WO Hart, WO Bonneteau and Maj Dandurand all understood the allegation to be about whether the military had appointed the wrong PNOK, resulting in the Fynes not having authority to plan their son's funeral.⁴³⁰ However, this was not investigated because Sgt Shannon's understanding of the complaint stopped at finding the meaning of PNOK, which he understood to be a complaint about the common-law spouse. These different understandings of the PNOK allegation should have come under the scrutiny of an informed supervisor. To provide meaningful comment on the conduct of the investigation, it was incumbent on the supervisors to first ensure that they understood what the investigators were investigating.

199. WO Hart and WO Bonneteau did not appear to appreciate what was being investigated. They appear to have assumed that issues important to resolving the allegations had been investigated without first checking what the investigators had examined. When asked if Sgt Shannon should have looked into who the executor was, WO Bonneteau testified this "was part of Sgt Shannon's investigation, so that was part of what he was supposed to do, not myself...I am assuming that he did look into it."⁴³¹ Similarly, when asked whether the basis for determining if Ms. A was the common-law spouse should have been provincial law rather than the military statutory declaration, WO Hart stated, "That was an area that my investigators were looking into and it was not an area that I investigated."⁴³² While Sgt Shannon did superficially examine both provincial law and the identity of the executor, these issues did not form a substantial part of the investigation. Had the investigation been properly focused on funeral planning, such issues would have been prominent.

Inadequate supervision of investigation plans and lack of follow up

200. The investigation plans compiled by MCpl Mitchell and Sgt Shannon, approved respectively by WO Hart and WO Bonneteau, show two very different approaches. The duties of the Operations WO, along with the OC, included approving or amending the plan and returning it to the investigators for implementation.⁴³³ MCpl Mitchell's investigation plan was interview-based, and he testified he wanted to interview anyone who had attended the casualty coordination meeting.⁴³⁴ Sgt Shannon's investigation represented a clear departure from this approach.

201. The command team decided interviews beyond those with the subject matter experts were not necessary,⁴³⁵ accepting Sgt Shannon's conclusion that the documents stood on their own.⁴³⁶ However, the command team was unaware Sgt Shannon had not found all the relevant documents,⁴³⁷ nor did they have a way of determining if Sgt Shannon had gone far enough in identifying all the available documents.⁴³⁸ Potentially important witnesses such as attendees at the casualty coordination meeting, as well as civilian witnesses such as Ms. A and the funeral director, were never interviewed, and important information, such as how the PNOK decision was made and by whom, was never gathered.

202. There was some attempt to provide supervisory direction at the November 2010 command team meeting. At the meeting, the command team appropriately questioned the conclusions reached by Sgt Shannon.⁴³⁹ As a result, Sgt Shannon made changes to his investigation plan and added eight issues requiring additional investigation.⁴⁴⁰ On that basis, he and MS Gazzellone conducted interviews with two subject-matter experts in Ottawa to find answers to the outstanding issues and "to determine if his interpretation of the policies, directives and orders was the correct interpretation."⁴⁴¹ Sgt Shannon did brief WO Bonneteau after the interviews⁴⁴² and Maj Dandurand received the "Coles Notes" version of the interviews.⁴⁴³ However, there does not seem to have been any significant supervisory follow-up as to what exactly had been learned about the issues of concern to the command team. There was no document produced in the GO file or elsewhere setting out the answers to the eight open questions.⁴⁴⁴ Despite Sgt Shannon's

opinion that the final PowerPoint presentation answered all of these questions,⁴⁴⁵ it clearly did not.⁴⁴⁶

203. Had the supervisors turned their minds to the actual questions, it would have been obvious the question concerning “the role of the Executor of a CF will in the planning process of a funeral of a CF member”⁴⁴⁷ had not been answered. In fact, the subject-matter experts had said that, in similar circumstances to those under investigation, they would have deferred to the expertise of the JAG.⁴⁴⁸ Sgt Shannon’s conclusions needed testing by his supervisors. Passive reception of a slide presentation is not tantamount to actual oversight and review.

Failure to adequately question conclusions

204. The decision to conclude the investigation occurred sometime after subject-matter expert interviews were conducted in November 2010.⁴⁴⁹ In the end, the supervisors accepted the conclusion of Sgt Shannon that PNOK was the equivalent of spouse and common-law spouse. But they did not understand how the conclusion was reached. When asked whether he shared Sgt Shannon’s understanding about NOK being the equivalent of spouse, WO Bonneteau simply replied:

[...] when Sgt Shannon was assigned as lead investigator on this investigation, being the experienced investigator I pretty much had a hands-off on it in that I allowed him to do his job. [...] it wasn’t my role to look over his shoulder and look at every little aspect of his investigation.⁴⁵⁰

205. Maj Dandurand also could not recall where or when Sgt Shannon would have explained the linkage between NOK and common-law spouse,⁴⁵¹ clearly a critical investigative conclusion. While supervisors do not need to be peering over the shoulders of their subordinates, they do need to ask probing questions and obtain satisfactory answers before determining whether an investigation can be closed. Blind faith in the abilities, professionalism and expertise of the lead investigator is not sufficient.

Failure to seek legal advice

206. While supervisors should not be expected to be subject-matter experts or have intimate knowledge of every detail, they should recognize when an investigation is complex and what appropriate outside expertise may be helpful in investigating the allegations. The Commission is not aware of any evidence indicating supervisors recommended legal advice be sought. Neither WO Bonneteau nor Maj Dandurand thought a legal opinion was necessary at the time.⁴⁵² While WO Hart stated in testimony he would have consulted the regional military prosecutor if he had been lead investigator, this was not a suggestion he made to anyone he was supervising.⁴⁵³ Rather than making a recommendation for legal assistance as they were entitled to do,⁴⁵⁴ the supervisors deferred to the investigators' judgment, stating investigators were always free to seek legal advice.⁴⁵⁵ Neither Sgt Shannon nor any of the supervisors involved in this investigation were lawyers. Yet the conclusions reached concerning the applicability of provincial law, the meaning of NOK based on customs of society rather than on existing law, and the role of the executor were all legal issues. It was the responsibility of the supervisors not simply to deflect the obligation for seeking legal advice to investigators, but to ensure the allegations were fully and properly investigated and engage legal counsel when appropriate.

ROLE OF CFNIS HQ

207. CFNIS HQ was not involved in the actual investigation of the allegations, fulfilling more managerial functions such as coordinating and approving procedures, strategic oversight and quality control.⁴⁵⁶ While it may have been appropriate for the CO not to be involved in the details of each investigation in the CFNIS, this particular investigation was different. It was legally and factually complex with complainants who had a challenging relationship with the CFNIS and the CF in general. Nevertheless, like the other supervisors involved in this investigation, HQ personnel took a hands-off approach to supervision, which meant they were not knowledgeable about the investigation and did not provide guidance or direction in its conduct.

208. LCol Sansterre, who was the CO CFNIS for all but the final month of the 2009 investigation,⁴⁵⁷ explained that from a day-to-day perspective, the CO did not oversee investigations – it was left to the DCO, Maj Francis Bolduc, to brief him on the cases where he needed to know details.⁴⁵⁸ In this investigation, LCol Sansterre was aware of the very basics: the fact the investigation had been opened; monthly status briefings on the file; and when it was concluded.⁴⁵⁹ He could not recall if the DCO had given him any oral briefings on the investigation and he could not recall being apprised of any issues throughout the course of the file.⁴⁶⁰ He had only a very vague understanding of the allegations concerning the PNOK and JAG lawyer, and believed incorrectly that the Fynes’ concerns about false information being given at the funeral home was under investigation.⁴⁶¹ He understood the decision to close the file was based on the conclusion the NOK had been properly appointed but he did not understand in detail the basis for that conclusion.⁴⁶²

209. LCol Sansterre did acknowledge in testimony that he did not “drill down” into the investigation.⁴⁶³ Nevertheless, he denied having a hands-off approach to supervision. Instead, he stated that he did not micromanage investigations but rather “empowered those who worked for me to do their jobs.”⁴⁶⁴ LCol Sansterre explained his lack of involvement and knowledge of this specific investigation as being, in part, a result of having 180 files in the course of a year come through the CFNIS. He also testified he would have had better knowledge of the file if it had resulted in charges being laid, since public affairs would have become involved.⁴⁶⁵

210. The only supervisory input from HQ in the file was in connection with the SI. LCol Sansterre testified he thought he and Maj Dandurand probably had a discussion in which he advised Maj Dandurand to speak to the President of the SI to ensure the CFNIS investigation would have precedence over the SI.⁴⁶⁶ On a practical level, this meant LCol Sansterre would expect the discussion to include determining if there were witnesses the SI needed to interview and confirming the CFNIS would have access to the witnesses before the SI.⁴⁶⁷ While LCol Sansterre did recall a meeting with the President of the SI, he did not have the “level of detail” to know why the SI was permitted to proceed with interviews of witnesses months prior to the CFNIS, even interviews with some of the

same witnesses later named on MCpl Mitchell's investigation plan.⁴⁶⁸ The CFNIS could have requested the SI be shut down if both investigations were dealing with the same issues. And, in this investigation, there was clearly overlap.⁴⁶⁹

211. Despite recognizing this as a potential issue and making a specific request to Maj Dandurand concerning the maintenance of a separate investigation, there does not seem to have been any follow up to determine whether the mandates of the two investigative bodies had been "deconflicted" and whether the ability of the CFNIS to conduct an independent investigation was given precedence. While knowledge of the day-to-day activities in ongoing investigations may be beyond the purview of the CO of the CFNIS, this may have been an instance where ensuring investigations were independent from the other CF processes should have engaged the CO's ongoing attention.

RECORDKEEPING

212. When a hands-off approach to supervision is adopted, it becomes important to maintain accurate records so supervisors at all levels can monitor and assess developments in the investigation at any time. In addition, with so many personnel changes, accurate records are an absolute necessity for incoming personnel, especially in circumstances where there is little if any overlap between investigators and little evidence of briefings or handover. However, in maintaining acceptably precise and detailed records for this investigation, the CFNIS failed miserably, with events not being recorded and important records being inaccurate or incomplete. Despite their stated reliance on SAMPIS as a source of ongoing information about the file, supervisors did little to ensure complete records were kept, merely making grammatical changes to text box entries.

Failure to record interviews

213. Poor recordkeeping was evident at the outset of the investigation with the incomplete recording of interviews with the complainants and as a result, of the allegations. Only half of the first interview with the Fynes in November 2009 was actually recorded. Estimates of the total length of the interview ranged from three hours to four and a half hours meaning at least an hour and possibly up to two and a half hours

of the Fynes interview did not get recorded.⁴⁷⁰ The explanation provided was that after the formal part of the meeting was completed, the interview continued in the hallway outside of Maj Dandurand's office.⁴⁷¹ Since MS McLaughlin had gone to make a copy of the recording of the first portion of the interview for the Fynes, this latter part of the interview was not recorded.⁴⁷² There is no obvious reason why Maj Dandurand could not have requested the Fynes return to his office and wait for MS McLaughlin before continuing the discussion. Despite Maj Dandurand's email assurance to the CFNIS public affairs officer that the meeting had been taped "so nothing was missed or omitted from our end"⁴⁷³, significant discussion did take place off tape, including the Fynes' allegation concerning the JAG officer.⁴⁷⁴

214. The meeting with the Ombudsman's investigator was also not recorded. MS McLaughlin viewed this as simply a meeting between two investigative bodies, discussing information to be passed on to the CFNIS.⁴⁷⁵ As a result, the only contemporaneous records of the meeting are brief notes in Maj Dandurand's notebook.⁴⁷⁶ MS McLaughlin's explanation for his failure to take any notes whatsoever during the meeting was that they were simply reviewing documents.⁴⁷⁷

215. These explanations are not satisfactory. The Ombudsman was considered by the CFNIS not simply to be another investigative body, but in some documents to be the complainant in the investigation. Under the circumstances, a complete audio recording or at least comprehensive notes should have been made of the meeting. The allegations which formed the basis for the investigation, as well as other concerns the CFNIS decided not to investigate, were discussed during the meeting.⁴⁷⁸ Had a more complete record of the meeting been created, it would have been available for review both by investigators and supervisors to ensure the allegations, as recorded in the file and as investigated, corresponded with the concerns brought forward by the complainants.

Failure to identify potential suspects

216. Another example of careless recordkeeping is the failure to identify potential suspects in writing regarding the PNOK allegation. The Fynes were firmly of the opinion Capt Lubiniecki was responsible for the decision which put Ms. A in the position of

PNOK.⁴⁷⁹ However, in testimony at the hearing, a number of the investigators stated they knew persons higher in the chain of command were likely responsible for making the final decision about who was NOK.⁴⁸⁰ Nevertheless, the only person ever mentioned as a suspect by name in the GO file was Capt Lubiniecki.⁴⁸¹ This remained the case even after the interviews with Capt Brown and Maj Parkinson in which they gave evidence about who was in attendance at the casualty coordination meeting and who was involved in making the NOK decision.⁴⁸² In his testimony, Sgt Shannon stated he had identified three suspects (Capt Lubiniecki, LCol Cadieu and LCol Demers) and had pinpointed LCol Demers as having made the NOK decision.⁴⁸³ While Sgt Shannon noted all three names (along with Maj Reichert) in his investigative plan as possible interviewees, he only ever identified Capt Lubiniecki in writing as a suspect.⁴⁸⁴ There is no evidence Sgt Shannon or any of the other investigators were deliberately trying to protect the higher ranks and, in fact, their testimony is quite the opposite.⁴⁸⁵ However, the fact remains that despite specifically identifying three suspects, only the lowest ranked member is actually mentioned by name in any documents on the GO file.

Failure to record investigative steps, analysis and plans

217. According to a CFNIS SOP, revised towards the end of the investigation, the text boxes in a GO file should be a reflection of the investigation plan and should be kept up to date as the investigation progresses.⁴⁸⁶ According to the SOP, there is a need to avoid “[v]ague entries or no entries at all in some portions of the investigative activities [because it] lead[s] to misunderstandings, poor thought flow or omissions.”⁴⁸⁷ Yet, despite this clear direction in the SOP, on many occasions investigators did not record steps or analysis they had undertaken. In his testimony, WO Hart candidly acknowledged:

If we were to actually sit and record everything that took place in a file, we would be spending all of our time recording rather than doing the investigation. So, yes, there’s always going to be investigative steps, there’s going to be thought processes that may or may not be captured in the file. It depends on what the investigator feels is relevant to the investigation.⁴⁸⁸

218. If investigative steps were not all recorded in the file, it is unclear how supervisors or incoming investigators could rely on the GO file to reflect what investigation had actually taken place. For example, WO Bonneteau was not aware Sgt Shannon had added a new allegation to the investigation concerning the Fynes' involvement in funeral planning based on a press conference given by Mrs. Fynes.⁴⁸⁹ The allegation was not recorded in the GO file for WO Bonneteau to review. In testimony, WO Bonneteau seemed unconcerned he was unaware of an entire avenue of investigation, stating it was simply a different form of the same complaint which was already being investigated.⁴⁹⁰ This attitude demonstrates how unfamiliar WO Bonneteau was with the limited scope of Sgt Shannon's investigation, focusing as it did only on whether the Fynes had input into the funeral and not on who was actually entitled to plan the funeral.

219. Milestone events were also not recorded in the GO file. The text boxes in the GO file do not state the command team met with Sgt Shannon in early November 2010 to review his conclusions, nor that it was the command team who raised specific questions during the meeting that were to be answered through further investigation.⁴⁹¹ While Sgt Shannon's notes indicate he was tasked with preparing a briefing for the chain of command on both the 2009 and 2010 investigations,⁴⁹² there is no indication in the file of the decision to conclude the investigation after the subject-matter expert interviews, nor of the thought process leading to Sgt Shannon's recommendation to conclude.⁴⁹³ Other than a copy of the PowerPoint presentation, there is no record of any other notes taken during the meeting of the command team held in February 2011.⁴⁹⁴

Incorrect or incomplete records of investigative steps

220. Even when investigative steps were recorded, the information contained in the GO entry was not always accurate. This is particularly evident in the witness statements produced after interviews. While there should have been an increased concern with accuracy, given that neither supervisors nor incoming investigators reviewed the actual audio or video tapes of the interviews, there were many examples of information either not being recorded or being recorded incorrectly.

221. In the witness statement following the interview of Capt Brown,⁴⁹⁵ there was no mention that he stated he may have given what turned out to be incorrect information, which was used to produce the registration of death, when he accompanied Ms. A to the funeral home.⁴⁹⁶ This was precisely a concern of the Fynes, and though MCpl Mitchell had asked questions about the issue during the interview and relevant information had been provided, it was not identified in the witness statement.

222. In the witness statement of the subject-matter expert Sgt Pelletier,⁴⁹⁷ Sgt Shannon failed to record that Sgt Pelletier said she would defer to the JAG when given the hypothetical situation in her interview (no will, parents on PEN form, there is a common-law spouse) and asked to comment on who would have authority to plan the funeral.⁴⁹⁸ When asked if the common-law statutory declaration created any rights for the spouse, Sgt Pelletier responded she did not know and was not expert in the legality of the situation.⁴⁹⁹

223. In the witness statement for the other subject matter expert, LCdr Gendron, Sgt Shannon overstated LCdr Gendron's expertise. In his testimony, LCdr Gendron referred to the description of him in the witness statement as "the subject matter expert regarding issues related to casualty support and related administrative actions mandated by CF policies and regulations" as "probably a bit embellished."⁵⁰⁰ Sgt Shannon also failed to note, in the witness statement he prepared based on LCdr Gendron's interview, that during the interview, when presented with a hypothetical situation corresponding to the facts under investigation, LCdr Gendron stated, since this situation was not something in which his directorate would get involved, any comment he had would be purely his personal opinion.⁵⁰¹ He also did not record LCdr Gendron's statement that if he had been the CO in the hypothetical situation, he would have consulted the JAG.⁵⁰²

CONCLUSION REGARDING RECORDKEEPING AND SUPERVISION

224. Overall, the recordkeeping in this investigation was poor. In reviewing the file, the supervisors do not seem to have been particularly concerned with ensuring consistency, completeness or accuracy in records. On the other hand, they seemed to have been concerned with ensuring GO file entries had proper grammar and were formatted

correctly.⁵⁰³ To be sure, this is a requirement in the SOPs – “Grammar, content, spelling, thoroughness of investigation, and essential SAMPIS items are all part of [the WO/Ops Sgt/Team Lead’s] vetting process.”⁵⁰⁴ But its importance pales in comparison to the goal of keeping a complete and accurate record. Given the reliance placed on the documents and text entries in the GO file, the supervisors should have made efforts to ensure the record of the investigation was fully maintained.

225. This was a complex investigation. To properly investigate the complaints, there needed to be a complete understanding of the allegations, a thorough legal analysis, and detailed witness interviews. This investigation required supervisors who would provide hands-on oversight based on a thorough knowledge of the investigation as it progressed. Instead, the supervisors chose a much more hands-off approach. Rather than providing the necessary guidance and oversight, the supervisors seemed averse to being perceived as micro-managers. The investigation was made more difficult by personnel changes and poor recordkeeping practices.

226. The consequences are reflected in the unsatisfactory conduct of this investigation. As Maj Dandurand himself noted in one of the interviews with the Fynes, “at the end of the day, you can push responsibility down, but if you’re the person pushing that responsibility down, you are actually accountable for what gets done.”⁵⁰⁵ The supervisors must ultimately accept some of the responsibility for the inadequacies of this investigation.

Timeliness

227. The complaint forming the basis of the 2009 investigation first came to the attention of the CFNIS WR on November 17, 2009, when Lt(N) Amirault of the CFNIS Central Region contacted Maj Dandurand to advise him of a complaint he had received from the Ombudsman’s investigator.⁵⁰⁶ The last activity on the file, other than the transfer of evidence, was a letter sent on May 6, 2011, to Mr. and Mrs. Fynes advising them of the conclusions of the investigation.⁵⁰⁷ The file was active for 535 days or for

almost a year and a half. The Fynes complained to the MPCC this was an unreasonably long time to complete the investigation.⁵⁰⁸

DELAYS

228. There were three significant periods of delay in the course of the investigation. The first was a period of inactivity of almost two months between the meeting with Ombudsman's investigators on December 18, 2009,⁵⁰⁹ and Maj Dandurand completing his investigative assessment on the file on February 12, 2010.⁵¹⁰ MS McLaughlin did compile the documents received from the Ombudsman's investigators, but little else was accomplished during this time period. This delay was never really explained except to say MS McLaughlin was deployed to Haiti. In his testimony, he explained this meant having to drop everything to get kitted up and ready to go prior to his departure from Edmonton in mid-January.⁵¹¹ There was no explanation for the lack of activity from mid-January to mid-February when only Maj Dandurand was assigned to the file.

229. The second period of delay occurred during MCpl Mitchell's investigation, which proceeded rather slowly. The investigative activity from mid-March to September 2010 involved only three witness interviews⁵¹² and obtaining and reviewing the SI report.⁵¹³

230. The Fynes repeatedly expressed their dissatisfaction with the pace of the investigation during their May 5, 2010, interview with MCpl Mitchell and Maj Dandurand.⁵¹⁴ At about the same time, the CF chain of command was also asking when investigations ancillary to the BOI, including the CFNIS investigation, would be complete.⁵¹⁵ Maj Dandurand testified the investigation had been featuring on:

[...] [the] Provost Marshal's watch list as a file that had CF interest in the sense that it was being tracked by the Vice-Chief of Defence Staff and the Provost Marshal as being requested to be able to speak to that at times, which is why the watch list existed. And I would have to say that I believe it was an effort to try and get this investigation concluded. It was perhaps one of the questions that was occurring in the margins with respect to not only this investigation, but others, to say what do you need in order to get this – this moving along at a quicker pace.⁵¹⁶

231. In accounting for the delays during MCpl Mitchell's investigation, it should be noted MCpl Mitchell stated he was unavailable to work on the investigation from May 10

to 21, 2010, while on training.⁵¹⁷ He also explained he was taken off the file in mid-August so he could leave for a course starting at the beginning of September 2010.⁵¹⁸ He candidly admitted he was not particularly good at policy review and there was a huge amount of paperwork he had to go through on the file.⁵¹⁹ Maj Dandurand agreed the investigation was more complex than most⁵²⁰ and covered “a myriad of issues.”⁵²¹

232. There was also a suggestion in connection with this particular delay that the detachment was very busy at this time and was understaffed. Maj Dandurand testified there were about 50 open investigations, divided amongst nine investigators in May 2010.⁵²² MCpl Mitchell confirmed there were not many investigators, and they were constantly on the go.⁵²³ Maj Dandurand stated if direction would have come from HQ to proceed more quickly with the investigation, it would have been necessary to put other files on hold, or it would have been necessary to augment staff for two to six months.⁵²⁴

233. The final period of delay took place between the time when the decision was made to conclude the file and its actual conclusion. There is conflicting evidence about the date the decision was made to conclude the investigation. It is known the decision was made no later than December 10, 2010, when, according to the records in the file, Sgt Shannon was tasked with preparing a PowerPoint briefing for the command team on both the 2009 and the 2010 investigations.⁵²⁵ The decision may have been made even earlier. The last interview occurred on November 17, 2010 with LCdr Gendron.⁵²⁶ There was no additional investigative activity after that date. In an affidavit produced before the Commission, Mr. Martel from the Ombudsman’s Office indicated he spoke to Maj Dandurand “in the late fall of 2010” and was told the investigation was substantially complete and the file was about to be closed.⁵²⁷ The formal conclusion of the file occurred much later, on May 6, 2011, when the Fynes were sent a letter signed by Maj Dandurand explaining the outcome of the investigation.⁵²⁸

234. In the almost five months between when the decision was taken and the actual conclusion of the investigation, Sgt Shannon was responsible for preparing the slide presentation for the command team, as well as drafting the concluding letter to the Fynes.⁵²⁹ He completed both of these tasks promptly.

235. The date for the actual briefing to the command team was dependent on the availability of Maj Dandurand.⁵³⁰ Once the date had been set, Sgt Shannon completed the presentation over the course of a weekend.⁵³¹

236. There was an attempt to schedule a verbal briefing with the Fynes, but the decision was quickly made to cancel it when they asked for their lawyer to be present.⁵³² When he was then tasked with drafting the concluding letter to the Fynes on February 24, 2011,⁵³³ Sgt Shannon prepared the draft and sent it to Maj Dandurand for approval on March 3rd, 2011.⁵³⁴

237. The significant delay at this stage in the investigation occurred principally as a result of Maj Dandurand, both in terms of scheduling the command team briefing and in signing the concluding letter to the Fynes.⁵³⁵

238. By this point, both the CF and the CFNIS leadership were anxious for the investigation to be completed. On February 14, 2011, Col Gerard Blais, who had been tasked with preparing a coordinated CF response to the Fynes' outstanding concerns, requested the date the CFNIS investigations were expected to be completed, suggesting all the ongoing investigations should be signed off as soon as possible.⁵³⁶ On the same date, Maj Bolduc, the DCO of the CFNIS, asked Maj Dandurand to confirm his plans regarding the outstanding investigations, since February 2011 had been set to brief the family.⁵³⁷ On February 17, 2011, Maj Bolduc followed up with another email to Maj Dandurand stating they "need to firm up the plan and complete these file[s] with the family brief very shortly. I would suggest that this is one of your high priorit[ies]."⁵³⁸

239. The command team was briefed on February 18, 2011.⁵³⁹ By March 8, 2011, the text of the letter to the Fynes had been approved by CFNIS HQ, and it had been decided the letter should go out under Maj Dandurand's signature.⁵⁴⁰ On April 11, 2011, LCol Robert Delaney, then CO of the CFNIS, emailed Maj Dandurand to ask if the Fynes letter had been signed off and sent.⁵⁴¹ On April 27, 2011, LCol Delaney again emailed Maj Dandurand to ask if the letter had been sent.⁵⁴² That day the letter was finally mailed, almost two months after having been approved.⁵⁴³ The letter was not delivered and was

returned to the CFNIS on May 5, 2011, because the mailing address was incomplete. The letter was ultimately sent to the correct address on May 6, 2011.⁵⁴⁴

240. To explain the delay in the PowerPoint presentation and in concluding the file, Maj Dandurand testified he wanted to do the briefings on the 2009 and 2010 investigations together because the files were intertwined, and he thought the Fynes would want all the answers at the same time.⁵⁴⁵ However, he could not clarify that rationale in light of the fact that according to the weekly file status reports, the 2010 investigation was marked as “to be concluded” the week of August 14, 2010,⁵⁴⁶ several months prior to the decision to conclude the 2009 investigation. Maj Dandurand did state in testimony that medical emergencies in his family in early 2011 prevented him from giving the file his full attention, and he was forced to rely on his second-in-command, MWO Terry Eisenmenger.⁵⁴⁷

241. Stronger management of the file by Maj Dandurand was needed to bring this investigation to a timely conclusion. With the exception of WO Hart, he was the only CFNIS member consistently involved in the file from its beginning to its conclusion. He had taken the initial complaint call and had conducted both the first interview with the Fynes and the meeting with the Ombudsman’s investigators. As the OC of the detachment, he received the weekly case summaries, which kept a running tab of how many days an investigation had been open. He was aware of the Fynes’ frustration with the pace of the investigation and of his own leadership’s desire to get the file concluded. He was responsible for liaison with his command structure to ensure he had the resources needed to complete ongoing investigations in a timely manner.

242. Even in terms of Maj Dandurand’s own investigative responsibilities on the file, there were significant delays. There was a period of unexplained inaction from mid-January to mid-February 2010 in which he was the only investigator on the file. There were further delays in both the timing of the concluding slide presentation and the mailing of the concluding letter to the Fynes, ultimately requiring the involvement of the CFNIS CO. While there may have been personal circumstances in early 2011 preventing

Maj Dandurand from ensuring the matter was concluded in a timely manner, the second-in-command should have been in a position to move the investigation forward.

243. As a supervisor, WO Hart could also have been more proactive in ensuring the investigation progressed more quickly while MCpl Mitchell was leading the file. When he was assigned to the file, MCpl Mitchell was a new recruit to the CFNIS. MCpl Mitchell acknowledged he had difficulty with researching policy and this was a complex investigation with challenging legal and policy questions. WO Hart and Maj Dandurand were the only two supervisors available in the command team at the time.⁵⁴⁸ More support should have been available to MCpl Mitchell which might have helped to speed up the investigation.

CONCLUSION REGARDING TIMELINESS

244. The consequences of not completing this investigation in a timely fashion were significant. The length of the investigation resulted in five different investigators being assigned to the file at various times. There were three main lead investigators successively in charge of the file, MS McLaughlin, MCpl Mitchell and Sgt Shannon, but there was apparently no direct communication between each departing and each incoming investigator. As a result, the investigation had to be started fresh each time there was a personnel change. While this did allow the new investigators to form their own opinions on the file, it also delayed the actual investigation of the complaints. Maj Dandurand, who could have provided continuity, was not involved in any active investigative activities after the interview with the Fynes in May 2010.

245. The length of the investigation led the complainants to lose faith in the entire investigative process. As Mr. Fynes explained in his testimony, “we got to the point where we just felt like we were being ignored. There was no real activity going on.”⁵⁴⁹ An unnecessarily long investigation made the complainants question the CFNIS’s commitment to the investigative process. This outcome was largely avoidable.

246. Overall, it is the responsibility of supervisors to ensure investigations are completed in a timely manner.⁵⁵⁰ In this situation, that responsibility ultimately lay with Maj Dandurand as the OC of the detachment.

¹ Although the concepts “next-of-kin” and “primary next-of-kin” are legally distinct, the documents and testimony at the hearings sometimes refer to next-of-kin (NOK) interchangeably with primary next-of-kin (PNOK). Strictly speaking, the term PNOK refers to someone from amongst persons with next-of-kin status who is given primacy for a specific purpose. In this chapter, the correct term PNOK is used, except where the source refers specifically to NOK. For purposes of the present discussion, there is no practical difference in the way the two terms are used.

² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518.

³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518.

⁴ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 5-6.

⁵ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, pp. 1-2.

⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518.

⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 231-232.

⁸ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, pp. 2 and 7.

⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 239-241.

¹⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1369.

¹¹ Exhibit P-147, tab 2, doc. 1423, pp. 72-75.

¹² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.

¹³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 294.

¹⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 1-2.

¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518.

¹⁶ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 34-39.

¹⁷ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 38-39.

¹⁸ Mr. Martel did contact the CFNIS twice to get updates on the investigation: Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 39-42.

¹⁹ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 39-42.

²⁰ Testimony of Sheila Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 49-50; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 182-183; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 142; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 36.

²¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 144-145.

²² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 39-40.

²³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 119-121.

²⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 97-98.

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- ²⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 39-42, 88 and 118-121.
- ²⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 27.
- ²⁷ Exhibit P-177, doc. 1457, p. 3.
- ²⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1261.
- ²⁹ Exhibit P-4, Collection D, vol. 9, tab 80, doc. 804; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 294. There is a short email exchange on December 1-2, 2009 between Maj Dandurand and Mr. Fynes concerning issues raised about the 2008 investigation: see Exhibit P-147, tab 1, doc. 1422, pp. 63-64.
- ³⁰ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ³¹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 166-167; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 259; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 114-115.
- ³² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 133.
- ³³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 259.
- ³⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 259.
- ³⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 186-187.
- ³⁶ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, p. 9, 31; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 186.
- ³⁷ See, generally, Section 4.5, CFNIS Interactions with the Fynes.
- ³⁸ Exhibit P-147, tab 1, doc. 1422, pp. 115-116.
- ³⁹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 199-200; Exhibit P-147, tab 1, doc. 1422, p. 115.
- ⁴⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 189-190.
- ⁴¹ Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 199-200.
- ⁴² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp.27; Exhibit P-177, doc. 1457, p. 3.
- ⁴³ Exhibit P-161, doc. 1087-O.
- ⁴⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1263-1265.
- ⁴⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1369.
- ⁴⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 141-142 and 203-205.
- ⁴⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ⁴⁸ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518; Exhibit P-2, Collection B, vol. 1, tab 1, doc.1087, pp. 31-32.
- ⁴⁹ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, pp. 2 and 7; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p.87.
- ⁵⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221.
- ⁵¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 31-32, 87 and 221; Testimony of PO2 McLaughlin, vol. 49, 18 September 2012, pp. 241-242.
- ⁵² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 31-221.
- ⁵³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 219.

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- ⁵⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 41-42, 89-113, 122-148 and 157-181.
- ⁵⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 39-40.
- ⁵⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1263.
- ⁵⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1263-1265.
- ⁵⁸ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, p. 2.
- ⁵⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 212-213; Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, p. 15.
- ⁶⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 264.
- ⁶¹ Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 16-17.
- ⁶² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 136 and 201-202.
- ⁶³ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 135-138, 186-191 and 268-269.
- ⁶⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 186-19.
- ⁶⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 113-114.
- ⁶⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 31-32 and 87.
- ⁶⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 236-241.
- ⁶⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 241-242.
- ⁶⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 251-252.
- ⁷⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 193.
- ⁷¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 27 and 221.
- ⁷² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 191.
- ⁷³ Exhibit P-150, tab 2, doc. 1430, p. 2.
- ⁷⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ⁷⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ⁷⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 294.
- ⁷⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 122.
- ⁷⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1105.
- ⁷⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1105.
- ⁸⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 231-232.
- ⁸¹ See below: "The Shannon Investigation".
- ⁸² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 224-228.
- ⁸³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 294 and 1369.
- ⁸⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 55; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 2.
- ⁸⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 13-14 and 101.

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- ⁸⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 55.
- ⁸⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 13-14.
- ⁸⁸ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 2 and 5-6.
- ⁸⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 27; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 44-51 and 54-55.
- ⁹⁰ See Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 48-49; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 526, 575 and 634.
- ⁹¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 48-49.
- ⁹² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 61-62.
- ⁹³ See Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 133-134.
- ⁹⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 33-34; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 284-285.
- ⁹⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 284-285.
- ⁹⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 284-285.
- ⁹⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 40.
- ⁹⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 40.
- ⁹⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 41.
- ¹⁰⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 40-42.
- ¹⁰¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 40-41.
- ¹⁰² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 91-99 and 102.
- ¹⁰³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 284-285.
- ¹⁰⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 284-285.
- ¹⁰⁵ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F.
- ¹⁰⁶ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 14-16.
- ¹⁰⁷ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 22-24 and 26-29.
- ¹⁰⁸ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 25-26.
- ¹⁰⁹ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 29 and 38-39.
- ¹¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 43.
- ¹¹¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 59-60.
- ¹¹² Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 15.
- ¹¹³ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 27-29, 37-39, 40, 42, 51 and 60.
- ¹¹⁴ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, p. 1.
- ¹¹⁵ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 24-25.
- ¹¹⁶ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 50, 64, 81 and 87.
- ¹¹⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 59-60.
- ¹¹⁸ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 55 and 59-60.

¹¹⁹ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 60 and 85-87; Testimony of Capt Brown, Transcript of Proceedings, vol. 18, 8 May 2012, p. 149.

¹²⁰ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 25 and 55-56.

¹²¹ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 52-55, 61 and 117-118.

¹²² Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H, pp. 25-26 and 30.

¹²³ Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H, p. 14-16.

¹²⁴ Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H, pp. 27-28.

¹²⁵ It had been provided by the Ombudsman's investigator and was part of the GO file: Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 217.

¹²⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 83-84.

¹²⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 16.

¹²⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 284.

¹²⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 301-406 and 1105.

¹³⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 31.

¹³¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 37-38.

¹³² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 426-428.

¹³³ Exhibit P-70, doc. 1358, p. 3.

¹³⁴ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 426-427 and 1143.

¹³⁵ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 426-428 and 1143. See also Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1037-1040; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 120-121 and 184.

¹³⁶ Exhibit P-70, doc. 1358, pp. 1-2.

¹³⁷ Exhibit P-22, doc. 1318, p. 1.

¹³⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 108-109.

¹³⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 19-20.

¹⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 201.

¹⁴¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 525.

¹⁴² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 122.

¹⁴³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 99.

¹⁴⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 547.

¹⁴⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 550.

¹⁴⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 526, 573, 575 and 831.

¹⁴⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1032.

¹⁴⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 110.

¹⁴⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 112-114.

¹⁵⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 79-80.

¹⁵¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 133-134.

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- ¹⁵² Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 49-52 and 64.
- ¹⁵³ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 52-55, 61 and 117-118.
- ¹⁵⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 38-39.
- ¹⁵⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 38-39; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 32.
- ¹⁵⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 84 and 120-121.
- ¹⁵⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 84-85.
- ¹⁵⁸ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 1; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 1.
- ¹⁵⁹ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, p. 1.
- ¹⁶⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1105; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 9-10.
- ¹⁶¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 122-123.
- ¹⁶² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 101.
- ¹⁶³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 285.
- ¹⁶⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1145.
- ¹⁶⁵ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 170-171; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 26-27 and 142-143.
- ¹⁶⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 122.
- ¹⁶⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1370.
- ¹⁶⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 98-100.
- ¹⁶⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 97-98.
- ¹⁷⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 97-98.
- ¹⁷¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 47-48.
- ¹⁷² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 286.
- ¹⁷³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 6-7.
- ¹⁷⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 219.
- ¹⁷⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 235.
- ¹⁷⁶ Exhibit P-3, Collection C, vol. 1, tab 3, doc. 1088-C, p. 27.
- ¹⁷⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 226; Exhibit P-75, tab 2, doc 1087-K, pp. 50-53.
- ¹⁷⁸ Exhibit P-75, tab 2, doc 1087-K, p. 50.
- ¹⁷⁹ Exhibit P-75, tab 2, doc 1087-K, p. 50; Exhibit P-3, Collection C, vol. 1, tab 3, doc. 1088-C, p. 26.
- ¹⁸⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 146-147; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 274.
- ¹⁸¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 210.

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- ¹⁸² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 210; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p.92; Exhibit P-75, tab 3, doc. 1087-L, pp. 5-130.
- ¹⁸³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 210.
- ¹⁸⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 210.
- ¹⁸⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 225 [Emphasis added].
- ¹⁸⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 149-150.
- ¹⁸⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 132.
- ¹⁸⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 132-133.
- ¹⁸⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 133.
- ¹⁹⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 133.
- ¹⁹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 133 and 135.
- ¹⁹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 137.
- ¹⁹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 133-134.
- ¹⁹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 207.
- ¹⁹⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 137.
- ¹⁹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 245.
- ¹⁹⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 150-151.
- ¹⁹⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 151.
- ¹⁹⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 151-152.
- ²⁰⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 225-226.
- ²⁰¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 227.
- ²⁰² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 221-222.
- ²⁰³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 217-218.
- ²⁰⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 177-179.
- ²⁰⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 5-6 and 26.
- ²⁰⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 224-228.
- ²⁰⁷ Exhibit P-75, tab 5, doc. 1087-N, p. 42.
- ²⁰⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 227-228; Exhibit P-75, tab 4, doc. 1087-M, pp. 111-114.
- ²⁰⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 71-75.
- ²¹⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 76.
- ²¹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 76.
- ²¹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 76-77; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 54.
- ²¹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 78.
- ²¹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 77.

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- ²¹⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 78-79.
- ²¹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 84.
- ²¹⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 175.
- ²¹⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 238-239.
- ²¹⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 7.
- ²²⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 286-289.
- ²²¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 224-228.
- ²²² Exhibit P-3, Collection C, vol. 1, tab 3, doc. 1088-C.
- ²²³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 214.
- ²²⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 196.
- ²²⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 197-198.
- ²²⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 201-202.
- ²²⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 33-34.
- ²²⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 35.
- ²²⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 261.
- ²³⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ²³¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 27; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 160-161, 192-193 and 252-253; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 118-119; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 156-157.
- ²³² See Exhibit P-2, Collection B, vol. 2, tab 1, doc 1087-B, p. 40.
- ²³³ Exhibit P-2, Collection B, vol. 2, tab 2, doc 1087-C, p. 50.
- ²³⁴ Exhibit P-6, Collection F, vol. 1, tab 55, doc 1292, p. 2; Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 5-6; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 3 October 2012, p. 269.
- ²³⁵ Testimony of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 138-139.
- ²³⁶ Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 169-170.
- ²³⁷ Exhibit P-6, Collection F, vol. 1, tab 24, doc. 1171, p. 2.
- ²³⁸ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, p. 139-140; Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 182-183; Testimony of Maj Jared, Transcript of Proceedings, vol. 9, 12 April 2012, pp. 128-129.
- ²³⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 27; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 160-161.
- ²⁴⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 118-119.
- ²⁴¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 252-253.
- ²⁴² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 94-95, 160-161 and 192-193.
- ²⁴³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 156-157.
- ²⁴⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 156-157.

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- ²⁴⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 160-161.
- ²⁴⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 28.
- ²⁴⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221.
- ²⁴⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ²⁴⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 284.
- ²⁵⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 120-121.
- ²⁵¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 120.
- ²⁵² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 122 and 139.
- ²⁵³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 122.
- ²⁵⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc 1087-C; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.
- ²⁵⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1346-1347; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 69-70.
- ²⁵⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 98-100.
- ²⁵⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 101.
- ²⁵⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 101.
- ²⁵⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 286.
- ²⁶⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 161.
- ²⁶¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 275-276.
- ²⁶² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 235.
- ²⁶³ Exhibit P-75, tab 2, doc. 1087-K, p. 50 [Emphasis added].
- ²⁶⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 147.
- ²⁶⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 124-125.
- ²⁶⁶ Exhibit P-6, Collection F, vol. 1, tab 52, doc. 1199.
- ²⁶⁷ Exhibit P-75, tab 2, doc. 1087-K, pp.68-70; Exhibit P-96, doc. 1379.
- ²⁶⁸ *Fasken v. Fasken*, [1953] 2 SCR 10, [1953] 3 DLR 431 at para 12 (SCC).
- ²⁶⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 112-113.
- ²⁷⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 229.
- ²⁷¹ Exhibit P-75, tab 2, doc 1087-K, pp. 72-80 [Emphasis added].
- ²⁷² Exhibit P-75, tab 3, doc. 1087-L, pp. 33 [Emphasis added].
- ²⁷³ Exhibit P-6, Collection F, vol. 1, tab 24, doc. 1171, pp. 2-3; Exhibit P-6, Collection F, vol. 1, tab 52, doc 1199; Exhibit P-75, tab 3, doc 1087-L, pp. 31, 35, 76 and 148-156.
- ²⁷⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 288.
- ²⁷⁵ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D, pp. 34-35; Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E, p. 25.
- ²⁷⁶ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D, pp. 52-53; Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E, pp. 25 and 32.

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- ²⁷⁷ Exhibit P-162, doc. 1444, p. 1.
- ²⁷⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 227.
- ²⁷⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 27.
- ²⁸⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 39-40.
- ²⁸¹ *Constitution Act, 1867* (UK), 30 &31 Vict, c 3, reprinted in RSC 1985, App II, No.5, s. 91 and 92.
- ²⁸² Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 1.
- ²⁸³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 120-122; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 154-155.
- ²⁸⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 34-36 and 38.
- ²⁸⁵ *Funeral Services Act*, RSA 2000, c F-29.
- ²⁸⁶ *Adult Interdependent Relationships Act*, SA 2002, c A-4.5.
- ²⁸⁷ *Funeral Services Act, General Regulation*, Alta Reg 226/1998, s.36(2).
- ²⁸⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 869-870.
- ²⁸⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 38.
- ²⁹⁰ *Adult Interdependent Relationships Act*, SA 2002, c A-4.5.
- ²⁹¹ *Adult Interdependent Relationships Act*, SA 2002, c A-4.5, s. 3(1).
- ²⁹² Testimony of Sheila Fynes, Transcript of Proceedings, vol.17, 7 May 2012, pp. 179-180; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 161-162.
- ²⁹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 32.
- ²⁹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 220-221.
- ²⁹⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 142-143.
- ²⁹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 146.
- ²⁹⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 831.
- ²⁹⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 25.
- ²⁹⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 287. He also identified a fifth interview with LCol King but noted later in the Plan that the interview was “not required.”
- ³⁰⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 135-136.
- ³⁰¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 152-153.
- ³⁰² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 152-153.
- ³⁰³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 40-42.
- ³⁰⁴ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 16-24.
- ³⁰⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 158-159.
- ³⁰⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 283-284.
- ³⁰⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 284.
- ³⁰⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 283-285.
- ³⁰⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 82-84.
- ³¹⁰ Testimony of Capt Hubbard, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 54-55.

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- ³¹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 122 and 139.
- ³¹² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 6.
- ³¹³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 7.
- ³¹⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 38 and 119-121.
- ³¹⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 61-63.
- ³¹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 188-190 and 213; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 97.
- ³¹⁷ Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H, pp. 33-36; Testimony of Sgt Weir, Transcript of Proceedings, 15 May 2012, vol. 22, pp. 37-38.
- ³¹⁸ Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, 25 April 2012, vol. 15, pp. 191-193.
- ³¹⁹ Testimony of Sgt Weir, Transcript of Proceedings, 15 May 2012, vol. 22, pp. 37-38.
- ³²⁰ Testimony of MCpl (Ret'd) Fitzpatrick, Transcript of Proceedings, 25 April 2012, vol. 15, p. 193
- ³²¹ Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H.
- ³²² Testimony of LCol Cadieu, Transcript of Proceedings, vol. 8, 11 April 2012, p. 171; Exhibit P-70, doc. 1358, p. 26.
- ³²³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 49-50; Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 171; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 91, 127; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 79.
- ³²⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 47; Testimony of Mrs. Fynes, Transcript of Proceedings, 26 April 2012, vol. 16, pp. 172-173.
- ³²⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 196.
- ³²⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 210.
- ³²⁷ Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 172.
- ³²⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 195.
- ³²⁹ Exhibit P-2, Collection B, vol.2, tab 1, doc. 1087-B, p. 40; Exhibit P-2, Collection B, vol.2, tab 2, doc. 1087-C, p. 54; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 30.
- ³³⁰ Exhibit P-2, Collection B, vol.2, tab 1, doc. 1087-B, p. 40; Exhibit P-2, Collection B, vol.2, tab 2, doc. 1087-C, p. 54; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 30.
- ³³¹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 50.
- ³³² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 50.
- ³³³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 271.
- ³³⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 173; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 96.
- ³³⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 153-154.
- ³³⁶ See Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 246 and 287.
- ³³⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 113-114.
- ³³⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 287.
- ³³⁹ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 71-72.

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- ³⁴⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 172; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 21.
- ³⁴¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 172.
- ³⁴² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 4.
- ³⁴³ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 4.
- ³⁴⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 28.
- ³⁴⁵ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 3.
- ³⁴⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 77-78, 81-85, 213-216, 1346-1347 and PDF pp. 82-84; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 119 and 121-122; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 1-2, 13-14, 27-32, 117 and 155.
- ³⁴⁷ Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 184-185 and 188; Testimony of Dirk Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, pp. 110-111.
- ³⁴⁸ Testimony of Dirk Velthuisen, Transcript of Proceedings, vol. 19, 9 May 2012, p. 109.
- ³⁴⁹ Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 114-115; Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, pp. 205-206.
- ³⁵⁰ Testimony of Sheila Fynes, Transcript of Proceedings, vol. 16, 26 April 2012, p. 185; Testimony of Sheila Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 172.
- ³⁵¹ Exhibit P-4, Collection D, vol. 6, tab 12, doc. 511.
- ³⁵² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp.27-32, 117 and 155; Exhibit P-2, Collection B, vol. 2, tab 1, 1087-B, pp. 40, 119 and 121-122.
- ³⁵³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 155.
- ³⁵⁴ Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 161-164.
- ³⁵⁵ Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 165.
- ³⁵⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 120; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 119-129; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp.152-153; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 168-170; Testimony of Sheila Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 172.
- ³⁵⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1347.
- ³⁵⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 67.
- ³⁵⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 69.
- ³⁶⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 68.
- ³⁶¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 70.
- ³⁶² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 578.
- ³⁶³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 869-870.
- ³⁶⁴ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 119; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 104.
- ³⁶⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 104-106.
- ³⁶⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1107-1109.
- ³⁶⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 34-37, 56-57, 59-60, 77-78 and 81-85.
- ³⁶⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1346-1347.

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- ³⁶⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc 1087-B, pp. 118-119 and 121-122; Exhibit P-2, Collection B, vol.2, tab 2, doc. 1087-C, pp. 9-11 and 105; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 1-2, 8-9, 13-14, 27-32, 117 and 155.
- ³⁷⁰ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, p. 2; Testimony of Patrick Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 7, 17 and 34-39.
- ³⁷¹ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 43 and 48-51.
- ³⁷² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 4.
- ³⁷³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 245.
- ³⁷⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 65-66.
- ³⁷⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 20-21.
- ³⁷⁶ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 65-66.
- ³⁷⁷ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 65-66.
- ³⁷⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 155.
- ³⁷⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p.175.
- ³⁸⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 188-189.
- ³⁸¹ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G; Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H.
- ³⁸² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 154; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 166-167.
- ³⁸³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 20-21.
- ³⁸⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 154.
- ³⁸⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 156.
- ³⁸⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 28.
- ³⁸⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p.140; Testimony of LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, p. 139.
- ³⁸⁸ Exhibit P-4, Collection D, vol. 5, tab 7, doc. 405.
- ³⁸⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 28.
- ³⁹⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 221.
- ³⁹¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 92-95.
- ³⁹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 281.
- ³⁹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 275-276 and 278-279.
- ³⁹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 276-277; Transcript of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 136-137; Testimony of LCol Cadieu, Transcript of Proceedings, vol.8, 11 April 2012, p. 168.
- ³⁹⁵ Transcript of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 136-137; Testimony of LCol Cadieu, Transcript of Proceedings, vol.8, 11 April 2012, p. 172.
- ³⁹⁶ Transcript of Maj Lubiniecki, Transcript of Proceedings, vol. 6, 5 April 2012, pp. 136-137; Testimony of LCol Cadieu, Transcript of Proceedings, vol.8, 11 April 2012, pp. 172-173; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 526 and 573.

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- ³⁹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 217.
- ³⁹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 281; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 227.
- ³⁹⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 115-117.
- ⁴⁰⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 116; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 71 and 110-111; Exhibit P-3, Collection C, vol. 1, tab 3, doc. 1088-C, p. 33.
- ⁴⁰¹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 4.
- ⁴⁰² Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 9; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 6.
- ⁴⁰³ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 11-12.
- ⁴⁰⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 5.
- ⁴⁰⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 26-27; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 170-171.
- ⁴⁰⁶ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 146.
- ⁴⁰⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 143; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 58-59.
- ⁴⁰⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 26-27; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 121-122.
- ⁴⁰⁹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 16-17 and 23-25.
- ⁴¹⁰ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 21-22.
- ⁴¹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 11-12.
- ⁴¹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 11-12.
- ⁴¹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 57, 62; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 115.
- ⁴¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 11-12.
- ⁴¹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 12-13.
- ⁴¹⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 129.
- ⁴¹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 52-53; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 129; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 57.
- ⁴¹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 233.
- ⁴¹⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 272-273.
- ⁴²⁰ Testimony of MCpl Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 53-54.
- ⁴²¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 58.
- ⁴²² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 7.
- ⁴²³ See Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 13-14; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 5-6.
- ⁴²⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 5-6.

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- ⁴²⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 7.
- ⁴²⁶ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 69-70.
- ⁴²⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 69-70.
- ⁴²⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 11.
- ⁴²⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 3-4.
- ⁴³⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 71-72; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 31, 95 and 105-106; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 27-28 and 89-90.
- ⁴³¹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 83.
- ⁴³² Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 33.
- ⁴³³ Exhibit P-147, tab 1, doc. 1422, pp. 115-116 and 119.
- ⁴³⁴ Testimony of MCpl Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 39-41, 65 and 88-92.
- ⁴³⁵ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 84, 126 and 131-132.
- ⁴³⁶ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 84 and 203.
- ⁴³⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 81-88; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 145-147.
- ⁴³⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 143.
- ⁴³⁹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 94 and 99; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 116-117; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 62-63.
- ⁴⁴⁰ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 100; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 64-65 and 89; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 120.
- ⁴⁴¹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 101-102.
- ⁴⁴² Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 139-140.
- ⁴⁴³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 133-134.
- ⁴⁴⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 65-66.
- ⁴⁴⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 66 and 89-90.
- ⁴⁴⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 99.
- ⁴⁴⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 288.
- ⁴⁴⁸ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D, pp. 49-52; Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E, pp. 27-32.
- ⁴⁴⁹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p.136; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 135.
- ⁴⁵⁰ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 69-70.
- ⁴⁵¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 162.

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- ⁴⁵² Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 104-108; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 133 and 171-172.
- ⁴⁵³ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 35-36.
- ⁴⁵⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 172.
- ⁴⁵⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 34-36 and 106; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 171-172.
- ⁴⁵⁶ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 7-8; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 6.
- ⁴⁵⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 16, 26 April 2012, p. 6.
- ⁴⁵⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 6.
- ⁴⁵⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 108.
- ⁴⁶⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 108-109.
- ⁴⁶¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 118-122.
- ⁴⁶² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 123.
- ⁴⁶³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 225.
- ⁴⁶⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 225-226.
- ⁴⁶⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 249-250.
- ⁴⁶⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 109-110.
- ⁴⁶⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 110.
- ⁴⁶⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 110-111; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 284; Exhibit P-70, doc. 1358, pp. 3-4; Exhibit P-147, tab 1, doc. 1422, pp. 53 and 55-56.
- ⁴⁶⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 111.
- ⁴⁷⁰ Testimony of Shaun Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 183; Testimony of Shaun Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 241-242; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332; Testimony of MS McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 96-97 and 288.
- ⁴⁷¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 196.
- ⁴⁷² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 93.
- ⁴⁷³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ⁴⁷⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 93-95; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 196.
- ⁴⁷⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 206-207.
- ⁴⁷⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1263.
- ⁴⁷⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 209-210.
- ⁴⁷⁸ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, pp. 2-3.
- ⁴⁷⁹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 9 and 12; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 6, 167 and 174.

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- ⁴⁸⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 219-221; Exhibit P-2, Collection B, vol. 2, tab 2, doc.1087-C, pp. 55 and 57-58; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 282-283; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 13-14; Testimony of MCpl Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 39; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 255-256.
- ⁴⁸¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 29, 221, 224 and 286-287.
- ⁴⁸² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 43-44.
- ⁴⁸³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 135-136 and 272.
- ⁴⁸⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 29, 224 and 286-287.
- ⁴⁸⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 269-270; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 298-299; Testimony of MCpl Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 75-76; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 86
- ⁴⁸⁶ Exhibit P-183, tab 26, doc. 1486, p. 1.
- ⁴⁸⁷ Exhibit P-183, tab 26, doc. 1486, pp. 1-2.
- ⁴⁸⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 107.
- ⁴⁸⁹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 127-128.
- ⁴⁹⁰ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 129.
- ⁴⁹¹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 134-135.
- ⁴⁹² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1196.
- ⁴⁹³ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 136-137; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 138.
- ⁴⁹⁴ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 136 and 138.
- ⁴⁹⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1351-1353.
- ⁴⁹⁶ Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G, pp. 76-78.
- ⁴⁹⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1359-1361.
- ⁴⁹⁸ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D, pp. 49-52.
- ⁴⁹⁹ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D, pp. 56-57.
- ⁵⁰⁰ Testimony of LCdr Gendron, Transcript of Proceedings, vol. 21, 14 May 2012, p. 44.
- ⁵⁰¹ Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E, pp. 27-31.
- ⁵⁰² Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E, pp. 27-32.
- ⁵⁰³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 136; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 172; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 104.
- ⁵⁰⁴ Exhibit P-183, tab 26, doc. 1486, p. 1.
- ⁵⁰⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 56.

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- ⁵⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518.
- ⁵⁰⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1100.
- ⁵⁰⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 4-5.
- ⁵⁰⁹ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, p. 2.
- ⁵¹⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 295.
- ⁵¹¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp.112-114.
- ⁵¹² Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F; Exhibit P-2, Collection B, vol. 2, tab 6, doc. 1087-G; Exhibit P-2, Collection B, vol. 2, tab 7, doc. 1087-H.
- ⁵¹³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 426-428, 1023 and 1143.
- ⁵¹⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 19, 27, 29, 31 and 39-40.
- ⁵¹⁵ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 52-53.
- ⁵¹⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 99.
- ⁵¹⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 134; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1024.
- ⁵¹⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 132-134.
- ⁵¹⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 79-80.
- ⁵²⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 175.
- ⁵²¹ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 52.
- ⁵²² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 98.
- ⁵²³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 79-81.
- ⁵²⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 98.
- ⁵²⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1196.
- ⁵²⁶ Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E.
- ⁵²⁷ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, p. 4.
- ⁵²⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p.1100.
- ⁵²⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 114-115, 172 and 221.
- ⁵³⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1196.
- ⁵³¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 172.
- ⁵³² See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁵³³ Exhibit P-4, Collection D, vol. 12, tab 68, doc. 1095.
- ⁵³⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1198; Exhibit P-147, tab 3, doc.1424, pp. 64-68.
- ⁵³⁵ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁵³⁶ Exhibit P-147, tab 2, doc. 1423, pp. 45-46.
- ⁵³⁷ Exhibit P-147, tab 2, doc. 1423, pp. 45-46.

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- ⁵³⁸ Exhibit P-147, tab 2, doc. 1423, p. 60.
- ⁵³⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1058.
- ⁵⁴⁰ Exhibit P-147, tab 2, doc. 1423, p. 70.
- ⁵⁴¹ Exhibit P-147, tab 1, doc. 1422, p. 102.
- ⁵⁴² Exhibit P-147, tab 1, doc. 1422, p. 105.
- ⁵⁴³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1096.
- ⁵⁴⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1100.
- ⁵⁴⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 184.
- ⁵⁴⁶ Exhibit P-147, tab 2, doc. 1423, pp. 202-205.
- ⁵⁴⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 268; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 27-28.
- ⁵⁴⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 63.
- ⁵⁴⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 237.
- ⁵⁵⁰ Exhibit P-147, tab 1, doc. 1422, pp. 118-120.

4.4 THE 2010 CRIMINAL NEGLIGENCE INVESTIGATION

Allegations

1. Shaun and Sheila Fynes make a number of allegations to the Commission concerning the conduct of the 2010 CFNIS investigation into their complaints against members of the LDSH chain of command and the military medical community for their treatment of Cpl Stuart Langridge prior to his death. They allege the CFNIS failed to properly address the issues to be investigated, and failed to properly investigate the potential criminal or service offences committed by members of the LDSH chain of command.¹ They also allege the CFNIS failed to investigate their allegations concerning the LDSH's failure to follow suicide prevention policies and the failure to conduct SIs following Cpl Langridge's suicide attempts.² The Fynes allege the investigation was aimed at exonerating members of the LDSH of any responsibility for Cpl Langridge's death.³ They further allege the CFNIS members involved in the investigation lacked the skills, professionalism, experience and training necessary to conduct this investigation.⁴ Finally, the Fynes allege the investigation was not completed within a reasonable time.⁵

The Fynes' Complaint to the CFNIS

2. This investigation file was opened following complaints made by the Fynes to members of the CFNIS WR detachment concerning alleged CF culpability in their son's death. The Fynes alleged members of the LDSH chain of command and the military medical community were negligent in their care of Cpl Langridge prior to his death and were negligent by failing to prevent his death.⁶ The allegations centered mainly on the care Cpl Langridge received on base and the conditions placed upon him in March 2008, shortly before his death, and/or the alleged suicide watch put together by LDSH.

3. On April 22, 2010, Maj Daniel Dandurand informed WO Blair Hart by email he had been contacted by the Fynes, and "they want to lodge a complaint/allegation of

Criminal Negligence against those who were responsible for Cpl Langridge's care.”⁷ On May 5, 2010, Maj Dandurand and MCpl David Mitchell met with the Fynes at CFB Esquimalt to take their complaint.⁸ The Fynes provided them with a lengthy account of their complaints and the facts they believed founded those complaints.

4. Mrs. Fynes was concerned about the medical care received by Cpl Langridge from the civilian and military medical systems. From the evidence, it is known that on the night of January 31, 2008, or early February 1, Cpl Langridge put a noose around his neck in an attempt to hang himself at home⁹ and on February 1, 2008, Cpl Langridge was admitted for a short stay crisis admission at the Royal Alexandra Hospital.¹⁰

5. During the May 5 meeting, Mrs. Fynes told the investigators Cpl Langridge attempted to kill himself on February 1 and was taken to hospital.¹¹ She referred to clinical notes and a Form 1 Admission Certificate completed by Dr. Melissa Butler, a physician at the base clinic where Cpl Langridge presented himself that morning, in which his suicidal ideation and past suicide attempts were noted.¹² Mrs. Fynes stated Cpl Langridge was discharged on February 4, 2008 despite having a further suicide attempt not long before (in fact, the previous evening).¹³ Mrs. Fynes claimed hospital personnel discharging Cpl Langridge made him sign a discharge note indicating he was leaving against doctor's advice when he was actually being forced out.¹⁴ The next day, Cpl Langridge drove himself to the AHE where he was committed for thirty days.¹⁵ The Fynes' complaint focused on the involvement of the LDSH in Cpl Langridge's care and on the investigations following his death.

6. According to the Fynes, toward the end of his stay at AHE, Cpl Langridge attempted to make plans to attend drug rehabilitation at a residential treatment facility.¹⁶ He offered to stay on at AHE as a voluntary patient until rehabilitation was available and to pay for his own travel.¹⁷ Despite this, he was ordered by his chain of command to leave AHE and return to Base. Dr. Bernard Sowa, his treating physician at AHE who had agreed to keep him on as a voluntary patient, was said to have testified at the BOI he had called the Base and confirmed Cpl Langridge was ordered to return.¹⁸ According to the

Fynes, this order was made in spite of Cpl Langridge having shown signs of improvement towards the end of his admission, as evidenced by his clinical records.¹⁹

7. The Fynes alleged, the day Cpl Langridge was ordered out of hospital, on March 5, 2008, he was transported directly to a group therapy session on base led by Dennis Strilchuk, where, given his discomfort with group therapy settings, he experienced an anxiety attack, left the session and collapsed in the parking lot.²⁰ As they understood it, Mr. Strilchuk reportedly lost his temper with Cpl Langridge and discharged him from care.²¹ The Fynes also alleged the Regiment should not have been given responsibility to watch Cpl Langridge:

[...] the regiment should never have been responsible for him. He was sick. He should have been in the hospital. The regiment should never have been passed with babysitting him. They were the wrong people, doing the wrong thing.²²

8. The Fynes alleged the LDSH had made no plans for Cpl Langridge's living arrangements despite having ordered him to return to Base, and alleged from March 5 to 7, 2008, he lived in his car.²³ They maintained the failure to have a plan in place was evidenced by two affidavits provided to them by the CF when they were attempting to have Cpl Langridge's Registration of Death amended. These affidavits reportedly provided different addresses for Cpl Langridge, only one of which was for the Duty Centre where he was required to live prior to his death. To their mind this indicated a failure on the part of the Regiment to know where he was living.²⁴

9. The Fynes went on to allege Cpl Langridge was forced on March 7, 2008, to accept a series of conditions restricting his movements and activities under false pretenses. They claimed the conditions were presented to Cpl Langridge by the LDSH as "structure" or accommodation, but were, in fact, a form of discipline.²⁵ In support of this claim, Mr. Fynes cited a passage from the 2008 Sudden Death Investigation Report in which CWO Douglas Ross, the Regiment RSM, had stated the conditions were orders and Cpl Langridge could be charged for failing to follow them.²⁶ He alleged there were further records indicating the conditions were "imposed" or "placed on" Cpl Langridge²⁷ and that MCpl William Fitzpatrick had been ordered to start documenting him for discipline. The conditions allegedly forced Cpl Langridge to live at the Duty Centre so

his discipline was public and embarrassing, amounting to an attempt to destabilize him and cause him to act out in order to give the CF grounds to discharge him.²⁸ In Mr. Fynes' view, Cpl Langridge was pressured into accepting the conditions on the basis that adhering to them would be the only way he could attend rehabilitation²⁹ even though (as he alleged in pointing to Capt Mark Lubiniecki's interview during the 2008 investigation)³⁰ the decision had already been made he was not going to be attending rehabilitation. In Mr. Fynes' words, "They were screwing with him."³¹ Meanwhile, according to Mr. Fynes, the LDSH had decided to keep a record to document the case for discipline.³²

10. Those responsible for imposing the conditions had allegedly characterized them as having been requested by Cpl Langridge despite the fact the conditions were orders. The Fynes claimed he was forced to acquiesce to them as the AHE could not re-admit him as a voluntary patient after he left, and he had been repeatedly discharged from the Royal Alexandra Hospital after crisis admissions.³³

11. They further alleged Capt Richard Hannah was negligent in imposing the conditions without adequate awareness of Cpl Langridge's medical conditions. They pointed to Capt Hannah's witness statement to the CFNIS during the 2008 investigation in which he reported he was unsure whether Cpl Langridge had been diagnosed with PTSD as evidence he was not in a proper position to approve the conditions.³⁴ They maintained Capt Hannah had never met Cpl Langridge prior to imposing the conditions and only met with him for ten minutes for that purpose.³⁵

12. Cpl Langridge allegedly protested he had not agreed to the conditions and wanted them changed after they were imposed. The Fynes told the investigators he attended at sick parade on March 11, 2008, and requested the conditions be relaxed because he felt embarrassed. When his request was denied, he stated he would rather kill himself than return to his Unit under the conditions.³⁶ Cpl Langridge was said to have again expressed his disagreement with the conditions on March 14, 2008. He phoned the Fynes to say he was embarrassed by the conditions and had told this to Capt Lubiniecki. Cpl Langridge told them Capt Lubiniecki had said, if he made it through the weekend, the chain of

command would look at relaxing the conditions. Cpl Langridge also reported he was told he would be going to Homewood (a residential drug rehabilitation treatment centre in Ontario) in two to three weeks.³⁷

13. The Fynes stated they had contacted the Regiment a few days before Cpl Langridge's death and were told he was under a "suicide watch,"³⁸ was living in the defaulters' room and was safe.³⁹ Mr. Fynes argued the LDSH was negligent in this regard as either Cpl Langridge was, at the time of his death, under a suicide watch that did not follow protocol or was otherwise defective, or he ought to have been under a suicide watch if, in fact, he was not.⁴⁰ The Fynes claimed they were not aware Cpl Langridge had been provided a barracks room (the room where he committed suicide) until after his death.⁴¹ They also claimed witnesses in the course of the BOI testified there was no such thing as a suicide watch in the military.⁴²

14. Finally, the Fynes made allegations the LDSH leadership had not complied with CF suicide prevention requirements. They alleged the CO LDSH was required to have a suicide prevention protocol in place and "if they were following it, in this case it was defective. If they weren't following it, there's your negligence right there."⁴³ They also stated there is supposed to be a Summary Investigation (SI) following any suicide attempt, but in Cpl Langridge's case, while there was one following his June 2007 suicide attempt, there were no others for his subsequent known attempts.⁴⁴

15. The essence of the complaint was captured in a comment made by Mrs. Fynes to Maj Dandurand and MCpl Mitchell:

I think, ultimately, he was [...] their soldier, okay? At the very end of the day, he belonged to the military. You sign the dotted line, you know you belong to the military. And if the military tells you to do something, you do it. And you do it unquestioningly, right? But there's -- that contract has two people in it. And just as Stuart had an obligation to do what the military told him, they had a responsibility to look after him.

They can't ever say they didn't know that he was sick or suicidal. But we maintain what they chose to do was they saw a drunk, they saw an addict, and they were going to get him out the back door.⁴⁵

16. Shortly afterwards, Mrs. Fynes was even more direct, declaring, “They killed him.”⁴⁶ Mr. Fynes, similarly, told Maj Dandurand and MCpl Mitchell, “I will go to my grave, [convinced] they killed our son [...]”⁴⁷

17. Mrs. Fynes told the investigators their complaint was made against Cpl Langridge’s chain of command.⁴⁸ When asked who she believed was “the most responsible and the most negligent,” she named CWO Ross and Capt Hannah.⁴⁹ Mr. Fynes also blamed “[w]hoever made the decisions to pull [Cpl Langridge] out of the hospital,” whom Mrs. Fynes stated she believed to be Capt Lubiniecki.⁵⁰ Mr. Fynes interjected to say he did not believe Capt Lubiniecki made that decision.

18. In the course of making their complaint, the Fynes identified several issues with the 2008 Sudden Death Investigation and with the subsequent BOI, which they believed demonstrated that investigators pursuing their present complaints should not rely on the reports of those investigations. Mrs. Fynes observed, and Maj Dandurand agreed, the BOI had a different purpose in conducting its investigation than a police investigation.⁵¹

19. Beyond the distinction in purpose, the Fynes claimed the BOI was of no value to the CFNIS investigation because of a number of process issues. Mrs. Fynes alleged the entire inquiry was “scripted,” claiming conflicting testimony was not challenged to determine what was accurate, and the inquiry was slanted towards proving Cpl Langridge was a drug addict so as to absolve the chain of command of any liability for his death.⁵² Mr. Fynes supported this allegation by pointing to the fact the doctor who diagnosed Cpl Langridge with PTSD was not called to testify at the BOI.⁵³ In addition, Mrs. Fynes alleged they were not permitted to participate in either process despite a requirement for BOIs to allow participation by the families of decedents in questioning and discussion.⁵⁴ She also alleged having overheard a conversation one evening after the BOI hearings where the OC for Cpl Langridge’s squadron, Maj Jared, would have commented to the BOI President, “Well, how are you supposed to get rid of these fucking guys?”⁵⁵

20. Mrs. Fynes complained there were inconsistencies in the testimony of witnesses in the 2008 Sudden Death Investigation and these were not addressed. As well, she complained of inaccuracies in the report.⁵⁶ She referred to the investigation report

generally as a “hatchet job that’s being done in an attempt to absolve people’s responsibility.”⁵⁷

21. The Fynes supplemented their verbal complaint with a written one,⁵⁸ dated May 5, 2010, and delivered during the interview,⁵⁹ addressed to Maj Dandurand in his capacity as OC CFNIS WR, and signed by Mr. Fynes. The letter states Mr. Fynes was making a formal request to the CFNIS to conduct further investigation into the circumstances of Cpl Langridge’s sudden death. It points to “sections 215(1)(c), 217.1 and 219.1”⁶⁰ of the *Criminal Code* of Canada as being potentially applicable to the case. These sections concern the duty to provide the necessities of life, the duty of supervisors to take steps to prevent bodily harm to any person working under their direction, and criminal negligence (though, in fact, criminal negligence is dealt with in sections 219 and 220 of the *Criminal Code*, and not section “219.1”).⁶¹ The letter makes a number of allegations echoing the verbal complaint, claiming Cpl Langridge was either under a suicide watch that was deficient, or ought to have been under a watch if he was not.⁶² It states, “Stuart’s death was absolutely preventable had he been given the medical treatment to which any soldier is entitled. His lack of treatment and imposed discipline went far beyond cavalier to, in my opinion, Criminal Negligence.”⁶³

Assurances Provided by CFNIS Investigators

22. In the course of taking the Fynes’ complaint, Maj Dandurand gave a number of assurances about the investigation and how it would be conducted.⁶⁴ These related mainly to: the manner in which the investigation would be conducted, including its scope, and the number of investigators; the involvement of the command team; a plan to review documents and witnesses; and the Fynes’ involvement in the case as witnesses.

23. The first assurance to the Fynes was that there was an onus on the CFNIS to investigate their allegations once they made a formal complaint.⁶⁵ Mrs. Fynes asked Maj Dandurand, “So my question, then, for you is that once we formally make this allegation [...] is there an onus upon you to investigate them?”⁶⁶ Maj Dandurand replied, “Yes.”⁶⁷

Mrs. Fynes then asked, “You have to investigate?”⁶⁸ Maj Dandurand again answered, “Yes.”⁶⁹

24. Maj Dandurand told the Fynes a new GO file would be created:

[...] so that we can say that the scope of the investigation is this. Because we look at the elements of the offence of what [an] allegation entails, and then we pursue down that investigative path.

There is no doubt with this that there will be a revisit of all documents. What we want to do is make sure that, if there’s something that snuck into a Board of Inquiry testimony here or a piece of paper or evidence there, it’s not missed.

So we revisit everything that’s available, and then we go looking for anything else that we say, “You know what, nobody ever thought to ask this question, and we’re going to go in, we’re going to pluck that and...”⁷⁰

25. Maj Dandurand told the Fynes the investigation would be conducted employing a major case management model, a form of investigation involving what he referred to as the “command triangle,” employed where the size of the file requires it.⁷¹ Maj Dandurand explained major case management involves three or more investigators and was necessary in this case due to “not only the volume of interviews that have to occur, but the manner and the order in which they have to occur.”⁷² Although he speculated he could assign two investigators, Maj Dandurand stated he believed the case would grow much larger and he would “need to analyze the work that has to occur with respect to this in order to investigate these three [*Criminal Code* offences] right here.”⁷³ He stressed major case management is employed to maintain the speed, direction and flow of an investigation.⁷⁴

26. Maj Dandurand stated the CFNIS would be moving as fast as possible in this investigation, though he speculated the early goings might be slow due to the vast amount of research required.⁷⁵ At several times in the course of the interview, he told the Fynes they would be updated on the investigation’s progress every two weeks,⁷⁶ though he was cautious to warn them to temper their expectations as to what could be achieved in two weeks’ time.⁷⁷ He went a step further, telling the Fynes he and MCpl Mitchell would be in contact “[...] literally. Not just for updates. We’ll probably pick your brain on something as well.”⁷⁸

27. Maj Dandurand was clear in telling the Fynes that, although the BOI would be reviewed, it would not be relied upon as fact by investigators. He stated it was the “first port of call” for the investigators,⁷⁹ allowing them to see what witnesses had said in order to formulate questions and lines of inquiry before re-interviewing the witnesses.⁸⁰

28. The Fynes were given two specific assurances with respect to issues they had identified as having been left outstanding following the 2008 investigation, BOI and SI. MCpl Mitchell told the Fynes he would investigate where Cpl Langridge was living prior to his death, because they complained the information contained in the SI was wrong.⁸¹ Maj Dandurand also told the Fynes he would find out why Cpl Langridge was living at the Duty Desk, as they complained the issue was still unresolved.⁸²

29. Maj Dandurand stressed the CFNIS considered this case very important, as shown by him personally flying out to take the Fynes’ complaint.⁸³ He made a general assurance with respect to the investigation, stating:

I give you this promise, if I say that a charge is merited, I have the reasonable [probable] grounds, as defined by all of police practices, I will lay that charge.

Equally, if I say that the charge is not warranted, I will have the justification for that statement.

It will be investigated without bias, right through to the truth. We will uncover the truth of what happened.

[...]

And that's all we can commit to you, is that that's what we do. We pride ourselves on excellence, truth and duty in the NIS. Those three things.⁸⁴

Translating Words into Deeds

30. Coming out of the May 2010 interview with Mr. and Mrs. Fynes, it was apparent Maj Dandurand recognized the Fynes were seeking a distinct and comprehensive investigation concerning the possibility members of the LDSH and the military medical community were criminally negligent in their son’s death.⁸⁵ Mrs. Fynes went so far as to ask Maj Dandurand to take away from their meeting the message that “I really need to look closer.”⁸⁶ Maj Dandurand’s statements indicated he also understood the proposed

investigation of their complaints should not rely on information from the BOI report and more was required.⁸⁷ The BOI had not been conducted with the same aims or to the standard required for a police investigation. The Fynes were, moreover, emphatic they did not trust the explanations offered for Cpl Langridge's treatment.⁸⁸ They stated the BOI witnesses would say "[...] whatever moves the heat from them [...]," and that such witnesses were in fact afraid of being implicated in negligence.⁸⁹ Maj Dandurand made it clear to the Fynes he understood the BOI report could not be taken at face value. He told them, even though the report and its annexes might serve as a starting point, the CFNIS would have to interview the relevant witnesses themselves and revisit every document.⁹⁰ In the same vein, he later testified he knew the BOI report alone would not constitute an adequate factual record for the criminal negligence investigation.⁹¹

31. Maj Dandurand was also aware the Fynes did not believe he could rely on the 2008 Sudden Death Investigation Report. The Fynes had stressed to Maj Dandurand and MCpl Mitchell they believed the 2008 Sudden Death Investigation Report was sorely lacking, being incomplete, inadequate, and often incorrect.⁹² Mrs. Fynes went so far as to say "[...] there's a pile of crap in there, I gotta tell you."⁹³ Maj Dandurand explained to the Fynes an investigator must take all information received into account and record it in the file, even if the information was false, in order to ensure nothing is omitted.⁹⁴

32. With Maj Dandurand's express acknowledgment of the rigorous investigative work that would be required to investigate the Fynes' serious allegations, it remained to be seen how MCpl Mitchell and the CFNIS WR investigative team would put this understanding – indeed, this *commitment* – into practice.

33. Shortly after the complaint intake interview with Mr. and Mrs. Fynes, members of the CFNIS WR began to consider the investigative implications of their allegations. MCpl Mitchell recorded a rough plan in his notebook at the conclusion of the interview, indicating he planned to: (1) open a GO file; (2) research case law related to the *Criminal Code* sections complained of; and (3) request BOI annexes.⁹⁵ On May 7, 2010, MCpl Mitchell recorded the initial complaint into SAMPIS, noting CFNIS WR assumed investigative responsibility and he had "[...] been tasked to conduct an investigation into

the allegation that the LdSH(RC) CoC and Medical community were negligent when failing to provide appropriate support for Cpl LANGRIDGE.”⁹⁶

34. During the interview with the Fynes, there was no indication the investigative process Maj Dandurand described to the Fynes was contingent upon some prior step, or that the promised investigation would not ultimately be what followed.⁹⁷ Nevertheless, the initial work on the file was scant. By May 10, 2010, just five days after the interview with the Fynes, the decision was made to seek legal advice before taking further action. MCpl Mitchell testified he sat down with Maj Dandurand and had a “brainstorm” session involving a discussion of what was known from the three investigations,⁹⁸ and at this or at another discussion they considered the volume of work “that was entailed in the entire situation.”⁹⁹ His recollection was he and Maj Dandurand agreed he would conduct an assessment of the file before proceeding to any investigation, and they decided to seek a legal opinion. MCpl Mitchell also testified his understanding was they deemed it unnecessary to actually adopt a major case management approach to the file.¹⁰⁰ MCpl Mitchell contacted Maj Anne Litowski on May 10 to obtain a “legal assessment.”¹⁰¹ MCpl Mitchell was unavailable to actively work on the file between May 10 and May 21, 2010, as he was tasked with completing his PLQ course.¹⁰² A File Status Report from CFNIS WR dated May 12, 2010, stated an assessment was being conducted on the file, documents from the BOI and SI were being reviewed, and the investigative complexity of the alleged offences and the severity of the alleged offences were “Low.”¹⁰³

35. Within days of the intake interview with the Fynes, WO Hart, the initial case manager for the file, had a discussion with Maj Dandurand and MCpl Mitchell about the allegations.¹⁰⁴ He himself did not have more than “a very basic understanding” of the circumstances of Cpl Langridge’s death, essentially being aware only that Cpl Langridge was living in Unit lines, had to check in periodically, and was under “some form of assistance and supervision to assist him during that time.”¹⁰⁵ Knowing only this, he believed the offences alleged weren’t appropriate.¹⁰⁶ WO Hart testified the investigators’ consensus from this first look was also that they didn’t believe the allegations were applicable in this case, stating “[...] based upon our experience as investigators, based upon our time doing the job, it just didn’t seem like appropriate charges or matters to

investigate.”¹⁰⁷ WO Hart testified that, following this initial assessment by the CFNIS WR,¹⁰⁸ the decision was made “relatively quickly” that the Fynes’ complaint could not be substantiated.¹⁰⁹

36. When asked about WO Hart’s evidence, Maj Dandurand testified he recalled discussing the allegations with WO Hart and MCpl Mitchell,¹¹⁰ but emphasized he wished to foster in the CFNIS WR office an environment of healthy debate with respect to interpreting the *Criminal Code*.¹¹¹ He explained these allegations were new territory for him, and he did not wish to decide one way or another whether the criminal negligence offences were applicable. He stated he wished to seek external advice first, and he denied this discussion meant they were “pre-positioning ourselves with respect to our mindset on this investigation.”¹¹² Despite WO Hart’s early conclusion, Maj Dandurand reiterated these views had not coloured his assessment of the investigation early on, stating, “And that’s the beauty of a Major Crimes unit, is you can have differing opinions, and I think that’s the strength of it.”¹¹³

37. There is reason to believe the discussion amongst the CFNIS WR members nevertheless had some impact on the direction and vigour of the ensuing action on the file. Very little was in fact done, and this stands in stark contrast with the sweeping assurances made by Maj Dandurand during the May 2010 interview with the Fynes. Acting on direction from his superiors and the discussions they held, MCpl Mitchell essentially did only two things for the file, both in May 2010. First, he compiled certain documents he identified as relevant for the assessment. Second, he sent the matter on for a legal opinion.

38. Maj Dandurand testified he relied on the interpretations and experience of his investigative team and on external advice to support the conclusion the offences could not be made out.¹¹⁴ This reliance would have been justifiable to the extent the interpretations were founded on an adequate factual basis.

39. MCpl Mitchell testified he did not review each and every relevant document in the course of his assessment. He explained this was because he felt sufficiently familiar with the facts of the case from his work on the 2009 investigation.¹¹⁵ He stated that in

order to form his own initial opinion of the case, he reviewed:¹¹⁶ an excerpt of Cpl Rohmer's CFNIS interview summary from the 2008 investigation;¹¹⁷ the interview summary from the 2008 CFNIS interview with Capt Lubiniecki;¹¹⁸ a document prepared by MCpl Ritco titled "MED DOC TIMINGS";¹¹⁹ a draft of the BOI Report;¹²⁰ and an Admission Certificate (Form 1) prepared for Cpl Langridge on February 1, 2008, by Dr. Butler at CFB Edmonton along with two pages of handwritten medical notes from the base clinic made on February 1 and February 4, 2008.¹²¹ These documents were not scanned into the 2010 investigation file, and MCpl Mitchell conceded he should have done so for the benefit of any successor to the file.¹²²

40. MCpl Mitchell did not include the 2008 GO file in this compilation. In fact, he testified he never read the 2008 file.¹²³ During his review, he only referred to the 2008 Case Summary and the handful of other excerpts (including those listed above) scanned into the 2009 GO file.¹²⁴ MCpl Mitchell testified he did not review any documents at the time he compiled them because his May 2010 PLQ course intervened.¹²⁵ The only activity he undertook before his time was occupied by coursework was to compile these documents and send off his request for the legal opinion.¹²⁶

41. Beyond these documents, MCpl Mitchell did not, at any point, specifically review or compile any documents to satisfy himself he possessed complete information concerning the knowledge Cpl Langridge's chain of command had concerning his past suicide attempts.¹²⁷ He did not seek out documents specifically concerning whether or not Cpl Langridge may have had PTSD.¹²⁸ MCpl Mitchell did not compile any specific information about the existence or non-existence of a suicide watch above and beyond the documents listed above.¹²⁹ He did not conduct any investigation or seek out any information about Mrs. Fynes' allegation she was assured Cpl Langridge was safe and was being watched constantly.¹³⁰ MCpl Mitchell also did not specifically seek out and compile information about the allegation Cpl Langridge may have been denied medical treatment.¹³¹ He also did not investigate or seek out information about the reasons for the conditions placed upon Cpl Langridge or any links between the work assigned to Cpl Langridge and his suicidal ideation.¹³² MCpl Mitchell testified these issues would have been explored had the decision been made to conduct a subsequent investigation.

42. MCpl Mitchell did not identify any suspects,¹³³ interview any witnesses,¹³⁴ speak to the investigators from the 2008 Sudden Death Investigation, or even obtain the BOI testimony and evidence annexes¹³⁵ as he had initially planned to do. MCpl Mitchell acknowledged in his testimony he did not take any investigative steps beyond compiling documents and sending off a request for advice.¹³⁶

43. MCpl Mitchell's assessment also seems to have focused only on the *Criminal Code* offences listed in Mr. Fynes' letter. MCpl Mitchell stated any service offences, such as the negligent performance of a military duty, would only have been considered if, upon assessment of the criminal offences, the decision was made to conduct an investigation.¹³⁷

44. This is somewhat difficult to understand. *Code of Service Discipline* offences would not have been derivative of, or dependent upon, establishing the elements of the *Criminal Code* offences. Part III of the *National Defence Act (NDA)* sets out the *Code*.¹³⁸ Section 124 of the *NDA* reads: "Every person who negligently performs a military duty imposed on that person is guilty of an offence and on conviction is liable to dismissal with disgrace from Her Majesty's service or to less punishment."¹³⁹ Section 129(1) of the *NDA*, which might also have been relevant, states "Any act, conduct, disorder or neglect to the prejudice of good order and discipline is an offence and every person convicted thereof is liable to dismissal with disgrace from Her Majesty's service or to less punishment."¹⁴⁰ Section 129 is a section often utilized when doubt exists that a more serious charge under the *NDA* (such as under s. 124) is appropriate.¹⁴¹

45. The Fynes had argued members of the LDSH chain of command owed a duty of care to Cpl Langridge by virtue of their positions, and they breached the standard of care in ordering him from hospital and imposing suspect conditions on him. A similar allegation was echoed against members of the military medical community. The Fynes also specifically claimed there was a CF policy requiring COs to employ a suicide prevention protocol. By failing to have such a protocol in place or failing to follow the protocol, the Fynes alleged the LDSH chain of command breached the standard of care.

The allegations, if verified, could plausibly have constituted service offences, and these should have been assessed alongside the *Criminal Code* offences.

46. On May 10, 2010, MCpl Mitchell sought a legal opinion concerning the Fynes' allegations.¹⁴² Because of claims of privilege asserted¹⁴² by the Minister of National Defence,¹⁴³ we do not know and cannot know what materials were sent. We also do not know and cannot know what advice the CFNIS investigators were later provided.

47. Whatever documents were sent, the legal advisor could not have had access to more than what the investigators had themselves gathered. WO Hart agreed with the proposition that the quality of the legal advice obtained with respect to the applicability of a given charge in a given set of circumstances would only be as good as the information provided about the specific circumstances.¹⁴⁴ WO Hart testified he was satisfied a comprehensive effort had been made to ascertain the applicable circumstances before the CFNIS WR assessment and the subsequent legal assessment.¹⁴⁵ He also testified, however, that to the extent any documents compiled and sent on for an external assessment might have included material from the 2008 investigation, there would not have been any indication the Fynes had lodged objections to how that investigation was conducted.¹⁴⁶ Maj Dandurand testified it was "absolutely" his view that in order to obtain a good legal analysis, it was necessary to ensure there was a complete factual record that could be consulted.¹⁴⁷ Maj Dandurand testified the BOI would not have been an adequate factual record for the assessment, at least, "[n]ot independently."¹⁴⁸ When asked whether he believed the 2008 investigation was an adequate factual record, Maj Dandurand testified he believed "[t]he totality of our investigations would have been what we would have expected to be considered."¹⁴⁹

48. In fact, however, the documents MCpl Mitchell assembled as being necessary for the file¹⁵⁰ were very limited in scope and detail. Even if the entire 2008 GO file was considered and made available to an outside advisor, this Commission has found the 2008 Sudden Death Investigation was deeply flawed and extremely limited in its understanding and assessment of potential negligence.¹⁵¹ The investigators in that case overlooked many significant witnesses, reached questionable conclusions, and failed to identify or pursue a

number of significant issues – particularly with respect to Cpl Langridge’s last weeks, the decisions about his treatment, and the arrangements made by the LDSH and the military medical community to provide supervision and care for him and to ensure his safety.

49. The allegations made by the Fynes in their interview with Maj Dandurand and MCpl Mitchell were, for the most part, not pursued or even considered during the course of the 2008 investigation. In particular, the 2008 GO file contained no information whatsoever about the following allegations:

- The allegation Cpl Langridge was forced to accept a return to Base from hospital;
- The allegation the conditions imposed on Cpl Langridge were intended to set him up to fail and thus to justify discharging him from the Canadian Forces;
- The allegation Cpl Langridge acquiesced to the conditions imposed upon him as a condition of being sent to a substance abuse treatment facility;
- The allegation Mrs. Fynes had been assured in March 2008 Cpl Langridge would be watched 24/7 and was being kept safe;¹⁵²
- The allegation the LDSH CO failed to implement a suicide prevention protocol or any factual underpinnings for this alleged failure; and
- The allegation the LDSH CO failed to conduct SIs as required by CF policy or any factual underpinnings for this alleged failure.

50. The BOI was also an unacceptable source of factual information for the CFNIS assessment and an unreliable source of information for any legal opinion. It consisted of the CF’s own conclusions about the matter based on their own investigation. The facts had not been gathered in accordance with police methods or with police-driven investigative aims. Having not obtained the annexes, the investigators did not even have access to the actual evidence assembled, (however imperfectly gathered), and could not see for themselves whether the manner in which it was collected left gaps. The CFNIS members could only access the BOI’s description of the evidence where said evidence was being used to support its findings.

51. The term “fruit of the poison tree” was used in the testimony of the subjects,¹⁵³ and WO Hart testified he understood the term to mean inculpatory information obtained by compulsory interviews in which the witness was not given a caution, and which would accordingly be unusable in a subsequent prosecution.¹⁵⁴ He also understood it to mean this tainted evidence could not even be used as a springboard for the CFNIS’ own subsequent investigation. In light of the weaknesses of the evidence and the dangers of using it, WO Hart testified it was unsafe to rely on a BOI to provide a factual basis for an investigation.¹⁵⁵

52. Relying on this material would have been completely improper from an independence perspective and from the perspective of the investigation itself.¹⁵⁶ Maj Dandurand testified he believed some of the information contained in the BOI could be relied upon “to an extent,” however, and that the information would be weighed in making an assessment.¹⁵⁷ WO Hart testified he was unaware of any circumstances in which the CFNIS “[...] would strictly rely upon that information without further substantiating it ourselves.”¹⁵⁸ WO Sean Bonneteau assumed the lead investigator would only have used the BOI as “background information,” and believed every investigator knows the appropriate weight to place on the documents they review, but stated, if any of the information was to be used in a criminal investigation, it would indeed be fruit from the poison tree.¹⁵⁹

53. The absence of comprehensive and accurate information about the circumstances underpinning the allegations meant the legal opinion would have been of limited value as a foundation for any investigative assessment by CFNIS WR.

The “Assessment” Concludes

54. There was almost no activity on the file after May 2010. On August 17, 2010, MCpl Mitchell contacted Mr. Fynes and provided an update. He reported to Maj Dandurand, he “Spoke to Shaun. Everything went fine. He seemed to be appreciative. Explained exactly what we talked about and he was happy with the explanation.”¹⁶⁰ Neither MCpl Mitchell¹⁶¹ nor Maj Dandurand¹⁶² could recall what Mr. Fynes was told,

though MCpl Mitchell recalled in testimony he would have provided an update “as to where I stood,” and advised Mr. Fynes another investigator would be taking over the file.¹⁶³ Mr. Fynes’ recollection of the last update was that MCpl Mitchell indicated he was seeking advice from superiors.¹⁶⁴

55. By this time, however, it appears CFNIS WR members had already decided to close the file. An August 14, 2010, File Status Report¹⁶⁵ concerning the 2010 Criminal Negligence Investigation states simply, “File to be concluded.”¹⁶⁶ MCpl Mitchell was taken off the file in mid-August because he was departing in September 2010 to undertake the residency portion of his PLQ course in preparation for an RCMP secondment that November.¹⁶⁷ No report of any activity appears in the file throughout the fall of 2010. Indeed, WO Bonneteau, who became the CFNIS WR Operations WO in the summer of 2010, testified his understanding was there was no investigation beyond obtaining the legal opinion.¹⁶⁸

56. An email message sent that October by Maj Francis Bolduc, the DCO CFNIS, confirms the decision that no charges were warranted had been made some time previously. In his October 28, 2010, message to the CFPM, Col Timothy Grubb, Maj Bolduc advised that the investigative assessment was complete and had concluded there was “nothing [to] indicate that a Code of Service offence or criminal offence such as criminal negligence causing death may have occurred.”¹⁶⁹

57. Maj Dandurand testified it was ultimately his decision to close the file and not proceed further.¹⁷⁰ He testified he would likely have concluded the charges were unlikely to have merit after “receiving input from external sources.”¹⁷¹ Because of solicitor/client privilege claims made on behalf of the Minister of National Defence, the Commission does not know and cannot know the content of the external input. The dates of the File Status Report and Maj Bolduc’s email establish that the CFNIS assessment was completed by the fall of 2010 and presumably before mid-August, 2010.

Sgt Shannon's Briefing

58. Sgt Scott Shannon joined CFNIS WR as a team leader in August 2010.¹⁷² He was not involved in the 2010 investigation before the winter of 2010/2011. At that time, WO Bonneteau tasked Sgt Shannon with preparing a briefing for the CFNIS WR chain of command for both the 2009 and the 2010 investigations.¹⁷³ Sgt Shannon testified he was assigned this task in February 2011,¹⁷⁴ although his notebook suggests he was tasked with this on December 10, 2010.¹⁷⁵ Whatever the case may be, his work would clearly have been informed by what was done before and the decisions made previously.

59. Sgt Shannon stated:

So upon receiving that task I read the file, the limited information that was available.

I took the letter of allegation that was presented to the NIS by Mr. Fynes. I conducted an independent and thorough review of the allegations that he presented.

I conducted an evaluation of the three *Criminal Code* sections that he identified in his letter.

I conducted an extensive case law review for the specific allegation of criminal negligence causing death.

And I determined through my own independent analysis of the *Criminal Code* and available case law that those applicable offences did not apply in this situation and, therefore, the task of offence validation which is part of a general investigation sequence was not successful and therefore there was no need to conduct any type of investigation into that matter.¹⁷⁶

60. Sgt Shannon's efforts must be understood in context. The decision had already been made to conclude the file. His role was to produce a PowerPoint presentation explaining to his chain of command what had already been decided.¹⁷⁷ MCpl Mitchell was never replaced by a new lead investigator when he was taken off the file in August 2010. It is fair to deduce this was because there was no need. Sgt Shannon's role was not to conduct an investigation or even to advance the file, and it is evident he was not expected to do so. Sgt Shannon was not given enough time to accomplish anything of the sort. At the earliest, he would have begun work on the briefing in mid-December 2010, just before Christmas holidays began, and (in addition to his regular caseload) his time for this would be divided with the briefing for the 2009 investigation. Whatever time he

did ultimately spend on the 2010 briefing, Sgt Shannon's evidence suggests he did most of his research and preparation on his own time during the weekends leading up to the briefing.¹⁷⁸ There was nothing left to do from an investigative perspective, and it is simply not the case Sgt Shannon conducted any further investigation. In essence, Sgt Shannon's task was to explain the thought process underlying the decision to close the file without further investigation.

61. Sgt Shannon stated his role "[...] was limited to an academic evaluation of the complaint," stressing he confined his analysis to Mr. Fynes' written complaint.¹⁷⁹ He also testified he considered his work to have been independent of any assurances or representations about the conduct of the investigation made by Maj Dandurand to the Fynes.¹⁸⁰ In the case of Maj Dandurand's promise to revisit all documents in detail and to re-interview witnesses, Sgt Shannon testified he did not take these steps because he never got past the analysis of the offence.¹⁸¹ Sgt Shannon also testified he did not believe this case met the requirements for the use of major case management.¹⁸² In fact, he never spoke to Maj Dandurand about his expectations for the investigation.¹⁸³

62. During the PIH, Sgt Shannon was asked how he prepared for the briefing. He testified he first identified the elements of each of the three *Criminal Code* offences cited by Mr. Fynes and then referred to jurisprudence noted in his annotated police officer's edition of the *Criminal Code* in order to get a better sense of these statutes.¹⁸⁴ Strikingly, Sgt Shannon testified "[...] it was clear that the conduct defined by those statutes does not apply in this case in any way, shape or form."¹⁸⁵ When asked if this meant he didn't feel it was necessary to do a review of the facts on hand before deciding the offences weren't applicable to the allegations, he answered that this was correct.¹⁸⁶ He elaborated by stating "[t]he defined conduct of those three sections does not apply at all in any way, shape or form to the incidents and to the history of this case."¹⁸⁷

63. On February 18, 2011, Sgt Shannon provided his briefing to the CFNIS WR command team with the aid of a PowerPoint presentation.¹⁸⁸ In the "Allegations" section of the presentation, there is a list of the three *Criminal Code* sections mentioned in Mr. Fynes' letter,¹⁸⁹ followed by a very brief summary of Mr. Fynes' allegations. The

presentation indicates “Mr Fynes does not accuse a specific individual of this alleged negligence nor did Mr Fynes provide any “new” evidence to support allegations [*sic*].”¹⁹⁰ The presentation then summarizes Sgt Shannon’s findings regarding each alleged offence, along with his ultimate conclusion none of the allegations were substantiated.

SGT SHANNON’S “OFFENCE VALIDATION”

64. In preparing the PowerPoint presentation, which would set out the basis for that conclusion, Sgt Shannon employed an analytical framework he referred to as an “offence validation.” According to him, this assessment involved setting out the elements of an offence and “[...] apply[ing] an examination of every piece of evidence and we conclude whether we can or cannot establish the elements of the offence.”¹⁹¹ With specific regard to the 2010 investigation, Sgt Shannon testified he:

[...] identified the elements of the offence for each of the three Criminal Code offences identified by Mr. Fynes and I proceeded to conduct a case law review and a law review to determine if the substance of those three statutes met the circumstances of the case as I knew them to be at that time.¹⁹²

65. Sgt Shannon did no original investigation.¹⁹³ The Commission understands Sgt Shannon’s evidence as indicating he believed he undertook a sufficient review of the law and the facts to allow him to feel confident in the accuracy of his presentation. He testified he saw no need to review the documentary record before conducting this assessment because he was content to rely on knowledge he acquired during a prior review. To the extent the PowerPoint presentation was merely intended to summarize the thinking and conclusions of others, this is a reasonable way of proceeding. To the extent the PowerPoint presentation may have been based on Sgt Shannon’s own analysis of the documentary record, it would be much more difficult to justify. Sgt Shannon did review material clearly related to the criminal negligence allegations including the 2008 investigation file and the BOI draft report.¹⁹⁴ However, he did this review of several hundred pages months before, in the context of an unrelated investigation about the appointment of a PNOK following Cpl Langridge’s death.¹⁹⁵ This would be entirely inadequate for the purposes of analyzing a file whose subject matter is the conduct of the CF in terms of medical treatment and support leading up to Cpl Langridge’s suicide.

66. Because of the Commission's conclusions as to the inadequacy of the factual basis for the offence validation exercise, it is not necessary to deal in detail with the legal analysis in the PowerPoint presentation. In general, however, the legal analysis in the presentation dealing with the elements of the three *Criminal Code* offences under consideration is open to a number of questions.

Duty to provide the necessaries of life

67. With respect to Mr. Fynes' allegation the CF failed to provide the necessaries of life, Sgt Shannon's presentation states section 215(1)(c) of the *Criminal Code* "creates a legal duty to provide necessary care to persons under their charge due to detention, age, illness, mental disorder."¹⁹⁶ It notes the person under charge must be unable to remove himself from that charge and unable to provide himself with the necessaries of life: food, clothing, shelter, and medical attention.¹⁹⁷ It concludes none of the elements of the offence of failing to provide the necessaries of life were made out by the facts of this case.¹⁹⁸

68. In testimony, Sgt Shannon elaborated on his analysis, providing his view Cpl Langridge was not under detention because he was not under a legal arrest. Sgt Shannon maintained the conditions did not constitute detention as Cpl Langridge "was free to come and go. He had to report in every two hours. In between, he could go wherever he wished."¹⁹⁹ Sgt Shannon stated Cpl Langridge was able to remove himself from the Regiment by disobeying the "lawful orders" he was under and could "face the consequences" if he chose to do so.²⁰⁰ This is an unusual interpretation of being "free to come and go." Sgt Shannon went on to say he did not conclude Cpl Langridge was under the charge of LDSH by reason of mental disorder because he did not believe Cpl Langridge had ever been diagnosed with a mental disorder. He testified he did not take any steps to confirm whether Cpl Langridge had been so diagnosed, relying on his memory of his file review.²⁰¹ He added he could not comment on whether suicidal ideation or alcohol and drug addictions could fall within the definition of mental disorders, twice stating "I'm not a psychiatrist."²⁰² Sgt Shannon simply did not have sufficient facts to assess the meaning of "mental disorder" in the context of criminal

negligence. To the extent they were even considered during the offence validation, the medical records in the 2008 GO file were incomplete, and Sgt Shannon did not attempt to gather further records from Cpl Langridge's civilian hospitalizations.

69. Sgt Shannon testified he did not consider whether taking steps to ensure Cpl Langridge could not commit suicide fell under the duty to provide the necessaries of life because it is not possible to understand why Cpl Langridge took his life.²⁰³ While he accepted it is possible to foresee a person's risk of committing suicide, he could not see this carrying into a discussion of failing to provide the necessaries of life.²⁰⁴ It should be noted here, at least in passing, however, the jurisprudence suggests the phrase "necessaries of life" may include "protection of the person from harm."²⁰⁵ Accordingly, further assessment of this complex legal duty was very probably required.

Duty of persons directing work

70. The PowerPoint presentation also considers the duties of persons directing work in light of section 217.1 of the *Criminal Code*. It concludes none of the elements of the offence were made out in this case.²⁰⁶ It notes:

- [T]his section creates a legal duty to take reasonable steps to prevent bodily harm to that person or any other person arising from that work task[.]
- The senior officer who is responsible [...] departs [...] markedly from the standard of care that, in the circumstances could reasonably be expected to prevent a representative of the organization from being party to the offence[.]²⁰⁷

71. The presentation goes on to note:

- Cpl Langridge was not at "work" at the time of death as he was in his barrack room[;]
- no aspect of his employment duties contributed to the circumstances of his death[; and]
- [t]he "directions" given by superiors on work performance did not contribute to his death[.]²⁰⁸

72. In testimony, Sgt Shannon elaborated on his thought process in analyzing this section. He stated the essence of the offence is a departure from, or failure to comply with, the legal duty to take reasonable steps to prevent bodily harm to a person in

circumstances where an employer directs work.²⁰⁹ He agreed the officer-subordinate relationship is a form of employer-employee relationship.²¹⁰ He had earlier testified he relied on Capt Lubiniecki and Capt Hannah's statements as proof Cpl Langridge had accepted the conditions²¹¹ and was adamant Cpl Langridge's consent had to be considered in determining whether the conditions were imposed upon him.²¹² Sgt Shannon reiterated Cpl Langridge was in his barrack room and not at work at the time of his death.²¹³ He added this section of the *Criminal Code* did not apply if Cpl Langridge took his life due to conditions imposed upon him at work, but while he was not *at work*.²¹⁴ Despite even the BOI's conclusion Cpl Langridge was "on duty" at the time of his death,²¹⁵ Sgt Shannon did not appear to consider the issue of whether the conditions requiring Cpl Langridge to reside on base and to report every two hours, which applied at the time of his death, meant Cpl Langridge was "at work" when he died.

73. Sgt Shannon ultimately concluded no aspect of Cpl Langridge's employment duties contributed to his death. In his view, Cpl Langridge's statement to medical professionals that he would rather kill himself than return to his Unit did not create a connection between his employment duties and the circumstances of his death.²¹⁶

Criminal negligence causing death

74. The presentation also concludes none of the elements of the offence of criminal negligence causing death were made out by the facts of this case.²¹⁷ It notes, "Criminal negligence can arise from either acts or omission, if the accused was under a legal duty to do the omitted act. If the act or omission shows a wanton or reckless disregard for the lives or safety of other persons, this makes out criminal negligence."²¹⁸ In the discussion of the offence, it states, "no evidence to suggest that any individual member of the CF contributed to decision making process of Cpl Langridge," and "no member of the CF had any knowledge of the intentions of Cpl Langridge on 15 Mar 08."²¹⁹ The analysis concludes by noting an organization can be held criminally responsible as a party to an offence of criminal negligence if a member of the organization acting within the scope of her or his authority contributed to or caused the negligence.²²⁰

75. Although Sgt Shannon concluded there was no evidence to suggest any member of the CF had contributed to Cpl Langridge's decision-making process,²²¹ he did not seem to question whether it was, in fact, a necessary element of the offence that someone knew of Cpl Langridge's *specific intention* on the day he committed suicide, as opposed to knowing only that Cpl Langridge was a danger to himself at that point.²²² When asked about his view of this, he stated, "in this situation the date that's critical and the only important date would be the 15th of March, because prior to the 15th of March, Corporal Langridge was among us."²²³

76. Sgt Shannon told the Commission it was his conclusion, based on his case law review and analysis of the elements of the offence, that the LDSH's actions could not constitute criminal negligence causing death as there was no precedent he could find to establish such a link in a case of suicide.²²⁴ On the other hand, he did agree precedent is not a requirement when a charge is applied to a novel set of facts.²²⁵ He also agreed the actions detailed in Mr. Fynes' complaint could constitute negligence, though he determined, in this case, they did not.²²⁶ Sgt Shannon stated he believed it was a "logical assumption" there is a "general duty in the Canadian Forces of superiors to protect subordinates from foreseeable harm."²²⁷ However, following his offence validation, he did not believe there was any reason to conduct further investigations with respect to this issue.²²⁸

THE FACTUAL FOUNDATION

77. Any possible errors of law in the PowerPoint presentation are secondary to the fact the conclusions set out in the presentation rely on a questionable foundation of facts which were frequently incompletely understood or wrongly assumed. To the extent the offence validation exercise was intended to be based on, in Sgt Shannon's words, "every piece of evidence" available to him,²²⁹ that foundation was entirely unreliable. There was no factual investigation undertaken, and whatever facts are cited in the presentation or are implicitly relied upon could only have come from an inadequate documentary record or from assumptions with no documentary foundation.

78. Sgt Shannon's testimony that there was no need to review relevant documents before undertaking the assessment for the 2010 Criminal Negligence Investigation is concerning. Sgt Shannon's decision to rely on his recollection of a review of several hundred pages of documents for an unrelated investigation done months previously cannot reasonably be said to be adequate. This review of documents focused on the 2008 and 2009 GO files as well as documents related to the SI.²³⁰ To the extent some of the documentary material collected for the 2009 investigation was relevant to the issues in the 2010 investigation, that material could only have been found in the BOI report. As has been discussed elsewhere,²³¹ the BOI report would not, on its own or possibly at all, be a suitable source for a police investigation in any event. Its problematic status is only amplified by the fact it was only the report itself, containing the BOI's conclusion, which was scanned into SAMPIS, and not the annexes that contain the actual evidence said to have led to these conclusions. As for the 2008 GO file, one of the bases of the Fynes' request for the separate investigation, which became the 2010 investigation, was their dissatisfaction with the 2008 investigation, including its alleged factual inaccuracies and, in their view, dubious conclusions. This Commission has found the 2008 investigation was flawed in ways that include its incomplete factual investigation of the issue of negligence and its inadequate understanding of how negligence might be manifested in the circumstances of the case. Be that as it may, it would appear to be a self-defeating exercise to conduct a fresh investigation, even at the assessment stage, which begins by accepting, without further investigation, facts and conclusions disputed by the complainants.

79. Offence validations or investigative assessments constitute a very preliminary stage of an investigation. Their purpose is to determine whether, without further investigation, enough is known to justify a conclusion the offences being considered cannot be made out. They are techniques often employed to weed out frivolous or vexatious complaints.²³² In this case, given the lack of reliable facts in the documentary record, a potential alternative approach would be to consider whether, even if all the facts alleged by the complainants were true, it would still nevertheless be impossible to satisfy all of the elements of the offence being considered. If there is no possibility, even if the facts alleged were found to be true, of making out the elements of an offence, there is no

use proceeding any further with the investigation. Otherwise, unless there are other valid reasons for exercising discretion not to investigate, the investigation should move on and begin to actually look into the facts. What cannot be done is simply to disregard the alleged facts or assume they are untrue without further investigation.

80. It appears this is precisely what Sgt Shannon did. The Fynes' allegations were not taken as true for purposes of the analysis. Either the facts Sgt Shannon relied on were precisely those said to be unreliable by the Fynes, or he relied only on assumptions.

81. Based on his testimony, it is clear Sgt Shannon did not even consider all of the allegations of facts made by Mr. and Mrs. Fynes during their interview with Maj Dandurand and MCpl Mitchell.²³³ In fact, he had not reviewed the recording for the interview.²³⁴ As such, he would only have been aware of the allegations described in summaries and notes included in the file.²³⁵ He would not have been aware of the allegations made about the suicide watch, the conditions being imposed on Cpl Langridge, the disciplinary measures being imposed on Cpl Langridge, or the negative effect the conditions had upon Cpl Langridge.²³⁶ Sgt Shannon stated he would only have examined such allegations if his investigation had gone past the offence validation stage.²³⁷ That is not the proper procedure for an offence validation.

82. The unavoidable conclusion is Sgt Shannon's "offence validation" did not have an adequate factual basis.

SERVICE OFFENCES

83. Members of the CF are subject to the *Criminal Code* as well as a system of penal military justice as set out in Part III of the *NDA*, known as the *Code of Service Discipline*.²³⁸ The CFNIS can investigate and lay charges for both criminal offences and service offences.²³⁹

84. Whatever the validity of the offence validation exercise described in the PowerPoint presentation with respect to the *Criminal Code* offences, there is no similar exercise set out in the presentation with respect to any potential *Code of Service Discipline* offence. Although the complainants only set out *Criminal Code* offences in

their letter of complaint, it is unreasonable for the police to expect a complainant to be aware of the potential legal categories involved in the facts giving rise to a complaint. Complainants set out the facts they believe demonstrate a wrong has been committed. It is for the police to determine whether those facts amount to a wrong recognized by the law. In the case of the Military Police, that law includes the *Code of Service Discipline*. Many of the complaints made by the Fynes indicated there needed to be an investigation of potential service offences, and it seems this may never have been seriously considered at the assessment stage.

85. When asked whether it was either policy or his practice to consider service offences as alternatives to *Criminal Code* offences, Sgt Shannon testified he generally did consider any potentially applicable service offences.²⁴⁰ He testified, in this case, he considered the potential applicability of the offence of negligent performance of a military duty, but was able to rule it out when ruling out the criminal negligence offence, as he considered the elements to be very similar.²⁴¹ There is nothing in the investigative record dealing with any such analysis, and it does not appear in the PowerPoint presentation. There is no mention of *Code of Service Discipline* offences anywhere in the file or in records related to the 2010 investigation other than in the File Status Reports to CFNIS HQ.²⁴²

MISSING ANALYSIS IN THE ASSESSMENT

86. Each of the potentially applicable *Criminal Code* offences, as well as each of the potentially applicable service offences, such as *NDA* s. 124 and s. 129(1), has in common the notion of a duty to do or not to do something and conduct in contravention of that duty. For each there is also a standard against which the alleged contravention is to be measured, as well as a requisite mental element of wilfulness or recklessness.²⁴³ Whether the elements of any of the offences would actually be made out, would of course depend on the evidence. At the time of Sgt Shannon's offence validation, there were insufficient facts in the documentary record to either establish or refute any of these elements. In the absence of a reliable factual record, the alternative would have been to ask whether, assuming the Fynes' allegations were true, it would still be possible to conclude the

elements of the offence in question could not be made out. Looking at all the elements of the *Criminal Code* offences being considered, as well as the elements of potentially relevant service offences, if the facts as alleged by the Fynes during the course of the May 5, 2010, interview were found to be true, it is not at all clear each and every element could not be made out.

87. If one were to assume the allegations made by the Fynes in the May 5 interview were true, then **if** the military had complete control over Cpl Langridge; **and if** it were true Cpl Langridge was compelled to agree to the conditions, and he had no choice but to abide by them; **and if** it were true that, to the knowledge of the military, he hated the conditions to the extent he preferred to kill himself rather than continue to abide by the conditions; then it might be concluded the military had, under the circumstances, a duty to keep Cpl Langridge safe.

88. Alternatively, **if** the military knew or ought to have known, absent close supervision, Cpl Langridge was in danger of attempting to kill himself; **and if**, despite this knowledge, the military ordered him out of the hospital in which he had been closely supervised; **and if**, in the past, the military had taken steps, either with respect to Cpl Langridge or others, to provide a “suicide watch” or other similar type of close supervision; then on that basis as well, it might arguably be possible to conclude the military was under a duty to provide the sort of close supervision that would keep him safe.

89. This is not to say an offence would have been made out. Each and every one of the allegations assumed to be true would still need to be proven on the facts, and it could well turn out to be the case that one or more of those allegations would not be substantiated through an investigation of the facts. There would also be further issues to resolve, including but not limited to establishing the requisite standard of care in order to assess whether the conduct in question fell below that standard. The facts might also not demonstrate the conduct complained of had any relationship to Cpl Langridge’s death. It might also be that the evidence would fail to demonstrate the requisite mental elements of wilfulness or recklessness applicable to the respective offences.

90. All an offence validation exercise based on an assumption the Fynes' allegations were true would have demonstrated was that it was unsafe to assume, without need for further investigation, that no charges could be warranted based on the facts alleged. If a further investigation were then conducted, its purpose would be to determine whether the allegations were in fact true and, if they were, whether any charges were warranted.

91. The offence validation undertaken by Sgt Shannon was a deeply flawed, inadequate and incomplete exercise, which evidently drew upon the flawed, inadequate and incomplete processes that came before it. The legal analysis was questionable and often relied on incorrect or incomplete facts and unfounded assumptions. This can lead to a suspicion there simply may never have been an intention to conduct an investigation.

92. If the CFNIS was indeed conducting a fresh investigation and not simply recycling the conclusions of the BOI and/or the 2008 investigation, it was not appropriate in assessing the *Criminal Code* or *Code of Service Discipline* offences simply to accept, without further investigation, that the facts were not consistent with the Fynes' allegations.

Failure to Investigate

93. On March 4, 2011, WO Bonneteau drafted the Case Summary for the 2010 Criminal Negligence Investigation:

On 5 May 10, at CFNIS WR, Mr FYNES requested an investigation be initiated into the manner in which Cpl LANGRIDGE was treated by unspecified members of the Canadian Forces which he alleges ultimately contributed to the death of Cpl LANGRIDGE on 15 Mar 08. In addition, Mr. FYNES alleges the inadequate medical treatment and/or care in which Cpl LANGRIDGE received by the Canadian Forces medical community and LdSH(RC), further contributed to his death. In the written complaint, Mr FYNES makes specific reference to s.215(1)(c) Duty to Provide Necessities of Life, s. 217.1 – Duty of Persons Directing Work and s. 219 – Criminal Negligence contrary to the Criminal Code of Canada.[sic]²⁴⁴

94. WO Bonneteau also drafted the Concluding Remarks for the 2010 Criminal Negligence Investigation on March 4, 2011:

This investigation has revealed there is no evidence to suggest any member of the Canadian Forces medical community or members of LdSH(RC) committed the Criminal Code of Canada offences detailed in Mr FYNES letter. [*sic*]

As no further investigative actions are anticipated by the CFNIS WR, this investigation is concluded.²⁴⁵

95. In testimony, WO Bonneteau conceded that when he wrote “there is no evidence,” he meant none of the evidence *forwarded to the legal advisor by MCpl Mitchell* was seen as sufficient to ground the allegation any member of the CF or the military medical community committed a *Criminal Code* offence.²⁴⁶ He also acknowledged, any such “evidence” had only been obtained through document review.²⁴⁷

96. Sgt Shannon drafted a letter to the Fynes providing a basic summary of the conclusions for the 2009 and 2010 GO files²⁴⁸ on March 3, 2011,²⁴⁹ and it was signed by Maj Dandurand on April 27, 2011.²⁵⁰ With respect to the 2010 investigation, it states:

The Canadian Forces National Investigation Service Western Region (CFNIS WR) has completed two detailed and comprehensive investigations regarding the alleged conduct of members of the Canadian Forces with regard to your son, Cpl Stuart Langridge. The allegations were presented to CFNIS WR verbally and in written form by you. [...]

GO 2010 – 12005 – Various Criminal Code Offence(s): [...]

This investigation focused on the allegations you presented in writing on 5 May 2010. In your written correspondence, you requested that CFNIS review the actions of unspecified members of the Canadian Forces regarding issues involving medical treatment and care provided to Cpl Langridge. In your letter, you provided reference to three offences defined by the *Criminal Code* of Canada; [...]

Conclusions of Lead Investigator:

After a complete review of all information and evidence gathered in relation to the manner in which Cpl Langridge received medical care and the manner in which he was provided with personal support by members of the Canadian Forces, the burden of proof required to establish that any of the noted offences were committed by any member of the Canadian Forces was not established by evidence.

The Lead Investigator, based on the review of all evidence, was not able to establish “reasonable and probable grounds” that any member of the Canadian Forces had committed the identified offences noted in your written submission of 5 May 2010. As such, the Lead Investigator did not recommend any charges be preferred at the conclusion of this investigation.

I have reviewed the submissions of the Lead Investigator in this matter and concur with the conclusion(s) that no charges be recommended pursuant to either the *National Defence Act* or the *Criminal Code* of Canada.²⁵¹

97. The evidence available to the Commission does not support the broad claims of thorough review and assessment of all information and evidence.²⁵² The investigators did not assemble sufficient facts to draw conclusions about the assessment. The CFNIS members neither conducted the thought experiment of assuming the facts alleged were true in order to see whether they would then make out the elements of a *Criminal Code* or *Code of Service Discipline* offence, nor did they conduct any actual investigation to confirm or deny the facts as alleged, nor did they otherwise have an adequate independent factual basis to support the conclusions they reached. Instead, they appear simply to have assumed what needed to be proven so as to close the books on the Fynes' complaint.

98. Maj Dandurand acknowledged in his testimony that, if one assumed all of the facts alleged by the Fynes were true, it would not be clear that neither *Criminal Code* nor service offences could be made out.²⁵³ He also acknowledged that it was incumbent on himself and his team to have conducted an investigation to the point where they could confirm or deny those allegations. However, he also believed this is precisely what they did.²⁵⁴ When asked to explain his view the CFNIS investigated the allegations and determined they were false, Maj Dandurand testified his belief was that examining the 2008 Sudden Death Investigation "identified for us facts that were relevant to this and we took those into consideration."²⁵⁵

99. In the rush to close the file, the CFNIS members never did the things they promised to do. Maj Dandurand conceded, he never did uncover "the truth of what happened."²⁵⁶ Moreover, they even did the things they promised they *wouldn't* do, such as taking the previous investigations at face value and relying on them for the assessment.

100. The 2008 investigation was clearly deficient and left many contradictions and discrepancies unresolved. On its own, it was simply incapable of being a sufficient source of facts the investigators could draw upon to form their conclusions. Despite this, and despite the fact the 2008 GO file only contained summaries of witness interviews and those documents gathered by the investigators in what the Fynes alleged (and what the evidence establishes) was a problematic investigation, Maj Dandurand appears to have believed he and his investigative team were able to derive from the file a reliable

assessment of the allegations made by Mr. and Mrs. Fynes and to conclude the allegations were unfounded. However, Maj Dandurand could not say what allegations, specifically, were concluded to be unfounded.²⁵⁷

101. Maj Dandurand was asked what happened to cause the 2010 investigation to depart from his assurances to the Fynes that, in order to get to the truth, it was necessary to interview witnesses who had been interviewed in the prior investigations, not to take anything at face value, revisit all documents in detail, and, in effect, mount a large and complex investigation in order to be sure the investigators had the facts right. Maj Dandurand acknowledged his initial view, based on the Fynes' allegations and concerns about the prior investigations, was that it was likely the CFNIS WR would pursue a criminal investigation. He testified he did not, at that time, anticipate the offences would be viewed as not applicable.²⁵⁸ Once again this appears to be circular reasoning. The only way the offences could be viewed as not applicable would be on the basis of reliable facts. Where the facts as previously found were put in dispute by the Fynes and were incomplete, it would seem difficult to conclude the offences were not applicable because of the facts and then to maintain no factual investigation was necessary because the offences were inapplicable.

102. Again, none of this is to suggest a case for a charge under the *Criminal Code* or for a service offence would have been made out. A factual investigation may well have confirmed facts that would undermine one or more necessary elements of a possible offence and/or evidentiary gaps may have remained that would have made it impossible to make out a charge. There would also have been the issue of *mens rea*, the mental element of the offence. As noted in the discussion of how negligence was investigated in the 2008 investigation,²⁵⁹ it may well be, even if it were possible to demonstrate under the circumstances there did exist a duty for the CF to protect Cpl Langridge from foreseeable harm and that the CF did fail to discharge that duty, there would still remain the important issue of demonstrating the requisite state of mind on the part of those alleged to have failed in their duty. Absent such evidence, it would not have been possible to justify a charge, let alone to contemplate a conviction. It may therefore be the case that a thorough investigation would have led to an entirely justifiable conclusion no

charges should be laid with respect to the Fynes' allegations. The activities of the CFNIS in response to those allegations do not amount to that sort of an investigation or to any investigation at all.

103. It is understandable the investigators would have wanted to take a cautious approach with respect to the allegations made by the Fynes. They were by no means ordinary allegations, and a decision that criminal or quasi criminal negligence charges could be laid on that basis may well have been without precedent. That does not, however, justify dismissing them out of hand without further investigation.

104. In the end, not only did the CFNIS members conduct a deficient assessment, they also failed to honour the commitments made to the Fynes and did not even provide them an explanation for their conclusions.²⁶⁰

Specific Issues Not Investigated

105. While many of the allegations made by the Fynes in the May 5, 2010 interview were dealt with, however imperfectly, in the 2008 Investigation, some of those allegations were never dealt with at all by the CFNIS. Whatever justification there may have been for not conducting a further investigation of matters already dealt with in some way in the 2008 Investigation, there was no justification for failing to investigate direct allegations of fact never previously investigated.

CPL LANGRIDGE'S DISCHARGE FROM THE AHE

106. One issue not pursued in any meaningful way during the 2008 Investigation concerned Cpl Langridge's hospitalization and return to Base. This meant there was insufficient information to assess the Fynes' allegation Cpl Langridge had been forced to return to Base against his will. There is evidence Cpl Langridge wanted to remain at the AHE following his 30-day committal but was ordered to leave by his Unit or otherwise felt he had no choice but to return to the Base if he wanted to undergo substance abuse treatment. The CFNIS investigators possessed, in the 2008 investigation file, Dr. Sowa's

discharge notification from the AHE prepared on March 4, 2008.²⁶¹ Along with the admission note, this made it clear Cpl Langridge had been admitted for 30 days. However, they did not possess the discharge summary subsequently prepared by Dr. Sowa. This report indicated Cpl Langridge agreed to stay at the hospital as a voluntary patient until arrangements could be made for him to attend a drug rehabilitation program:

Our plan was to keep him in the hospital until he could be discharged directly to the military.

[...]

Unfortunately the military called as to inform us and that they actually they did want him back at the Garrison and that they would make their own arrangements for him to be referred to a drug rehab program. We were rather surprised by this as Stuart had indicated his willingness to stay with us in hospital so that could be done.

However based on that request he was escorted the day after his certificates expired directly to the military Garrison and handed over to his sergeant and this was done on the 5th of March 2008. [*sic*] ²⁶² [Emphasis added]

107. Dr. Sowa confirmed these facts in his testimony before the Commission. He was willing to keep Cpl Langridge as a voluntary patient until the arrangements he was trying to make with the rehabilitation centre were confirmed. Dr. Sowa testified it was his understanding the Regiment wanted Cpl Langridge back instead, and this surprised him:

Well, not necessarily [surprised by] the military but, in general, yes, we have difficulties sending patients out. And really with him, it wasn't like I was pushing to discharge him. I really, you know, what I was saying is 30 days are up, we don't necessarily have to renew certificates, he is willing to stay here, but he has to engage in treatment programs as I had previously arranged. And then when the final destination was arranged, he could go directly there. We had no problem with that. If during the course of his stay for the two weeks things turned negative, we always have the option of applying certificates to him again.

But notice I was being more flexible with him.²⁶³

108. Dr. Sowa testified his understanding was the Regiment had its own substance abuse program on the base and Cpl Langridge would attend that program upon his return. In two weeks, arrangements would be made to send him on to residential substance abuse treatment. He felt the treatment goal was important, because Cpl Langridge's addiction was a primary focus, and he was surprised by the requirement to send him back to Base before going on to treatment when Cpl Langridge was already in hospital and could be

sent directly from there. Dr. Sowa testified he confirmed the LDSH decision to have Cpl Langridge return to Base with “Leo,” who he believed was a nurse or counsellor with the base medical team (likely Leo Etienne, a Base Addictions Counselor).²⁶⁴

109. There was also information about Cpl Langridge’s discharge from the AHE in a statutory declaration in support of an application for survivor benefits made in July 2009 by Ms. A.²⁶⁵ The document indicates:

After the 30 days [as a patient], Stuart’s certification was reviewed. His doctor asked that Stuart remain at the hospital for another 30 days. Stuart wanted to stay, as he was finally making progress, and he said that he was scared to leave.

The military requested that Stuart be released into their care, where **they would force him to live under close supervision on the base, for two weeks.** At which time, they would commit to sending Stuart to another Drug/Alcohol rehabilitation center. **Stuart’s time on the base was mandatory in order for the military to continue assisting him with his treatment.**²⁶⁶ [Emphasis added]

110. Had investigators in either the 2008 or the 2010 investigations obtained the AHE records or spoken to Dr. Sowa, Mr. Etienne or Ms. A, they could have learned Cpl Langridge may well have been ordered out of the AHE and forced to return to the Base and comply with whatever measures the Regiment decided to put in place, or, at a minimum, may well have reasonably believed this was the case. However, the possibility Cpl Langridge was ordered to return to the Unit was never investigated by the CFNIS.

DUTY TO IMPLEMENT SUICIDE PREVENTION PROTOCOLS AND DUTY TO CONVENE SUMMARY INVESTIGATIONS

111. MCpl Mitchell²⁶⁷ and Sgt Shannon also never investigated the essentially separate allegation the CO LDSH was under a duty to implement and follow certain suicide prevention protocols and had not done so. The Fynes alleged the LDSH failed to have a suicide prevention protocol (which was indisputably required) and failed to hold an SI after each of Cpl Langridge’s known suicide attempts (which they were indisputably required to do). MCpl Mitchell testified the allegation did not even “ring a bell.”²⁶⁸

112. CFAO 19-44 states that suicide intervention – defined as the “use of measures including confrontation, therapeutic consultation and hospitalization to effectively

manage incidents of suicide and attempted suicide”²⁶⁹ – begins when signs of potential suicidal behaviour are first observed in an individual. It requires that signs and symptoms of potential suicide be reported immediately to medical staff or certain others if medical staff are unavailable. Base commanders and COs are **required “to develop appropriate intervention plans to allow a rapid, coordinated and effective response to reports that an individual displays signs of suicidal behaviour.”**²⁷⁰ The CFNIS never investigated whether the failure to develop and implement such intervention plans could constitute negligent conduct.

113. LCol Pascal Demers testified he had not instituted any intervention policies, relying instead on the guidance of CFAO 19-44 as a “national policy.”²⁷¹ One stipulation in that document was that COs are responsible for ensuring suicide prevention was given appropriate priority in the Unit.²⁷² LCol Demers testified the extent of any educational programs in place in 2007 and 2008 geared to recognizing and responding to the signs and symptoms of suicidal behaviour came in the form of running peer counselling for a “select number of soldiers.”²⁷³ LCol Demers testified suicide prevention was also discussed at some routine safety meetings, directing members who experienced suicidal ideation to seek out medical attention.

114. The allegation of a failure to implement a suicide prevention policy is not a trivial matter. The evidence discloses that Cpl Langridge was displaying behaviour classically associated with a high risk of suicide just before he killed himself, including giving away his belongings.²⁷⁴ The linkage between behaviours like giving away one’s belongings and suicidal intent was specifically discussed by the CF in CFAO 19-44²⁷⁵ and would presumably have formed part of the sort of suicide awareness training contemplated by CFAO 19-44.

115. The CFNIS appears to have done nothing to investigate this allegation.

116. Paragraphs 12 and 13 of CFAO 24-6²⁷⁶ required an SI to be convened after a suicide attempt. LCol Demers testified he did not believe there was any latitude, and “there always must be an investigation.”²⁷⁷ He confirmed it was his expectation if any member of the chain of command or another individual with authority became aware of a

suicide attempt, it should be reported and an SI convened. There is evidence the chain of command was, in fact, aware of multiple suicide attempts by Cpl Langridge,²⁷⁸ and yet only one SI, regarding one attempt, was ever conducted. The CFNIS never investigated whether the LDSH chain of command had knowledge of Cpl Langridge's other suicide attempts and whether the failure to appropriately report the attempts and conduct an SI after each attempt could constitute negligent conduct.

Timeliness

117. The complaints forming the basis of the 2010 investigation were formally made on May 5, 2010. There was initial activity between May 5 and May 12, 2010. There was nominal activity in August 2010, when the assessment was complete and the file was evidently deemed to be concluded. The next activity in the file occurred when Sgt Shannon was tasked with preparing the PowerPoint presentation. Assuming Sgt Shannon was tasked with the briefing in December 2010, as indicated in his notes, rather than February 2011, as indicated in his testimony, a generous estimate suggests this constitutes perhaps 60 days of activity over the course of the nearly one year in which the file was open.

118. Although it was clear by August 2010 that little if anything would now be done in the investigation, the 2010 file remained open and continued to be listed in the File Status Reports and noted as "to be concluded" until May 2, 2011.²⁷⁹ Maj Bolduc testified the file was kept open in case the 2009 investigation yielded evidence to change the assessment.²⁸⁰ A CFNIS WR File Status Report dated November 15, 2010, again indicated the file was to be concluded, and the entry for "Date of last activity" stated only "Waiting for Conclusion of GO 09-34538."²⁸¹ It is not clear how evidence relevant to the issue of who Cpl Langridge's next of kin were might be thought of as relevant to the issue of potential culpability for his death. Although it is true the conclusions reached in the 2010 investigation were not well supported and were premature, and in fact, much more should have been done by the investigators, it is also unacceptable that the file languished and remained open without activity or accountability.

119. As noted elsewhere in the report,²⁸² the Fynes were not regularly updated about the progress of the file. They made it clear they did not require updates every two weeks, but they expected to be kept apprised of significant developments. Nevertheless, they found themselves having to contact the CFNIS WR to remind them of this responsibility. After a promising start to the investigation, and with the complainants having made clear their distrust and lack of faith in the CF and in prior investigations, the delays and the sporadic communication encountered appeared to be more of the same.

120. Overall, it is the responsibility of supervisors to ensure investigations are completed in a timely manner.²⁸³ In this situation, that responsibility ultimately lay with Maj Dandurand as the OC of the detachment.

¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, pp. 3-4.

² Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, pp. 3-4.

³ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 1.

⁴ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 5.

⁵ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, p. 5.

⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 47, 49-54, 92-93 and 124.

⁷ Exhibit P-147, doc. 1422, p. 73.

⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.

⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 474-475; Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 62-63.

¹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 474-477.

¹¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 48-49.

¹² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 48-49 and 119-120; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 475-478.

¹³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 49 and 145-146; Exhibit P-6, Collection F, vol. 2, tab 4, doc. 1296, pp. 43-45.

¹⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 144-146.

¹⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 144.

¹⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 50.

¹⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 51-52.

¹⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 49-52.

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- ¹⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 124.
- ²⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 57-58.
- ²¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 57.
- ²² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 124.
- ²³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 53.
- ²⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 59-61.
- ²⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 64.
- ²⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 66-68.
- ²⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 55.
- ²⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 64-66 and 83.
- ²⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 62-63.
- ³⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 192-193.
- ³¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 63.
- ³² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 64.
- ³³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 53-55.
- ³⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 92-93.
- ³⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 53-54.
- ³⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 56.
- ³⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 91.
- ³⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 46-47.
- ³⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 55.
- ⁴⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 47.
- ⁴¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 55.
- ⁴² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 46-47.
- ⁴³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 117.
- ⁴⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 117.
- ⁴⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 82-83.
- ⁴⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 95.
- ⁴⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 94.
- ⁴⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 115.
- ⁴⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 115-116.
- ⁵⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 116.
- ⁵¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 45-46.
- ⁵² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 130-131.

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- ⁵³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 118-119.
- ⁵⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 108-110.
- ⁵⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 125-126.
- ⁵⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 14-16.
- ⁵⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 16.
- ⁵⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 127-128.
- ⁵⁹ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 117.
- ⁶⁰ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 127.
- ⁶¹ *Criminal Code*, R.S.C. 1985, c. C-46, s. 215(1)(c); s. 217; s. 219; and s. 220.
- ⁶² Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 127-128.
- ⁶³ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 128.
- ⁶⁴ Section 4.5.4, CFNIS Interactions with the Fynes – 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁶⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42.
- ⁶⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42.
- ⁶⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42.
- ⁶⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42.
- ⁶⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42.
- ⁷⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 42-43.
- ⁷¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 130.
- ⁷² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 160.
- ⁷³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 163-164.
- ⁷⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 164-165.
- ⁷⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 165.
- ⁷⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 39-40, 114, 143-144 and 167-168.
- ⁷⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 167-168.
- ⁷⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 143-144 (Maj Dandurand) and 176 (MCpl Mitchell).
- ⁷⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 131-132.
- ⁸⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 133-134.
- ⁸¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 77.
- ⁸² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 142.
- ⁸³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 178.
- ⁸⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 170-171.

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- ⁸⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 132-134, 158-160, 163-166, 170-171 and 173-174.
- ⁸⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 128-129.
- ⁸⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 42-43, 130-131 and 133-134.
- ⁸⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 83-85 and 92-94.
- ⁸⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 83-85.
- ⁹⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 42-43 and 130-134.
- ⁹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 231-232.
- ⁹² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 15-16 and 43-45.
- ⁹³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 43.
- ⁹⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 43-45.
- ⁹⁵ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 5.
- ⁹⁶ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 69.
- ⁹⁷ Section 4.5.4, CFNIS Interactions with the Fynes – 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁹⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 142-144.
- ⁹⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 157-158.
- ¹⁰⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 144-145.
- ¹⁰¹ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 71.
- ¹⁰² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1024.
- ¹⁰³ Exhibit P-147, tab 2, doc. 1423, pp. 142-143.
- ¹⁰⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 108-110.
- ¹⁰⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 113-114.
- ¹⁰⁶ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 113-114.
- ¹⁰⁷ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 108-111 and 113-114.
- ¹⁰⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 108-110 and 117-118.
- ¹⁰⁹ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 108-109.
- ¹¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 224-231.
- ¹¹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 230-231.
- ¹¹² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 230-231.
- ¹¹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 232-233.
- ¹¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 234-235.
- ¹¹⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 145.
- ¹¹⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 2-3.

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- ¹¹⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 45.
- ¹¹⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 48-49.
- ¹¹⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 50-52.
- ¹²⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 302-406.
- ¹²¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 591-593.
- ¹²² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 3-4.
- ¹²³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 19.
- ¹²⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 19-20.
- ¹²⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 95-97.
- ¹²⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 95-100.
- ¹²⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 166-168.
- ¹²⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 168-169.
- ¹²⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 169.
- ¹³⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 169-170.
- ¹³¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 170.
- ¹³² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 170-171.
- ¹³³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 204-210.
- ¹³⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 145-146; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 8-9 and 12-13.
- ¹³⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 22-23.
- ¹³⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 184.
- ¹³⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 10-11.
- ¹³⁸ *National Defence Act*, RSC 1985, c N-5, s. 2, “Code of Service Discipline”; Part III, ss. 55 to 249.26.
- ¹³⁹ *National Defence Act*, RSC 1985, c N-5, s. 124.
- ¹⁴⁰ *National Defence Act*, RSC 1985, c N-5, s. 129(1).
- ¹⁴¹ Exhibit P-163, doc. 1445, pp. 4-5.
- ¹⁴² Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 71; Testimony of Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 97-98.
- ¹⁴³ Section 2.0, The Hearing Process.
- ¹⁴⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 118-119.
- ¹⁴⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 118-119.
- ¹⁴⁶ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 129-130.
- ¹⁴⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 231-232.
- ¹⁴⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 231.
- ¹⁴⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 231-232.

¹⁵⁰ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 183-185; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 1-4.

¹⁵¹ Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 4.1.3, The 2008 Investigation –The Investigation Plan; Section 4.1.4, The 2008 Investigation – The Concluding Remarks; Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping; Section 4.1.9, The 2008 Investigation – The Consequences of Inexperience.

¹⁵² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 46-47 and 55.

¹⁵³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 182-184; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 42-43; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 125-126.

¹⁵⁴ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 125-126.

¹⁵⁵ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 125-126.

¹⁵⁶ Section 4.6, CFNIS Independence and Impartiality.

¹⁵⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 249.

¹⁵⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 124-126.

¹⁵⁹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 42-43 and 171.

¹⁶⁰ Exhibit P-119, doc. 1396, p. 88.

¹⁶¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 200.

¹⁶² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 69.

¹⁶³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 200.

¹⁶⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 54.

¹⁶⁵ Exhibit P-147, tab 2, doc. 1423, pp. 202-208.

¹⁶⁶ Exhibit P-147, tab 2, doc. 1423, p. 205.

¹⁶⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 133-134 and 201.

¹⁶⁸ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 192-193.

¹⁶⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 248.

¹⁷⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 233.

¹⁷¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 224.

¹⁷² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 97.

¹⁷³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1196; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 104-105.

¹⁷⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 104-105.

¹⁷⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1196; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 104-105.

¹⁷⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 105.

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- ¹⁷⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 188-189.
- ¹⁷⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 97-98; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 171-172 and 269-270.
- ¹⁷⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115-116.
- ¹⁸⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 138; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 127-128.
- ¹⁸¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 140-146.
- ¹⁸² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 147-151.
- ¹⁸³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 151.
- ¹⁸⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115-116.
- ¹⁸⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 117-118.
- ¹⁸⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 117-118.
- ¹⁸⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 118.
- ¹⁸⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 76 and PDF pp. 117-152.
- ¹⁸⁹ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 118.
- ¹⁹⁰ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 119.
- ¹⁹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 102-103.
- ¹⁹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115-117.
- ¹⁹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 291-292.
- ¹⁹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 119-121.
- ¹⁹⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1038-1039; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 119-121.
- ¹⁹⁶ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 120.
- ¹⁹⁷ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 120.
- ¹⁹⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 124.
- ¹⁹⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 187-189.
- ²⁰⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 191-192.
- ²⁰¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 189-190.
- ²⁰² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 189-190.
- ²⁰³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 192-194.
- ²⁰⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 194.
- ²⁰⁵ *R. v. Peterson*, 2005 CanLII 37972 (ON CA), 201 CCC (3d) 220; 34 CR (6th) 120; 203 OAC 364 (leave to appeal dismissed, 2006 CanLII 6167 (SCC)) at para. 34: “The phrase “necessaries of life” includes not only food, shelter, care, and medical attention necessary to sustain life but also appears to include protection of the person from harm: *R. v. Popen*, (1981), 60 C.C.C. (2d) 232 (Ont. C.A.) at 240. Thus, s. 215(1)(c) obligations are driven by the facts and the context of each case.”

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- ²⁰⁶ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 128.
- ²⁰⁷ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 125.
- ²⁰⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 127.
- ²⁰⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 202.
- ²¹⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 202.
- ²¹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 175-176.
- ²¹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 202-203.
- ²¹³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 204.
- ²¹⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 204-205.
- ²¹⁵ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 305 and 355-356.
- ²¹⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 205-206.
- ²¹⁷ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 132.
- ²¹⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 129.
- ²¹⁹ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 131.
- ²²⁰ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF p. 134.
- ²²¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 210.
- ²²² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 212-213.
- ²²³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 212-213.
- ²²⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 160-161.
- ²²⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 162-163.
- ²²⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 169.
- ²²⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 173.
- ²²⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 181.
- ²²⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 102-103.
- ²³⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 119-121.
- ²³¹ Section 4.6, CFNIS Independence and Impartiality.
- ²³² Exhibit P-6, Collection F, vol. 1, tab 39, doc. 1186, p. 1.
- ²³³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 183-186.
- ²³⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 122 and 139.
- ²³⁵ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 122.
- ²³⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 184-185.
- ²³⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 183-186.
- ²³⁸ *National Defence Act*, R.S.C. 1985, c. N-5, s. 55-249.
- ²³⁹ *National Defence Act*, R.S.C. 1985, c. N-5, s. 156; *Criminal Code*, R.S.C. 1985, c.C-46, s.2; *QR&O*, 22.02, 107.02.

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- ²⁴⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 90-94.
- ²⁴¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 105-107.
- ²⁴² Exhibit P-147, tab 2, doc. 1423, pp. 142-453.
- ²⁴³ For general discussions of the principles applicable to the various offences, see *R. v. F. (J.)*, [2008] 3 S.C.R. 215, paras. 7-11; *R. v. Kazenelson*, 2013 CarswellOnt 1765, 2013 ONCJ 63, 105 W.C.B. (2d) 132 (Ont S.C.J.); *Military Justice in Action: Annotated National Defence Legislation*, p. 261; Létourneau, Gilles and Drapeau, Michel, *Canadian Military Law Annotated*, (Toronto: Thomson Carswell, 2006), pp. 660-664; *R. v. Brocklebank*, 1996 CarswellNat 1888, 134 D.L.R. (4th) 377, 106 C.C.C. (3d) 234, 30 W.C.B. (2d) 564, 5 C.M.A.R. 390; *R. v. Creighton*, [1993] 3 S.C.R. 3, pp. 73-74; Exhibit P-162, doc. 1444; Exhibit P-96, tab 3, doc. 1381, pp. 146-147 and 156-160; Exhibit P-163, doc. 1445; *R. v. MCpl Bona*, 18/99 (SCM).
- ²⁴⁴ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 70.
- ²⁴⁵ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 113.
- ²⁴⁶ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 204-205.
- ²⁴⁷ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 205-206.
- ²⁴⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 225-228; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1198; Exhibit P-147, tab 3, doc. 1424, p. 64; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, PDF pp. 1145-1149.
- ²⁴⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 225-228; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1198; Exhibit P-147, tab 3, doc. 1424, p. 64; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, PDF pp. 1145-1149.
- ²⁵⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, PDF pp. 1145-1149.
- ²⁵¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, PDF pp. 1145-1149.
- ²⁵² Section 4.4, The 2010 Criminal Negligence Investigation; Section 4.5.4, CFNIS Interactions with the Fynes – 2009/2010 Investigations – Interviews, Updates and Briefing.
- ²⁵³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 236-237.
- ²⁵⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 237-238.
- ²⁵⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 238.
- ²⁵⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 210-217.
- ²⁵⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 238-240.
- ²⁵⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 232-233.
- ²⁵⁹ Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ²⁶⁰ Section 4.5.4, CFNIS Interactions with the Fynes – 2009/2010 Investigations – Interviews, Updates and Briefing.
- ²⁶¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 484.
- ²⁶² Exhibit P-4, Collection D, vol. 14, tab 1, doc. 1202, pp. 2-4.
- ²⁶³ Testimony of Dr. Bernard Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 53-55.
- ²⁶⁴ Testimony of Dr. Bernard Sowa, Transcript of Proceedings, vol. 4, 3 April 2012, pp. 53-58.

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- ²⁶⁵ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, pp. 49-54.
- ²⁶⁶ Exhibit P-5, Collection E, vol. 5, tab 9, doc. 1231, p. 52.
- ²⁶⁷ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 180-181.
- ²⁶⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 180-181.
- ²⁶⁹ Exhibit P-6, Collection F, vol. 1, tab 47, doc. 1194, p. 1.
- ²⁷⁰ Exhibit P-6, Collection F, vol. 1, tab 47, doc. 1194, p. 3 [Emphasis added].
- ²⁷¹ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 63-64.
- ²⁷² Exhibit P-6, Collection F, vol. 1, tab 47, doc. 1194, p. 2.
- ²⁷³ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 60-61.
- ²⁷⁴ Testimony of WO Hiscock, Transcript of Proceedings, vol. 8, 11 April 2012, pp. 16-20.
- ²⁷⁵ Exhibit P-6, Collection F, vol. 1, tab 47, doc. 1194, pp. 2-3.
- ²⁷⁶ Exhibit P-4, Collection D, vol. 4, tab 39, doc. 337, p. 2.
- ²⁷⁷ Testimony of Col Demers, Transcript of Proceedings, vol. 11, 17 April 2012, pp. 68-70.
- ²⁷⁸ Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ²⁷⁹ Exhibit P-147, tab 2, doc. 1423, pp. 209-453.
- ²⁸⁰ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 227 [Translation].
- ²⁸¹ Exhibit P-147, tab 2, doc. 1423, p. 310.
- ²⁸² Section 4.5.4, CFNIS Interactions with the Fynes – 2009/2010 Investigations – Interviews, Updates and Briefing.
- ²⁸³ Exhibit P-147, doc. 1422, pp. 118-120.

4.5 CFNIS INTERACTIONS WITH THE FYNES

1. Many of the allegations in this complaint relate to CFNIS interactions with the Fynes.¹ The complaints cover a number of issues, including an alleged lack of ongoing updates or briefings; insufficient, inaccurate or offensive information or explanations provided by the CFNIS to the Fynes; and the cancelling of a verbal briefing about the investigations. In order to assess these allegations, it is important to understand the history of the interactions between the CFNIS and the Fynes, from the moment the CFNIS first became involved on the day of Cpl Langridge's death in March 2008 to the conclusion of the last investigations in the spring of 2011.

2. Establishing proper communication with complainants matters. At times, it can allow for issues to be resolved before they become complaints. During her testimony before this Commission, Mrs. Fynes was asked what actions the CF could have taken to “make the Fynes go away” or satisfy their concerns. She answered all the Fynes ever really wanted was for someone to sit down with them, have an honest discussion about what happened and provide an acknowledgement that lessons needed to be learned from it.² She stated:

[...] but the overriding concern for us was somebody give us some honesty and show us what lessons have been learned. That's it.³

3. According to Mrs. Fynes, if this had been done, “that would have been the end of it.”⁴

4. It is possible that, had the contacts between the CFNIS and the Fynes been more frequent or more productive, some of the other complaints before this Commission would not have resulted. Be that as it may, these issues are important in their own right. The manner in which a police force interacts with victims and complainants is an essential part of its work. In this respect, the CFNIS' performance in its interactions with the Fynes was less than stellar.

4.5.1 Early Contact

THE 2008 INVESTIGATION

5. There was limited contact between the Fynes and the CFNIS during the 2008 investigation. Neither Mrs. Fynes nor Mr. Fynes was contacted by anyone from CFNIS asking them to provide relevant information they might have had, or advising them about the progress or results of the investigation. In fact, but for the Fynes' own attempt to contact the investigator in charge, there would have been no contact at all during or immediately after the 2008 investigation.

6. During the first month following Cpl Langridge's death, the CFNIS lead investigator, MCpl Matthew Ritco, made no attempt to contact Cpl Langridge's mother or stepfather in the course of the investigation. He initially considered that the Fynes might potentially need to be interviewed.⁵ However, a decision was made on April 15, 2008 by the Case Manager and the Detachment MWO that it was not necessary to contact them.⁶ Mr. Fynes was surprised that he was not formally interviewed in the 2008 investigation. He stated:

If you're inquiring into our son's condition, his medical condition and his life and his recent history prior to his death to the point where you're invading his personal medical and mental health files, it may have been relevant to speak to his immediate family as to his condition and to the conditions under which he was living.⁷

7. With that, it was Mr. Fynes who contacted CFNIS and not the other way around. He initiated contact in May 2008. He testified he was distraught over the possible release of Cpl Langridge's Jeep by the LDSH Regiment and, as a result, called CFNIS Edmonton and asked to speak to the investigator involved in investigating Cpl Langridge's death.⁸ Several days later, he received a call from MCpl Ritco, whose immediate concern, according to Mr. Fynes' testimony, was to find out how Mr. Fynes knew his name.⁹ In his testimony, MCpl Ritco explained he received a message on his desk asking him to contact the Fynes.¹⁰ When he did, he initially reached Mrs. Fynes and spoke with her for approximately 40 minutes.¹¹ A few days later, he also had a conversation with Mr. Fynes that lasted a little over 30 minutes.¹² These conversations were apparently unplanned.

While some information relevant to the investigation was provided by the Fynes during the conversations, little attempt was made by MCpl Ritco to elicit information or ask follow-up questions, and no formal interview was conducted with either Mr. or Mrs. Fynes.¹³ Mr. Fynes testified, in his view, no part of his conversation with MCpl Ritco was in aid of the 2008 investigation, aside from his expectation that Cpl Langridge's phone would be checked.¹⁴

8. The progress of the investigation was not discussed during MCpl Ritco's telephone conversations with the Fynes. According to MCpl Ritco's notes, Mr. Fynes indicated he was not calling in an attempt to obtain inside information about how the investigation was going.¹⁵ No information was provided to the Fynes about the status of the investigation at any other time during the investigation. LCol Robert Delaney, who became the CO of the CFNIS after the 2008 investigation was completed, testified contact with victims or complainants could generally be initiated by the Victims Assistance Coordinator (VAC) or by the investigators.¹⁶ He explained records of calls made by VAC were maintained in an activity log kept by VAC, while records of calls made by investigators were incorporated in their notes and entries within the GO file.¹⁷ Commission counsel requested a copy of any activity log kept by VAC that would record contact with the Fynes during the three CFNIS investigations.¹⁸ No such log was produced.¹⁹ There was evidence before this Commission indicating the Fynes declined the assistance of CFNIS victims' services when an offer was made in November 2009.²⁰ However, there was no evidence such services were offered to them during or immediately after the 2008 investigation. Based on the evidence, the only contact between the CFNIS and the Fynes during the 2008 investigation was made through their telephone calls to MCpl Ritco, which did not involve any update to them about the status of the investigation or any information at all about the investigation.

9. When the investigation was concluded in June 2008, no attempt was made to contact the Fynes to advise them or to provide any kind of briefing to them about the findings.²¹ The Detachment MWO at the time, MWO Barry Watson, testified that providing closure to the family "didn't cross [his] mind" in this case.²² He explained, looking at the CFNIS SOPs now, he believes providing closure to the family is one of the

goals of a sudden death investigation. However, at the time, he did not think of it and he was unable to recall exactly why.²³ He indicated it would have been part of his duties as the Acting OC for CFNIS Western Region during the relevant time period to determine whether a briefing to the family should take place and to organize it.²⁴ He added the earlier decision that it was not necessary to speak to Cpl Langridge's mother was unrelated to the issue of whether a briefing should be conducted, but was solely based on an assessment of whether there was information of value she could provide during the investigation.²⁵

10. Sgt Jon Bigelow, who was involved in assisting with the sudden death investigation, indicated he could not say contacting the family was normal practice, but noted it was "something that should have been done."²⁶ Asked whether this was something that came into his own mind at the time, he indicated:

I'd like to say – I'd like to believe that that would have been one of the ideals or one of the thoughts that should have been done.

[...]

Yes, at some point in time the family should have been notified that an investigation was taking place, right, and to obtain background information of the deceased.²⁷

11. MWO Watson explained next of kin notification and relations with a family were not part of the role of the CFNIS in 2008, but rested solely with the Military Unit.²⁸ Up to that point, he had not done any family briefing in any of the sudden death investigations in which he was involved.²⁹ It appears there was an expectation on the part of the CFNIS members involved – to the extent they turned their minds to the issue at all – that the briefing for the family at the conclusion of the investigation would be done by Cpl Langridge's Unit, the LDSH Regiment. There is no evidence before this Commission of any formal protocol between the CFNIS and the Regiment providing for such a procedure. There is no indication in the GO file the CFNIS ever contacted the Regiment to discuss the need for a briefing for the family, or the potential content of such a briefing. The only contact with the Unit at the conclusion of the investigation occurred on July 1, 2008, when MWO Watson transmitted the report to the LDSH CO in accordance with the usual procedure followed for all CFNIS investigations.³⁰ There is no indication

any follow up contact was initiated with the Unit to ensure a briefing took place and, in fact, it appears the Unit never provided any briefing to the Fynes about the 2008 investigation. Neither Mrs. Fynes nor Mr. Fynes mentioned receiving such a briefing from the LDSH Regiment or the AO appointed to them by the Regiment.³¹

12. Mrs. Fynes testified the only contact she had with respect to the 2008 Sudden Death investigation, aside from her telephone conversation with MCpl Ritco, was in November 2009, when the Fynes had their first meeting with Maj Daniel Dandurand and MS Eric McLaughlin.³² Mr. Fynes stated there was no briefing about the 2008 investigation and no contact with the CFNIS aside from his conversation with MCpl Ritco in relation to Cpl Langridge's Jeep.³³ The Fynes' AO, Maj Stewart Parkinson, also testified in these proceedings. There is no mention in his testimony or in the detailed notes and records he kept throughout his duties as AO of any briefing he might have received about the progress or conclusion of the CFNIS investigation, nor of any request to provide a briefing to the Fynes about the investigation.³⁴ It does not appear Maj Parkinson was provided any useful information about the 2008 investigation. In fact, it appears what little information he learned about the investigation was erroneous. His only reference in testimony to the 2008 investigation related to his belief that the CFNIS had tried to go into Cpl Langridge's computer and did not find anything.³⁵ In reality, the CFNIS never obtained or accessed Cpl Langridge's computer.³⁶ Without access to accurate information, Maj Parkinson was in no position to provide a briefing to the Fynes about the investigation.

13. The failure to provide information to the Fynes about the investigation into their son's death was not conducive to establishing good relations. It likely contributed to making matters worse for both the Fynes and the CFNIS when the failure to disclose Cpl Langridge's suicide note was discovered the following year. The Fynes should have been treated in accordance with the applicable protocols for dealing with victims and complainants. They should have been provided with notification about the existence of the investigation, updates about the status of the investigation, and a briefing when the investigation was concluded.

14. Both the MPPTP and a CFNIS-specific SOP provide for the principles to be followed by the CFNIS in dealing with victims and complainants.³⁷ Chapter 5, Annex F of the MPPTP specifies the MP “shall ensure the fair treatment of victims of crime through the provision of immediate information, referral to support agencies and the availability of continuous contact with the victim throughout the investigation.”³⁸ It also provides for follow up to be done every 30 days at a minimum.³⁹ The CFNIS SOP on this issue incorporates many of the same principles, and provides for call backs every two weeks.⁴⁰

15. The family of a soldier who is the subject of a sudden death investigation should be categorized as “victims”. A restrictive or legalistic definition of the term serves no purpose. In many cases, it will not be known immediately whether a crime was committed in connection with the death, or it may be immediately apparent that the death was the result of suicide. The CFNIS SOP already specifies that a person who “appears to be the victim of a crime against the person shall be treated as such,” regardless of “any legal opinions.”⁴¹ The ultimate result of an investigation or prosecution should not impact on the level of information, courtesy and contact offered to the apparent victim by the police. When a death is being investigated by the CFNIS, the family of the deceased should be offered regular contact and information. As with any investigation, the level of information provided to the family will obviously be adjusted if there are any risks of compromising the investigation, particularly in circumstances where family members may be suspects. However, in a case like this one, where it was clear very early the death was the result of suicide and no foul play was involved, there was no reason for not providing more information to the Fynes.

16. The previous practice of having the Military Unit provide briefings to the family at the conclusion of sudden death investigations – if indeed this was the practice followed by the CFNIS – was not adequate. It should be abandoned entirely. This practice was not ideal in terms of maintaining CFNIS independence and fostering confidence in the CFNIS’ independence.⁴²

17. The evidence in these proceedings reveals the information provided to CF Units about CFNIS investigations is quite limited. When the investigation report is transmitted to the CO of a Unit at the end of an investigation, only three documents are sent: the Complaint Synopsis, the Case Summary and the Concluding Remarks, as edited by Case Managers.⁴³ Leaving aside for the moment the issue of editing by the Case Managers,⁴⁴ it is clear the general information contained in a Case Summary and Concluding Remarks would not be sufficient to prepare for and provide an adequate briefing to the family about the facts uncovered during the investigation, the conclusions reached, and the reasoning supporting those conclusions. Someone relying solely on the Case Summary and Concluding Remarks to provide a briefing about the 2008 investigation would have no information to provide about the suicide note left at the scene or the investigation conducted by the CFNIS into the issue of whether or not Cpl Langridge was on a suicide watch.⁴⁵

18. Further, from a purely perceptual point of view, it seems inappropriate for a Unit whose members have been under investigation in connection with events surrounding a death – as was the case for the LDSH Regiment, at least with respect to the suicide watch issue – then to be tasked with briefing the family about the results of the investigation, whether or not it was concluded there was any wrongdoing.

19. After the 2008 investigation was concluded, the CFNIS developed a specific SOP on the conduct of Sudden Death investigations, which includes references to next of kin briefings. The SOP provides for initial contact with the family of a deceased to be conducted in person by a CFNIS Region Detachment WO or higher, as appointed by the Detachment OC.⁴⁶ It provides for two briefings to the family – the initial and the final briefing – to be conducted in the presence of the AO appointed by the CF.⁴⁷ The section related to the final briefing makes it clear such briefings are to include a description of the conclusions reached, as well as a discussion of the timeline for the investigation and various aspects investigated.⁴⁸

20. Final briefings to the family should be more than simply a notification that the investigation is concluded. They ought to be understood as an opportunity for the family

to learn about the facts uncovered during the investigation, and to understand the conclusions reached and the reasoning supporting the conclusions. For this reason, the briefing should be conducted by CFNIS members familiar with the investigation who will be in a position to answer the family's questions.

21. The Commission considers the current SOP to be a step in the right direction when it comes to contact with families during death investigations. Conducting the briefings as set out in the SOP is a good approach. However, reconsideration should be given to the requirement in the SOP for the family's AO to be present at family briefings.⁴⁹ In many cases, involving the AO will be helpful, as it will maximize the support available to the family. On the other hand, as the AO is appointed by the CF – generally by the deceased's Unit – care should be taken to ensure the family does not view his or her presence as an indication the CFNIS is not acting independently from the CF. As such, it would be preferable to afford the family a choice about whether they wish the AO to attend, particularly in cases where there are contentious issues between the CF and the family, or where the family believes or alleges the CF has some responsibility for the death. Further, in addition to the briefings provided for in the SOP, ongoing updates should be offered, similar to what is done for victims or complainants in other investigations.

22. It is important the conduct of the briefings – and, more generally, the provision of information to families, victims and complainants – be viewed by CFNIS members as an integral part of their duties and responsibilities. Part of the normal functions of police officers is interacting with victims and complainants and, in cases of death, families of the deceased, whether this is done through referral to VAC or directly by the investigators involved. Indeed, when representatives from other police forces testified before this Commission about their conduct of death investigations, S/Sgt William Clark of the EPS mentioned next of kin notification as one of the primary duties for the attending police officers involved in non-suspicious death investigations.⁵⁰ Det. Insp. William Olinyk of the OPP also referred to the conduct of debriefings with the family to answer their questions.⁵¹

23. Positive interactions and support for victims and complainants can serve to improve overall confidence in law enforcement authorities. The CFNIS has a role in providing assistance to CF Commanders and the CF in general in maintaining order and discipline, but also has the same role as civilian police forces in providing direct assistance to victims and complainants with respect to the investigations within its jurisdiction. CFNIS members should strive to ensure they provide adequate and timely information and maintain the appropriate level of contact. This, in fact, appears to be the spirit behind the recent CFNIS SOP on the conduct of sudden death investigations.

THE DISCLOSURE OF THE SUICIDE NOTE

24. After the 2008 investigation was closed, from the Fynes' point of view, the next development in the case was their being notified 14 months after his death that Cpl Langridge had left a suicide note. At that time, the CFNIS again missed an opportunity to establish communication and provide information and support to the Fynes.

25. In April 2009, following a specific request made by the BOI, the CFNIS WR provided the BOI a copy of the suicide note.⁵² The CFNIS did not at the time provide a copy of the note to the Fynes and did not advise them of the note's existence or content. It was the BOI President, Maj Bret Parlee, who on May 22, 2009, advised the Fynes of the existence of the suicide note.⁵³ A few days later, they received a photocopy of the note.⁵⁴ This was provided to them by the BOI President, and not by the CFNIS.⁵⁵

26. On May 27, 2009, the Fynes contacted their AO, Maj Parkinson, to request the original of the note.⁵⁶ There then followed a flurry of correspondence between the Regiment, the Brigade, the Area, the CFNIS and the AO, in an attempt to find out what had happened and to provide the Fynes with the original of the suicide note.⁵⁷ The Adjutant of the LDSH Regiment, Capt Eric Angell, contacted WO Ken Ross at the CFNIS Detachment, who initially responded the "best course of action" would be for the AO to the Fynes to make an Access to Information request for the note.⁵⁸ When Capt Angell explained such a request would be of no assistance because the family wanted the original note, WO Ross advised the original was still retained as evidence and indicated he did not foresee it being turned over, but would make further inquiries.⁵⁹ On May 29,

2009, Maj Dandurand, the OC for CFNIS WR, was asked by LFWA if the original of the note could be released to the family as soon as possible.⁶⁰ He indicated he had just received authority to do so from CFNIS HQ and would be returning the original note the following Monday.⁶¹ He was asked by LFWA to provide the note to staff from the Brigade who would “prepare an appropriate way of getting this to the family.”⁶² Capt Angell was advised the CFNIS would provide him the original “to deliver to the Fynes as they have requested.”⁶³ On June 1, 2009, the note was provided to Capt Angell by CFNIS WR.⁶⁴ The original note was delivered to the Fynes on June 3, 2009 by their AO, Maj Parkinson.⁶⁵

27. Mr. Fynes testified about the chain of events surrounding the delivery of the suicide note in May-June 2009:

You know, in the first instance when we were apprised of the suicide note they forwarded the – they Puolated the note out to the NIS in Esquimalt. A Captain hand-delivered it to my wife.

I came home from work that night and the Puolator envelope was sitting on our table unopened. My wife couldn't bring herself to open it.

And I have to tell you when we opened that envelope together and I saw that it was a photocopy with an exhibit stamp on it, I was just through the roof.

And we went back and demanded that we get our son's suicide note, his last communication to us, and that was delivered shortly thereafter in person by our Assisting Officer who stood in our room and reached it to us and said – I believe his exact words were: “I have no words.”⁶⁶

28. Throughout the period of a few days between the time the Fynes received the copy of the suicide note and the time the original was provided to them, a great deal of email correspondence on the issue was exchanged among the various actors involved.⁶⁷ In the context of these exchanges, the Fynes' initial e-mail requesting the original note was forwarded to CFNIS members, including Maj Dandurand, the CFNIS WR OC, and LCol Gilles Sansterre, the CO of the CFNIS.⁶⁸ That message left no doubt about the Fynes' state of mind upon receiving the copy of their son's note more than 14 months after his death. It read:

Attached is a copy (of a photocopy) of Stuart's farewell to his family.

That his note was concealed and withheld from us for over fourteen months was cruel, callous and disrespectful.

I expect the "original" to be provided to us immediately [...] ⁶⁹ [Emphasis added]

29. During this time, the CFNIS still took no steps to contact the Fynes. No apology or explanation was provided when the original suicide note was finally delivered to the Fynes. In fact, no contact at all took place until a few weeks later. The CFNIS did not even deliver the suicide note personally to the Fynes. Later, when the issue began to attract significant media attention in October 2010, questions were asked about whether and when the Fynes received an apology from the CFNIS. The CFPM was then advised Mrs. Fynes had received a "face to face personal apology" from the CFNIS WR Detachment Commander, Maj Dandurand, and was told the "apology and explanation of why the delay happened and how the CFNIS would stop recurrence was given at the time that the original note from Stuart Langridge was provided to her."⁷⁰ The testimony heard in these proceedings revealed this information to be inaccurate. Maj Dandurand agreed it was "entirely incorrect,"⁷¹ and testified no apology was given to the Fynes by the CFNIS when the suicide note was delivered to them in June 2009.⁷² He added the face to face apology he provided was in November 2009, during a meeting with the Fynes.⁷³

30. It was three weeks after the Fynes received the original suicide note that the first direct contact between the CFNIS and the Fynes took place, when the then CO of CFNIS, LCol Sansterre, inadvertently called the Fynes' home.⁷⁴ Mr. Fynes described this as the first time the Fynes began direct communication with the CFNIS about the issues related to the Sudden Death investigation.⁷⁵ On June 18, 2009, LCol Sansterre called the Fynes' residence and had a conversation with Mrs. Fynes.⁷⁶ He had in fact intended to call the Fynes' AO, Maj Parkinson, but was provided the Fynes' telephone number by mistake.⁷⁷ In testimony, LCol Sansterre explained the purpose of his call was to contact the Fynes' AO to set up an appointment with the Fynes so the CFNIS, "who obviously have not given the information to the Fynes to this date, that we could meet with them, give them the information, give them a brief on the investigation."⁷⁸ LCol Sansterre testified he apologized about the suicide note during his telephone conversation with Mrs. Fynes.⁷⁹

Mrs. Fynes testified LCol Sansterre “talked about the note a bit and confirmed that we now had it.”⁸⁰ She could not recall specifically what was said about the note, but was adamant neither she nor Mr. Fynes had ever received an apology “from anybody” for the failure to disclose the suicide note.⁸¹

31. LCol Sansterre had been aware of the suicide note issue since at least May 30, 2009,⁸² but did not immediately take measures to have the CFNIS contact the Fynes and provide an apology and explanation. It is not clear whether the original purpose of his intended call to the Fynes’ AO included providing such an apology. LCol Sansterre emphasized in testimony the main purpose was to set up an appointment with the Fynes, so they could be briefed by someone from CFNIS Western Region.⁸³ He did not specify what would be covered in the intended briefing, but he did indicate he was really concerned about this matter of the suicide note, and as a result, got personally involved in attempting to contact the AO, something he did not do on any other occasion during his tenure as CO of the CFNIS.⁸⁴

32. While it was appropriate for LCol Sansterre to apologize when he did speak to Mrs. Fynes on June 18, 2009 – and the Commission accepts his testimony that he did in fact say he was sorry⁸⁵ – it is surprising this simple and obvious measure did not appear to be on the CFNIS’ radar prior to this fortuitous contact between LCol Sansterre and Mrs. Fynes. This is particularly disconcerting when one considers the amount of time and energy expended by the CFNIS on creating Media Response Lines and conducting media monitoring surrounding the issue.⁸⁶ It is clear the CFNIS was greatly concerned about the impact of this issue on its public image, and was taking measures to provide explanations and expressions of regret to the public. Unfortunately, no similar measures were taken to provide immediate explanations and expressions of regret to those most affected, Mr. and Mrs. Fynes.

33. The Commission is of the view that, upon learning in May 2009 the suicide note had not been disclosed or provided to the Fynes, the CFNIS should have taken immediate measures to (a) personally deliver the suicide note to the Fynes; (b) provide an immediate official apology; and (c) find out exactly what happened and provide the necessary

explanations to the Fynes.⁸⁷ This should have been considered a priority, and given at least as much attention as was given to the public relations aspects of the matter.

34. It is obviously to be hoped such late disclosure of a suicide note by the CFNIS will never occur again. However, if a similar situation were ever to recur in the future, or if some other unfortunate error were ever to be made by the CFNIS causing significant distress to victims, complainants or members of the public, lessons should be drawn from this incident. Immediate measures should be put in place to provide an official apology to the persons affected, along with any necessary explanations outlining how the error occurred.

4.5.2 Obtaining the 2008 Investigation Report

35. After the initial lack of communication during the 2008 investigation and the shock of discovering the suicide note, relations between the CFNIS and the Fynes improved a little when LCol Sansterre became personally involved and assured them they would be provided with a copy of the report for the CFNIS' 2008 investigation. However, relations soon began to sour again when the Fynes were provided with heavily redacted versions of the CFNIS 2008 investigation report. This gave rise to a specific complaint alleging the CFNIS "improperly withheld information" from the Fynes by providing them with a copy of its report containing "numerous redactions having no justification in law or privacy protection."⁸⁸

THE REQUEST AND THE FIRST VERSION OF THE REPORT

36. On the evening of June 18, 2009, following Mrs. Fynes' conversation with LCol Sansterre, Mr. Fynes sent an email to LCol Sansterre requesting a copy of the CFNIS file for the investigation into Cpl Langridge's death.⁸⁹ Mrs. Fynes testified LCol Sansterre was "very obliging" in responding to this request.⁹⁰ The very next day, he advised the Fynes he had initiated a request with the Military Police Access to Information Section, and indicated the gathering of documents had begun. LCol Sansterre informed the Fynes

the process would involve “the vetting of the report to determine if there are any Privacy Act related issues that will require severance.”⁹¹ He also suggested a debriefing could be scheduled with CFNIS investigators once the Fynes had received the report.⁹² On June 29, 2009, he advised the Fynes the disclosure of the file had been completed by the MP Police Policy Directorate and the file had been sent to the Director of Access to Information and Privacy (DAIP) for “final vetting.”⁹³ He added he had requested an estimate of the time required and was awaiting an answer.⁹⁴ On July 27, 2009, he advised that the file had been returned by DAIP and would be sent shortly.⁹⁵ The Fynes received their first copy of the CFNIS report on July 29, 2009.⁹⁶

37. Mrs. Fynes described this copy as “very abbreviated,” with approximately 260 pages, and containing “mostly redactions.”⁹⁷ Mr. Fynes indicated this version was about 40 per cent of a 500-plus-page report “and I was -- I couldn’t figure out why there was so many redactions.”⁹⁸

38. Indeed, the redactions to the file were extensive. In this hearing, a complete and unredacted copy of the GO file for the 2008 Sudden Death investigation was produced. The file has 714 pages.⁹⁹ By contrast, the file provided to the Fynes totalled 270 pages.¹⁰⁰ The basis for some of the redactions was difficult to understand. Many of Mr. Fynes’ own statements – made during his telephone conversation with MCpl Ritco – were redacted.¹⁰¹ All summaries and references to witness interviews, including those for the interviews with Capt Mark Lubiniecki, MCpl Erin Bowden, Cpl Jon Rohmer, Sgt Trent Hiscock, Cpl Roger Hurlburt, MCpl William Fitzpatrick, MWO Douglas Ross and Capt Richard Hannah, were redacted.¹⁰² All of the 105 pages of officer notes included in the investigation file were missing.¹⁰³ Documentation about the exhibits seized and how and when they were disposed of was also redacted.¹⁰⁴ The entry detailing the processing of the scene, along with the Evidence Collection Log recording the items seized, was redacted. Only the copy of the suicide note – which by then had already been provided to the Fynes – remained unredacted, along with copies of certain medical forms seized.¹⁰⁵

39. In an instance that especially angered the Fynes, an account by Sgt Hiscock of a directive he gave to cut down Cpl Langridge’s body was redacted. MCpl Ritco’s Case

Summary included the following sentence referring to information learned during his interview with Sgt Hiscock: “Cpl Hurlburt returned and informed him, that he located Cpl Langridge in his room, hanging from the neck; Sgt Hiscock directed Cpl Hurlburt to return, and cut him down, and await emergency personal [sic] to attend.”¹⁰⁶ In the copy of the file provided to the Fynes, the words “and cut him down” were redacted.¹⁰⁷ Mr. Fynes took strong exception to this redaction.¹⁰⁸ He testified he believed it was “an unlawful redaction,” as it was not aimed at protecting personal information, national security or investigative techniques, but at protecting the CFNIS from embarrassment.¹⁰⁹

40. Upon receiving this copy of the file, Mr. Fynes wrote to LCol Sansterre indicating his “first reaction was one of amazement that more than half of the file had been severed.”¹¹⁰ He noted his own comments were redacted, as well as information about the exhibits.¹¹¹ He added he was “left to wonder what is being hidden from view and why?”¹¹² In response, LCol Sansterre assured Mr. Fynes all of the redactions were done by “personnel who are trained and conversant with the Privacy Act and who are employed with the Director of Access to Information [DAIP].”¹¹³ He added, the CFNIS had no intent to hide any information and indicated this was the reason why a briefing by CFNIS personnel familiar with the file was being offered.¹¹⁴ Mr. Fynes renewed his expression of concern. He indicated Cpl Langridge had designated him on his PEN form to receive his personal information, and noted the report did not relate to sensitive, intelligence or national security information, as the ME had confirmed the death was the result of suicide.¹¹⁵ He indicated he remained “concerned about what was withheld, and more importantly what justifies the lack of transparency?”¹¹⁶

41. Two weeks later, in mid-August 2009, Mr. Fynes again wrote to LCol Sansterre, explaining the Fynes were in no position to formulate intelligent questions on the basis of “only 40% of your report.”¹¹⁷ He referred to the redaction of the directive to cut down Cpl Langridge’s body and wrote: “whose privacy is being protected here? The extent of this redaction is neither acceptable nor justifiable.”¹¹⁸ He noted those who applied the redactions likely did not appreciate he was designated as Cpl Langridge’s personal representative. He asked LCol Sansterre for assistance in obtaining a less redacted report.¹¹⁹ In response, LCol Sansterre advised Mr. Fynes he had forwarded his concerns

to the DND DAIP, explaining it is this office “that is responsible for the severance of our report and they are in the best position to answer your query.”¹²⁰ He wrote to the DAIP, Ms. Julie Jansen, indicating he was “looking for your advice on how to respond” to Mr. Fynes’ email, which he forwarded to the DAIP.¹²¹

42. On September 17, 2009, LCol Sansterre forwarded to Mr. Fynes a response from DAIP Acting Deputy Director, Ms. Marie Carle. The response explained DAIP is the delegated authority to administer the Access to Information and Privacy Acts. It went on to state DAIP’s position that the PEN form only authorized the release of personal information that existed at the time of signature, and “[t]herefore, a PEN form cannot be used as a release authority for the Military Police Report or any other report created after the death of an individual.”¹²² Consequently, Ms. Carle explained the only provision authorizing release of personal information in this case was s. 8(2)(m) of the *Privacy Act*¹²³ – which provides for release of information where the head of a Government institution considers the public interest in disclosure to clearly outweigh any invasion of privacy. She indicated “DAIP exercised their authority in this case to release the personal information that would help the family to understand the circumstances surrounding the death of Corporal Stuart Langridge.”¹²⁴

43. The next day, Mr. Fynes wrote to LCol Sansterre. He indicated he was surprised by DAIP’s position that a PEN form only affords access to information in existence at the time of signing, pointing out there was no such annotation on the form, and indicating “by that logic, the entire PEN form would always be out of date and could not be actioned or relied upon in the event of injury, illness or death.”¹²⁵ Mr. Fynes noted he understood LCol Sansterre was only the “messenger”. However, he stated he did not accept DAIP’s position and he mentioned the Fynes were not being provided with closure.¹²⁶ In testimony, Mr. Fynes reiterated his objections to the interpretation of the PEN form being advanced, indicating it would make the PEN form consent itself invalid, since it is meant to be used in the event of a soldier’s death or injury.¹²⁷

44. LCol Sansterre forwarded Mr. Fynes’ message to DAIP and discussed the matter by telephone with them.¹²⁸ Parallel discussions also occurred within LFWA, the Area in

charge of Cpl Langridge's Regiment. This led to the involvement of LCol Bruce King, who had acted as the legal advisor to the BOI into Cpl Langridge's death and would act as the legal advisor to the eventual SI in anticipation of litigation related to the post-death administration issues.¹²⁹ When Mr. Fynes wrote to LCol Sansterre to complain about the redactions and DAIP's response, he copied his AO, Maj Parkinson.¹³⁰ Maj Parkinson forwarded the message to his superiors in Vancouver, who in turn forwarded it to recipients at LFWA and 1 CMBG, asking that "the interpretation on the PEN form regarding issue of access to information when mbr is killed or injured" be confirmed.¹³¹ A request was then made to contact JAG to get a response.¹³² After a string of emails involving LCol King, which were redacted in the records produced before this Commission, there was an email dated September 29, 2009 from Ms. Carle to LCol King, indicating DAIP were having a management meeting the next day "on this subject" and noting LCol King should get a response soon.¹³³

45. On October 27, 2009, after the Fynes contacted him to arrange for a briefing in late November, LCol Sansterre forwarded a new response he had received from Ms. Carle.¹³⁴ In this message, Ms. Carle indicated DAIP acknowledged the PEN form "is subject to different interpretations" and as a result, "we have to reconsider the release of the complete Military Police report."¹³⁵ Ms. Carle was unable to provide an estimate of the time required to complete this, but indicated the file was being processed as a priority.¹³⁶ As of November 12, 2009, LCol Sansterre wrote he had still not been able to find out from DAIP when the report would be released.¹³⁷ He pointed out he had no control over when the report would be released, but indicated CFNIS members would nevertheless be available to provide a briefing to the Fynes in late November as requested.¹³⁸

REVISITING THE REDACTIONS: THE SECOND VERSION OF THE REPORT

46. The second version of the report was provided to CFNIS by DAIP on November 20, 2009 and was shipped to the Fynes the following week.¹³⁹ In the cover letter, dated November 23, 2009, LCol Sansterre advised Mr. Fynes "the report received from Access to Information and Privacy" was enclosed.¹⁴⁰ In total, five months elapsed between the

Fynes' initial request for the file in June 2009 and the receipt of this version in November 2009.

47. Mrs. Fynes testified the second report received was "much more complete," though there were still "tons of pages redacted, lots of lines redacted," including information about the Fynes or that the Fynes already had.¹⁴¹ Mr. Fynes testified this version was less redacted, estimating about 80 per cent of what was in the report was now provided, but noting the Fynes had since received another version that included officer notes.¹⁴²

48. The second version of the report contained 476 pages,¹⁴³ almost double what had been provided in the first version. The file now contained information about the witness interviews,¹⁴⁴ as well as some information about the exhibits.¹⁴⁵ The mention of the directive to cut down Cpl Langridge's body was no longer redacted.¹⁴⁶ However, the officer notes continued to be missing or redacted in full,¹⁴⁷ and some of Mr. Fynes' own comments to MCpl Ritco continued to be redacted.¹⁴⁸ Other information that remained redacted in the second version of the report included: information about MCpl Ritco's contacts with EPS to obtain reports about Cpl Langridge;¹⁴⁹ MCpl Ritco's requests for access to Cpl Langridge's medical and mental health records and all interactions related to them;¹⁵⁰ MCpl Ritco's Investigation Plan;¹⁵¹ information about the time of arrival of the ME at the MP Garrison and the time of arrival of the ME and the CFNIS investigators at Cpl Langridge's room on the day of his death;¹⁵² extracts of the summary of MCpl Bowden's interview relating to her discussions with the RSM about the use of the term "suicide watch";¹⁵³ information about CFNIS' request for an analysis of Cpl Langridge's BlackBerry;¹⁵⁴ the sketch prepared by MCpl Ritco of the room where Cpl Langridge was found;¹⁵⁵ the letter to LDSH seeking authority for disposal of the exhibits by the CFNIS, as well as information about the drafting of the letter, including the list of exhibits sent to LDSH in the authorization request;¹⁵⁶ and the entry indicating that the then Acting CO of the CFNIS had reviewed the report and concurred with the findings of the investigation.¹⁵⁷

49. The Fynes could not know exactly what information was redacted and why, but continued to be concerned about the extent of the redactions to this second version of the report.¹⁵⁸ They nevertheless agreed to meet with CFNIS members on November 28, 2009 to discuss the investigation.¹⁵⁹

WHO IS RESPONSIBLE FOR THE REDACTIONS?

50. Every time the Fynes complained about the redactions to the 2008 report, the CFNIS members they dealt with told them this was not their responsibility, but that of DAIP, and indicated they essentially had no say in the redactions. The evidence heard in these proceedings reveals the actual situation was somewhat more complex. As a result, these explanations were not entirely accurate.

51. Throughout his dealings with the Fynes about this issue, LCol Sansterre repeatedly reiterated he was not responsible for making decisions about the redactions to the report, stated he had “no control” over when the report would be released by DAIP, and indicated he would forward the Fynes’ concerns about the redactions to DAIP, which he did.¹⁶⁰ During the November 2009 briefing, Maj Dandurand and MS McLaughlin provided similar explanations. Maj Dandurand assured the Fynes the version of the report they had now received had been severed “in line with the Privacy Act.”¹⁶¹ He told them DAIP had redacted the first copy of the report they received, and DAIP redact all the reports.¹⁶² Maj Dandurand was emphatic the Military Police was not responsible for the redactions to the two versions of the report, indicating: “so your issues are with DAIP, not with us. I completely empathize with the frustration, but I can’t.”¹⁶³ He later added:

Here's the irony, or perhaps the bizarre nature of this – [...] It's not for me to say. This report disclosure to you is a Directorate of Access to Information Privacy issue. **It is completely separate from the military police --**

[...]

It has nothing to do with -- they do this on behalf of the whole department¹⁶⁴
[Emphasis added]

52. He explained the process as follows:

[...] I am no expert on the Privacy Act, the DAIP Department is, which is why -- one of the areas where we have input in the severance is police tactics -- obvious reasons; right?

The methodology in which we conduct our job is protected under the Privacy -- or under the legislation.

So what we'll do, is we will highlight the portions that we believe to be tactics, and provide that to them and say -- they know the Privacy aspects, they know the National -- or even National Security aspects -- [...] But DAIP holds -- that's why it's highlighted. We don't black it out, photocopy it, and send it back to them. We highlight it because they hold the final say. They will look at it and they will say, in their estimation, having severed several military police reports, no, what you guys are asking for is not severable, we're including it. Or they may say, yes, you're right, and they sever that.¹⁶⁵

53. This general explanation is in line with the evidence heard in this hearing about the process usually followed when access to information requests for MP information are received.¹⁶⁶ However, it is not entirely in line with the way things happened in this case.

54. What the evidence in these proceedings has revealed is, before the file went to DAIP for review and redaction, a selection had been made -- intentionally or not -- by the MP analyst who printed the file. Ms. Jansen, who had been the DAIP for the past eight years when she testified before this Commission, explained her office does not have access to SAMPIS, the electronic system used by the CFNIS to store data.¹⁶⁷ When a CFNIS report is requested, MP personnel produce a print out or PDF version of the file that is sent to DAIP for review and redaction as necessary.¹⁶⁸ In this case, the total number of pages in the report provided by the MP to DAIP was 578,¹⁶⁹ as opposed to the 714 pages in the report produced in these proceedings.¹⁷⁰ Ms. Jansen could not explain the difference between the two files.¹⁷¹ A review of the files reveals that, aside from a small number of pages created subsequently when Maj Dandurand modified the concluding remarks,¹⁷² what accounts for the difference is mostly the fact the officer notes included in the copy of the file provided to the Commission were missing or blacked out in the copy sent to DAIP in response to the Fynes' request.¹⁷³ There is also a difference in the amount of information included in the section detailing the handling of exhibits.¹⁷⁴

55. Sgt Arlene Bomback-Fortin, the ATIP coordinator with the MP Group HQ, provided testimony to assist the Commission in its attempt to understand what was sent to DAIP and the underlying reasoning. Sgt Bomback-Fortin was not personally involved in

preparing the file provided to DAIP in this case. Another employee, who was no longer working with the MP at the time of this hearing and who was not available to provide testimony, was in charge of this specific release.¹⁷⁵ Sgt Bombback-Fortin explained, in her experience since joining the MP ATIP section in 2010, the entire report would be provided to DAIP following the receipt of a request from the family either made to DAIP or directly to CFNIS.¹⁷⁶ She could not explain why the officer notes included in the 2008 report provided to this Commission were not included in the version of the file printed for DAIP following the Fynes' request to LCol Sansterre,¹⁷⁷ nor could she explain why the few pages of officer notes that were printed – as well as a few other documents – were redacted in full prior to the document being sent to DAIP.¹⁷⁸ She was not aware of any policy preventing the inclusion of officer notes.¹⁷⁹ She did not think it was likely the notes had not yet been scanned into the report at the time of printing.¹⁸⁰ Indeed, what little information could be obtained about this indicates many of the notes were scanned previously.¹⁸¹ Sgt Bombback-Fortin and her colleague, Mr. Karl Beaulieu, who was the SAMPIS application manager, also did not think it was likely the notes were not included because of printing issues, since the notes were printed with the version of the file provided to the Commission.¹⁸² Some of the CFNIS members involved at the time believed police notes were not normally disclosed when MP information was requested.¹⁸³ However, without the testimony of the employee responsible for the printing, the reason why the notes were not included in this case cannot be confirmed.

56. The difference in the number of pages of information relating to the exhibits was explained by the manner in which the printing was done, as well as some subsequent activity in the file. Only information about seizure and disposal of exhibits was printed in the version of the file sent to DAIP. The details related to the chain of custody and transfers for each item – including the suicide note – were not included.¹⁸⁴ The SAMPIS system revealed another version of the file, this one including the details of the chain of custody and having 623 pages rather than 578, was printed in June 2009.¹⁸⁵ It is not known what was done with this version, but it was not the one sent to DAIP and subsequently provided to the Fynes.¹⁸⁶

57. While some aspects of what was done remain unclear, it is clear that what was sent to DAIP was not the entirety of the CFNIS file. It is also clear DAIP had no involvement in making this initial selection. This was the responsibility of the Military Police.

58. With respect to the decision-making authority over the redactions added to the report after it was sent to DAIP, the Commission heard testimony from the DAIP herself, Ms. Jansen, about the process in place at the time. Ms. Jansen explained that as the DND DAIP, her role is to administer the Access to Information and Privacy acts on behalf of the Minister of National Defence.¹⁸⁷ She explained she is the delegated authority for the DND to ensure the statutes are respected, and, as such, she is involved in making decisions about the release and redaction of information.¹⁸⁸ Ms. Jansen described two types of requests for information that can be received: formal and informal. A formal access to information request must be directed to the DAIP's office. When the request relates to MP information, DAIP obtains the information directly from the MP, sometimes with suggestions from the MP about redactions related to police techniques, and then proceeds to make a final determination as to what information will be released.¹⁸⁹ By contrast, informal requests do not have to be addressed to DAIP.¹⁹⁰ Where the MP or CFNIS receive such a request, they do have the authority to release their own records without advising or consulting DAIP.¹⁹¹ However, they must be careful to ensure personal information is not released contrary to the applicable legislation.¹⁹² In some cases, the MP will consult DAIP about what can be released in response to an informal request, and DAIP will provide advice to the MP.¹⁹³ In such instances, it is DAIP making recommendations, and the MP making decisions about what information to release.¹⁹⁴ However, as was learned from Ms. Jansen's testimony about the facts of this case, in some circumstances, DAIP's "advice" is binding.

59. Mr. Fynes' request for the Sudden Death investigation file was viewed and treated as an informal request.¹⁹⁵ The file was sent to DAIP by the MP who were "asking our advice to see if there is anything we can suggest, if there is personal information that we should redact."¹⁹⁶ However, Ms. Jansen indicated the determination as to what information could be released in the public interest pursuant to s. 8(2)(m) of the *Privacy*

Act – the criterion used to redact the first version of the report – was still made by DAIP, without consultation with the MP.¹⁹⁷ She added, in a case such as this one involving a Sudden Death investigation, the recommendations or advice DAIP would provide to the MP would be based on the DAIP's views of what it is in the public interest to release.¹⁹⁸ She indicated that, having consulted DAIP, the MP are in fact bound to follow their recommendations, at least when it comes to issues related to the release of personal information and the application of the *Privacy Act*.¹⁹⁹ In other words, where an informal request is received by the CFNIS, the MP can decide to release the information without consultation. However, if they do seek advice from DAIP, they are bound to follow it. They are free to redact more than what DAIP recommends, but not less.²⁰⁰

60. According to Ms. Jansen, a further distinction between the formal and informal process is that for formal requests, the MP would have an obligation to provide DAIP with the entire report, whereas for an informal request, they only have to provide the information about which they decide to seek DAIP's advice.²⁰¹

61. Based on this evidence, it appears in this case, the Military Police and DAIP were both responsible for the redactions applied to the report provided to the Fynes. The MP made an initial selection of certain information when printing the report – essentially deciding to exclude officer notes – and then made a decision to seek advice from DAIP about the redaction of personal information contained within the selection the MP had made. Because this advice was sought, DAIP then essentially became the arbiter of the minimum necessary redactions with respect to the parts of the file sent to it. As stated in the cover letter sent by DAIP to CFNIS with the second version of the report, the final redactions done by DAIP were the same as those that would have been applied to the report if a formal request had been received and processed by DAIP.²⁰² For the parts of the report initially sent to DAIP by the MP, this was a DAIP release, and DAIP was responsible for the redactions because the MP chose to consult with DAIP.

62. Possibly because of the complexity of the process, many of the CFNIS members involved had a different understanding about who was responsible for what redactions. MS McLaughlin testified he believed DAIP was responsible for making decisions about

all redactions.²⁰³ He thought there was nothing he and Maj Dandurand could do about the Fynes' complaints regarding the redactions because the MP section having conducted an investigation would not have the authority to make those decisions. DAIP would have the authority.²⁰⁴ Maj Dandurand also had a similar understanding. He testified DAIP ultimately held the "trump card," although the MP ATIP coordinator could request certain redactions.²⁰⁵ However, he did agree DAIP would not be in a position to debate the MP's views that certain documents or information revealed police techniques.²⁰⁶ Maj Dandurand did not think the MP could decide on its own not to produce certain parts of a report, and he was not aware the file sent to DAIP by the MP was incomplete.²⁰⁷ He personally had no involvement in applying or proposing redactions to the 2008 report, or in selecting parts of the file to be sent to DAIP.²⁰⁸ He testified no one in CFNIS WR was involved and, to the best of his recollection, "nobody within the NIS even had access to that."²⁰⁹ He also stated he never found out why the direction to cut down the body had been redacted, and he did not pursue this matter.²¹⁰ It appears Maj Dandurand did not take steps to address any of the Fynes' complaints about these issues, short of providing them with an explanation of his understanding of the process, because he believed the CFNIS was not responsible for decisions about the redactions.

63. LCol Sansterre, for his part, testified he was not aware there was a formal and an informal process to request information.²¹¹ He was aware there had been a change in procedure allowing families wishing to obtain copies of CFNIS reports to present the request directly to the CFNIS through their AO, rather than having to submit an official Access to Information request.²¹² However, he did not understand the MP or CFNIS would then have a choice about whether or not to consult with DAIP about the redactions and what parts of the file to provide. He was not aware of which parts of the 2008 report were, in fact, sent to DAIP for redaction. He believed the MP Access to Information section played a role in redacting information related to police techniques, but was not aware of exactly how the process worked.²¹³ His understanding was, when the Fynes' request was received, the CFNIS sent the report to DAIP, who then sent it back to CFNIS with redactions.²¹⁴ LCol Sansterre believed the CFNIS would not make their own decisions about what to release, because "the Access to Information Act and the Privacy Act are very complicated laws," and because DAIP are "the ones that are applying the

law for us. They are the department organization that applies the legalities.”²¹⁵ When he realized Mr. Fynes was not happy with the redactions, LCol Sansterre agreed with some of his complaints and assisted him in trying to get a different copy from DAIP.²¹⁶ Nevertheless, LCol Sansterre believed, in the end, the CFNIS could not overrule DAIP’s decisions.²¹⁷

64. The evidence revealed some of the staff working in the MP ATIP section did have a clearer understanding of the process and decision-making authority over redactions. The MP ATIP Manager who was in charge of dealing with the Fynes’ request, Mr. Austin Ambrose, wrote a message to DAIP indicating the original request from the Fynes was “treated as an informal Privacy 8(2)(m) request” and stating it would seem “CFNIS are regarded, in this instance, as the keeper of the file and the authority for its release.”²¹⁸ Mr. Ambrose indicated he thought they could “extricate CFNIS” by treating Mr. Fynes’ correspondence as a formal request to DAIP. He asked DAIP to assume responsibility and to be the point of contact with the Fynes.²¹⁹ LCol Sansterre, who was copied on the original message, responded he wished to remain the point of contact with the family and indicated, “the family is aware that I am not responsible for the disclosure of the report.”²²⁰ The DAIP Acting Deputy Director, for her part, responded that in this case, DAIP had “agreed to review the complete MP report in accordance with the Privacy Act and provide a copy to Mr. Fynes through LCol Sansterre.”²²¹ She added, if the Fynes wished to request the complete MP report, “they should be informed to submit a request under the Privacy Act directly to our office.”²²² This would then be considered a formal request and DAIP would deal with the family directly.²²³

65. Despite having been copied on this correspondence (and perhaps potentially having access within MP HQ to a clearer understanding of the applicable process if he had made inquiries), it is clear LCol Sansterre was sincere in his understanding about the redaction of the CFNIS report being solely within DAIP’s decision-making authority. When he was contacted by Mr. Fynes about the redactions to the first version of the report, he wrote to the DAIP to ask for advice on how to respond and indicated: “it is obvious that the sender is confusing me as the CO CFNIS as having some authority or being responsible for the release of this investigation.”²²⁴ Obviously, whatever the MP

ATIP staff may have been aware of, LCol Sansterre did not know there was some discretion about the release of information in the case of informal requests, and he did not know a selection was made when the file was sent to DAIP. Throughout the process for the disclosure of the 2008 report to the Fynes, LCol Sansterre attempted to be as helpful and courteous as possible to the Fynes. Mr. Fynes testified:

I think Colonel Sansterre was making a genuine effort to be helpful to us and to justify that their actions had been professional [...] ²²⁵

66. Indeed, LCol Sansterre provided timely responses and updates, and explained the process as best he could, in accordance with his own understanding.

67. The Commission now understands some of the information provided by LCol Sansterre and Maj Dandurand to the Fynes was not entirely accurate. However, this was simply the result of a lack of understanding on the part of these CFNIS members, and not of any intention to deceive the Fynes. It is unfortunate better information was not available to those in charge of interacting with the Fynes about this issue. Ms. Jansen testified DAIP has a section in charge of providing training to other DND organizations, including the MP, about matters relating to the release of information. As a result, she testified she was confident the MP have enough training to proceed with the release of information in response to informal requests without consulting DAIP, and would also know when consultation is necessary. ²²⁶ The evidence in these proceedings has revealed, while the members of the MP ATIP section may possess some of the necessary knowledge as a result of this training, other CFNIS members who are dealing directly with complainants making informal requests for information do not. In this case, making this information more widely available within CFNIS may have allowed these members to provide more accurate information to the Fynes in response to their concerns, and perhaps even to address some of the redaction issues directly resulting from the selection made by the MP when sending the file to DAIP.

WERE THE REDACTIONS JUSTIFIED?

68. The redactions to both versions of the 2008 report provided to the Fynes were extensive. The Commission does not propose to review each in detail. However, a number of them are of particular concern and merit comment.

69. First, the redaction of all officer notes from both versions of the report provided to the Fynes was the result of a decision made by the MP, and not DAIP. The Commission sees no justification for this redaction, which covered over 100 pages of materials. When the Fynes raised this issue in their first meeting with CFNIS members, Maj Dandurand and MS McLaughlin assured them police notes are not available for disclosure through access to information requests.²²⁷ In testimony, MS McLaughlin indicated this was and remains his understanding.²²⁸ When asked where he obtained that information, he explained:

It's not specific to any training, so we can rule that out. There's no actual training that I've ever received based on DAIP or anything like that.

But police notes often speak to police tactics, interview tactics, and those things there typically are not released. So there's serious redaction that has to be done. Notes contain all personal sensitive information.

As a general rule, my understanding based off of the amount of information that's available in police notes, that wouldn't typically be available in the report anyway.

No, police notes are not released based on that practice. It seems logical to me because there's just too much stuff within police notes that is not something you would disclose.

The actual information on why those don't get disclosed would be available from ATIP coordinators.²²⁹

70. During his testimony, Maj Dandurand also confirmed his own belief police notes are not available through Access to Information requests.²³⁰

71. By contrast, Ms. Jansen testified it is not DAIP's general policy to redact all police notes. Rather, the content of the notes is reviewed and only portions relating to an accepted ground for severance – such as personal information or police techniques – are redacted.²³¹ She could not explain why the police notes were redacted in both versions of the report provided to the Fynes.²³² Maj Gord Wight of the MP Directorate in charge of

the ATIP section testified about the process currently followed for the release of MP information. He stated the MP assemble everything on the file, including MP notebooks, when formal requests are received under the legislation.²³³ He added there is no blanket policy to recommend notebooks be redacted entirely as a matter of course.²³⁴ Instead, the MP will recommend certain redactions based on the content of the information.²³⁵ The reason for excluding the police notes from the copy of the report sent to DAIP and then to the Fynes in this case remains unclear. However, based on the evidence, it is clear this redaction was not appropriate.

72. Another particularly problematic redaction, as pointed out by Mr. Fynes on numerous occasions – was the blacking out of the direction to cut down Cpl Langridge’s body. The evidence indicates this particular redaction was applied by DAIP and was appropriately removed from the second version of the report released to the Fynes. Ms. Jansen explained it was DAIP’s view personal information about Cpl Langridge included in the report could not be released for a period of 20 years, as it belonged to the deceased.²³⁶ As a result, DAIP applied the redactions to the report pursuant to s. 8(2)(m) of the *Privacy Act*, which Ms. Jansen explained “left to my discretion to see if it’s in the interest of the public to release that kind of information.”²³⁷ She explained the direction to cut down Cpl Langridge’s body, even though it immediately followed an unredacted notation indicating he was found “hanging from the neck,”²³⁸ would be redacted pursuant to the DAIP’s public interest determination “out of consideration and respect for the family.”²³⁹ She added, “it’s information that can be harsh to read for the parents or the family.”²⁴⁰ She explained, anything “that could be difficult for the family to read, I would consider not to release.”²⁴¹

73. In making these public interest determinations about what information would help the family understand the circumstances of the death,²⁴² what information could be difficult for the family to learn, or what information should be redacted out of consideration for the family,²⁴³ Ms. Jansen testified DAIP does not consult with the family requesting the information to find out what their preferences are and what type of information they feel they need to obtain.²⁴⁴ The MP members having conducted the investigation are also not consulted.²⁴⁵

74. Mr. Fynes believed that the direction to cut down Cpl Langridge was redacted for the purpose of protecting the MP from embarrassment.²⁴⁶ The evidence has revealed this was not the case. The redaction was applied by DAIP. The CFNIS members involved in the case had no input in applying or recommending it. Further, there is no indication the CFNIS were even aware at the time of the Fynes' complaints about the length of time Cpl Langridge's body was left hanging, so it is difficult to imagine how the information about the direction to cut down the body could have been viewed by anyone as embarrassing. However, this does not mean this redaction was appropriate. On the contrary, it was both unfortunate and unnecessary. It gave rise to an appearance the CFNIS was trying to hide information, and it was nearly impossible to explain rationally. The process of having DAIP apply redactions on the basis of their perception of what the family would need to know, without knowing or consulting the family and without having any familiarity with the background of the case, was bound to lead to such absurd results. In this case, it resulted in an unjustified redaction that contributed to eroding the trust between the Fynes and the CFNIS.

75. The application of this discretionary determination by the DAIP as to what information the Fynes could receive was a direct result of DAIP's interpretation of the PEN form. Because they did not view the consent to the release of personal information as extending to information created after signature or after death, they determined only the public interest analysis was available to authorize the release of the CFNIS report. The CFNIS was not involved in coming up with this interpretation, and some of the members involved appeared to disagree with it. For instance, Maj Dandurand explained to the Fynes that when he received the first version of the redacted report, he thought there had been an error in redacting it as if an Access to Information request had been made by a third party, instead of acknowledging Mr. Fynes, as Cpl Langridge's PNOK, was entitled to obtain information about him.²⁴⁷ In testimony, he indicated his "immediate assumption," upon reviewing the report provided to the Fynes, was there had been a "clerical error," because the Fynes, as next-of-kin and executor, were entitled to receive a report redacted "as though Corporal Langridge were requesting this report himself."²⁴⁸ Maj Dandurand testified he made attempts to rectify the situation when he received the report, indicating he contacted his HQ to suggest the CFNIS enter into

discussions with DAIP in order to have a report with fewer redactions provided to the Fynes.²⁴⁹

76. In her testimony, Ms. Jansen confirmed her view, as the DAIP, that the consent to release personal information in the PEN form cannot apply to information not in existence at the time of signing of the form or, at least, not in existence at the time of the person's death, including post-death BOIs and MP investigations.²⁵⁰ However, she added the situation was not clear:

I wish it would have been that clear and we could make a decision on something so clear but we had to work with the PEN form that was not clear and left to the impression that it was giving authorization to give everything when the purpose was to only give access to limited information, so we had to work with that kind of situation at the time.²⁵¹

77. Nevertheless, she confirmed the advice provided by DAIP to the MP was that the PEN form could not authorize the release of information created after Cpl Langridge's death.²⁵² The subsequent change of position that led to the second version of the report being provided to the Fynes was not representative of an overall change of policy at DAIP about the interpretation of the PEN form. Rather, Ms. Jansen explained a decision was made specifically for this case to adopt a different approach, because "any act is left to interpretation or any law is left to interpretation."²⁵³ This change in approach by DAIP was the main factor accounting for the significant difference in the number of pages released in the first and second versions of the report provided to the Fynes, and largely explains why the report nearly doubled in size between the two releases.²⁵⁴ As a result, many of the questionable redactions applied by DAIP to the first version were removed in the second version.

78. It should be noted, in this particular instance, the CFNIS members involved did advocate for the release of more information, and this may have contributed to DAIP's decision to adopt a different approach in this case. However, there has been no general change of policy at DAIP.²⁵⁵ As a result, requests for Sudden Death investigation reports made in the future will be treated in the same manner as the Fynes' request was initially treated, even where the PEN form includes a signed consent to the release of information.²⁵⁶ The newest version of the PEN form no longer provides for the option to

sign this consent, so any requests involving a CF member who signed a new PEN form would be processed pursuant to the DAIP's discretionary determination of what information should be released in the public interest.²⁵⁷ There is no evidence the CFNIS has taken any steps to challenge this general approach or to advocate for a different approach to the release of their death investigation reports to families.

79. One of the other redactions that appeared to strike the CFNIS members involved as inappropriate was the blacking out of Mr. Fynes' own comments to the investigator. LCol Sansterre testified he agreed with some of Mr. Fynes' complaints because "there was stuff redacted that was his own personal stuff."²⁵⁸ Maj Dandurand thought errors were made in the redaction of the first version of the report, and specifically indicated references to the person making the request and their own statements should not be redacted.²⁵⁹ During his meeting with the Fynes, he speculated the desk officer in charge of severing the second version of the report likely understood it would go to Cpl Langridge's personal representative, but did not understand Mr. Fynes was the person making the request,²⁶⁰ which would explain why Mr. Fynes' own statements are redacted.

80. Ms. Jansen indicated DAIP does not generally redact the requestor's own comments to an investigator, unless the comments are about another person.²⁶¹ About the release of video recorded interviews conducted by the CFNIS, she indicated DAIP would normally release the entire recording to the individual who was interviewed "without even doing any severances whatsoever."²⁶² In this case, only Mr. Fynes' comments about Ms. A were redacted in the second version of the report.²⁶³ These redactions were stated to have been made because the information was about an individual other than the person who requested the information.²⁶⁴ In the first version, much more information was redacted, including Mr. Fynes' comments to MCpl Ritco about Cpl Langridge's cell phone, his hopes the persons who sold drugs to Cpl Langridge would be investigated, his comments about the state of Cpl Langridge's residence and the arrangements made with the Regiment for him to move out, as well as all of his comments about the funeral.²⁶⁵ The grounds invoked for those redactions were that the information related to police techniques or was information about another individual.²⁶⁶ Ms. Jansen could not indicate with certainty whether the redactions were the result of MP suggestions or DAIP

decisions.²⁶⁷ It should be noted the relevant MPPTP Chapter applicable at the time contained a section indicating that “any individual who gives a statement has the right to a copy of that statement in whatever form it was recorded, pursuant to the provisions of the *Privacy Act*.”²⁶⁸

81. It is difficult to understand why any of the information provided by Mr. Fynes to the CFNIS should be redacted from the report provided to Mr. Fynes. The notion any of this information could be covered by an exemption for police techniques stretches credulity. While it is not for the Commission to pass judgment on the legal aspects of the application of the *Privacy Act*, redacting information about another individual also appears to make little sense when applied to Mr. Fynes’ own comments to the investigator. For these reasons, the Commission considers the redactions to Mr. Fynes’ own statement in the first version of the report not to have been justified, and the redactions in the second version to be, at best, questionable. It is not clear whether DAIP, the MP, or both were responsible for these specific redactions. The CFNIS members who were subjects of this complaint certainly did not agree with them.

82. Other redactions covered information essential for any reader to gain an understanding of the investigation. The most important was the redaction of MCpl Ritco’s Investigation Plan in full, on the basis that it would reveal police techniques.²⁶⁹ Based on the evidence, it is likely, but not confirmed, this redaction was recommended by the MP and accepted by DAIP. It is difficult to see how disclosing the investigation plan for this concluded investigation would risk revealing police techniques. On the other hand, without this document, it would have been difficult for the Fynes to understand the investigation report and the issues being investigated.

83. The following two paragraphs from the summary of the interview with MCpl Bowden were also redacted:

d) she attended lunch and upon returning to the LDSH she was confronted by MCpl Fitzpatrick who questioned her on what she did as the LDSH RSM wants to see her in his office;

e) she attended the RSM office, where she was confronted on who gave her permission to use the word “suicide” on her email, she explained that no one had given her permission and that she was just following MCpl Fitzpatrick’s direction regarding replying to his

request via email;²⁷⁰

84. This was an important piece of information obtained by the CFNIS in their investigation of the suicide watch issue. Removing it from the Fynes' copy of the file would hinder their ability to understand the circumstances described by the witness. The ground invoked for this redaction was that it was personal information pertaining to an individual other than the person requesting the information.²⁷¹ This justification is difficult to accept. The information related to what witnesses did in the course of their work duties, and removing it was liable to give the impression there was an intention to prevent public disclosure of the LDSH chain of command's displeasure at the words "suicide watch" being used. Based on the evidence, it is likely this redaction was applied by DAIP, as the ground invoked relates to privacy and not police methods.

85. Also redacted was the entry indicating the Acting CO of the CFNIS had reviewed the report and concurred with the findings of the investigation.²⁷² The ground invoked for this redaction was that the information could reveal police techniques.²⁷³ Again, this is difficult to understand, and again, it would have been relevant for the Fynes to know the CFNIS chain of command had reviewed and approved the findings they took issue with. As it relates to police techniques, this redaction was likely the result of an MP recommendation.

86. Information related to the handling of the exhibits was redacted in both versions of the report. Part of this information was not printed at all by the MP when the report was sent to DAIP. The part that was printed was redacted in full on the ground that it would reveal police techniques.²⁷⁴ Ms. Jansen explained this type of information is generally redacted by DAIP at the request of the MP, as relating to "evidence and technique of investigation."²⁷⁵ She indicated DAIP's usual practice is to agree to redact all information about exhibits, even after an investigation is concluded.²⁷⁶ While the detailed information about the chain of custody for each item seized would likely have been of little interest to the Fynes, the justification for removing this information in the case of a concluded investigation is dubious. A justification for entirely redacting even the items seized, the date of seizure and the disposal information simply does not exist in

this case. At a minimum, the Fynes would have had an interest in finding out more about when their son's suicide note was seized and exactly what was done with it during the investigation. There was no reason for redacting this information in their copy of the report.

87. In conclusion, many of the redactions in both versions of the report were either not justified at all or, at a minimum, difficult to understand. The responsibility for this rests both with the MP and DAIP. In some cases, it is not possible to determine who made the decision. Where the MP were not directly responsible for the redactions, it still remains the case it was their decision to seek advice from DAIP prior to releasing the report – whether or not they were aware or supportive of the approach DAIP used or even knew there was a choice about seeking advice.

88. More broadly, the CFNIS and the MP have not sought to challenge the existing process, which takes away much of their decision-making power with respect to the release of their own information.²⁷⁷ As a result, the CFNIS ended up in the embarrassing position of providing two versions of the report to the Fynes, with the second containing more than double the information and the reasons for the redactions difficult and at times impossible to explain. In the end result, it took five months for the Fynes to obtain a copy of the report about the investigation into their son's death that still contained many unjustified redactions. This missing information, coupled with the haggling over the redactions and the resulting delay in providing the report to the Fynes, was bound to give rise to an appearance the CFNIS lacked transparency and was not forthcoming in providing information. Coming just on the heels of the late disclosure of the suicide note, these types of unfortunate incidents could only hinder any possibility of establishing a relationship of trust and open communication between the Fynes and the CFNIS.

4.5.3 The November 2009 Briefing

89. On November 28, 2009, almost 18 months after the investigation was concluded, the CFNIS provided a briefing to the Fynes about the 2008 investigation into their son's

death.²⁷⁸ The purpose of the briefing, from the CFNIS' perspective, was largely to appease the Fynes in light of their mounting displeasure following the discovery of the suicide note and the redactions made to the investigation report. Indeed, this face-to-face meeting was an opportunity for the CFNIS to remedy some of its past failures, in particular as they related to the lack of contact and the lack of meaningful information provided to the Fynes. Unfortunately, the conduct of the briefing and the events that followed only provided another illustration of the pitfalls of not establishing proper communication with complainants.

90. The Fynes raised most of the complaints they subsequently brought before this Commission about the 2008 investigation during the briefing. The responses they received fuelled, rather than eased, their frustrations. Had the complaints been better handled when they were initially received, it is possible at least some of them may not have later become part of this hearing. Instead, this was a missed opportunity to establish a much needed open dialogue with the Fynes, and the briefing itself became the source of additional concerns and eventual complaints.

PURPOSE OF THE BRIEFING

91. The decision to provide the briefing was made at the CFNIS HQ level.²⁷⁹ Maj Dandurand, the Officer Commanding the Detachment who was tasked with conducting the briefing, testified he agreed a briefing was necessary.²⁸⁰ In his notes, he had indicated the purpose of the meeting was to provide the Fynes with a briefing on the investigation and to answer their questions.²⁸¹ In testimony, he explained, from his perspective, the desired outcome was “to make sure that the famil[y] had the opportunity to ask all of their questions, to have an open and frank dialogue with us with respect to the investigation.”²⁸²

92. In testimony, Maj Dandurand could not recall whether he was aware of the Fynes' concerns in advance of the meeting.²⁸³ He did know they had received a copy of the investigative report and that it was “significantly redacted.”²⁸⁴ He was also aware there were other issues. He had contacted Maj Parlee, the President of the BOI into Cpl Langridge's death, in advance of the meeting to ask about any concerns the Fynes may

have communicated to him about the CFNIS or the investigation report.²⁸⁵ Maj Parlee had advised the Fynes' main concern would likely be the suicide note, why it was not disclosed to them for so long, and why they did not receive a copy immediately. He had also indicated the Fynes would likely ask for specific details about the processing of the scene where Cpl Langridge's body was found and may have questions about Cpl Langridge's personal effects.²⁸⁶

93. MS McLaughlin, the other CFNIS member tasked with participating in the briefing, testified he was briefed by Maj Dandurand about the reasons for the meeting with the Fynes.²⁸⁷ He understood the purpose was to provide the Fynes a briefing about the 2008 investigation because they had requested to discuss this.²⁸⁸ Based on the information he received from Maj Dandurand, he also understood, prior to the meeting, that the Fynes were "dissatisfied with certain portions of what had been done in the Ritco investigation" and that the briefing would provide an opportunity for the CFNIS members to discuss these issues with them.²⁸⁹ In particular, he was told there had been an issue with the length of time in the release of the suicide note, which Maj Dandurand indicated he would have to address during the meeting.²⁹⁰ Aside from this issue, MS McLaughlin had no knowledge of any other specific issue the Fynes would be raising or discussing about the investigation.²⁹¹

94. In testimony, LCol Sansterre indicated he had no prior discussions or awareness of what Maj Dandurand planned to speak about in the meeting, but assumed he would brief the family about the file and answer their questions.²⁹² He noted that conducting face to face briefings with families about a concluded investigation was not the usual practice at the time.²⁹³

95. It is clear this briefing to the Fynes was ordered by CFNIS HQ over a year after the investigation ended because of the special circumstances of this case. The CFNIS members in command at HQ and in the Detachment knew before the briefing the Fynes took issue with some of what had been done or had been left undone by the CFNIS and were hoping the briefing would contribute to alleviating the Fynes' frustration in these respects. The briefing followed LCol Sansterre's initial offer in the summer of 2009 to

have CFNIS investigators or “CFNIS personnel familiar with the file” provide a briefing to the Fynes about the police investigation.²⁹⁴ This offer directly followed the discovery of the suicide note.²⁹⁵ It was reiterated in response to Mr. Fynes’ strong objections about the redactions to the report.²⁹⁶ Maj Dandurand was also aware of the issues.²⁹⁷ He had contacted the Fynes’ AO, Maj Parkinson, shortly after LCol Sansterre’s initial call to the Fynes and had asked him to “track” the Fynes’ satisfaction with the timeliness of the receipt of the 2008 report.²⁹⁸ Maj Parkinson had advised the CFNIS’ efforts would “go a long way to right the wrongs” but had indicated the Fynes were a difficult family to please.²⁹⁹ Maj Dandurand had reported back to LCol Sansterre that he understood the Fynes’ frustrations and hoped he and his colleagues could “end those frustrations as far as the CFNIS goes.”³⁰⁰

PREPARATION FOR THE BRIEFING

96. Neither of the two CFNIS members who conducted the briefing had been involved in conducting the 2008 investigation. Maj Dandurand became the OC for the Detachment in July 2008,³⁰¹ after the investigation was concluded. He had been involved in the discussions surrounding the discovery of the suicide note in 2009,³⁰² but had no prior involvement in the file. Maj Dandurand was tasked with conducting the briefing because of his position. In testimony, he explained providing family briefings was generally a task performed by Detachment Commanders or “as high up the chain as possible.”³⁰³ MS McLaughlin, for his part, was an investigator at the Detachment since 2007.³⁰⁴ He had been involved briefly in taking notes during an interview conducted in the 2008 investigation, but had no other involvement in the case.³⁰⁵ He testified he was asked to attend the briefing because he was still working at the Detachment and was available to attend at the requested time.³⁰⁶ He explained part of the reason for his presence was also “to speak on my experience and expertise as an investigator should they have any questions related to investigative process and procedures and techniques,” since Maj Dandurand was the OC for the Detachment and not a general investigator.³⁰⁷ When the meeting was held, MS McLaughlin had been an investigator with the CFNIS for two years.³⁰⁸

97. MCpl Ritco, the lead investigator for the 2008 investigation, was still a CFNIS member when the briefing was held, but was on secondment with the RCMP at the time.³⁰⁹ In testimony, Maj Dandurand was asked why MCpl Ritco was not present at the briefing. He indicated it was not customary for the CFNIS to have the actual investigator in charge of the file present in such meetings.³¹⁰ MS McLaughlin stated he was not aware of the reasons and never had any discussions about it.³¹¹ When Mrs. Fynes commented during the briefing that MCpl Ritco should have been present to answer their questions, Maj Dandurand answered that he could not “speak to that decision.”³¹² No other explanation was provided to the Fynes or to this Commission.

98. In preparation for the meeting, Maj Dandurand reviewed the 2008 investigation file.³¹³ He explained his focus was to make sure he had a sense of the totality of the information found in the file, as some of it would be redacted in the Fynes’ copy. He stated he wanted to be able to speak to the general themes addressed in the redacted portions, in order to assure the Fynes that nothing was redacted except national security, police practices and private information.³¹⁴ It does not appear Maj Dandurand had any discussions with MCpl Ritco or the other CFNIS members involved in the 2008 investigation in preparation for the meeting. He recalled one conversation with MCpl Ritco about the investigation after the meeting, and possibly one other when the failure to disclose the suicide note was discovered, but did not mention any specific discussion in preparation for the meeting.³¹⁵ He did not discuss the 2008 investigation with Sgt Bigelow or WO Ross Tourout, as they had left the Detachment by the time he assumed command.³¹⁶ The one issue Maj Dandurand did inquire into prior to the meeting related to the notation in the investigation report that Cpl Langridge’s room was “in disarray.”³¹⁷ Maj Dandurand was told this simply indicated “bachelor-type living,” as opposed to the room being “trashed.”³¹⁸ In testimony, he could not recall whom he spoke to about this issue, but though he likely discussed it with MS McLaughlin, as they were working in close collaboration to prepare for the meeting.³¹⁹

99. MS McLaughlin, for his part, did not review the file prior to the briefing.³²⁰ He also did not discuss the investigation with MCpl Ritco or other investigators involved.³²¹ He testified his only tasking in preparation for the meeting was to verify what exhibits

were still held in the Detachment's evidence room.³²² Maj Dandurand explained he asked MS McLaughlin to look into "exactly what the state of our evidentiary holdings was at that time" for the 2008 investigation file.³²³ MS McLaughlin indicated this was done "to ensure that everything that had to be returned or disposed" had in fact been returned or disposed, so that only police exhibits like interview recordings and witness statements were retained.³²⁴ According to him, this type of verification was common.³²⁵ In order to carry it out, MS McLaughlin went through the evidence continuity logs to identify what items were still retained.³²⁶ He then physically signed out all of the items.³²⁷ He explained the goal was to be able to confirm for the Fynes the CFNIS were only holding in their evidence room items that "were NIS property such as videos, statements, etc."³²⁸ MS McLaughlin provided the items to Maj Dandurand for review, and discussed them with him, as Maj Dandurand wanted to know before the meeting about everything still being held.³²⁹

CONDUCT OF THE BRIEFING

100. The meeting with the Fynes lasted approximately four hours,³³⁰ during which time the Fynes did most of the talking.³³¹ The discussions were wide ranging and, at times, difficult to follow. The Fynes' frustration was obvious. Mr. Fynes testified: "to their credit, [the CFNIS members] listened to us with a litany of complaints."³³² Many of these complaints were unrelated to the CFNIS investigation.³³³ For the most part, the CFNIS members listened in silence and attempted to understand the chronology of events and the Fynes' concerns. Other concerns were directly related to the CFNIS investigation. The CFNIS members participated more actively in discussions about those concerns.

101. The Fynes had just received a less redacted version of the report for the 2008 investigation.³³⁴ During the briefing, they expressed many concerns and formulated several complaints about the conduct of that investigation. Their complaints included:

- strenuous objections to Cpl Langridge's body being left hanging for hours, along with allegations this showed a lack of respect for him as a soldier, and this was motivated by the CFNIS members' view that Cpl Langridge was a defaulter or a "failure" and hence not deserving of proper respect;³³⁵

- equally strenuous and frequent complaints about the fact Cpl Langridge’s suicide note was withheld from the Fynes and not mentioned on any lists of property provided to them, including the fact that, as a result, the Fynes were unaware their son did not want a military funeral;³³⁶
- complaints about the finding in the 2008 investigation report’s Concluding Remarks indicating “Cpl Langridge suffered from alcohol and cocaine addiction which caused him to have mental health issues” and concluding this was a factor in the suicide,³³⁷ – which Mr. Fynes characterized as a “medically incorrect” opinion³³⁸ – as well as about the finding that Cpl Langridge’s military unit made efforts “to provide structure and support to Cpl Langridge”³³⁹ and “made several attempts to help Cpl Langridge in dealing with his problems”³⁴⁰ – which Mr. Fynes characterized as irrelevant editorializing, emphasizing instead, in his view, it was treatment Cpl Langridge needed and did not receive;³⁴¹
- repeated complaints and questions about why “such a big investigation on the part of the police” was necessary in this case, why the investigation was so comprehensive, and why the CFNIS continued its investigation beyond the ME’s determination the death was a suicide;³⁴²
- several complaints reflecting the Fynes’ apparent belief the CFNIS members involved in the 2008 investigation exhibited bias in their approach to Cpl Langridge, including:
 - the lead investigator “cherry-picked” information from an incomplete portion of Cpl Langridge’s medical files and used it to come to his conclusions, despite contrary information being present in other portions of the medical files;³⁴³
 - lack of respect for Cpl Langridge even tainted the manner in which the CFNIS investigators initially described the room where his body was found, describing it as being in “disarray”;³⁴⁴ and

- witnesses who provided information reflecting poorly on Cpl Langridge were interviewed, while others who could speak to his military career and accomplishments were not;³⁴⁵
- complaints about the fact CFNIS reported holding “approximately 13 exhibits,” but had the investigation “signed off as complete” while exhibits were still outstanding, and did not return the exhibits to the Fynes in a timely manner after the conclusion of the investigation;³⁴⁶
- a complaint the ME Investigator inaccurately noted in his report that Cpl Langridge had disciplinary issues and an allegation this was based on information provided to him at the scene;³⁴⁷ and
- complaints about the redactions made to the copies of the report provided to the Fynes.³⁴⁸

102. Maj Dandurand and MS McLaughlin did not take any steps during or after the briefing to refer these complaints to Professional Standards for investigation. They also did not advise the Fynes about the existence of a complaints process. Instead, they attempted to deal with the issues directly. However, not having been involved in the investigation, they were often unable to answer the Fynes’ questions or to provide factual information to address their concerns. The discussions focused on general explanations and justifications. Some of the information provided was not entirely accurate or not entirely applicable to the specific facts of this case. In other instances, the members promised to obtain additional answers but never provided them.

103. In response to the complaints and questions about why Cpl Langridge’s body was left hanging, Maj Dandurand and MS McLaughlin explained it was the ME who owned the scene and was entitled to make such decisions.³⁴⁹ Maj Dandurand also pointed out CFNIS members approach scenes with impartiality and do not know the individual involved, so any delay in cutting down Cpl Langridge’s body could not have been the result of any feelings of disrespect for Cpl Langridge as an individual.³⁵⁰ While this was

correct in the abstract, neither member knew who had in fact been responsible for making the decision about when to cut down Cpl Langridge's body in this case or why the body was not cut down sooner.³⁵¹ Maj Dandurand told the Fynes he would need to speak to the lead investigator to obtain an answer to these questions.³⁵²

104. Maj Dandurand also provided this description of the ME's authority at the scene:

Here's the thing -- the thing is, Sheila, the medical examiner owns the scene [...] It's actually not my scene until he attends, and until he says what's to happen. And actually [...] the military police follow his directions explicitly. I mean, he's going to -- if he says "do this", then we do it. If he says "seize that bottle.", "Grab that 26-ounce bottle.", "Grab that pill case.", then that's what we do.

[...]

And then once he's satisfied -- or she -- once they are satisfied that their direction has been followed, and they determine what occurs, then we have the scene, and we can process it for all the other criminal/forensic processing that we need to do.³⁵³

105. This does not correspond to the actual events in this case. The investigators involved in the 2008 investigation did not follow the ME's direction in determining what exhibits to seize or how to process the scene.³⁵⁴

106. With respect to the suicide note, Maj Dandurand expressed regret that it took so long after the investigation was concluded to disclose the note, but insisted on the need to keep the note for a certain period after the death.³⁵⁵ Maj Dandurand's explanations – which were generally interrupted and were never completed – focused on how CFNIS policies and practices had been changed as a result of this case.³⁵⁶ He told the Fynes there was at the time a policy dictating not to divulge such notes until it was determined the death was in fact a suicide, indicating: “you have to appreciate that at the time, when you're dealing with a death, it's viewed as suspicious.”³⁵⁷ He began to describe what would be done under the current practices, indicating the note would still not be provided until foul play was ruled out, which he said might not happen “until well after the funeral”, but certainly hinting it would be provided much sooner than in the Fynes' case.³⁵⁸ Regarding the specific mention in Cpl Langridge's suicide note of his wishes for his funeral, Maj Dandurand said:

The thing is, though, is this: What if -- what if it was foul play, and there was this left behind, and then you act on that?³⁵⁹

107. Entirely absent from Maj Dandurand's explanations was any account of the specific reasons why Cpl Langridge's suicide note was not disclosed to the Fynes in this case. He did not tell them whether this was the result of an oversight or of a deliberate decision made at the time, and, if there was a decision, what it was based on. He also did not discuss whether foul play was in fact ruled out in this case – or could have been – before Cpl Langridge's funeral.

108. With respect to the Fynes' complaints and questions about why the CFNIS investigation took so long and was so comprehensive, Maj Dandurand provided general explanations about CFNIS caseload and the need to keep an open mind.³⁶⁰ He also indicated the CFNIS does not "put all our eggs in that one basket" by relying 100% on the coroner's findings without independent investigation.³⁶¹ Maj Dandurand did not provide any specifics about what was actually being investigated during the three-month investigation into Cpl Langridge's death. He made no reference to the investigation into the suicide watch issue, which was the main issue pursued after the first few days of the investigation, and which was unrelated to confirming suicide as the manner of death.³⁶²

109. Maj Dandurand did provide an example of a step that might need to be completed by the CFNIS prior to placing reliance on an ME's suggestion that the death was suicide, referring to a potential examination of the outside of the building, presumably for the purpose of determining whether someone else could have been present when Cpl Langridge died.³⁶³ As it happens, this was in fact a step that never was undertaken in this case. The omission had been explicitly criticized in a Quality Assurance report about the investigation, which Maj Dandurand had received in June 2009.³⁶⁴ When this example was used during the meeting, the Fynes were not told this step had not been completed in their son's case, nor that it was subsequently determined it should have been.

110. When Mr. Fynes questioned a reference in previous correspondence to the CFNIS holding "approximately 13 exhibits," Maj Dandurand told the Fynes "our [SAMPIS] system won't lie."³⁶⁵ He then indicated MS McLaughlin had signed for all the exhibits

that were still held.³⁶⁶ Both Maj Dandurand and MS McLaughlin assured the Fynes the remaining exhibits were police-related exhibits – like officer notes and videos – and not Cpl Langridge’s personal belongings.³⁶⁷ Mrs. Fynes specifically asked whether they had any of Cpl Langridge’s personal effects and MS McLaughlin answered: “No, we do not. The personal effects, those are all gone, they’re all returned.”³⁶⁸ This did not answer the Fynes’ concerns about the initial description of the number of exhibits seized. No further information was provided about the actual number of exhibits seized or the reason for not returning them to the Fynes immediately when the investigation was concluded.

111. It is also not clear the statements made about the exhibits retained were entirely accurate. When they had conducted their review of the exhibits before the meeting, Maj Dandurand and MS McLaughlin had discovered, in addition to the officer notes and videos, that the CFNIS were still holding four other items: a pill dispenser, an empty pill bottle, a bubble pill pack, and a copy of a medical form for Cpl Langridge seized from his Jeep.³⁶⁹ No explanation was provided as to why, when this topic was specifically discussed with the Fynes during the briefing, they were assured only “police exhibits” were retained and were not told about these other items. In their testimony, all Maj Dandurand and MS McLaughlin stated was they did not view these items as personal property.³⁷⁰ They explained some of the items contained prescription medication, which was the reason for not returning them to the family, but could provide no clear or consistent explanation about why the other items were not returned.³⁷¹ Maj Dandurand testified he was thinking at the time CFNIS WR were holding all remaining items “in line with our evidence policy and, therefore, that we were right to have them.”³⁷² He did not inquire – before or after the meeting – into the reasons why these items were still being held in the evidence room almost a year and a half after the conclusion of the investigation or into the reasons why they were not listed with other evidence disposed of following the conclusion of the investigation.³⁷³

112. As for the concerns raised by the Fynes about the mention of disciplinary issues in the ME’s certificate, Maj Dandurand told the Fynes that, while there was an initial note in the investigative file indicating Cpl Langridge was suspected of being on defaulters, this point was cleared up during the investigation, and it was clarified that he was not on

defaulters.³⁷⁴ No information was provided about what the CFNIS investigators had in fact told the ME and whether their comments were the source of the reference in the certificate.

113. About the redactions made to the investigation report, Maj Dandurand and MS McLaughlin provided general explanations about the process – including a statement that police notes are not generally disclosed, which turned out to be inaccurate – but could provide no information about the specific reasons for the redactions made to the report.³⁷⁵ Their overall message was that the CFNIS was not responsible for making decisions about the redactions and there was nothing they could do about this issue.³⁷⁶ This explanation did not reflect the actual process followed in this case for redacting the 2008 investigation report.³⁷⁷

FOLLOW UP

114. In the first paragraph of the notes Maj Dandurand made about the briefing, he wrote: “the purpose of the interview was to provide them a briefing [...] and to ensure their questions were either answered or taken down for providing them answers at a later date.”³⁷⁸ During the briefing, Maj Dandurand repeatedly assured the Fynes he would be providing them with answers to all of their questions and concerns.³⁷⁹ He specifically stated they should have full satisfaction that all queries related to CFNIS responsibilities were either answered or noted down to be answered later.³⁸⁰ He also made specific commitments to obtain answers to particular questions. For example, he indicated he would be speaking to his CO “on Monday morning” to discuss the Fynes’ concerns about the Concluding Remarks.³⁸¹ He also promised he would speak to MCpl Ritco to get an answer to the Fynes about why the body was left hanging for so long.³⁸²

115. Two days after the briefing, Maj Dandurand wrote to the CFNIS PAO.³⁸³ He provided an update about the meeting and indicated:

We have many questions to answer and have created a list of them from the interview tape itself (I taped it so nothing was missed or omitted from our end). I plan to now answer [these] questions; however, I wish to send my responses to the CO and yourself for input. I’ll be in touch tomorrow.³⁸⁴

116. On the same day, MS McLaughlin prepared an e-mail containing a list of questions the Fynes posed during the briefing.³⁸⁵ In testimony, Maj Dandurand explained he had asked MS McLaughlin to prepare this list in order to ensure they would have “quick references” to the Fynes’ concerns.³⁸⁶ MS McLaughlin explained the e-mail was an attempt to list and separate the issues, and was prepared on the basis of his recollection of the meeting and his review of the audio recording for the portion of the meeting that was recorded.³⁸⁷

117. In his e-mail, MS McLaughlin noted the questions listed were those concerning the CFNIS and its investigation.³⁸⁸ He added, the Fynes also made comments about the BOI process, but these were not listed as the BOI report had not yet been released.³⁸⁹ The following fifteen items were listed:

- Why was the suicide note not disclosed until 14 months after the suicide
- Why was Stewart [*sic*] left hanging for 4 hours before he was cut down
- Someone was surfing the internet from Stewart’s [*sic*] BB account just after his death. How is that possible
- What is the role of the CFNIS vice the BOI
- Why did an investigation into an “obvious suicide” take so long
- Why was the investigation so comprehensive
- MCpl Ritco stated in his concluding remarks that Stewart [*sic*] was addicted to drugs and alcohol. This should not be since MCpl Ritco is not qualified to make this assessment (**either change the concluding remark or provide an apology**)
- MCpl Ritco concluded that the Unit tried to provide structure and support for Stewart [*sic*]. Further, the report indicates Stewart [*sic*] was residing in defaulters barrack. This indicates that Stewart had disciplinary issues. Why does the investigation reflect Stewart [*sic*] as having been a disciplinary problem [versus] having suicidal tendencies and being on suicide watch
- MCpl Ritco took details and photographs of the condition of the jeep. It appears the person(s) responsible for the jeep allowed for it to incur damages during the time they were in possession of it. Why are the photos not disclosed to the family.
- several people were interviewed and provided information that reflects poorly on Stewart [*sic*]. Why was no one interviewed that would provide information speaking to Stewart [*sic*] bright Military Career and accomplishments.
- Why did MCpl Ritco comment in his report that Stewart’s [*sic*] room was in disarray, with pornographic posters. Further, why have the parents not received his pornographic posters

- Why did it take so long for the family to be provided with Stewart's [*sic*] belongings. They incurred a cost to maintain a storage container to place all the items in, however the items were not released for three months after
- What was the location of a chair and stool held by the unit. The unit was itemized and was to be sent to the family. The items were not provided to the family until they threatened a lawsuit and police involvement.
- Why has the Fynes family not been given the memorial cross in memory of Stewart's [*sic*] death
- A member of the BOI had requested a meeting with the Fynes' lawyer [versus] speaking with the Fynes' directly. This cost was incurred on the Fynes'. Why are they responsible for paying for this meeting if the member requested to speak with their lawyer [versus] speaking with the Fynes' personally.³⁹⁰ [Emphasis in original]

118. Despite Maj Dandurand's expressed intentions and his early plans to provide answers to all of the Fynes' questions, follow up activity was limited.

119. Maj Dandurand did follow up on the issues raised about the Concluding Remarks. He spoke to the CFNIS CO and suggested the Remarks should reflect the cause of death, "be kept short and be factually representative of what had happened and not editorialize."³⁹¹ On March 2, 2010, the day before a second meeting was scheduled with the Fynes,³⁹² Maj Dandurand entered a note in the 2008 investigative file indicating LCol Sansterre had provided authorization to amend the Concluding Remarks for the investigation.³⁹³ In testimony, he explained this was likely done at that time because he was catching up on his administrative tasks and ensuring everything was done prior to the second meeting, but did not necessarily reflect the time when he had the discussion with LCol Sansterre about this issue.³⁹⁴ Indeed, MS McLaughlin testified Maj Dandurand had told him prior to the December 2009 break that the Concluding Remarks would be rewritten to address Mr. Fynes' concerns.³⁹⁵

120. The new Concluding Remarks, also dated March 2, 2010 and authored by Maj Dandurand, simply stated it was determined, following examination of the scene and subsequent interviews, and further supported by the ME's findings, there were no signs of foul play in the death of Cpl Langridge and the death was deemed to be a suicide.³⁹⁶ The accompanying GO file entry described the two issues identified as problematic by the Fynes, stated the Remarks would be rewritten and indicated the new version would form

the official Concluding Remarks for the report.³⁹⁷ During his March 3 meeting with the Fynes, Maj Dandurand presented the new Remarks to them.³⁹⁸ He explained the original Remarks would remain on the file, but this new version would now be the official Concluding Remarks.³⁹⁹ The Fynes indicated they did not take issue with this manner of proceeding,⁴⁰⁰ and thanked Maj Dandurand several times for changing the Remarks.⁴⁰¹

121. Follow up was also done with respect to the CFNIS pictures of Cpl Langridge's Jeep. During his second meeting with the Fynes, Maj Dandurand provided them with the pictures taken shortly after the death, which could be used to demonstrate the Jeep was not in the same condition when the Regiment subsequently returned it.⁴⁰² The CFNIS members also made inquiries in an attempt to follow up on the issues raised about the BlackBerry usage.⁴⁰³

122. Further, Maj Dandurand brought some of the Fynes' concerns to the attention of the LFWA during a meeting held to address issues viewed as peripheral to the CFNIS investigation.⁴⁰⁴ After the meeting with the Fynes, Maj Dandurand had written in his notebook that the concerns they raised would be forwarded to those responsible for the BOI, as they fell outside the CFNIS mandate.⁴⁰⁵ During his subsequent meeting with LFWA, he communicated several of the Fynes' concerns, including: issues about the condition of the Jeep and the return of Cpl Langridge's property by the Regiment; the cost they incurred to have Cpl Langridge's death certificate corrected; the cost they incurred for legal fees in connection with the meeting held with the BOI's legal advisor; issues surrounding the awarding of the Memorial Cross to the Fynes and the recognition of Cpl Langridge at the Western Area Memorial; as well as the issues raised by the Fynes about certain comments they overheard during the BOI process.⁴⁰⁶ In testimony, Maj Dandurand explained he brought the matters he "deemed not criminally relevant" to the attention of the LFWA because he believed they would be in a position to rectify them.⁴⁰⁷ All of these issues were unrelated to the CFNIS' own prior investigation.

123. The concerns directly related to the 2008 investigation did not receive the same (or any) follow up. Aside from the changes made to the Concluding Remarks, there is no evidence any action was taken to address them.

124. When asked about how follow up was conducted to address the issues raised by the Fynes, MS McLaughlin explained his own focus was on investigating the PNOK allegations.⁴⁰⁸ He described the other issues raised about the 2008 investigation as “administrative” and indicated Maj Dandurand was in charge of following up on all such issues.⁴⁰⁹ He explained:

[T]hose issues would be dealt with because they're not investigative issues, they're administrative issues. They want action and answers taken on some of these because they're relative to the investigation conducted by Master Corporal Ritco.

[...]

So, those are put to the OC so that he can liaise with those higher authorities either whether it's within our own chain of command or outside of that chain of command to identify how we're going to address these issues. So, that's with him.⁴¹⁰

125. MS McLaughlin was not aware of how Maj Dandurand planned to address these issues.⁴¹¹ He was not involved in any follow up on these matters beyond forwarding the list of questions.⁴¹² He was not aware whether the Fynes ultimately received any answers, either before he left for deployment in January 2010 or at any time after.⁴¹³

126. In testimony, Maj Dandurand confirmed no written response was prepared to the questions listed in MS McLaughlin's email.⁴¹⁴ LCol Sansterre did not recall receiving a list of the Fynes' questions or of the proposed answers.⁴¹⁵

127. Of the 15 questions listed in MS McLaughlin's e-mail, eight received some form of follow up, or at least were discussed by Maj Dandurand with LFWA. The remaining seven questions, as well as additional questions not noted in MS McLaughlin's list but raised by the Fynes during the meeting – all of which were directly related to the 2008 CFNIS investigation – were not addressed. As a result, aside from the limited discussions that occurred during the briefing itself, questions about the following issues remained unanswered:

- the suicide note;
- the treatment of the body;
- the length of the investigation;

- the comprehensiveness of the investigation;
- the distinction between the role of the CFNIS and the BOI;
- the notation in the report indicating that Cpl Langridge may have been on defaulters and not indicating he was on suicide watch;
- the reasons for interviewing persons who provided information reflecting poorly on Cpl Langridge while not interviewing persons who could provide positive information;
- the reasons why the entirety of the property described as being in Cpl Langridge's room was never returned to the Fynes;
- the mention of disciplinary issues in the ME's certificate; and
- the redactions to the 2008 investigation report.

128. The Fynes were still asking many of those same questions over a year later when Col Gerard Blais was appointed as their contact for all CF-related matters.⁴¹⁶

129. In particular, Maj Dandurand did not get back to the Fynes after the briefing as promised with an answer about the reasons for leaving Cpl Langridge's body hanging during the processing of the scene or with an explanation as to why this length of time was required prior to removing it, nor did he ask MCpl Ritco those questions. In testimony, Maj Dandurand indicated he could not recall whether he provided the Fynes with an answer about this issue.⁴¹⁷ He did have a discussion with MCpl Ritco after the meeting, but he did not recall asking him a specific question or obtaining a specific explanation about the time it took to cut down Cpl Langridge's body.⁴¹⁸ Instead, he indicated he asked MCpl Ritco to provide a description of the sequence of events that unfolded.⁴¹⁹ During his next meeting with the Fynes in March 2010, the issue was discussed again and Maj Dandurand indicated he could not provide insight about the reasoning of the MP first responders for not cutting down the body sooner, as he had not asked the question.⁴²⁰ He did not then provide an explanation about the reasons why the body was not cut down sooner after the CFNIS investigators arrived. The Fynes were still asking the question in January 2011.⁴²¹

130. In testimony, Maj Dandurand admitted “the follow-up was sparse and was not up to the standard of follow-up that we would come to expect from an NIS detachment.”⁴²² He provided no additional information to explain the failure to follow through with his initial plan to prepare answers to the Fynes’ questions. He was asked whether the questions listed in MS McLaughlin’s e-mail were addressed during subsequent meetings with the Fynes. He indicated he believed some of them were discussed, but noted he would have to go through the list in more detail to confirm whether he answered each of the questions specifically.⁴²³ On the whole, he testified his general impression was that the issues listed had “for the most part” been addressed during the subsequent meetings with the Fynes.⁴²⁴ Having reviewed the transcripts for those two meetings, it is apparent to the Commission, while many of the topics were brought up again by the Fynes – both to seek answers and express their dissatisfaction – the discussions continued to focus on general explanations or justifications.⁴²⁵ No additional specific, factual answers were provided to the questions listed.

COMPLAINTS ABOUT THE CONDUCT OF THE 2008 INVESTIGATION

131. The *National Defence Act* establishes the process that must be followed when complaints about the conduct of Military Police members are made. The Act provides that such complaints may be made orally or in writing to a number of designated persons, as well as to “any member of the military police.”⁴²⁶ The member of the MP who receives the complaint has a number of obligations, including, if the complaint is not in writing, to put it in writing, and to “ensure that notice of complaint is sent as soon as practicable” to the CFPM and the MPCC Chair.⁴²⁷ Under the Act, the CFPM is then responsible for dealing with the complaint (in practice these duties are delegated to the Deputy Commander of the CF MP Gp).⁴²⁸ The CFPM has authority to determine whether the complaint can be resolved informally and to attempt such resolution if considered appropriate.⁴²⁹ The CFPM also has authority to determine whether an investigation of the complaint is required.⁴³⁰ Where an investigation does take place, the CFPM Professional Standards personnel will conduct it, and the CFPM will then determine what actions to take to dispose of the complaint.⁴³¹ If a complainant is dissatisfied with the results of the CFPM investigation – or with the CFPM’s decision not to investigate – the complainant

can refer the complaint to the MPCC for review.⁴³² In certain cases – in particular, where the MPCC Chair considers it advisable in the public interest – the MPCC, rather than the CFPM, will be in charge of conducting the initial investigation into the complaint.⁴³³

132. The policy guidance available to MP members at the time of the briefing to the Fynes emphasized the importance of advising complainants about the complaints process. Chapter 13 of the MPPTP stated that members of the public often contact the MP to seek explanations about specific incidents or policies, seeking to obtain information rather than to lodge a complaint.⁴³⁴ In such cases, the policy encouraged MP members to answer the queries and provide assistance in preparing a complaint form if the person still wished to submit a complaint after receiving the information. The policy stipulated:

The complainant **shall** be made aware that if his/her queries are not satisfactorily answered, the complaint **shall** be documented by either the complainant or the Military Police member on the Military Police Public Complaint form and forwarded to the Deputy Provost Marshal Professional Standards for action.⁴³⁵ [Emphasis added]

133. The policy also reiterated the statutory requirement to transmit complaints to the CFPM, indicating “if a member of the Military Police receives the complaint, he/she **shall** forward the complaint to the CFPM.”⁴³⁶

134. The complaints made by the Fynes about the conduct of the 2008 investigation were not forwarded to the CFPM or the MPCC. The Fynes were not notified, during or after the briefing, about the existence of a complaints process overseen by a civilian agency.⁴³⁷ Mr. Fynes testified he learned of the existence of such an agency over a year later through Internet research.⁴³⁸ It was as a result of acquiring this knowledge that the Fynes filed their initial complaint with this Commission, which includes many of the allegations they had already made during the briefing.⁴³⁹

135. In testimony, Maj Dandurand recognized many of the concerns expressed by the Fynes during the briefing were complaints about an investigation conducted by the CFNIS.⁴⁴⁰ However, he testified he did not believe the complaints needed to be referred to the relevant authorities or processed as complaints.⁴⁴¹ He stated he was dealing with a family who were “full of questions” and may have had a “lack of understanding of

contemporary investigations” and of the manner in which the CFNIS conducted investigations.⁴⁴² As a result, he testified he did not believe their comments constituted formal complaints, but rather thought they “required discussion.”⁴⁴³ He indicated he was “making an assessment of the situation and trying to conduct a briefing with the family.”⁴⁴⁴ He explained:

I can say that my goal in that first meeting was to be able to have a good relationship with them, to be able to have them walk away with questions answered and to feel as though their interaction was what they would come to expect from a major crimes unit, not at first sign of their dissatisfaction with something to turn around and say, well, it's all well and good that you've come to me but here's another phone number to call to raise your concerns with, because it was very evident at that time that they were not satisfied with their interactions with the Canadian Forces, at the same time they were frustrated and my goal wasn't to do that, it was -- as well, one of the trains of thought that I had was it became evident very early on through our first interaction that they were very cognizant of -- my interpretation was, they were very cognizant of various bodies that were out there and avenues were open to them and although I did not ask them if they were cognizant of the Military Police Complaints Commission, I had no doubt that they would have been.

That was an assumption on my part.⁴⁴⁵

136. Maj Dandurand also testified that in order for complaints to be reported, it was his experience CFNIS members would normally verify whether the individual intended to complain formally: “We pose the question: Is this what you’re complaining about?”⁴⁴⁶ In this case, he did not pose the question because, as he explained it, he did not think he was dealing with possible complaints.⁴⁴⁷

137. LCol Sansterre, for his part, was not aware of the details of all of the issues raised during the meeting with the Fynes. He did receive a verbal briefing from Maj Dandurand after the meeting, and he was advised of some of the Fynes’ questions, particularly about the Concluding Remarks, the suicide note, the treatment of Cpl Langridge’s body, as well as the intrusiveness and length of the 2008 investigation.⁴⁴⁸ He could not recall whether any consideration was given to treating these matters as complaints against the CFNIS and referring them to the appropriate authorities.⁴⁴⁹ He believed Maj Dandurand would be providing answers to the questions raised by the Fynes.⁴⁵⁰ LCol Sansterre had a clear understanding of the MP policies and obligations where potential complaints were received, but explained he did not perceive the issues Maj Dandurand reported were

being raised by the Fynes as complaints by the family, but rather as requests for information.⁴⁵¹ He stated: “they were issues that [Maj] Dandurand was going to address with them -- get answers to and address them with them.”⁴⁵² He could not confirm whether Maj Dandurand in fact addressed the issues to the satisfaction of the Fynes.⁴⁵³

138. From its review of the briefing and limited subsequent follow up, it is clear to this Commission the Fynes’ concerns were not addressed by the CFNIS members. In many cases, no information addressing the concerns was provided. In other cases, explanations were provided, but the Fynes indicated in no uncertain terms during the briefing itself and in subsequent meetings that they did not accept them.

139. The Fynes openly disputed the explanations provided about the ME being responsible for deciding when to cut down Cpl Langridge’s body.⁴⁵⁴ In their March 3, 2010 meeting with Maj Dandurand, they indicated Mr. Fynes had made inquiries with the Alberta Solicitor General’s Office and believed, as a result, that it was the CFNIS who had jurisdiction.⁴⁵⁵ They reiterated their strong view it was disrespectful to leave Cpl Langridge’s body hanging for so long.⁴⁵⁶ During the initial briefing, Mr. Fynes had also openly disputed Maj Dandurand’s claim that the CFNIS approach scenes with impartiality, indicating instead that the CFNIS’ approach to the scene in this case was tainted from the beginning by a belief that Cpl Langridge was a defaulter.⁴⁵⁷ Not surprisingly, Maj Dandurand testified he did not form the impression the Fynes were satisfied with the answers to their questions about the timing for cutting down Cpl Langridge’s body.⁴⁵⁸

140. Mrs. Fynes also made it quite clear during the briefing she did not accept the explanations provided about why the CFNIS investigation took so long and was so comprehensive. She indicated:

So you're telling me that [you see] it from a premise of Stuart may have been murdered, or Stuart may have committed suicide, and that's what you were investigating for months?

I find that a real stretch. I'm sorry, I do.⁴⁵⁹ [Emphasis added]

141. Throughout the meeting, she reiterated forcefully she did not believe anyone in the CFNIS thought Cpl Langridge had been murdered, indicating “I just don’t buy it.”⁴⁶⁰ She made it clear she did not see why such a big investigation was necessary.⁴⁶¹ It was eventually suggested to move on to another topic, with Mr. Fynes stating: “we’ll just agree to disagree.”⁴⁶² Later, during the interview, Mrs. Fynes added the following, which could leave little doubt about her views:

But, you know what? When somebody says to me, "Well, you know, we had to do a huge investigation to make sure that he did commit suicide.", **that I find offensive.** Like I said, everybody on the base new [sic] Stuart committed suicide. Everybody. You didn't need to do this--⁴⁶³ [Emphasis added]

142. In testimony, Maj Dandurand acknowledged he did not believe this issue was or could be resolved through discussions. He explained:

And we would go around and around and around discussing this only to agree to disagree.

[...]

But at the end of the day it wasn't something that I saw was going to be easily resolved.⁴⁶⁴

143. With respect to the suicide note, the Fynes testified they did not view Maj Dandurand’s expressions of regret as an apology for what happened, let alone a sufficient or adequate apology.⁴⁶⁵ During the briefing itself, Mrs. Fynes interrupted Maj Dandurand’s explanation about the policy changes, stating: “But what does it do for us? How does it impact how we feel?”⁴⁶⁶ She then stated plainly she did not accept the explanations provided about why the note was not disclosed immediately:

Okay, I'm only going to say this once, and then I'm pretty much done with this bit about the note, because I'm not going to be talked into thinking anything other than what I already think: Okay, my son had a last communication with me. I do not believe for one second, nor will I ever, that anybody on that base thought that there was anything other than a suicide in that room that day. And I don't believe that anybody, even for a heartbeat, thought that. And I think that to expect us to believe that is -- **I think it's almost insulting our intelligence.**

[...]

I think that -- I think it was cruel, I think it was really cruel. I think that at the very most, all you needed was a copy of that note [...] ⁴⁶⁷ [Emphasis added]

144. Maj Dandurand was aware his explanations did not satisfy the Fynes' concerns. In testimony, he confirmed "there was a definite air of displeasure throughout the duration of that discussion."⁴⁶⁸ He also discussed this with the Fynes' AO, Maj Parkinson, during a March 2010 interview. He then indicated the Fynes had been told many times the note could have had no bearing on funeral dealings because the determination of foul play had not yet been made at that time, but that they still continued to bring up this issue and "[...] insinuat[e], that they should have been told right away –".⁴⁶⁹

145. Mr. Fynes also remained steadfast in his complaint about the CFNIS' initial approach to the case and the impact he believed it had on the ME's certificate, despite Maj Dandurand's explanations.⁴⁷⁰

146. With respect to the Concluding Remarks, Mr. Fynes had expressed his concerns in strong terms during the meeting. He had alleged the remarks were "part and parcel of the demeaning of [Cpl Langridge]" and aimed at blaming him for his condition and his death while simultaneously exonerating the Army.⁴⁷¹ He had complained not only about the findings' continued presence in the report, but about the fact they were made in the first place. He had directly asked for an apology: "[...] I would like to see that corrected, and I would like an apology for that. To err is human, to cover up is inexcusable."⁴⁷² The action taken by the CFNIS in response to these complaints was to remove the mentions of addiction, mental health issues and assistance provided by the Unit from the Concluding Remarks.⁴⁷³ However, there was no acknowledgement that the initial comments found in the Remarks were substantively wrong, and no apology was provided for having initially included them in the report. Not surprisingly, this issue continued to form part of the Fynes' complaints.⁴⁷⁴ In his testimony before this Commission, Mr. Fynes stated that, although the findings were "officially removed" from the report, "they spoke to a mind-set that was exculpatory for the military and passing blame to the victim."⁴⁷⁵ Considering the manner in which the Fynes had presented their concerns during the briefing, it was to be expected that simply changing the Remarks without admitting any error would not be sufficient to address this complaint.

147. In light of this, it is surprising the CFNIS members continued to view the Fynes' complaints as requests for information or points that could be addressed or resolved through discussion. It is difficult to understand why they did not report the complaints once it became clear that the Fynes did not accept the explanations provided, that no further action would be taken to provide additional information, and that the Fynes continued to reiterate the concerns. That being said, on the basis of the testimony heard, the Commission concludes there was no deliberate attempt to frustrate the complaints process in this case. It rather appears this aspect was overlooked in the midst of an attempt to address the multitude issues raised in the briefing – some related to new complaints for investigation by the CFNIS, others relating to the conduct of CF members unconnected to the CFNIS, and yet others directly related to the previous CFNIS investigation. It also appears both Maj Dandurand and LCol Sansterre held an honest (though misguided) belief that discussion of the issues would be sufficient to resolve them. LCol Sansterre's knowledge of all matters raised was also not as complete or detailed.

148. Nevertheless, having Maj Dandurand attempt to address the Fynes' concerns directly was problematic. MS McLaughlin, when he was asked why he did not investigate the Fynes' concerns about the 2008 investigation, indicated:

Let's look at this from the transparency portion first. I've worked with Sergeant Ritco now, Sergeant Ritco at the time I spoke with Ritco for the entire time that I have been at the NIS he has been there as well. So, (a), **there is a conflict of interest with me investigating one of the investigators I work with, that just makes no sense, I can't do it.**

[...]

So, I focused on the actual allegations as brought forward with regards to the new negative performance military duty allegations. So, **those wouldn't take me into looking into whether sergeant Ritco did a good job, bad job, a half-way job, anything like that,** it wouldn't take me there, so -- and that makes sense.⁴⁷⁶ [Emphasis added]

149. While MS McLaughlin believed Maj Dandurand, as the OC for the Detachment, could investigate and address those issues,⁴⁷⁷ the fact is the Fynes' complaints related to the conduct of CFNIS members Maj Dandurand also knew personally. Some of the

allegations were quite serious, putting in question the integrity and motives of the investigators.

150. Maj Dandurand had already expressed strong views about the integrity of the members involved in the investigation. In an email to the CFNIS PAO dated June 18, 2009, he had written:

In a nutshell, the investigator and the case management team did everything in good faith and at no point was the family's well being pushed aside. [...] Mr. Pugliese's persistence in asking about disciplinary measures needs to be curbed because it would be completely inappropriate for any actions to be taken against anyone in this case. Believe me, if there was an appropriate disciplinary action to be recommended and taken, I would be the first to say so.⁴⁷⁸

151. In testimony, Maj Dandurand discussed the basis for the beliefs expressed in this correspondence and reiterated his views:

The basis would be that the investigators that I had the pleasure of working with always conducted themselves in good faith and had no ulterior motives in anything that they would ever do.⁴⁷⁹

152. He also shared some of these views with the Fynes during a subsequent meeting with them in March 2010, indicating:

For [MCpl Ritco], he tackled everything with vigour, and I can tell you that, of all my investigators, he is one of the most un-- well, he is one of the most proficient that I have.⁴⁸⁰

153. There is a reason for having a separate complaints process. The investigation of complaints by a separate Professional Standards section supervised by an independent agency provides a level of confidence for complainants that their complaints will be examined and resolved objectively and independently. Given his own working relationship with the individuals complained about, Maj Dandurand's involvement could not provide these same assurances, regardless of the sincerity or good faith of his efforts.

154. Some of the events about which the Fynes were complaining took place after Maj Dandurand assumed command of the Detachment and involved matters that may have been under his responsibility. Complaints about the failure to return exhibits in a timely

manner after the investigation and the failure to disclose the suicide note for 14 months related to events which occurred or continued after July 2008, when Maj Dandurand took command of the Detachment.⁴⁸¹ As the OC, his responsibilities included conducting semi-annual inspections of evidentiary holdings,⁴⁸² which may have affected the return of both the suicide note and other exhibits.⁴⁸³ As a result, addressing the Fynes' complaints in these respects may have put in question – directly or indirectly – Maj Dandurand's own conduct since assuming command of the Detachment.

155. For all these reasons, it is of concern that when the Fynes presented their complaints, Maj Dandurand took it upon himself to make his own attempt to resolve the issues. It is also of significant concern that during his testimony before this Commission, Maj Dandurand referred to his own assessment of the merits of the Fynes' complaints to explain why he did not report them. He indicated:

I think that if I had at the time believed that there was a marked departure from normal practices, then I would have referred that to another body in order to investigate or I would have recommend[sic] we investigate it ourselves.⁴⁸⁴

156. By contrast, LCol Sansterre testified that a perception by an MP member that a complaint is not well founded would not constitute a legitimate basis for failing to refer the complaint to the appropriate authorities.⁴⁸⁵ Indeed, both the *National Defence Act* and the MP policy applicable at the time clearly stipulated the decision to classify a complaint as frivolous, vexatious and/or made in bad faith – and therefore not requiring further investigation or resolution – belongs to the CFPM and not the MP member receiving the complaint.⁴⁸⁶ Further, Maj Dandurand's factual knowledge about the issues raised by the Fynes was not sufficient to allow him to assess whether there was a "marked departure from normal practices" in this case.

157. The Fynes' complaints should have been referred for investigation. At the very least, the Fynes should have been advised of the avenues available to them through the complaints process.

PUBLIC RELATIONS AND FAMILY BRIEFINGS

158. In a case like this one, it was inevitable there would be concern at the CFNIS about the potential for negative publicity. Throughout all of the events in this case, media attention always resulted in a flurry of activity at the CFNIS to provide responses and put new measures in place, both in terms of internal procedures and contact with the Fynes.⁴⁸⁷ Those concerns may not have been entirely absent from LCol Sansterre's mind when he directed Maj Dandurand to provide the briefing to the Fynes, or from Maj Dandurand's mind when he provided it.

159. The late disclosure of the suicide note had led to media attention in June 2009. Both Maj Dandurand and LCol Sansterre had been involved in preparing Media Response Lines about that issue.⁴⁸⁸ The initial contact with the Fynes and the initial offer to provide the briefing were part of the efforts to mend relations in light of what had happened. On the Monday morning immediately following the briefing, Maj Dandurand wrote to the CFNIS Public Affairs Officer, asking her to "please tell me I'm NOT in the papers this morning, after the family brief I gave Saturday."⁴⁸⁹ He then described the briefing, indicating the discussion lasted approximately four and a half hours, the family presented their points very well and did not yell at him. He concluded: "from that perspective I believe it met the purpose of the meeting."⁴⁹⁰ He also indicated he was planning to provide his draft responses to the Fynes' questions to both the CFNIS CO and the PAO for input.⁴⁹¹ LCol Sansterre had also sought input from the PAO about his earlier communications with the Fynes.⁴⁹² In both cases, the PAO testified it was not usual for her to be asked for advice about communications with families.⁴⁹³ She believed her input was sought about wording or "the way that things are said" because of the earlier media interest about the case.⁴⁹⁴

160. The CFNIS members involved cannot be faulted in any way for recognizing the obvious public relations reality. It was certainly not inappropriate for them to have a desire to preserve the CFNIS' image and to attempt to rehabilitate it in the Fynes' eyes, both because of their pride in the institution they served and because of their awareness of the potential for public attention or negative publicity. However, at times, because this

matter was seen as having the potential to attract media attention and cause embarrassment, the concern to preserve the CFNIS' image appears to have become exaggerated. Throughout the events that occurred before, during and after the briefing, it may be observed too much emphasis was sometimes placed on this aspect, at the expense of other important requirements. The focus was often on defending the CFNIS' actions instead of providing substantive answers.

161. In the preparation for the briefing, Maj Dandurand reviewed the redacted portions of the file carefully for the purpose of assuring the Fynes nothing was redacted that should not be. MS McLaughlin was asked to conduct a detailed review of the remaining exhibits for the purpose of assuring the Fynes no exhibits that should have been returned to them were still being held. Meanwhile, no attempt was made to find out the reasons why their son's suicide note was not disclosed to the Fynes for 14 months, and no answer was provided to them about this.

162. In the follow up done after the briefing, the only step taken to address the Fynes' concerns about the 2008 CFNIS investigation was carried out in a manner that specifically avoided recognizing any substantive error. In the note added to the GO file to explain the change to the Concluding Remarks, the passages to be removed were described and it was stated: "**while these may have been uncovered during the process of the investigation**, these facts do not speak to the primary focus of the investigation as identified in the investigation plan."⁴⁹⁵ Both in conversation with the Fynes and in testimony before this Commission, Maj Dandurand explained the removal of the comments by reference to their relevance, rather than their substantive correctness.⁴⁹⁶

163. This reasoning for changing the Remarks did not entail any examination of the underlying complaints made by the Fynes that the comments themselves were inaccurate and possibly biased. Further, the notion that the comments were not relevant to the investigation or did not speak to its primary focus is perplexing. The comments were about addiction, mental health and assistance provided by the Unit. All of these aspects were directly related to what was, in fact, the focus of the investigation, both as conducted and as represented in the Investigation Plan.⁴⁹⁷ In their final submissions,

counsel for the subjects of the complaint defended the original Concluding Remarks and explained the reasons for changing them as follows:

[MCpl] Ritco wrote in his concluding remarks that Cpl Langridge “suffered from alcohol and cocaine addiction which caused him to have mental health issues”. These statements were based on the evidence he had before him from the medical records and the explanation of the records he received from [Capt] Hannah...

[MCpl] Ritco put these details in his report to provide those reading the report an understanding of the information he had uncovered related to what happened to Cpl Langridge. It was not to discredit Cpl Langridge in any way. **Out of compassion for the Fynes, the concluding remarks were later changed.** [...] ⁴⁹⁸ [Emphasis added]

164. This attempt to satisfy or appease the Fynes without admitting any error was in line with the overall approach to the briefing.

165. During the briefing itself, references to general practices and procedures rather than specific facts about this case were used to defend past CFNIS conduct. This was not surprising, since the two members who provided the briefing were not involved in the investigation and had not received a detailed briefing from those who were. In many cases, they would not have been aware some of their general statements did not accurately represent the way things actually unfolded during the investigation. Involving members with more knowledge about the case may have made the discussions more substantive and meaningful, but a decision was made not to involve them.

166. At the time of the briefing to the Fynes, the CFNIS had no specific policies about family briefings for sudden death investigations. As explained by Maj Dandurand, the practice was to have senior ranking members, rather than the investigators involved, provide such briefings. The CFNIS SOP created subsequently specifically stipulates the contact with and briefings to the family must be done in person by a member of the rank of Detachment WO or above, as appointed by the Detachment OC.⁴⁹⁹ It is not known what the reasons are for this policy and the similar practice followed previously.

167. Sgt Scott Shannon, who participated in drafting the SOP, testified his understanding of the reasons for not involving the investigators in the initial briefing to the family is to ensure they are not distracted from the task at hand.⁵⁰⁰ He provided no explanation about the reasons for not involving them in the final briefing, other than to

indicate this briefing should be done by the same members who conducted the initial briefing because “a bond has been established.”⁵⁰¹

168. During a CFNIS Detachment Commanders’ conference held in May 2011, the OC for the Atlantic Region Detachment, who had been put in charge of elaborating the new SOP on Sudden Death investigations, provided a presentation about the family briefings.⁵⁰² He noted shifting responsibility for dealing with the family to the chain of command relieved the investigators from distractions in their investigation.⁵⁰³ With respect to the final briefing, he stated it was for the Chain of Command to decide who would provide the briefing.⁵⁰⁴ He indicated the lead investigator could give the briefing, but cautioned they should “stick to [the] script” very closely.⁵⁰⁵ He also noted “if family starts interacting, Chain of Command intervenes and deals with family.”⁵⁰⁶

169. Whatever the reasons might be for having higher ranking members provide the family briefings, those members are unlikely to have detailed factual knowledge about the case or to be able to provide complete and accurate answers to the family’s questions. The Commission sees no reason for not involving the lead investigator in final family briefings in all cases where it is possible. Even where the investigator has moved on to a different posting or secondment, efforts should be made to involve him or her in the briefing.

170. To the extent the CFNIS’ approach to the Fynes briefing was motivated in part by a concern to preserve the CFNIS’ image, it can only be observed that it was entirely counterproductive. The Fynes have complained to this Commission that the CFNIS failed to provide adequate and timely information to them and participated in broader CF efforts to withhold information from them.⁵⁰⁷ They have also alleged CFNIS members provided inaccurate rationales to explain or justify the actions taken by CFNIS, referring specifically to explanations provided about the suicide note, the treatment of Cpl Langridge’s body, the information contained in the ME’s certificate and the return of the exhibits.⁵⁰⁸ While some of the specific allegations related to these complaints did not relate solely – or in some cases at all – to discussions that occurred during the November 2009 briefing, many of the discussions that did occur contributed to setting the stage for

the Fynes' perception – in some cases justified – that they were not being provided complete or accurate information, that their questions were not being answered, and that rationales they did not accept were being offered to justify or explain CFNIS behavior.

171. The Commission recognizes the Fynes' own exasperation had crystallized significantly by the time this briefing was held, in part because of the CFNIS' failure to communicate with them earlier, and in part because of their other issues with the CF. As such, satisfying their concerns entirely or changing their views would have been difficult, perhaps even impossible. Nevertheless, it was not inevitable the briefing would completely fail to address their concerns. At a minimum, it could have been approached in a way that would have avoided creating new concerns.

172. Even bearing in mind all the difficulties for the CFNIS, the approach adopted to deal with the Fynes' concerns is difficult to understand. In this case, putting the Fynes in a room with two CFNIS members who had no detailed knowledge about their son's case, who provided broad justifications instead of answering their questions, and who promised answers that never came, was just about the worst possible course of action. It could only exacerbate an already tense situation. Regrettably, the responses provided to the Fynes' complaints about past CFNIS conduct often only served to illustrate the importance of having a separate process to investigate complaints.

4.5.4 2009/2010 Investigations – Interviews, Updates and Briefing

173. During the November 2009 briefing, in addition to the issues raised about the 2008 investigation, the Fynes had also discussed their concerns about the designation of Ms. A as Cpl Langridge's PNOK, with authority to plan his funeral.⁵⁰⁹ An investigator from the DND/CF Ombudsman's office had also brought this issue to the attention of the CFNIS.⁵¹⁰

174. A few weeks after the November briefing, on February 12, 2010, Maj Dandurand contacted Mr. Fynes to advise the CFNIS had decided to open an investigation into

allegations of negligence in the determination of Cpl Langridge's PNOK.⁵¹¹ He also indicated MCpl David Mitchell would be replacing MS McLaughlin, who had been deployed since the last meeting.⁵¹² Shortly after, on March 3, 2010, an interview was held with the Fynes to discuss this new investigation (the 2009 PNOK investigation).⁵¹³ On May 5, 2010, another interview was held to discuss another new investigation, the 2010 Criminal Negligence investigation.⁵¹⁴ These investigations remained open until the spring of 2011, when the Fynes were provided a letter outlining the CFNIS' decision not to proceed with charges in either file.

175. In these proceedings, the Fynes have made specific allegations about the CFNIS' failure to provide them with adequate and timely information during the 2009 and 2010 investigations.⁵¹⁵ In particular, they have complained about the lack of regular updates or communication, the cancelling of a verbal briefing about the investigations, the delay in providing the written briefing offered in replacement and the contents of that briefing.⁵¹⁶

176. The evidence before this Commission has revealed there was a clear failure on the part of the CFNIS members to make regular contact and to provide information to the Fynes during these investigations. To make matters worse, the CFNIS members made direct commitments to the Fynes about the updates they would be providing and the manner in which they would be conducting the investigations. None of those commitments were fulfilled, and yet the Fynes were provided no explanations.

THE INTERVIEWS AND THE PROMISES

177. During the March 3, 2010, interview, the Fynes' concerns and allegations about the PNOK issue were discussed at length.⁵¹⁷ Maj Dandurand made several statements about the investigation to be conducted. He indicated:

[...] we have documents and, quite frankly, **documents only bring us so far, in my opinion.**

And as an investigator, I want to uncover as much as I can with respect to what transpired regarding that [PNOK] decision.

We have reviewed so much that we have assumptions, but those assumptions need to be put to rest, so that we deal exactly with what happened, because that's the whole point of

the investigation, is to get to the truth of what occurred.⁵¹⁸ [Emphasis added]

178. Maj Dandurand told the Fynes the CFNIS would conduct interviews in order to find out how the PNOK decision was made. He stated he was “going to be poking around, and asking everyone and their dog what happened and why, with regard to this next of kin decision.”⁵¹⁹ He explained the CFNIS would be questioning those involved in the decision to find out how and why it was made.⁵²⁰ When Mrs. Fynes suggested LCol Bruce King, the JAG Officer who had written to their counsel, should be on the list of persons to be interviewed, Maj Dandurand indicated he was “already there, don’t worry.”⁵²¹ He also stated the CFNIS would be interviewing Cpl Rohmer and Ms. A’s Assisting Officer.⁵²² When the Fynes expressed concern witnesses might not provide complete or accurate information to the CFNIS, Maj Dandurand assured them the appropriate interview techniques would be used:

But Sheila, I want to make this also clear, to hopefully appease some of your -- maybe your trepidation, is there **I'm pretty loose in how we speak here, but some of our witnesses are not going to have that luxury, to be as loose.**

There will be a **very structured interview**. We'll be pulling out -- we'll be **pulling out all the investigative tools**. [...] So, you know, what I like to think of -- my charms and good looks will not be at the forefront, it will **definitely be our more savvy investigative tactics**.⁵²³ [Emphasis added]

179. Maj Dandurand also discussed the individuals the CFNIS intended to investigate. He noted the Regiment Adjutant was not the only person of interest, emphasizing, “there is a chain of command.”⁵²⁴ He explained he did not believe a single person would be the sole decision-maker in a case like this, and noted the CFNIS would be looking into the role played by the Chief Clerk, the RSM, the OC for Cpl Langridge’s squadron, and the Regiment CO.⁵²⁵

180. In addition, Maj Dandurand explained administrative changes could result from the CFNIS investigation, even if charges were not laid:

One of the -- one of the interesting things -- [...] that stems out of a military police criminal investigation, or investigation into a code of service discipline offence is that, for instance, **if charges are not laid, that doesn't mean -- [...] that's the end of it.** [...]

[W]hat comes with my report is not just, "Yeah, we couldn't do anything." I put a covering letter on it, it goes to every commanding officer, it goes to every department in NDHQ, and -- needless to say, all the other things that come of it is accounted in the report. That's the wonderful thing about the report. Even though a charge doesn't get laid, all the data is there, all the evidence is there to say, "You know what? The reason why -- I can't prove you stole that weapon, but I can prove this: A unit was negligent in their administrative procedures for losing that weapon." [...]

So while they're not criminally negligent, they are administratively negligent, and all of a sudden, hands start getting slapped, and **procedures start getting changed**, and that unit has audits every six months for the next two years.

My point being is that, even in this particular case, hypothetically, if I cannot meet the elements of the offence for negligence, one of my determining factors in that is should somebody ought to have known that the primary next of kin, were Mr. and Mrs. Fynes.⁵²⁶ [Emphasis added]

181. Mrs. Fynes testified what she took away from this meeting was the CFNIS were still investigating the matter.⁵²⁷ She stated both she and Mr. Fynes told the CFNIS members they still had many questions, and the CFNIS members assured them they were still investigating and would get back to them with answers.⁵²⁸

182. During the next meeting, held on May 5, 2010, the PNOK investigation was discussed again. MCpl Mitchell told the Fynes he was trying to determine when the PNOK decision was made and by whom.⁵²⁹ He indicated he was completing his review of the SI relating to Cpl Langridge's post-death administration and noted the list of persons he planned to interview was "growing by the day" as a result.⁵³⁰ He explained the information he reviewed had allowed him to identify additional individuals who may have been involved in the PNOK decision, and he indicated he was using the SI to prepare for his own interviews and find information he could use to confront the witnesses if necessary.⁵³¹ Maj Dandurand also told the Fynes:

Now, the information may be in a Summary Investigation, however, if somebody has provided information to the investigating officer, **that investigating officer is not a military policeman. We need to go and speak to that person.** And we have, as you know, a manner in which we ask questions -- [...] and deal with things and investigation, and that is also, in large part, to support our independence, because we may not come to the same conclusion or formulate the same theories that a Summary Investigation has.⁵³² [Emphasis added]

183. Maj Dandurand also indicated the Regiment Adjutant, Capt Mark Lubiniecki, had not yet been interviewed because the CFNIS had not "gotten to that stage in the

investigation yet.”⁵³³ Overall, he assured the Fynes the investigation was being conducted in a thorough manner:

And all I beg of you is the patience that **we are moving through this extremely methodically to make sure that at the end of the investigation, when we finalize our report, it is final, there is no question mark.**

And as you've seen from our investigative work, we don't leave stones unturned.⁵³⁴
[Emphasis added]

184. The remainder of the May 5 interview was devoted to discussing the Fynes' new allegations of criminal negligence related to Cpl Langridge's death, which led to conducting the 2010 investigation.⁵³⁵ During the interview, Maj Dandurand commented on his intentions regarding the conduct of this investigation, stating:

There is no doubt with this that there will be **a revisit of all documents.** What we want to do is make sure that, if there's something that snuck into a Board of Inquiry testimony here or a piece of paper or evidence there, it's not missed.

So we revisit everything that's available, and **then we go looking for anything else** that we say, "You know what, **nobody ever thought to ask this question**, and we're going to go in, we're going to pluck that and [...]"⁵³⁶ [Emphasis added]

185. Maj Dandurand told the Fynes the investigation would be conducted in accordance with the Major Case Management (MCM) model.⁵³⁷ He explained:

I'm looking at this and I'm saying -- my gut right now is saying that **this is not a run-of-the-mill major investigation** that we deal with, in the sense that I can assign two investigators. I suspect this **will become bigger** – [...] and I need to analyze the work that has to occur with respect to this in order to investigate these three things right here.

And just **based on my experience and my gut, I think it's going to be more than just a two-man team** dealing with this. [...]

But the one thing that is certain is that the decision to go down that path is not bureaucratic, **it is in the interest of expediency** because of the recognition that it is so big.

The three things that have to be maintained by the case manager is **the speed, the direction and the flow** [...]

So **it will be moving as fast as possible.** What I do suspect early on is that the **degree of research will be vast** in order to have the investigators and the investigative team wrapped around the issues.⁵³⁸ [Emphasis added]

186. In addition to the volume of information to review, Maj Dandurand spoke of the number of interviews to conduct, and of the preparation necessary for these interviews:

In this case, we have so much information that has to be analyzed systematically and accounted for that we don't go over it six times, we actually -- "Okay, that's been analyze[d]. All right. This hasn't. Okay".

If you have more than two guys on an investigation, right away, you can imagine -- [...] the flow of communications issues that are going to arise. We need to make sure that the speed of the investigation remains at its top notch, the direction of the investigation stays focused on what needs to be done, and the flow, in other words the communication among the team is there.

The minute that you employ three or more investigators, you're into what is considered a **major case management model** of an investigation and in policing circles there's the academics of that, which **in this case is not only the volume of interviews that have to occur, but the manner and the order in which they have to occur.**

And as Dave says, **you have to have your homework done so that when you go and ask that question**, you already know what three possible answers -- [...] are going to be given when you go into that room. And that's why we do as much thorough background, so that when we get in that interview -- nothing worse, when you're asking a question, there's a surprise answer, right? Nothing worse.

You want to **know every possible theory or iteration of answer that could come of that question**, and then see where that answer leaved [*sic*] you. And based on your assumption of what some of those answers may be, you **anticipate your next move.**

This is what we're trained in doing, and this is why I say it's huge. **It's huge in volume of activity that has to occur, and it's also huge in terms of importance.** I mean, that's why it comes to the NIS[...] ⁵³⁹ [Emphasis added]

187. Maj Dandurand also assured the Fynes the CFNIS would not be relying on the BOI's conclusions.⁵⁴⁰ He indicated because "we can't take anything at face value," the CFNIS would "have to go point by point, minute by minute, through that BOI."⁵⁴¹ He explained the BOI testimony would be examined critically and would be used by the CFNIS members to formulate their own questions.⁵⁴² He specifically stated the CFNIS would be revisiting the BOI witnesses.⁵⁴³

188. On the whole, Maj Dandurand committed to conducting a vigorous and thorough investigation:

I give you this **promise**, if I say that a charge is merited, I have the reasonable probabl[e] grounds, as defined by all of police practices, I will lay that charge.

Equally, **if I say that the charge is not warranted, I will have the justification for that statement.**

It will be investigated without bias, right through to the truth. **We will uncover the truth of what happened.**⁵⁴⁴ [Emphasis added]

189. During the May 5 interview, the issue of the updates to be provided to the Fynes by the CFNIS was also discussed. The Fynes had not received any update about the 2009 investigation since the March 3, 2010 meeting.⁵⁴⁵ Mrs. Fynes noted they had “no idea what’s going on” because they had not been contacted.⁵⁴⁶ She added they experienced significant frustration because they “keep getting ignored and ignored and ignored” by the military.⁵⁴⁷ Mr. Fynes stated he was not complaining about the lack of updates from the CFNIS specifically, as this was not something about which they had previously agreed upon with the CFNIS, but did note he felt the general lack of information from the CF contributed to increasing their frustration.⁵⁴⁸ Maj Dandurand assured the Fynes the CFNIS would “increase the frequency of our updates.”⁵⁴⁹ He indicated MCpl Mitchell could call the Fynes every two weeks to provide updates.⁵⁵⁰ The Fynes both agreed this “would be great.”⁵⁵¹

190. Later in the interview, Mr. Fynes clarified he did not insist on receiving calls every two weeks.⁵⁵² Instead, he insisted on the importance of receiving substantive information about the case, rather than mere courtesy calls. Mr. Fynes wanted contact to be regular so they would not be ignored, but he mostly wanted the updates to be meaningful.⁵⁵³ In testimony, he explained, “[...] to be fair, **I never asked that they observe the two-weekly updates**, I asked only for **regular**, because I had been warned by other people that you get the phone call every two weeks, but there is nothing to report.”⁵⁵⁴

191. During the interview, he told the CFNIS members the updates could be provided “when they’re due or when appropriate.”⁵⁵⁵ He also explained his expectations regarding the substance of the updates:

I’ve talked to another dad [...] this one particular father, a couple of weeks ago we had a long discussion, and he was updated on a regular basis, but after many months he got frustrated because he said he was getting his phone calls on a regular basis, but there was

no information being passed. [...] So when you use the word "information", I like to hear that.

Sorry, and if there's no information or nothing new, I understand that, **but I just don't want somebody ticking off a box, "Well we called the Fyneses today and we told them there's nothing new for them"**. Now, **if that goes on for six months**, that's not – [...] **that's not enough**, right?⁵⁵⁶ [Emphasis added]

192. In response, Maj Dandurand indicated “Absolutely not, no” and assured Mr. Fynes one thing the CFNIS was “really good at” was to get “movement on the files.”⁵⁵⁷

193. Maj Dandurand reiterated his commitment to provide regular updates on several occasions during the interview, stating “All I can control is the sphere in which I operate, and we've touched on the fact that **we were remiss in our commitment to update you**. That is done. **That's changed.**”⁵⁵⁸

194. He also promised there would be an “open flow of communication.”⁵⁵⁹ He explained, “**We will be giving you an update**. And it may not be as voluminous as perhaps you may assume it should be for that period of two weeks o[f] time, but it will be [...] it will be an update nonetheless. And [...] **it'll be transparent**, that's the bottom line.”⁵⁶⁰

195. When Mrs. Fynes noted she felt they were “always the back burner,” both Maj Dandurand and MCpl Mitchell assured her the file was not on the back burner for the CFNIS.⁵⁶¹ MCpl Mitchell apologized for not calling the Fynes previously, and assured them he was doing as much work as possible on the file.⁵⁶²

196. During the interview, the Fynes explained clearly to the CFNIS members how important it was for them not to be ignored during the investigations. When Maj Dandurand expressed concern the CFNIS’ regular updates may become a stressor for the Fynes by constantly reminding them of the issues, Mrs. Fynes indicated they would not be.⁵⁶³ She insisted, “What's **really important for you to know** is that **the stressors for us aren't getting the information, it's being ignored**. Because we've had it up to here with that.”⁵⁶⁴

197. In response, Maj Dandurand assured Mrs. Fynes “that won’t happen with us. And that’s why I’m here.”⁵⁶⁵

198. Having received those assurances, the Fynes were entitled to expect, at a minimum, that the CFNIS would stay in contact with them and keep them informed of the progress of the investigations. They could also expect the case would be taken seriously and large-scale investigations would be conducted, as described by Maj Dandurand. While it would not have been reasonable for them to expect the CFNIS’ conclusions would necessarily be in accordance with their wishes, the Fynes could certainly expect to receive a complete explanation of those conclusions, based on all the investigative work completed and all the evidence gathered. Regrettably, events did not unfold as could have been expected on the basis of the promises made during the interviews.

FAILURE TO PROVIDE REGULAR UPDATES

199. In the period immediately following the May 5, 2010, interview, there was an effort to contact the Fynes regularly. However, the frequency of the updates quickly diminished, and the Fynes ended up receiving very little information about the investigations.

200. On May 25, 2010, MCpl Mitchell contacted Mr. Fynes to provide an update.⁵⁶⁶ He advised he had completed his review of the SI materials for the 2009 investigation, and would be scheduling witness interviews shortly.⁵⁶⁷ With respect to the 2010 investigation, he advised he had “submitted the file for legal review.”⁵⁶⁸

201. On June 23, 2010, MCpl Mitchell spoke to Mr. Fynes again, providing an “update on the progress of the file” for each of the investigations.⁵⁶⁹ The nature of the information provided was not recorded in the GO files.⁵⁷⁰ The next day, Mr. Fynes contacted MCpl Mitchell by email to inquire about the SI conducted by the CF, and also to express concern about any reliance to be placed on the BOI draft report in support of the 2010 investigation.⁵⁷¹ MCpl Mitchell responded on July 5, 2010. He indicated he was aware of only one SI having been conducted and, in response to the concerns about the BOI report,

he noted the CFNIS legal advisor was “aware that the BOI is the still unapproved draft.”⁵⁷²

202. No further contact was initiated by the CFNIS during the ensuing weeks. On August 16, 2010, Mr. Fynes contacted MCpl Mitchell by email, copying Maj Dandurand.⁵⁷³ He noted they had not spoken since June and indicated he would appreciate receiving an update.⁵⁷⁴ The following day, MCpl Mitchell contacted Mr. Fynes.⁵⁷⁵ There is no record in the file of the content of the conversation. In an email he sent to Maj Dandurand at the time, MCpl Mitchell reported, “Spoke to Shaun. Everything went fine. He seemed to be appreciative. Explained exactly what we talked about and he was happy with the explanation.”⁵⁷⁶

203. In testimony, Maj Dandurand could not recall the discussion he had with MCpl Mitchell, and was not able to provide further information about the update MCpl Mitchell would have provided.⁵⁷⁷ MCpl Mitchell recalled only that he provided “an update as to where I stood,” and advised Mr. Fynes another investigator would be taking over the file, as MCpl Mitchell was going on training and would then be transferred from the Unit.⁵⁷⁸

204. Mr. Fynes, for his part, could not recall the exact timing, but did remember receiving two updates from MCpl Mitchell. In the first one, MCpl Mitchell advised the CFNIS had referred the matter to their legal advisors.⁵⁷⁹ In the second update, MCpl Mitchell advised, “not that the legal advisors were holding up their investigation, but now he was seeking advice from superiors.”⁵⁸⁰

205. After the August 17 update, MCpl Mitchell had no further contact with the Fynes. The file was turned over to Sgt Scott Shannon in September.⁵⁸¹ On September 17, 2010, Sgt Shannon contacted Mrs. Fynes to advise he was now the lead investigator.⁵⁸² In testimony, he recalled providing Mrs. Fynes with his contact information and giving her a general understanding of his credentials.⁵⁸³ He also recalled telling her he would make this his “priority file.”⁵⁸⁴ In her testimony, Mrs. Fynes indicated Sgt Shannon was “very nice” during the conversation, and told her he had taken over the file from MCpl Mitchell and would be spending his weekend reading up on it.⁵⁸⁵ She recalled he also said they would hear from him again “the very next business day.”⁵⁸⁶

206. The Fynes did not hear again from Sgt Shannon, or from any other CFNIS member, until February 2011, when the investigations were concluded and the Fynes were contacted to schedule a briefing.⁵⁸⁷

207. In testimony, Sgt Shannon explained he was aware of the previous commitment to provide regular updates to the Fynes.⁵⁸⁸ However, Maj Dandurand advised him he would be providing the updates himself.⁵⁸⁹ As a result, Sgt Shannon did not think there was any need for him to contact the Fynes until he was tasked to do so at the end of the investigations.⁵⁹⁰ He testified he felt he had fulfilled his own commitment to Mrs. Fynes by making this file his priority.⁵⁹¹

208. The two case managers involved in supervising the investigations recalled Maj Dandurand had directed there be no further communication with the Fynes.⁵⁹² WO Sean Bonneteau believed the direction had been issued after Mrs. Fynes held her press conference in late October 2010.⁵⁹³ He testified Maj Dandurand had then “directed that we [...] not make any telephone contact with her until we heard back.”⁵⁹⁴

209. In testimony, Maj Dandurand confirmed he instructed Sgt Shannon not to contact the Fynes, as he would be contacting them personally.⁵⁹⁵ He also confirmed this direction was issued as a result of Mrs. Fynes’ press conference.⁵⁹⁶ However, he testified the ultimate failure to make contact had “nothing to do” with the press conference.⁵⁹⁷ He explained, “at that point I did not feel that it was something that I wanted my investigators to be preoccupied with. **I, as the detachment commander, would take on that responsibility, and I had full intention of communicating; however, things got away from me and I never did.**”⁵⁹⁸

210. Maj Dandurand recognized he did not live up to his commitment to provide regular updates.⁵⁹⁹ He explained this was “a complete oversight on my part,”⁶⁰⁰ and testified:

At the time I had those discussions with Mr. and Mrs. Fynes, I had proposed every two weeks, and it very quickly shifted to: No, no, just when there is a -- We don't need that every two weeks, just when there is a development. And we agreed to that.

I had **lost track of time throughout**, and not only that, but had drawn assumptions, as well, that others would be making contact, up to a certain point, where I believed that it

would be my place to make contact with them.⁶⁰¹ [Emphasis added]

211. Of all the CFNIS members involved in these investigations, MCpl Mitchell was the only one who at least attempted to make contact with the Fynes regularly. Still, he only provided two updates, and then only contacted Mr. Fynes again after receiving a specific request. In testimony, MCpl Mitchell recognized he was not able to fulfill the commitment to contact the Fynes every two weeks.⁶⁰² He explained this was due to his caseload and travel schedule.⁶⁰³ The actual commitment agreed upon with Mr. Fynes was not to make contact every two weeks, but rather to provide regular updates. With three updates in four months, MCpl Mitchell may not have quite achieved the regular contact expected by the Fynes, but at least he took action and came closer to fulfilling the commitment than did any of the other members.

212. Overall, the CFNIS' track record of keeping the Fynes informed about the progress of the investigations was extremely poor. During the nine-month period between the May 2010 meeting and the conclusion of the investigations in February 2011, the Fynes were only contacted four times. Of these, only three involved actual updates, as Sgt Shannon made only an introductory call. One of the remaining three contacts had to be specifically requested by Mr. Fynes. Between Sgt Shannon's introductory call and the contact made at the end of the investigations, five full months went by without any contact whatsoever.

213. Not surprisingly, both Mrs. and Mr. Fynes testified they felt the CFNIS did not fulfill their promise to provide regular updates.⁶⁰⁴ As a result, they felt they were being ignored by the CFNIS.⁶⁰⁵ Mrs. Fynes testified, "It was like everything else to do with everything administrative after Stuart died it was just more of the same, being ignored and Major Dandurand did it with a smile on his face, but **the fact was we got no answers and we were ignored as much as possible.**"⁶⁰⁶

214. It is difficult to understand how there could be a reasonable justification for this failure to make contact and provide information. The explanations heard during this hearing did not reveal any acceptable justification. Maj Dandurand did mention he was dealing with family emergencies in early 2011.⁶⁰⁷ This could explain, to some extent, his

own lack of contact, at least during the final portion of the investigations. However, it still does not explain why other members were not tasked with providing the updates.

215. There were policies in place at the time of the investigations requiring regular updates be provided to complainants by CFNIS investigators or Victims Assistance Officers. The general MP policy provided for contact every 30 days, while the CFNIS SOP provided for call backs by the Victims Assistance Coordinator every two weeks.⁶⁰⁸ In this case, the Fynes apparently declined an offer for victims' assistance services.⁶⁰⁹ As a result, the CFNIS SOP requirement for contact every two weeks may not have applied. However, at a minimum, the general policy requiring contact every 30 days should have been followed. More importantly, the CFNIS members had made a specific commitment to provide regular updates. The failure to honour this commitment was a serious oversight on the part of the Detachment and its OC, Maj Dandurand.

216. The failure was especially serious in this case because the Fynes had specifically explained the hardships they suffered when they did not receive updates. They had told the CFNIS there was nothing worse for them than to be ignored. Yet, the CFNIS proceeded to let weeks and months go by without making any contact, leaving the Fynes feeling ignored and side-stepped, which was exactly the result they had told the CFNIS they wanted to avoid.

FAILURE TO PROVIDE SUBSTANTIVE INFORMATION ABOUT THE INVESTIGATIONS

217. During the May 5, 2010 interview, Mr. Fynes had insisted on the importance to him of being provided substantive information about the investigations, rather than simply receiving regular telephone calls. In the end, he testified he felt the few updates he did receive from the CFNIS had no content.⁶¹⁰ Mr. Fynes explained, "We never really had any information as to an investigation that was being done or what the reasons were, we were just largely ignored."⁶¹¹

218. The updates provided by MCpl Mitchell did contain some information about the immediate steps being taken in each of the investigations. However, throughout the months following the May 5 interview, the Fynes were never provided with information

which could have allowed them to understand what was really happening with the investigations, what decisions had been made about how they were being approached, or what the reasoning was for coming to certain preliminary conclusions or deciding not to pursue certain avenues. Largely due to the CFNIS' silence during most of the investigations, as well as because of the limited information included in the updates provided, the Fynes never did receive substantive information about the progress of the investigations.

219. This was particularly unfortunate in light of the statements made by the CFNIS members about how the investigations would be conducted. These commitments, as contrasted with how things were actually unfolding, made it all the more necessary for the CFNIS to keep the Fynes informed. Having received specific assurances about the manner in which the investigations would be conducted, and in the absence of contrary information, the Fynes could reasonably expect things were proceeding as planned and as promised. At a minimum, they were certainly entitled to expect they would be told if there was a significant change in approach. The failure to provide information in this case was likely to create the impression the investigations were proceeding as outlined during the interviews with the Fynes. In reality, that was not at all the case.

220. In the 2009 investigation, the plan to conduct numerous "structured" interviews was abandoned after only three fact witnesses were interviewed.⁶¹² The members of the Regiment chain of command, and those involved in the PNOK decision, were not interviewed.⁶¹³ Other witnesses Maj Dandurand had specifically mentioned as being on the list to be interviewed, like LCol King, Cpl Rohmer and Capt Lubiniecki, were also not interviewed.⁶¹⁴ Despite assurances the CFNIS would not be relying solely on documents and would be interviewing the SI witnesses again, the investigation became entirely focused on document review once Sgt Shannon took over the file.⁶¹⁵ No more fact witnesses were interviewed, and the majority of the SI witnesses who had information about the PNOK issue were never interviewed.⁶¹⁶ Contrary to what the Fynes had been told would be done, the CFNIS never determined who made the PNOK decision and how it was made.⁶¹⁷ The final report provided no information about this issue.⁶¹⁸ It also contained no information that could have been used in making administrative

changes.⁶¹⁹ The CFNIS concluded, on the basis of Sgt Shannon's document review and policy analysis, that the correct decision had been made with respect to the PNOK, and, as a result, did not pursue the lines of investigation discussed with the Fynes.⁶²⁰

221. In testimony, MCpl Mitchell indicated his own plans for the investigation were generally consistent with many of the representations made to the Fynes, although he only planned to use "structured interviews" for suspects or subjects under investigation.⁶²¹ Still, he did intend to conduct numerous interviews and find out how and why the PNOK decision was made.⁶²² In the end, he only conducted three interviews before his involvement with the file ended.⁶²³ As a result, he was not able to make a determination about how the PNOK decision was made and by whom.⁶²⁴

222. When he took over the file, Sgt Shannon did not investigate the facts surrounding the PNOK decision made by the Regiment.⁶²⁵ His own approach to the investigation did not include conducting any interviews, "structured" or otherwise, with fact witnesses, as he preferred to rely on the documentary record.⁶²⁶ In testimony, he explained he did not share the views expressed by Maj Dandurand during the meetings with the Fynes about the importance of conducting witness interviews and of not relying solely on documents.⁶²⁷ Nor did he feel bound to conduct the investigation in accordance with the representations made to the Fynes by Maj Dandurand.⁶²⁸ He did not take those representations into account when making his own plans for the investigation.⁶²⁹ He did not receive any instruction from Maj Dandurand, nor did he have any discussion with Maj Dandurand about his initial assumptions or plans for the investigation.⁶³⁰

223. Sgt Shannon believed any commitments made by Maj Dandurand were "between him and Mr. and Mrs. Fynes," and were not made on behalf of the Detachment, but rather in Maj Dandurand's personal capacity as an investigator involved in the file.⁶³¹ He testified:

MR. FREIMAN: Major Dandurand seems to be under the impression that it's necessary to interview these people as part of the investigation.

SGT SHANNON: Yes, if he made those statements, but this is at the very early onset of the investigation. **Those are his initial thoughts on how he's going to proceed.** By the **time months later that this file was transferred to me there was so much more**

additional information available[...]⁶³² [Emphasis added]

224. The 2010 investigation also did not unfold as outlined by Maj Dandurand. In fact, the reality could hardly have been more different from the plans outlined. Rather than, as Maj Dandurand had described, a major investigation involving numerous interviews and re-visitation of all documents, there was only an investigative assessment.⁶³³ No investigation at all was conducted in support of the assessment. There were no witness interviews, nor were the documents revisited.⁶³⁴ In testimony, MCpl Mitchell explained it was not necessary to investigate the facts or revisit documents and witnesses at the assessment stage.⁶³⁵ With respect to the earlier representations Maj Dandurand made to the Fynes about the conduct of the investigation, MCpl Mitchell explained, “Essentially **what he is describing here** in looking at it, again, I don't want to speak for him, but **this is the steps that we would have done in the investigation phase, not in an assessment phase.**”⁶³⁶

225. Sgt Shannon, who was tasked to conduct an “offence validation” analysis before the file was concluded, also agreed there was no need to revisit documents or interview witnesses, since the file “never got past the analysis of the offence.”⁶³⁷

226. Further, contrary to the representations Maj Dandurand made to the Fynes, the MCM model was never used.⁶³⁸ MCpl Mitchell did not recall being advised of a specific determination not to use MCM in this case, although he did recall general discussions about the option of using MCM to address the volume of work required to investigate the totality of the Fynes’ allegations in the two cases.⁶³⁹ Sgt Shannon testified he never contemplated using MCM for this investigation.⁶⁴⁰ He did not think the model would have been helpful or even applicable in this case.⁶⁴¹ In fact, he felt using it would have been a “hindrance.”⁶⁴²

227. The specific assurances provided to the Fynes about how the BOI report would be used in support of the investigation were also not honoured. During the May 5, 2010 meeting, Maj Dandurand had insisted the BOI report would not be taken at face value, and had indicated the evidence before the BOI would be examined in detail and the

witnesses interviewed again.⁶⁴³ In testimony, he explained the message he intended to convey to the Fynes:

It was very clear to us at the time that the Fynes had had an experience with the Canadian Forces through the process of the BOI and through their interactions with the Canadian Forces as a whole, that they had become very skeptical and perhaps distrusting.

And what I wanted to specifically address in there is that **if we're going to be pursuing something, we're going to be pursuing it according to our methods**, not according to anybody else's song, **we're going to be doing it ourselves** and we have our **own methods of getting to the bottom of things.**⁶⁴⁴ [Emphasis added]

228. Nevertheless, the BOI report was included in the documents reviewed in support of the assessment.⁶⁴⁵ Yet, there was no review of the evidence presented at the BOI, and no interviews with any of the BOI witnesses.⁶⁴⁶

229. In the end, Maj Dandurand recognized he did not “uncover the truth of what happened” as he had promised the Fynes he would do.⁶⁴⁷ He explained:

At the time, with the presentation of the allegations and my understanding in that meeting [...] **I was of the thought that we would be pursuing a criminal investigation in this** and that I had perhaps situated the -- situated the investigation such that I had no expectation going external that it would be viewed as not applicable.⁶⁴⁸ [Emphasis added]

230. The investigations were open for more than a year, but at no time were the Fynes ever advised of the change in approach in the two investigations.

231. The few updates the Fynes received from MCpl Mitchell about the 2009 file were generally consistent with the initial plans described to them, as MCpl Mitchell still intended to proceed with numerous interviews.⁶⁴⁹ When the focus moved to documentary review after Sgt Shannon took over the file, the Fynes were not advised.

232. The Fynes were provided limited information about the steps being taken in the 2010 investigation. Maj Dandurand testified he had no reason to believe the Fynes did not understand what the steps were.⁶⁵⁰ He thought he might even have advised them during the May 5 interview of his intention to conduct an assessment and seek legal advice before proceeding with the investigative steps he outlined.⁶⁵¹ However, he could not recall with certainty whether this was discussed with the Fynes or when the conversation

would have taken place.⁶⁵² MCpl Mitchell also could not recall whether this plan was discussed with the Fynes during the interview, although he did recall a discussion with Maj Dandurand.⁶⁵³ The transcript for the May 5 interview shows the Fynes were not advised during the meeting of any plan to conduct a preliminary assessment or to seek legal advice.⁶⁵⁴ When the initial representations were made to them by Maj Dandurand about the extensive investigation to be conducted, the Fynes were not provided with any indication those plans were conditional upon a preliminary assessment being conducted.

233. In the subsequent updates received by the Fynes, they were provided with some information about legal advice being sought and consultation taking place with supervisors.⁶⁵⁵ On the basis of this information, they did understand the CFNIS were “still assessing” the case, and they knew there was “no actual investigation at that point.”⁶⁵⁶ They were also aware the BOI report was included in the materials being reviewed as part of the assessment.⁶⁵⁷ However, as recognized by Maj Dandurand during his testimony, the Fynes were never formally advised a decision had been made not to proceed with any of the extensive investigative steps he had described during the initial interview.⁶⁵⁸

234. The documentary record suggests the decision to conclude the file without conducting an investigation may have been made as early as August 14, 2010.⁶⁵⁹ By October 28, 2010, the CFNIS DCO advised the CFPM the investigative assessment was “completed” and a determination had been made there was “nothing indicat[ing] that a Code of Service offence or criminal offence such as criminal negligence may have occurred.”⁶⁶⁰ In testimony, Maj Francis Bolduc explained the file was kept open in case evidence uncovered in the 2009 investigation changed this assessment.⁶⁶¹ The last update the Fynes received about this investigation was on August 17, 2010.⁶⁶² There is no record of its content, and the witnesses had no specific recollection.⁶⁶³ While Maj Dandurand testified he had no reason to believe the Fynes did not understand the current status of the investigation at the time, as he was confident MCpl Mitchell “would have had an open and candid conversation with them,” he also recognized MCpl Mitchell would not have told the Fynes about the contents of any legal opinion received.⁶⁶⁴ As of January 2011, the Fynes were under the impression the investigation had “fallen inactive,” as they had

received “no further update or response” about it.⁶⁶⁵ They were not told about any preliminary decision not to pursue an investigation, either when the decision was made, or at any time afterward.⁶⁶⁶ Even at the very end, the Fynes were advised of the ultimate result of the assessment – the determination that no charges were warranted – but they were still not told no investigation had been conducted or that the final determination was based solely on an investigative assessment.⁶⁶⁷

235. WO Blair Hart, one of the supervisors for the investigations, testified he was not aware of any policy requirement to notify complainants of a change in approach during the course of an investigation in cases where initial representations were made about how the investigation would proceed.⁶⁶⁸

236. WO Bonneteau, the other supervisor, testified he did not know about the representations made to the Fynes, and, as a result, had no discussions with Maj Dandurand about the difference in approach.⁶⁶⁹ However, he stated he believed Maj Dandurand was aware the “new plan” for the investigations did not involve the type of extensive interviews or MCM he had discussed with the Fynes.⁶⁷⁰

237. In testimony, Maj Dandurand recognized the Fynes were never told the investigations did not end up unfolding as he had indicated during their meetings.⁶⁷¹ He explained it was his intent to advise them of the change in approach during the final briefing at the end of the investigation.⁶⁷² He did not provide any explanation or reason why the Fynes could not have been advised earlier through the regular updates promised to them.⁶⁷³

238. In all cases, updates provided to complainants should involve more than mere courtesy calls without substantive content. In light of the need to protect the integrity of ongoing investigations, there will be limits regarding the amount of detail that can be shared. However, if they are to serve their intended purpose of keeping complainants informed, updates must be meaningful. Substantive information must be provided to allow complainants to understand the investigative approach and the direction of the investigation. At least a general outline of the investigative steps required should be

provided. Each update should then allow complainants to gain an understanding of the progress made and the work remaining to be done.

239. Where specific representations are made to complainants about the conduct of the investigation, additional obligations will arise to provide information. There will not be an obligation to carry out the investigation in accordance with the plans outlined to the complainants since, for obvious reasons, decisions about how to conduct a police investigation should be dictated solely by the needs of the investigation and by the investigators' assessment of the steps necessary to carry out their policing duties. However, there will be an obligation to advise the complainants when a different approach is adopted. Otherwise, they could be misled about the extent of the investigative work being conducted.

240. In this case, the CFNIS' failure to provide substantive information about the investigations not only left the Fynes feeling they were being ignored, but was also likely to leave them with the impression the promised investigative steps were being taken. When they eventually found out this was not the case, it could only make their already strained relationship with the CFNIS more difficult, and erode what little trust the CFNIS had managed to establish in previous encounters.

FINAL BRIEFING

241. In February 2011, after months without any contact, the CFNIS finally contacted the Fynes to schedule a briefing about the conclusion of the two investigations. Shortly after, the CFNIS decided not to provide this briefing after all, because the Fynes had requested it be conducted in the presence of their counsel. The Fynes were told they would be receiving a written briefing instead. Many more weeks went by without further contact. Then, in early May 2011, the Fynes were provided with a three-page letter outlining the CFNIS' conclusions in the two investigations. The letter contained practically no substantive information about the investigations, and it became a source of further concern and complaints for the Fynes.

The cancelled verbal briefing

242. On February 20, 2011, Sgt Shannon contacted the Fynes to advise the two investigations were completed and to schedule a formal briefing about their outcome.⁶⁷⁴ In testimony, Mrs. Fynes explained her understanding at the time was the CFNIS intended “to give us a PowerPoint presentation at a hotel room.”⁶⁷⁵ She noted they did not want to receive such a presentation, but wanted a “back-and-forth conversation” about the investigations’ findings.⁶⁷⁶ In the end, the briefing did not take place.

243. The Fynes requested the briefing be held at their lawyer’s office with their lawyer present.⁶⁷⁷ In testimony, they explained they wanted the briefing to be held in a neutral location to avoid having to receive CFNIS members into their home or having to attend the military base.⁶⁷⁸ They also explained they wanted their lawyer present as an observer or “as a witness on our behalf.”⁶⁷⁹ Mr. Fynes testified it had been “clearly delineated” the lawyer would not be asking questions “and wasn’t going to interfere” with the briefing in any way.⁶⁸⁰

244. Sgt Shannon forwarded the Fynes’ request to Maj Dandurand.⁶⁸¹ After consultation with CFNIS HQ, a decision was made to cancel the briefing and to advise the Fynes of the outcome of the investigations in writing instead.⁶⁸² On February 24, 2010, Sgt Shannon told the Fynes of this decision and advised they would be receiving written correspondence from the CFNIS “in the near future.”⁶⁸³

245. As part of their allegations about the CFNIS’ failure to provide them with adequate and timely information, the Fynes have specifically complained about the CFNIS’ decision to cancel the verbal briefing because of the Fynes’ request for their lawyer to be present.⁶⁸⁴

246. The briefing was cancelled because of concerns about the presence of a lawyer having an impact on the briefing and on the interests of the investigators involved in the briefing.⁶⁸⁵ Based on the testimony of the CFNIS members, it appears the CFNIS was reluctant to become involved in eventual civil litigation they were aware the Fynes intended to pursue.⁶⁸⁶ They did not want the briefing to turn into a contest between

lawyers, and they did not want the investigation to be “picked apart” or scrutinized for civil litigation purposes.⁶⁸⁷

247. This reluctance to become involved in an external process was understandable. It is not the role of the police to conduct investigations in support of civil litigation claims. CFNIS participation in this process could create additional demands on its resources and could lead to scrutiny or questioning of its investigative process from a perspective unrelated to the needs of its criminal investigations or eventual prosecutions. The CFNIS could also risk being viewed as demonstrating a lack of neutrality as a police force. As a result, it is not surprising the CFNIS did not wish to provide a briefing in the presence of the complainants’ civil litigation lawyer.

248. Nevertheless, the CFNIS’ understandable aversion for litigation also had to be balanced with its responsibility to provide meaningful information to the complainants. In light of the commitments made to the Fynes about how the investigations would be conducted and about the updates to be provided, and in light of the woefully inadequate information provided during the investigations, the Fynes’ interest in finally receiving information about the investigations should have been given more consideration. The CFNIS had a responsibility to provide this information, both to honour its own direct commitments and to fulfill its duties as a police force to provide information and support to complainants.

249. The Commission considers giving precedence to the CFNIS’ desire to stay out of the civil litigation process over the interests of the complainants to receive information was not the appropriate decision. This decision would only have been acceptable if the CFNIS could find an alternative meaningful way to provide timely, substantive, accurate and complete information to the Fynes. As it happened, the failure to provide the verbal briefing simply led to a further period without any communication, leaving the Fynes, once more, without any information about the steps taken to investigate their complaints or the conclusions reached. The written briefing eventually provided by the CFNIS could not possibly convey the information that would have been available in a verbal briefing, and in fact, did not contain adequate or sufficient information.

250. Under the circumstances, the decision to cancel the briefing could only further aggravate the Fynes' frustrations and the perception they were being ignored by the CFNIS. Since the CFNIS' own conduct had contributed to creating this perception, the CFNIS should not have allowed its own interests and desire to avoid becoming involved in the civil litigation to prevail over the need to finally fulfill its basic responsibilities towards the Fynes.

Delay in providing the written briefing

251. It was February 24, 2011, when the Fynes were advised the verbal briefing would not take place and were told they would be receiving a written briefing soon.⁶⁸⁸ After this, they did not hear from the CFNIS again until over two months later. The written briefing was signed on April 27, 2011.⁶⁸⁹ Because of an address error, it was returned to the CFNIS and finally mailed to the Fynes on May 6, 2011.⁶⁹⁰ In their allegations before this Commission, the Fynes made a specific complaint about the failure to provide the written briefing within a reasonable time after the verbal briefing was cancelled.⁶⁹¹

252. The delay in providing the written briefing to the Fynes remains largely unexplained. After the verbal briefing was cancelled, Sgt Shannon promptly prepared a draft for the written briefing. It was sent to Maj Dandurand for approval on March 3, 2011.⁶⁹² By March 8, 2011, the text of the letter had been approved by CFNIS HQ and the decision had been made it should go out under Maj Dandurand's signature.⁶⁹³ There was no further activity on the file, nor were there any changes to the letter. Yet, it took almost two months for Maj Dandurand to sign the letter. In testimony, Maj Dandurand could not recall any reason or provide an explanation for this delay.⁶⁹⁴ He did mention he was dealing with family emergencies in early 2011, and explained, as a result, he could not give the file his full attention and was forced to rely on his second-in-command (2iC).⁶⁹⁵

253. On April 11, 2011, the new CFNIS CO, LCol Robert Delaney, wrote to Maj Dandurand to ask whether the written briefing had been sent.⁶⁹⁶ Maj Dandurand responded he intended to sign and send the letter "when I get back."⁶⁹⁷ He explained the letter was ready to go, but indicated: "I just need to finalize the file so that when I send it

the file [is] ready for ATIP.”⁶⁹⁸ In testimony, he explained he was referring to the need “to close out the file in order for it to formally be concluded in SAMPIS.”⁶⁹⁹ He testified that, until the file was officially concluded, it would not be accessible following Access to Information requests, because it would be considered ongoing.⁷⁰⁰ He indicated while this was not necessary, he wished to have the file concluded and accessible at the same time as the letter was sent to the Fynes.⁷⁰¹ The Concluding Remarks for the investigations were dated March 3 and 4, 2011.⁷⁰² The files were marked as concluded in the SAMPIS system by Maj Dandurand on May 2, 2011.⁷⁰³

254. Maj Dandurand provided no explanation to this Commission as to why the Detachment 2iC or other supervisors or investigators could not have provided assistance in moving forward the process of concluding the files and providing the written briefing to the Fynes. After such a long period without contact or information, and following on the heels of the decision to cancel the verbal briefing, the additional delay of two months for the Fynes to receive information about the investigations created unnecessary anxiety and frustration for them. The Fynes should have received timely updates and information during the investigations, and they should have been advised promptly of the results once the investigations were concluded.

Lack of substantive information contained in the written briefing

255. The Fynes’ chief complaint about the written briefing is that it did not contain sufficient information to answer their questions.⁷⁰⁴ Mr. Fynes testified, “We got a letter that was kind of a gunny sack of things. **Didn’t really tell us anything**, except that they were all finished and closed and done. [...] And no one was being charged or found responsible for anything.”⁷⁰⁵

256. Mrs. Fynes, for her part, stated, “We felt, to sum this letter: We did nothing wrong then and we are doing nothing wrong now and will do nothing wrong in the future.”⁷⁰⁶

257. There is no question, and all of the CFNIS witnesses agreed, the written briefing contained less information than would have been provided in the verbal briefing initially planned.⁷⁰⁷ Comparing the written briefing to the PowerPoint presentation Sgt Shannon

had prepared in anticipation of the verbal briefing, he testified, “the two are night and day.”⁷⁰⁸ The PowerPoint slides contained a discussion of at least some of the CFNIS’ individual conclusions about the issues they identified as relevant, and some of the reasoning supporting those conclusions.⁷⁰⁹ They would have allowed the Fynes to understand, at a minimum, some of the reasons why the CFNIS members came to their conclusions. In addition, Maj Dandurand testified he expected the verbal briefing to involve “free and frank dialogue, not just on the topics covered on the slide but, rather, the entire -- the totality of the investigations.”⁷¹⁰ LCol Sansterre also thought an oral briefing would have led to discussions and much more information being exchanged.⁷¹¹ By comparison, the information contained in the written briefing was very limited.

258. In testimony, Sgt Shannon recognized the letter was limited to presenting conclusions and did not really set out any of the reasoning supporting those conclusions, although he indicated he still believed the written briefing answered “the substantive questions based on the allegations that were referred to.”⁷¹² LCol Sansterre felt the written briefing “strictly spoke to what the investigation was and what the outcome of that investigation was.”⁷¹³ He maintained the letter to the Fynes “did give them the fullness of the results of the CFNIS investigation.”⁷¹⁴ However, he recognized the letter had “less detail” about the analysis supporting the conclusions.⁷¹⁵

259. In total, the letter was three pages long.⁷¹⁶ It contained very little information about the basis for the CFNIS’ conclusions and no information about the steps taken during the investigations.

260. The first page of the letter provided an overview of the two files. It included a general description of the allegations investigated in each case, and advised no charges would be brought. The only information about the investigations was a statement indicating they required “extensive review” of “all matters relating to Cpl Langridge,” as well as statutes and policies, and a statement only federal legislation, policies and regulations valid and in force on March 15, 2008, were considered.⁷¹⁷

261. The second page of the letter was devoted to the 2009 PNOK investigation. It set out the two allegations investigated by the CFNIS and listed the potential offences

considered during the investigation. It then went on to provide some information about the conclusions drawn. It stated the investigator had concluded Cpl Langridge was in a common-law relationship at the time of his death, and had found the Regiment Adjutant did not “appoint” his next-of-kin, but rather confirmed the existence of valid documentation indicating Cpl Langridge was in a common-law relationship. It advised no repealed policy had been quoted to support the determination of Cpl Langridge’s common-law status, as the relevant policy was in effect until 2009. As a result, the letter indicated no evidence had been identified to suggest any CF member had failed to fulfill his or her duty, and concluded the “elements of the offence” were not established.⁷¹⁸

262. This limited information was capable of informing the Fynes about at least some of the conclusions reached in the investigation. In particular, it made it clear the CFNIS concluded Cpl Langridge was in a common-law relationship at the time of his death. However, it provided no explanation at all about why this was viewed as determinative of the issue under investigation, namely, who Cpl Langridge’s PNOK should have been and who should have had authority to plan his funeral.⁷¹⁹

263. During this hearing, it was learned the lead investigator believed the common-law spouse was always the correct PNOK.⁷²⁰ This was based on the investigator’s understanding of the applicable laws and policies and of the “customs of society.”⁷²¹ However, nothing in the letter provided to the Fynes could have alerted them to this or allowed them to discern how or why the CFNIS arrived at its ultimate conclusion in the investigation. It is not surprising they complained the written briefing did not answer their questions.⁷²² They complained about the wrong PNOK being appointed to plan the funeral, and were told in response, the person in question was correctly recognized as Cpl. Langridge’s common-law spouse. In testimony, Mr. Fynes explained:

But [we] asked the question about why was Stuart's ex-girlfriend inserted as the primary next of kin to arrange the funeral, I guess more appropriately is, the person arranging the funeral at least technically should have been the executor.

And we -- answered back that she was still considered by the military or recognized in status as being common-law.

So, the answer isn't an answer to the question that [we] asked. Who inserted that person and why was she inserted in, because she was common-law. Oh, okay. That's not the

criteria for arranging the funeral.⁷²³

264. Indeed, without more information, it was not possible for the Fynes to understand what link the CFNIS investigator made between the PNOK, the common-law spouse, and the responsibility for planning the funeral. As such, they could not understand and assess the basis for the conclusions reached by the CFNIS.

265. Further, the briefing contained no information at all about the investigative steps or the overall approach adopted during the 2009 investigation. On the basis of this letter, the Fynes could not have known the plan to interview all those involved in the PNOK decision was ultimately not carried out.⁷²⁴ They could not have known Sgt Shannon's conclusions were based solely on his own analysis of the "documentary record" and of the policies he considered applicable, supported only by interviews with policy witnesses and the three previous interviews conducted by MCpl Mitchell.⁷²⁵ They could not have understood, based on the written briefing they received, what kind of investigative activity was carried out to support the conclusion arrived at.

266. The third and last page of the letter was devoted to the 2010 Criminal Negligence Investigation.⁷²⁶ It contained even less information than had been provided about the 2009 investigation. After setting out the *Criminal Code* sections invoked by Mr. Fynes in his initial complaint letter, the briefing simply indicated that after "a complete review of all information and evidence gathered," it was concluded "reasonable and probable grounds" to believe CF members committed the listed offences were not established, and the "burden of proof" for the offences was not established "by evidence."⁷²⁷ There was no information about what materials were reviewed, about whether any investigative steps were taken to gather the "evidence" referred to, or about what the reasoning was for concluding no charges were warranted. On the basis of the information contained in the briefing, it would have been impossible for the Fynes to gain any understanding of how the 2010 investigation was approached by the CFNIS.

267. All of this was particularly problematic in light of Maj Dandurand's earlier commitments. During the May 5 interview, he had specifically told the Fynes he gave them his "promise" if he concluded a charge was not warranted, he would "have the

justification for that statement.”⁷²⁸ Yet, the briefing simply stated the conclusion without providing any explanation or justification.⁷²⁹ In testimony, Maj Dandurand recognized he never provided the Fynes with the justification he had promised.⁷³⁰ He explained:

I did not give them that justification. One of the intents of the family briefing that would have occurred at the conclusion of this investigation and the other would have been to discuss that exact issue, and **I had full anticipation that this would be a point of contention and would require me to explain it at length.**⁷³¹ [Emphasis added]

268. Maj Dandurand testified he did not “get a chance” to provide the justification in the end, because the CFNIS “backed out of the family briefing” when the Fynes requested it take place at their lawyer’s office.⁷³² He did not explain why the justification could not have been provided in the letter sent in lieu of the verbal briefing.⁷³³ He only commented, “the letter was not a briefing, per se.”⁷³⁴ At the time, he had not considered the question of whether the Fynes’ insistence to conduct the verbal briefing in the presence of their lawyer relieved him of his own commitment to provide a justification for determining charges were not warranted.⁷³⁵ He made no other effort to provide the Fynes with an explanation regarding the basis for the CFNIS’ conclusions in the 2010 file.

269. The written briefing also provided no information about the investigative steps in the 2010 file. From the letter they received, the Fynes could not have known only an investigative assessment had been done. On the contrary, some of the language in the letter could have created the inaccurate perception an investigation was conducted. The first page of the letter referred to “**two** detailed and comprehensive investigations” having been conducted.⁷³⁶ In addition, the portion of the letter devoted to the 2010 investigation referred to a “complete review of all information and evidence gathered in relation to the manner in which Cpl Langridge received medical care and the manner in which he was provided with personal support by members of the Canadian Forces.”⁷³⁷ The words “all information” appeared to imply, at a minimum, that all existing materials were reviewed, which was not the case.⁷³⁸ More importantly, the reference to a review of “all evidence gathered” created the impression evidence had actually been gathered by the CFNIS and an investigation had been conducted, especially in light of Maj Dandurand’s initial representations about the plans for this investigation. In the letter, there was nothing

indicating the “information and evidence” reviewed was limited to a selection of previously held information, with no new evidence being gathered and no investigation being conducted. In testimony, Maj Dandurand recognized the letter, as drafted, would not have allowed the Fynes to know the CFNIS did not do the things he had said they would do during the May 5 interview.⁷³⁹ He testified:

MR. FREIMAN: Is it your belief that this letter would have given the Fynes the ability to understand that there was no investigation at all conducted or no direct investigation conducted with respect to 2010 investigation ... ?

Would the Fynes have known that you didn't do the things that you said on May the 5th that you were planning to do?

MAJ DANDURAND: No, they would not.

MR. FREIMAN: Should they have known that?

MAJ DANDURAND: It was my intent to discuss that at the family briefing.⁷⁴⁰

270. The CFNIS members did not provide a satisfactory explanation for the failure to include substantive information in the written briefing. Sgt Shannon, who drafted the text of the letter, testified the lack of detailed explanations was the result of his understanding of “typical rules of writing” when drafting correspondence.⁷⁴¹ He explained the reason he did not break down the elements of the offences or provide individual explanations of the conclusions was “just for simplicity.”⁷⁴² He also indicated preparing this type of briefing in a case like this was unusual, as normally the complainants would be advised of the results of the investigation through a phone call only.⁷⁴³ Maj Dandurand, for his part, explained the intent of preparing the letter was to ensure the Fynes were at least provided with information about “what it was that we were investigating and what it was that we had concluded.”⁷⁴⁴ He could not recall why it was decided to include significantly less detail in the written briefing than would have been provided in the verbal briefing.⁷⁴⁵ He only noted: “We do not normally encounter this and that was the decision that we made at the time.”⁷⁴⁶

271. Final briefings provided to complainants at the conclusion of an investigation must be more than mere courtesy exercises. They must provide meaningful information. Once an investigation is concluded, concerns about the need to protect its integrity are

less important. Hence, final briefings should include more information than updates during the investigation. At a minimum, they must provide complainants with an outline of the investigative steps taken and an explanation of the basis for the conclusions. If substantive information is not included, the mere fact of providing a final briefing to complainants, whether by phone call, in a meeting, or through a letter, will not be sufficient to fulfill the CFNIS' duties or commitments to keep complainants informed about its investigations.

272. In this case, the decision to use written communication instead of a verbal briefing was, by its very nature, bound to result in the Fynes receiving less information. However, had the CFNIS provided adequate information in the letter about the steps taken in each of the investigations and the reasoning supporting the conclusions reached, the written briefing could have provided the Fynes with at least some of the information they were entitled to receive. As it was, the letter did neither. It ended up answering none of the Fynes' questions beyond the final outcome of the investigations and providing no substantive information about the investigations. Most concerning, the written briefing left the Fynes entirely in the dark about what was done in the investigations and how it differed from what they had been told would be done. In particular, the Fynes should have been advised clearly of the decision to conduct only an investigative assessment in the 2010 file. The decision to cancel the verbal briefing did not relieve the CFNIS members of their obligation to provide this information. Even after receiving their final "briefing" about the investigations, the Fynes still had no way of knowing the extensive investigation Maj Dandurand had promised was never carried out. Had there not been proceedings before this Commission, and had the Fynes not made an Access to Information request for the investigative file, they would still not know there had been no investigation.

Accuracy of written briefing

273. In addition to their more fundamental complaints about the lack of substantive information in the written briefing, the Fynes have also made specific allegations about inaccurate information they believe was included in the briefing.⁷⁴⁷

274. The Fynes have alleged the briefing improperly characterized the 2009 investigation as having been opened at their request.⁷⁴⁸ Instead, they believe this investigation was “the result of the Military Ombudsman’s Office contacting the NIS to start that investigation.”⁷⁴⁹ In testimony, Mr. Fynes explained he wanted to “set the record straight” by making this allegation, because he believed they did not initiate the 2009 investigation, although he noted they were “sort of parties to it.”⁷⁵⁰

275. The evidence before this Commission has revealed there was a lack of clarity as to the identity of the complainant within the 2009 investigative file. As both the Ombudsman’s office and the Fynes had communicated similar concerns to the CFNIS, some notations in the file appear to indicate the Fynes were the complainants, while others appear to indicate the investigation was opened as a result of the allegations communicated by the Ombudsman’s investigator.⁷⁵¹

276. However, the evidence has also revealed the CFNIS members involved in the investigation generally viewed the Fynes as the true complainants, while they viewed the Ombudsman’s investigator as a “third party complainant” or a conduit for the Fynes’ complaint.⁷⁵² Since the information communicated by the Ombudsman’s investigator originated from the Fynes, and the concerns he communicated to the CFNIS were the result of the Fynes’ complaint to the Ombudsman’s office, this view was not unreasonable.⁷⁵³ In fact, when he was first advised by Maj Dandurand of the allegations brought forward by the Ombudsman’s investigator, Mr. Fynes himself stated, “I made that allegation a long time ago, so I won’t hide behind anybody else.”⁷⁵⁴ In her testimony, Mrs. Fynes also recognized they had complained about the NOK issue “all along,” and indicated she expected the Ombudsman’s investigator contacted the CFNIS on the basis of the information she and Mr. Fynes had provided.⁷⁵⁵ As to her views about the identity of the “complainant” in the 2009 file, she testified:

Q. Moving on to the 2009 investigation. You had stated, and I know that this is one of the allegations in your complaint, you object to any reference that you and Mr. Fynes were the complainants in the 2009 investigation.

A. I’m not saying I object to it. What I’m saying is that we voiced our complaints to the military ombudsman and eventually he told me that he had spoken to the NIS and there would be an investigation done and then when we met with Major Dandurand, we did

voice our complaints with him.⁷⁵⁶

277. On the basis of the evidence, the Commission cannot conclude the information contained in the written briefing provided to the Fynes was inaccurate. While the lack of clarity in the file about the identification of the complainant was unfortunate for other reasons,⁷⁵⁷ the statements made in the final briefing did not misrepresent the situation. In fact, strictly speaking, the statements were accurate. The letter did not purport to identify the Fynes as the sole complainants. It simply stated they had made verbal allegations regarding the NOK issue and noted the investigation focused on those allegations.⁷⁵⁸ This represented the investigators' genuine and reasonable understanding about whose allegations were being investigated.

278. The Fynes have also alleged the statement in the written briefing, "the NDA hold[s] precedence over provincial legislation," was inaccurate.⁷⁵⁹ In testimony, Mr. Fynes explained his understanding was the NDA "does not override or supersede provincial legislation in matters of provincial jurisdiction."⁷⁶⁰ He added, "So, I don't know if the investigator doesn't understand that or if he's deliberately misrepresenting it."⁷⁶¹

279. The Commission has noted elsewhere in this report, Sgt Shannon's categorical rejection of the relevance of provincial law on the basis of his understanding the NDA held legal precedence was based on a great over-simplification and was not the correct approach to address the issues raised in this investigation.⁷⁶² Whether federal law will prevail over provincial law in specific circumstances depends on a number of factors, which were not considered by Sgt Shannon.⁷⁶³ In this case, provincial law should not have been dismissed out of hand, and may well have been relevant to answer some of the questions under investigation.⁷⁶⁴ As such, the unqualified statement included in the final briefing was indeed not accurate in the context of this investigation.

280. However, the statement was not a deliberate misrepresentation, and it was not intended to mislead the Fynes. It represented the investigator's honest belief about the applicable law. While the Commission is of the opinion this belief was misguided, and a legal opinion should have been sought before coming to such conclusions,⁷⁶⁵ it was

appropriate to advise the Fynes in the final briefing of the approach actually taken by the investigator. This would have allowed them to make their own assessment of the investigation, and to pursue any available recourse to challenge the investigator's approach. The statement included in the briefing did accurately report the legal theory adopted during the investigation. It was inaccurate because of a failure in the legal analysis, not because of a failure to provide information to the complainants.

281. Aside from the specific points complained about by the Fynes, there were other concerns with the content of the written briefing. Not only was very little substantive information provided, but also the manner in which the allegations were described did not present a complete picture of the issues the Fynes had asked the CFNIS to investigate. While the descriptions included in the briefing were not intended to mislead the Fynes, since they did represent the investigator's understanding, they were nevertheless overly narrow and, certainly for the 2009 allegations, they contributed to creating the impression the answers provided in the briefing were more responsive than they in fact were.

282. The main allegation investigated in the 2009 file was described as an allegation CF members "misinterpreted documents and policies regarding the common-law status of your son," as well as an allegation Ms. A "had been appointed as the next-of-kin (common-law spouse) [...] in the absence of any documentation to support that [Ms. A] had ever been formally appointed as such by Cpl Langridge."⁷⁶⁶ In the GO file, this allegation had consistently been described as an allegation CF members had been negligent in appointing Ms. A as the NOK, and not in recognizing her as the common-law spouse.⁷⁶⁷ During interviews with the CFNIS, the Fynes had made it clear their complaint related to the appointment of Ms. A as the NOK for purposes of making decisions about Cpl Langridge's funeral.⁷⁶⁸ Sgt Shannon was of the view the common-law spouse was the appropriate NOK and, as a result, believed if Ms. A had been appropriately recognized as the common-law spouse, it would necessarily follow she had also been appropriately recognized as the NOK.⁷⁶⁹ In the written briefing, this conclusion was incorporated into the description of the allegation being investigated. While this represented an accurate description of the investigator's ultimate view of the file and of

his own understanding of the issue to investigate, it did not represent an accurate description of the allegations as presented by the Fynes.

283. The issue brought to the CFNIS for investigation was whether Ms. A had appropriately been recognized as the NOK, specifically for purposes of funeral planning. The conclusions set out in the letter indicating she was appropriately recognized as the common-law spouse,⁷⁷⁰ did not, without more explanations, answer the question. However, because the letter inaccurately stated the question to be investigated as only relating to common-law status, the conclusions appeared to answer the question.

284. The description of the 2010 criminal negligence allegations also did not capture all of the Fynes' complaints. The allegations were described as relating to "unspecified members" of the CF.⁷⁷¹ In fact, during their interview with the CFNIS, the Fynes had identified at least some specific individuals they believed were responsible.⁷⁷² Strictly speaking, the information in the briefing was not inaccurate, as it referred only to the Fynes' written complaint, and this complaint did not specify the individuals allegedly involved.⁷⁷³ However, by using this narrow description of the allegations, the briefing did not present a full picture of the issues at stake. While Sgt Shannon's focus in completing the offence validation in this case was on the written complaint, in testimony he recognized the Fynes' verbal allegations were also relevant.⁷⁷⁴

285. Maj Dandurand, who signed the briefing letter, testified the description of the allegations included in the letter was not meant to indicate the investigation would be limited to the allegations made in the Fynes' written complaint.⁷⁷⁵ He stated the omission to record the identity of the persons complained about in the investigative file and in the letter was not deliberate.⁷⁷⁶ If, indeed, the overall approach the CFNIS meant to adopt was to take into account the Fynes' verbal allegations, and not just their written complaint, this was not reflected in the written briefing.

CONCLUSION

286. On the whole, the series of failures and mishandling of communications observed in the CFNIS' interaction with the Fynes during the 2009 and 2010 investigations

provided an unfortunate example of how not to act when interacting with complainants. The Fynes were not treated with the respect and consideration they were entitled to receive. They were not provided with meaningful information either during the investigations or after the investigations were concluded. Their questions were not answered, and they had numerous promises made to them, which were never fulfilled. Regrettably, these missteps and communication failures represented a continuation of similar problems observed since the beginning of the 2008 investigation.⁷⁷⁷

4.5.5. The ‘Stockholm Syndrome’ Comment

287. The Fynes have alleged to this Commission CFNIS members commented during an interview that a statement made by their AO indicating the Fynes had been “deceived, misled, and intentionally marginalized in their dealings with DND and the CF”⁷⁷⁸ was likely the result of ‘Stockholm syndrome.’ They claim this comment demonstrated a bias against criticism of the CF and such views acted to prevent CFNIS members from conducting independent investigations.⁷⁷⁹ In her testimony, Mrs. Fynes suggested the recordings for this interview had been altered.⁷⁸⁰

288. The Commission finds these allegations are unsubstantiated. The evidence available indicates no CFNIS member made such a comment to the Fynes during the interview in question. A forensic analysis of the interview tapes conclusively determined no alterations were made to the audio or video recordings.

CONTEXT OF THE ALLEGATIONS

289. The circumstances giving rise to these allegations begin with an email from Maj Parkinson to Maj Glen Hamilton-Brown on January 21, 2009.⁷⁸¹ The email was reportedly sent after the Fynes met with Maj Parkinson at his Reserve Unit one evening. Mrs. Fynes stated they were “angry” at that point, feeling they were being ignored by the CF in the lead up to the BOI and went to speak with Maj Parkinson to see if he could help.⁷⁸² Maj Parkinson testified he sent the email to Maj Hamilton-Brown in an effort “to

ensure that the Fynes were participants in the board of inquiry.”⁷⁸³ The email states, in part:

I personally have no issues but I feel it my duty to inform you that the Fynes definitely have a multitude of issues not the least of which is their participation in the BOI in a meaningful way. You'll understand if after 10 months of being deceived, misled, and intentionally marginalized a [sic] various points that they have no faith left in the system.⁷⁸⁴

290. Mr. and Mrs. Fynes complained to this Commission and maintained in their testimonies that Maj Dandurand commented Maj Parkinson's statements were likely the result of 'Stockholm syndrome'. They believed the comment was made during the third interview between the Fynes and CFNIS investigators at CFB Esquimalt on May 5, 2010.⁷⁸⁵ Mr. Fynes stated he believed the comment was made near the middle of the interview.⁷⁸⁶

291. None of the audio recording, video recording,⁷⁸⁷ or transcript⁷⁸⁸ of the interview shows Maj Dandurand making such a comment. When confronted with this information during her testimony, Mrs. Fynes acknowledged there was no such comment in the recordings, but alleged there are portions of the interview "missing" from the recordings.⁷⁸⁹ Mr. Fynes did not make any such allegation, but did state he could think of no reason he would accept for the comment not being captured in the recordings.⁷⁹⁰

292. The Fynes' allegations are very serious in nature and are concerning for a number of reasons. If investigators had made such a comment, it would suggest a bias against criticism of the CF and would call into question their impartiality in conducting their investigations. It would also be unprofessional for investigators to liken a family's AO to a hostage victim, and by implication, the family to hostage-takers. The allegation that portions of the interview are "missing" amounts to an allegation the interview recordings were altered to remove the impugned statement. Editing a witness interview recording would be highly unprofessional as the contents of the recording would no longer be a complete and accurate representation of events. It would risk jeopardizing an investigation and the professional reputations and integrity of the investigators involved.

THE INVESTIGATORS' RESPONSES AND THE EVIDENCE

293. For their part, neither investigator involved in the interview recalled any such comment being made. Maj Dandurand testified he did not recall making any comment regarding 'Stockholm syndrome' as alleged by the Fynes, and he was unaware of any basis for their belief the interview tapes were altered.⁷⁹¹ MCpl Mitchell testified he could not recall any discussion of 'Stockholm syndrome' or of Maj Parkinson being stigmatized for the comments he made.⁷⁹²

294. The interview recordings and transcript indicate neither Maj Dandurand nor MCpl Mitchell made any comment about Maj Parkinson suffering from 'Stockholm syndrome'. There is no record of Maj Parkinson's email, or of any fallout that may have occurred as a result of it, being discussed. Maj Parkinson's name does come up during the interview, as MCpl Mitchell had interviewed him as part of the 2009 investigation. MCpl Mitchell told the Fynes he thought Maj Parkinson was a "very nice man."⁷⁹³ The only other mention of Maj Parkinson was made by the Fynes when they told investigators he had informed them, in the days following Cpl Langridge's death, they were not PNOK.⁷⁹⁴ This is the extent of the discussions relating to Maj Parkinson.

295. This Commission ordered a forensic analysis of the May 5, 2010, audio and video interview recordings from the RCMP Audio and Video Analysis Section to determine whether they had been altered in any way. The analyses conducted included frame-by-frame video analysis, audio comparison of the separate audio and video recordings, and digital file property analyses.⁷⁹⁵ A comprehensive report on the analyses concluded there was no "evidence of deletions or modifications done to any of the recordings. On the contrary, there is strong evidence they are exactly what they are purported to be."⁷⁹⁶ Thus, there is no evidence to support Mrs. Fynes' allegation the recordings were altered.

4.5.6 CFNIS Answers to the Col Blais Questions

296. During the five-month period when the Fynes had no contact from the CFNIS, while the 2009 and 2010 investigations were still ongoing, the Fynes transmitted questions about the CFNIS' past and present investigations to Col Gerard Blais. The Fynes had raised many of these previously but had not received satisfactory answers or, in some cases, any answers.⁷⁹⁷

297. The CFNIS prepared responses to the Fynes' questions and transmitted them via Col Blais. The Fynes were not satisfied with the answers.⁷⁹⁸ In many cases, the responses only increased their general concerns and complaints about the failure of the CFNIS to provide them with information.⁷⁹⁹ The responses also led to further complaints alleging inaccurate information or rationales were provided to explain or justify the CFNIS' actions.⁸⁰⁰

COMPILING THE CFNIS INFORMATION

298. Col Blais was the Director of the CF's Casualty Support Management Unit.⁸⁰¹ Shortly after Mrs. Fynes' October 2010 press conference, he was appointed as the point of contact to answer the Fynes' questions on behalf of the CF.⁸⁰² Col Blais asked the Fynes to provide a list of their questions or concerns and undertook to obtain answers from the relevant CF organizations.⁸⁰³

299. On January 4, 2011, the Fynes sent Col Blais a document listing a number of questions they wanted answered by the CF, including six questions specifically related to the CFNIS investigations.⁸⁰⁴ Col Blais forwarded the questions to "subject matter experts" within the CF in order to obtain the necessary information.⁸⁰⁵ On January 11, 2011, the CO of the CFNIS, LCol Sansterre, received the questions, along with Col Blais' request to provide answers as soon as possible.⁸⁰⁶ On the same day, the questions were forwarded to Maj Dandurand, the OC of the WR Detachment, and he was asked to provide answers.⁸⁰⁷

300. MWO Terry Eisenmenger, the Detachment chief investigator, was tasked with compiling information to answer the Fynes' questions.⁸⁰⁸ On January 14, 2011, he sent Maj Dandurand draft responses for five of the six CFNIS questions.⁸⁰⁹ On January 18, Maj Francis Bolduc, the CFNIS DCO, transmitted the CFNIS responses for all six questions to Col Blais.⁸¹⁰

301. It is not clear who prepared the final version of the answers sent by Maj Bolduc. The content was the same as in the draft responses prepared by MWO Eisenmenger.⁸¹¹ The only difference was MWO Eisenmenger had reproduced entire sections of MP policies he considered relevant, whereas the final version contained only references to the sections and a more general description of their content.⁸¹² Text was also added to MWO Eisenmenger's response to the sixth question, dealing with the failure to disclose the suicide note. As well, a response was added for the fifth question, dealing with the "next of kin" investigation, which MWO Eisenmenger had left unanswered.⁸¹³

302. In testimony, Maj Bolduc indicated he received the answers directly from Maj Dandurand and passed them on to Col Blais without making any changes.⁸¹⁴ Maj Dandurand, for his part, explained he was dealing with family emergencies during this period.⁸¹⁵ As a result, he could not give the file his full attention and was forced to rely on his 2iC.⁸¹⁶ He could not recall whether he made changes to the draft answers provided by MWO Eisenmenger, or whether he drafted the additional answers included in the final version.⁸¹⁷ Maj Dandurand did note the new responses corresponded to his own belief at the time.⁸¹⁸ He also testified it would have been common practice for MWO Eisenmenger to forward the draft answers to him for review and input.⁸¹⁹ On the basis of this evidence, it is likely Maj Dandurand contributed to creating the final version of the CFNIS answers ultimately forwarded to Col Blais.

ANSWERS PROVIDED TO THE FYNES

303. After Maj Bolduc sent the CFNIS answers to Col Blais on January 18, the answers were incorporated into a larger document containing responses from other CF organizations.⁸²⁰ The document was reviewed and edited by the CF before it was sent to the Fynes.⁸²¹ There were a few minor edits to the CFNIS answers, but their substance

remained unchanged.⁸²² The answers were sent to the Fynes by Col Blais on January 31, 2011.⁸²³

Question 1: “Why was Stuart not shown any respect and his body left to hang for several hours?”

304. This was a question the Fynes had asked CFNIS members in their first two meetings on November 28, 2009, and March 3, 2010.⁸²⁴ Maj Dandurand had specifically undertaken to find the answer, but did not get back to the Fynes with the information.⁸²⁵ During the meetings, general information had been provided about the legal authority to make decisions to move or remove the body, but there was no specific answer addressing what happened in this case.⁸²⁶ The answer provided through Col Blais was no different.

305. The Col Blais answer begins by explaining all sudden death investigations are treated as homicide investigations where the cause of death is unknown.⁸²⁷ It notes the intent is to prevent the loss of evidence and ensure the scene is not contaminated.⁸²⁸ It then states, “The decedent can not be removed until authorization has been provided by the Lead Investigator who receives direction from the coroner.”⁸²⁹ The response goes on to describe the events of March 15, 2008. It indicates Cpl Langridge was discovered in the “defaulter Barrack room.”⁸³⁰ It states both MP and emergency services attempted to save his life upon arriving at the scene, but quickly determined he could not be revived.⁸³¹ It notes the room was formally declared a crime scene and indicates, “At 1725 hrs, 15 Mar 08, the CFNIS Lead Investigator and the Coroner arrived and commenced processing the crime scene which consisted of video recording and photographing the crime scene.”⁸³² The response notes Cpl Langridge’s body was removed at 1916 hrs, and concludes with a statement indicating the methodology for processing a potential homicide scene is “extremely lengthy and labour intensive.”⁸³³ It states investigators must be cautious to collect all possible evidence as any uncollected evidence may be lost to an investigation or inadmissible in court. It indicates if Cpl Langridge’s body had been removed while the scene was being processed, “it would have further contaminated the crime scene [...] which could potentially have had a significant impact on the criminal investigation.”⁸³⁴

306. This response does not answer the Fynes' question. It contains many general statements about policies and requirements, but there is limited information about the actual events in this case. It provides little clarity about who made the decision not to remove Cpl Langridge's body earlier and the basis for such a decision. Some of the factual information included is also inaccurate.

307. While the point is not expressed as clearly as it could have been, the response does indicate it was the ME who had authority to provide direction to move or remove the body.⁸³⁵ This is consistent with the statements CFNIS members had made during earlier meetings with the Fynes.⁸³⁶ Mr. Fynes disagreed with this interpretation of the law and believed it was the CFNIS, rather than the ME, who had authority to determine when the body could be removed.⁸³⁷ In their allegations to this Commission, the Fynes specifically complained CFNIS members "inaccurately stated that the responsibility for failing to promptly cut down Cpl Langridge's body rested with the Alberta Medical Examiner."⁸³⁸ To the extent it was based on the Fynes' understanding regarding legal responsibility for making decisions about the removal of the body, this allegation is not well founded. The ME did have the legal authority to make the decision and, as such, the description of the applicable legal framework included in the response is factually accurate.⁸³⁹

308. However, the response, as drafted, provides no clarity about the respective roles played by the ME and the CFNIS investigators in determining when Cpl Langridge's body could be removed in this specific case. By focusing on information about the legal responsibility for making the determination and providing no detail about the facts, the response appears to imply the decision was made by the ME. In reality, while the CFNIS investigators did not have the authority to determine when Cpl Langridge's body could be removed, they did influence the time it took to remove the body by asking the ME Investigator to wait while they exhaustively catalogued the room and its contents through photographs and video.⁸⁴⁰

309. The Commission has found the time taken by the investigators to process the scene in this case was within the range of what can be considered reasonable under the

circumstances.⁸⁴¹ As such, the CFNIS investigators cannot be faulted for the length of time Cpl Langridge's body was left hanging. However, the fact remains the main reason Cpl Langridge's body was not removed earlier was their request to the ME Investigator to wait while they completed the various steps they wished to undertake. The response provided to the Fynes entirely omits this information. To the extent the response implies the ME was, in fact, responsible for the decision regarding the timing of the removal of Cpl Langridge's body, it is not accurate.

310. The response also makes reference to a potential contamination of the scene if the body had been removed earlier. It is not clear the statements to this effect are supported by the facts. The description of the general procedures and methodology followed at the time by the CFNIS in such cases is accurate. It is also accurate, in the abstract, to state one of the reasons for having these procedures is to avoid contaminating the scene or losing evidence. However, on the facts of this case, it is not clear these statements have any special application.

311. While the Commission has found the time taken to conduct detailed surveys of the room prior to removing the body was not unreasonable and was in accordance with the usual CFNIS methodology and procedures,⁸⁴² there is no basis for an implication the length of time taken was necessary. The response provided to the Fynes affirms it was and categorically states the scene would have been contaminated if this had not been done. The evidence before this Commission does not support that claim. There is no evidence to support a conclusion to the effect that once the ME Investigator had examined Cpl Langridge's body and photographs and/or video had been taken to show its position in the room, removing the body prior to conducting the more exhaustive catalogue of the room would have interfered with or affected the remainder of the investigators' work or would have "contaminated" the scene.⁸⁴³ The blending in this response of a description of the general procedures with a description of the facts of this case resulted in potentially misleading information being provided to the Fynes.

312. The response also contains a number of factual inaccuracies in the description of the events of March 15, 2008. It states MP and emergency services personnel attempted

to save Cpl Langridge's life when they attended at the scene, but there is no evidence indicating this. Instead, emergency personnel simply confirmed there were no vital signs.⁸⁴⁴ Under the circumstances, this was the appropriate course of action, as it was clear Cpl Langridge was already deceased.⁸⁴⁵ There were no failures or inappropriate behaviour by the MP or CF members involved in this respect. However, the response does not accurately describe the events. The confusion again appears to have resulted from an attempt to blend a description of applicable protocols with a description of actual events. Because the normal protocols generally involve attempting resuscitating measures,⁸⁴⁶ it was apparently assumed this was done in this case.

313. The notation indicating Cpl Langridge was discovered in the "defaulter Barrack room" is also not accurate.⁸⁴⁷ In testimony, Maj Dandurand admitted this was a "false statement."⁸⁴⁸ In fact, while he was required to reside in the defaulter's room, Cpl Langridge was discovered in his room in the barracks.⁸⁴⁹ There is no indication the error was intentional or intended to mislead the Fynes. It was likely the result of confusion or a misunderstanding in reviewing the investigative file. However, the error was significant for the Fynes, as they were involved in a disagreement with Cpl Langridge's Regiment about the appropriate address for Cpl Langridge at the time of his death.⁸⁵⁰ When they received this response from the CFNIS, the Fynes specifically noted the inaccuracy of the information about where Cpl Langridge was found.⁸⁵¹

314. These types of errors and inaccuracies in the description of the basic facts surrounding the discovery of their son's body were not likely to inspire confidence by the Fynes in the responses being provided from the CFNIS. Not surprisingly, Mr. Fynes testified he did not accept the explanations provided by the CFNIS, and believed the response was "inconsistent with what actually happened at the scene."⁸⁵² While this perception was partly based on the Fynes' own misunderstanding about the legal responsibility for making decisions about removing the body, it was also true the response did not contain an accurate description of the events or an account of the actual reasons why Cpl Langridge's body was not removed earlier.

Question 2: “Why did the NIS need to access Stuart’s ‘Personal Information’ contained in his medical and health records?”

315. The brief CFNIS response provided to the Fynes identifies two reasons why Cpl Langridge’s medical records were obtained. First, it states the CFNIS investigators had received information indicating Cpl Langridge may have suffered from drug dependency and had attended a medical institution to receive treatment for mental health issues, including “suicidal tendencies.”⁸⁵³ Second, the response indicates medication was found at Cpl Langridge’s residence and “confirmation was necessary to establish/corroborate that he was issued the medication by the Canadian Forces, and to determine if the medication may have contributed in any way to his death.”⁸⁵⁴

316. Although it does not provide elaborate explanations about how the medical information being sought could be used to confirm suicide was the most likely cause of death, this response is generally factually accurate. The investigators had received information indicating Cpl Langridge had mental health and substance abuse issues, and they had been told about past suicide attempts.⁸⁵⁵ They had also found medication in Cpl Langridge’s storage locker and Jeep, and investigators were seeking to determine what medications he was taking, what the potential side effects were, and whether his actions were influenced by the medications or their side effects.⁸⁵⁶ All of these reasons were specifically referred to by the investigators during their testimony and were listed in the request for the medical records.⁸⁵⁷ The only aspect not specifically mentioned was the need to confirm the medications were issued by the CF.

Question 3: “Why does the Certificate of the Alberta Medical Examiner erroneously state that Stuart had been suffering with discipline issues?”

317. The Fynes had complained about this issue in previous meetings with the CFNIS, but had been unable to obtain details about the statements made to the ME by the CFNIS investigators.⁸⁵⁸ The response provided through Col Blais contains more information. It explains the ME had requested clarification about the meaning of the term “defaulters” and had been told a defaulter was a CF member who demonstrated poor or improper discipline, but had not been told Cpl Langridge was a defaulter.⁸⁵⁹ It then states it was

believed “the ME on his own accord and without influence or direction from the Lead Investigator annotated on the ME Certificate that Corporal Langridge suffered from discipline issues.”⁸⁶⁰

318. The Fynes were not satisfied with this answer.⁸⁶¹ In their complaint to this Commission, they specifically alleged the CFNIS provided inaccurate rationales to justify its actions by taking the position “it was not their responsibility if the ME overheard things during the processing of the scene and made his inaccurate comment about the disciplinary issues on that basis.”⁸⁶²

319. The evidence before the Commission has revealed the CFNIS investigators were not, in fact, responsible for the comment included in the ME Certificate. They did mention to the ME Investigator that they had received information indicating Cpl Langridge may have been on defaulters, but they specified the information was unconfirmed, and they provided further clarification when they learned additional information.⁸⁶³ In testimony, the ME Investigator recognized the mention of disciplinary issues included in the Certificate was the result of his own interpretation and not of statements made by the CFNIS members.⁸⁶⁴ The answer provided through Col Blais is accurate, and the Fynes’ allegations with respect to this issue are not well founded.

Question 4: “Why was the NIS investigation of Stuart’s death closed after three months without return of seized exhibits?”

320. The Fynes had raised this issue in previous meetings with CFNIS members. They had not been given an explanation regarding the delay in returning seized exhibits at the conclusion of the 2008 investigation.⁸⁶⁵ The response provided through Col Blais also fails to provide clarity about the actual reasons for the delay. It focuses on a general description of policies and procedures, not all of which were applicable in this case, and it does not provide information about the facts. It also contains clearly inaccurate information.

321. The response begins by stating items seized as evidence may be held until all investigative activity has been taken, including potential additional investigation.⁸⁶⁶ It

notes the legal owner or executor of the estate must be identified prior to the release of property when the time comes.⁸⁶⁷ The response then proceeds to outline MP policies on the return of seized property. It notes property related to, or suspected of being related to, an offence may be seized as evidence until it is no longer required as evidence and/or authority for its disposal has been received.⁸⁶⁸ It states Senior MP Advisors, Case Managers and investigators “shall institute procedures to track returns and diary dates on requests for extensions to retain seized items.”⁸⁶⁹ It explains evidence disposal begins when the Senior MP Advisor requests disposal instructions from the disposal authority.⁸⁷⁰ It notes this occurs when “the time within which an appeal may be commenced has expired, or, when no judicial proceeding has commenced on a case, and the owner cannot be identified, within one year after the investigation was concluded or suspended.”⁸⁷¹ The response then concludes stating, “With respect to this specific case, the **ownership of property between Corporal Langridge’s parents and his common-law spouse at the time of the suicide had not been clearly determined.**”⁸⁷²

322. The Fynes were particularly dissatisfied with this response.⁸⁷³ As part of their allegations about inaccurate rationales being provided to justify CFNIS actions, they complained “NIS members advised the complainants that, under MP policies, they were allowed to retain the exhibits for a period of one year to provide for an appeal period.”⁸⁷⁴ In testimony, Mr. Fynes explained:

When I questioned why they held Stuart’s property the response that I got back from Ottawa was to quote me an exhibit retention policy in the event of an appeal. **There was nothing to appeal.** There was no criminal offence and there were no charges.⁸⁷⁵
[Emphasis added]

323. While many of the policies described in the response were in force at the time,⁸⁷⁶ they were not particularly applicable to the facts in this case and did not, in fact, play any role in delaying the return of the exhibits. In testimony, Maj Dandurand recognized the reference to the policy regarding the appeal period had no relevance to explaining what happened with the exhibits in this case.⁸⁷⁷ He speculated it had been included for Maj Bolduc’s information, with the expectation it would be deleted if it was not appropriate to include it in the response provided to the Fynes.⁸⁷⁸ In general, Maj Dandurand felt the description of the MP policies included in the response “seems to be an attempt to answer

the question not specific to the case file itself, but from a common practice point of view.”⁸⁷⁹ He recognized it was “not ideal” to attempt to answer a question about a specific situation by referring to a general practice.⁸⁸⁰

324. Aside from its description of general practices, the response does not answer the Fynes’ question. After reviewing this response during his testimony, Maj Bolduc, the CFNIS DCO, was still unable to answer the question, as he did not know why the final step to return the exhibits was not completed.⁸⁸¹ The evidence before this Commission has revealed the reason the exhibits were not returned immediately at the conclusion of the 2008 investigation was the absence of adequate processes in place at the Detachment for the return of exhibits.⁸⁸² As a result, it was not uncommon for exhibits to remain in the Detachment evidence room for years, with no steps being taken for their return.⁸⁸³ In this case, steps were eventually taken to return the exhibits only as a result of a request from the Director of Estates.⁸⁸⁴ The response provided through Col Blais contains no information at all about any of these facts. By referring to all of the policies related to the return of exhibits, the response appears to imply these policies were the reason the exhibits were not returned immediately upon the conclusion of the investigation. In fact, this was not the case.

325. In addition to failing to answer the question, the response also contains inaccurate information. It states the ownership of property had not been clearly determined between the Fynes and Ms. A and implies this contributed to explaining the delay in its return.⁸⁸⁵ When they received the answer, the Fynes noted this was a “falsehood.”⁸⁸⁶ They stated there was never any question about Mrs. Fynes being the beneficiary of the estate, and noted the executor had been identified prior to the conclusion of the 2008 investigation.⁸⁸⁷ Indeed, as recognized by Maj Dandurand in testimony, there were no questions about the ownership of Cpl Langridge’s property when the 2008 investigation was concluded.⁸⁸⁸ MWO Barry Watson, who was involved at the time of the events, specifically testified concern over the ownership of Cpl Langridge’s property was not a factor in delaying the release of the seized items.⁸⁸⁹ It is not known how this inaccurate information came to be included in the response. Its presence, however, was certainly

capable of heightening the Fynes' concerns about inaccurate rationales being provided to justify CFNIS actions.

Question 5: “Why has a subsequent investigation into the insertion of a non-designated next of kin been stalled for fourteen months and call backs to our family discontinued?”

326. This was the only question not related to the 2008 investigation and not previously asked by the Fynes. The response was added after MWO Eisenmenger handed in his draft answers and was likely prepared by Maj Dandurand himself.⁸⁹⁰ It contains limited information. It begins by stating the 2009 investigation was not stalled, but rather remained in progress.⁸⁹¹ It maintains the investigation was approaching its conclusion as of January 15, 2011, and indicates a final case file briefing was being prepared to brief the family on the outcome of the 2009 and 2010 investigations.⁸⁹² It concludes by recognizing a commitment had been made to contact the family every two weeks, but explains:

Commencing **in the fall of 2010**, it was **determined that the investigation was near completion and calls were no longer warranted** until the CFNIS were prepared to announce to the family that a final briefing was available. Unfortunately, the lapse in time was not noticed and several months passed since the last call to the family. This was not done with intent, **it was an oversight for which the CFNIS apologizes**. A briefing to the family will be conducted as soon as possible after the investigation closes.⁸⁹³
[Emphasis added]

327. This response does not provide a complete answer to the Fynes' question, and the accuracy of some of the statements it contains is questionable. Aside from the blanket statement asserting the investigation was not stalled, no information is provided to explain why the investigation took so long or what still needed to be done to conclude it. It was not technically inaccurate to state the investigation was still “in progress” as of January 15, 2011. In fact, however, the last interviews had been conducted in November 2010, and the lead investigator had been instructed to prepare a briefing to the command team on December 10, 2010.⁸⁹⁴ The only activity that remained “in progress” was to determine the availability of the Detachment commander to receive the briefing.⁸⁹⁵

328. With respect to the lack of contact, the explanation provided is generally consistent with the explanation provided by Maj Dandurand during his testimony in this hearing.⁸⁹⁶ However, the reference to a determination being made in the fall of 2010 that the investigation was near completion and calls were no longer warranted is perplexing. In fact, after the command team received a briefing about Sgt Shannon's preliminary assessment of the matter, they directed him to conduct interviews with policy witnesses.⁸⁹⁷ Those interviews proceeded on November 16 and 17, 2010, and, in December 2010, Sgt Shannon was instructed to prepare a briefing to the command team about his conclusions.⁸⁹⁸ The determination the investigation was about to be concluded could not have been made before mid-to-late-November 2010.

329. When he reviewed this answer during his testimony, Maj Dandurand indicated it did "coincide completely with my view at the time."⁸⁹⁹ However, when he explained the reasons why the Fynes were not contacted during the investigation, he did not mention any determination having been made not to contact them because the file was near completion. Instead, he testified, after Mrs. Fynes' press conference in late October 2010, he issued a direction to the investigators not to make contact with the Fynes because he felt he should be contacting them personally.⁹⁰⁰ He then failed to make contact because he "lost track of time."⁹⁰¹ As a result, it is not clear the answer provided through Col Blais to explain the lack of contact was entirely accurate.

330. Further, while it was appropriate for the CFNIS to apologize in the response for its failure to contact the Fynes, it is surprising the receipt of this question did not prompt the CFNIS members to make contact, now that the matter was specifically brought to their attention. Instead, a further period of more than a month went by without any contact being made with the Fynes after this question was received.⁹⁰² It was only on February 24, 2011 that the Fynes were finally contacted to schedule a final briefing about the investigations.⁹⁰³

Question 6: “Why is still it not understood [sic] by the NIS that there was no legitimate justification for suppression and improper retention of a suicide note written by Stuart?”

331. The Fynes had been asking this question and complaining about the failure to disclose Cpl Langridge’s suicide note to them ever since they learned about the note’s existence in late May 2009.⁹⁰⁴ They had never been provided an explanation of what happened in this case and what led to the CFNIS’ failure to disclose the note at the time of the events.⁹⁰⁵ The response sent to them through Col Blais continues to provide little clarity about the matter. Some of the statements it contains are inaccurate. Its overall tone and content appear to be aimed at justifying at least part of the CFNIS’ actions and fail to convey any recognition on the part of the CFNIS of the seriousness of its failure in this case and of the significant impact on the Fynes.

332. The original response was drafted by MWO Eisenmenger.⁹⁰⁶ Additional content was then added, likely by Maj Dandurand, before the response was provided to the Fynes.⁹⁰⁷ The response begins by stating, while the suicide note should have been provided to the executor of the estate at the conclusion of the investigation, it would have only been released following a review of the evidence held and a determination it no longer had a bearing on ruling out foul play.⁹⁰⁸ The response then continues:

The usage of the word “suppression” is not correct. The suicide note found with Corporal Langridge was seized as part of the criminal investigation into the sudden death. Upon conclusion of the investigation, **the suicide note was intended to be released** to the decedent’s parents. However, **this was not conducted as expediently [sic] as it could have been.**⁹⁰⁹ [Emphasis added]

333. The response finally indicates the release of a suicide note fourteen months after the fact “is not normal practice.”⁹¹⁰ It states the CFNIS had formally apologized to the family and indicates this occurrence had “led to the revision and ‘tightening’ of the Standing Operating Procedure associated with this topic.”⁹¹¹ As a result, the response concludes the likelihood of a similar event recurring was “even more remote.”⁹¹²

334. This response is problematic in several respects.

335. First, some of the information it contains is clearly inaccurate. The description of the facts of the case implies the failure to return the note was caused by a mere lack of promptness and specifically states there was intent to return the note. This is not consistent with the evidence before this Commission. The evidence reveals the note was only disclosed to the Fynes in 2009 because of the BOI's intervention.⁹¹³ There is no evidence the investigators intended to return the note at the end of the investigation. Indeed, there is no evidence that by then they remembered the note even existed.⁹¹⁴ The statement about the relevant SOP having been revised and "tightened" is also inaccurate. While there had been revisions to the SOP for family briefings, nothing relating to the disclosure of suicide notes was added to any SOP until July 2011, well after this response was sent to the Fynes.⁹¹⁵ As detailed elsewhere in this report, there were changes made to the practices being followed.⁹¹⁶ However, the response, as formulated, refers to a revision of the actual SOP and, in this respect, the information provided does not align with the facts.

336. More importantly, the response, as drafted, continues to maintain there was justification for the failure to disclose the existence of the note to the Fynes prior to the conclusion of the investigation. The reference to the timing for when the note should have been disclosed – i.e., "at the conclusion of the investigation, following a review of the evidence held" or "when it was deemed to have no bearing on the investigation (ie: ruling out of foul play or relevance of the note in this regard)"⁹¹⁷ – was in line with the views of some of the CFNIS members.⁹¹⁸ It certainly was in line with Maj Dandurand's own view and therefore was a truthful explanation of his perspective.⁹¹⁹ However, to the extent it implied it was necessary to go through a lengthy process, or to wait for official confirmation about the cause of death or for the conclusion of the investigation, the response was not in line with the proper approach to determining when the CFNIS ought to disclose the existence of suicide notes.⁹²⁰ The fact members of the CFNIS chain of command continued to maintain this view so long after the events, and presented it to the Fynes as the official CFNIS response, seems to reflect a failure by the CFNIS to appreciate the lessons to be learned from this episode. It also reflects the consequential failure to ensure an adequate common understanding of the procedures to be followed for

the disclosure of suicide notes was developed and disseminated throughout the organization.⁹²¹

337. On the whole, the response transmitted through Col Blais continued to leave the Fynes with no adequate explanation for one of the most important CFNIS failures in this case. It also contributed to fuelling the Fynes' perception – justified in many cases – of inaccurate rationales being provided to explain or justify CFNIS behaviour.⁹²² The Fynes had posed a clearly rhetorical question by asking why it was “still ... not understood by the NIS that there was no legitimate justification for suppression and improper retention of a suicide note written by Stuart?”⁹²³ By answering the question as they did, the CFNIS members seem to have confirmed they in fact did not understand there was no legitimate justification for failing to disclose the note in the days following Cpl Langridge's death.

CONTINUED FAILURE TO PROVIDE INFORMATION

338. On the whole, most of the CFNIS answers provided through Col Blais were inadequate. While a few were consistent with the evidence heard in this hearing, many contained clearly inaccurate information. Most did not actually answer the Fynes' questions. In general, the answers were similar to those provided during the November 2009 briefing.⁹²⁴ They focused on general information not necessarily related to the facts of this case and often appeared to be aimed at justifying the CFNIS' handling of the case, rather than providing factual information about what was done.

339. The inaccuracies and the failure to provide information do not appear to have resulted from any intentional attempt by CFNIS members to mislead the Fynes. At the same time, the evidence also reveals the efforts made to provide accurate answers were extremely limited. The individual in charge of compiling the information, MWO Eisenmenger, had no involvement in the actual investigation.⁹²⁵ There is no evidence he had any prior knowledge of the file.⁹²⁶ He had approximately three days to prepare the draft answers.⁹²⁷ There is no indication any of the CFNIS members actually involved at the time of the events were consulted or even contacted when the responses were prepared.⁹²⁸ The only source of information available to MWO Eisenmenger would have been the 714-page investigative file.⁹²⁹ Under the circumstances, it is not surprising the

answers were not always complete or accurate. Maj Dandurand and Maj Bolduc, the only other CFNIS members who reviewed the answers and had an opportunity to provide input, also had no direct knowledge of the facts as far as the 2008 investigation was concerned, because they were not at all involved in the case at the time of the events.⁹³⁰

340. While the failure to provide accurate information was not intentional, the failure to make appropriate efforts to gather the information was unacceptable. There could be no legitimate justification for continuing to provide the same non-responsive and inaccurate answers in January 2011 as had been provided in November 2009. By then, the CFNIS members were well aware of the Fynes' questions and, in some cases, had specifically undertaken to provide answers, but had failed to do so.⁹³¹ By then, the Fynes had also been left without any updates, information, or contact from the CFNIS for approximately four full months, despite explicit commitments to the contrary.⁹³² Under the circumstances, the least the CFNIS members could do was to make all necessary efforts to finally answer the Fynes' questions in a complete and accurate manner. The answers provided do not give evidence of any such efforts.

4.5.7 Conclusion

341. From the beginning of the 2008 investigation, all the way through to the end of the 2009 and 2010 investigations a little over three years later, the CFNIS did not treat the Fynes properly. The Fynes were not kept informed, were not contacted regularly, and they were not provided with adequate information. Their son's suicide note was kept from them, and they received no immediate apology or explanation when this fact came to light. Even subsequently, the Fynes were never provided with an explanation as to what happened. Furthermore, throughout the CFNIS' interactions with the Fynes, the practice of providing only general information not related to the specifics of the case, and the failure to advise the Fynes when earlier plans changed, often left the Fynes with inaccurate perceptions about the investigative work. The CFNIS did nothing to correct those perceptions or to ensure the Fynes knew what was happening. As a result, the Fynes

felt they were being misled, and this was not an unreasonable perception under the circumstances.

342. Considering how the CFNIS treated them throughout the investigations, it is not surprising the Fynes ended up doubting everything the CFNIS did and said. Mr. Fynes testified, “The outcome of their investigation and all of our contacts has been just a web or a construct of **deliberate deceit**, as far as I’m concerned. We were **distanced**.”⁹³³

343. While the CFNIS members involved did not intentionally seek to deceive the Fynes, their conduct in interacting with them made it impossible to establish any relationship of confidence and trust. They did not appear to understand that providing information and support to victims and complainants is an integral part of their role and responsibilities as police officers.

344. It is likely this serious mishandling of communications played a role in the Fynes’ ultimate decision to pursue their complaints before this Commission. The CFNIS certainly missed every opportunity to resolve issues and address the Fynes’ concerns appropriately. It can only be hoped the CFNIS will learn lessons from the totality of events in this case and will take measures to ensure such mistakes will not be repeated.

¹ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 8, 9, 13, 26, 30, 32b), 32c) and 33.

² Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 104-105.

³ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 105.

⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 105.

⁵ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 48.

⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 96-97; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 50-51. See, generally, section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 24.

⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 22.

⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 22.

¹⁰ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 51-52.

¹¹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 104-108 & 254.

¹² Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 109-112 & 256.

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- ¹³ See section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ¹⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 23-24.
- ¹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 109.
- ¹⁶ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 77-78.
- ¹⁷ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 78-80.
- ¹⁸ Email from Geneviève Coutlée, Legal Counsel, MPCC, to Dominique Babin, Legal Counsel, DND/CFLA (30 April 2012 at 1532 hrs) subject: Disclosure Request.
- ¹⁹ See Email from Maj Tim Langlois, CFPM Legal Advisor, to Geneviève Coutlée, Legal Counsel, MPCC (4 May 2012 at 1551 hrs) subject: RE: Disclosure Request.
- ²⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 58-60 & 91-92.
- ²¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 52.
- ²² Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 131.
- ²³ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 131-132.
- ²⁴ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 135-136.
- ²⁵ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 137.
- ²⁶ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 176.
- ²⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 175-176.
- ²⁸ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 132 & 271-272.
- ²⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 272.
- ³⁰ Exhibit P-1, Collection A, vol. 2, tab 12, doc. 001-Q; Testimony of CWO(Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 181-183.
- ³¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 16-17, 26 April 2012 & 7 May 2012; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42-43, 5-6 September 2012.
- ³² Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 46.
- ³³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 52.
- ³⁴ See Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012 & Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 200-206 & 207-212.
- ³⁵ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 59.
- ³⁶ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001; Section 4.1, The 2008 Investigation.
- ³⁷ See Exhibit P-6, Collection F, vol. 1, tab 36, doc. 1183; Exhibit P-183, tab 1, doc. 1461, p. 4; Exhibit P-183, tab 41, doc. 1501; Exhibit P-52, doc. 1349.
- ³⁸ Exhibit P-6, Collection F, vol. 1, tab 36, doc. 1183, p. 2.
- ³⁹ Exhibit P-6, Collection F, vol. 1, tab 36, doc. 1183, p. 3.
- ⁴⁰ Exhibit P-52, doc. 1349.
- ⁴¹ Exhibit P-52, doc. 1349, s. 9.
- ⁴² See, generally, Section 4.6, CFNIS Independence and Impartiality.

⁴³ See Testimony of CWO(Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 272-273; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 72-73.

⁴⁴ For a discussion of these issues, see Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.

⁴⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 143-144 & 521. See, generally, Section 4.1.4, The 2008 Investigation – The Concluding Remarks; Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.

⁴⁶ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15.

⁴⁷ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15.

⁴⁸ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 50-51.

⁴⁹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15.

⁵⁰ Testimony of S/Sgt Clark, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 202 & 267-268.

⁵¹ Testimony of Det. Insp. Olinyk, Transcript of Proceedings, vol. 44, 10 September 2012, p. 259.

⁵² Exhibit P-147, doc. 1423, p. 26. See, generally, Section 4.2, The Suicide Note Left by Cpl Langridge.

⁵³ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390; Exhibit P-5, Collection E, vol. 5, tab 1, doc. 1223, p. 112; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 2.

⁵⁴ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15; Exhibit P-147, doc. 1422, p. 18.

⁵⁵ Exhibit P-5, Collection E, vol. 4, tab 7, doc. 1214, p. 390; Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 347; Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, pp. 32-33.

⁵⁶ Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 15.

⁵⁷ See Section 4.2, The Suicide Note Left by Cpl Langridge.

⁵⁸ Exhibit P-147, doc. 1422, pp. 13-14.

⁵⁹ Exhibit P-147, doc. 1422, p. 13.

⁶⁰ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 245-246.

⁶¹ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245

⁶² Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 245.

⁶³ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 225.

⁶⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 633.

⁶⁵ Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, p. 227. See also Testimony of Maj Angell, Transcript of Proceedings, vol. 26, 23 May 2012, pp. 235-236.

⁶⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 18.

⁶⁷ See Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 344-353; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, pp. 11-15; Exhibit P-147, doc. 1422, pp. 13-14.

⁶⁸ See Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 344-353; Exhibit P-147, doc. 1422, p. 20 & Exhibit P-5, Collection E, vol. 4, tab 9, doc. 1216, pp. 35-45.

⁶⁹ See Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 352-353.

⁷⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 446-447.

⁷¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 66-67.

⁷² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 63.

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- ⁷³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 67-68.
- ⁷⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 52.
- ⁷⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 52.
- ⁷⁶ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 19-20.
- ⁷⁷ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 196-197; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 70.
- ⁷⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 70.
- ⁷⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 70-71.
- ⁸⁰ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 47-48.
- ⁸¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 183-184. See, generally, Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁸² Exhibit P-147, doc. 1422, p. 20.
- ⁸³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 71 & 74.
- ⁸⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 72.
- ⁸⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁸⁶ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁸⁷ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁸⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(a).
- ⁸⁹ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 19-20.
- ⁹⁰ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 48.
- ⁹¹ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 19.
- ⁹² Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 19.
- ⁹³ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 18.
- ⁹⁴ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 18.
- ⁹⁵ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 17.
- ⁹⁶ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 16.
- ⁹⁷ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 48.
- ⁹⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 26.
- ⁹⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ¹⁰⁰ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523.
- ¹⁰¹ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 171. Compare to Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 256.
- ¹⁰² See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 193-194, 249-253, 533-563, 566-583, 590-610, 611-613, 614-616 & 620-622 vs Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, which contains none of these entries.
- ¹⁰³ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 2-7, 11-20, 47-117, 119-125, 127-128, 132-133, 525 & 527-532 vs Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, which contains none of these notes.

¹⁰⁴ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 434 (the file copy ends with the Concluding Remarks) vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714 (the file ends with extensive clearance information related to each of the items seized or generated during the investigation).

¹⁰⁵ See Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, pp. 66-88 vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 161-173.

¹⁰⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 141.

¹⁰⁷ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 57.

¹⁰⁸ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹⁰⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 26-27 & 28.

¹¹⁰ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 16.

¹¹¹ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 16.

¹¹² Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 16.

¹¹³ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 15-16.

¹¹⁴ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 15-16.

¹¹⁵ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹¹⁶ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹¹⁷ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹¹⁸ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹¹⁹ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 15.

¹²⁰ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 14.

¹²¹ Exhibit P-138, tab 1, doc. 1403, p. 17.

¹²² Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 13.

¹²³ R.S.C., 1985, c. P-21.

¹²⁴ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 13.

¹²⁵ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 12 [emphasis in original].

¹²⁶ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 13.

¹²⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 27.

¹²⁸ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, p. 9.

¹²⁹ See Section 4.6, CFNIS Independence and Impartiality.

¹³⁰ Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, p. 4.

¹³¹ Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, pp. 3-4.

¹³² Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, p. 3.

¹³³ Exhibit P-5, Collection E, vol. 4, tab 14, doc. 1221, pp. 1-3.

¹³⁴ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, pp. 9-10.

¹³⁵ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, p. 10.

¹³⁶ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, p. 10.

¹³⁷ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, p. 8.

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- ¹³⁸ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, p. 8.
- ¹³⁹ Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, pp. 6-7.
- ¹⁴⁰ Exhibit P-4, Collection D, vol. 9, tab 84, doc. 808.
- ¹⁴¹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 48-49.
- ¹⁴² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 28.
- ¹⁴³ See Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524. The document contains 514 pages in total, of which 38 are redacted in full.
- ¹⁴⁴ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 108-109, 164-166, 445-475, 478-494, 501-513, 522-527 & 531-533.
- ¹⁴⁵ A copy of the Evidence Collection Log was included: Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 80-82, but the clearance information about the chain of custody and disposal of the exhibits remained redacted: Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 534-578 vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714.
- ¹⁴⁶ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 57.
- ¹⁴⁷ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 2-7, 11-20, 47-117, 119-125, 127-128, 132-133 & 527-532 vs Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, which contains none of these notes.
- ¹⁴⁸ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 171.
- ¹⁴⁹ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 151 vs Exhibit P-139, tab 3, doc. 1409, p. 151, redacted on grounds that the information was obtained in confidence from a provincial institution and was obtained by a law enforcement institution: *Privacy Act*, R.S.C., 1985, c. P-21, s. 19(1)(c) & 22.
- ¹⁵⁰ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 152-154, 156-159, 170, 172 & 192 vs Exhibit P-139, tab 3, doc. 1409, pp. 152-154, 156-159, 170, 172 & 192 redacted on ground that the information was prepared by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵¹ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 178-182 vs Exhibit P-139, tab 3, doc. 1409, pp. 178-180, redacted on ground that the information was prepared by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵² Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 178-182 vs Exhibit P-139, tab 3, doc. 1409, p. 181, redacted on ground that the information was prepared by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵³ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 164 vs Exhibit P-139, tab 3, doc. 1409, p. 164.
- ¹⁵⁴ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 413-417, 419-426 & 534-578 vs Exhibit P-139, tab 3, doc. 1409, pp. 413-414, 419-425 & 534-535, redacted on ground that the information was prepared or obtained by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵⁵ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 413-417 vs Exhibit P-139, tab 3, doc. 1409, pp. 416-417, redacted on ground that the information was prepared or obtained by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵⁶ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 419-426 & 431 vs Exhibit P-139, tab 3, doc. 1409, p. 426 & Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517, redacted on grounds that the information was prepared or obtained by a law enforcement body in the course of an investigation and/or was personal information about an individual other than the person requesting the information: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a) & 26.

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- ¹⁵⁷ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 436 vs Exhibit P-139, tab 3, doc. 1409, p. 436, redacted on ground that the information was prepared or obtained by a law enforcement body in the course of an investigation: *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ¹⁵⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 98-99.
- ¹⁵⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B.
- ¹⁶⁰ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 14-16; Exhibit P-138, tab 1, doc. 1403, p. 17; Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, pp. 8-9.
- ¹⁶¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 98.
- ¹⁶² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 101-102.
- ¹⁶³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 104.
- ¹⁶⁴ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 122-123.
- ¹⁶⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 107-108.
- ¹⁶⁶ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 63-71. See also, Section 4.6, CFNIS Independence and Impartiality.
- ¹⁶⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 7-8 & 10-11.
- ¹⁶⁸ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 11-12; Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 75.
- ¹⁶⁹ See Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523 & tab 25, doc. 524.
- ¹⁷⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ¹⁷¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 76-78.
- ¹⁷² See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 519 & 522.
- ¹⁷³ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 2-7, 11-20, 47-117, 119-125, 127-128, 132-133 & 527-532 vs Exhibit P-139, tab 3, doc. 1409, which is the copy of the file as received by DAIP, and which contains only some of the notes, all redacted in full: pp. 2-7 & 11-20.
- ¹⁷⁴ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714 vs Exhibit P-139, tab 3, doc. 1409, pp. 537-578.
- ¹⁷⁵ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 164-165.
- ¹⁷⁶ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 154-155.
- ¹⁷⁷ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 156-157.
- ¹⁷⁸ Exhibit P-139, tab 3, doc. 1409, pp. 2-8, 11-23, 25 & 431; Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 161-162.
- ¹⁷⁹ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, p. 157.
- ¹⁸⁰ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, p. 157.
- ¹⁸¹ Exhibit P-158, tab 1, doc. 1432, pp. 26, 29, 59, 60 & 84.
- ¹⁸² Testimony of Sgt Bombback-Fortin and Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 157-158.
- ¹⁸³ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 99-100; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 74-75; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 183-184.

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- ¹⁸⁴ Testimony of Sgt Bombback-Fortin and Mr. Beaulieu, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 159-160.
- ¹⁸⁵ See Exhibit P-140, tab 4, doc. 1413, p. 1; Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 163-164; Exhibit P-146, tab 6, doc. 1420, pp. 540-623 vs Exhibit P-139, tab 3, doc. 1409, pp. 537-578.
- ¹⁸⁶ Testimony of Sgt Bombback-Fortin, Transcript of Proceedings, vol. 40, 26 June 2012, pp. 162-163.
- ¹⁸⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 7.
- ¹⁸⁸ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 7.
- ¹⁸⁹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 8-9, 10, 12-13.
- ¹⁹⁰ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 14-15.
- ¹⁹¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 15-16.
- ¹⁹² Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 15.
- ¹⁹³ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 16-17.
- ¹⁹⁴ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 17.
- ¹⁹⁵ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 18-20 & 54; Exhibit P-4, Collection D, vol. 9, tab 85, doc. 809.
- ¹⁹⁶ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 20.
- ¹⁹⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 22-23.
- ¹⁹⁸ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 35-36.
- ¹⁹⁹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 44-45.
- ²⁰⁰ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 70-71.
- ²⁰¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 76-78.
- ²⁰² Exhibit P-4, Collection D, vol. 9, tab 85, doc. 809. See also Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 54-55.
- ²⁰³ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 75-76.
- ²⁰⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 76-77.
- ²⁰⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 184-185.
- ²⁰⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 185.
- ²⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 185-186.
- ²⁰⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 54-55.
- ²⁰⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 55.
- ²¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 186.
- ²¹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 78.
- ²¹² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 63-64.
- ²¹³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 82-83.
- ²¹⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 78.
- ²¹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 83-84.
- ²¹⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 84.

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- ²¹⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 84.
- ²¹⁸ Exhibit P-138, tab 1, doc. 1403, p. 15.
- ²¹⁹ Exhibit P-138, tab 1, doc. 1403, p. 15.
- ²²⁰ Exhibit P-138, tab 1, doc. 1403, p. 15.
- ²²¹ Exhibit P-138, tab 1, doc. 1403, p. 14.
- ²²² Exhibit P-138, tab 1, doc. 1403, p. 14.
- ²²³ Exhibit P-138, tab 1, doc. 1403, p. 14.
- ²²⁴ Exhibit P-138, tab 1, doc. 1403, p. 17.
- ²²⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 29.
- ²²⁶ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 91.
- ²²⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 99-100.
- ²²⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 74.
- ²²⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 74-75.
- ²³⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 183-184.
- ²³¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 57.
- ²³² Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 62-65.
- ²³³ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 73.
- ²³⁴ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 73-74.
- ²³⁵ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 73-74.
- ²³⁶ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 21.
- ²³⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 21.
- ²³⁸ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 57.
- ²³⁹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 33.
- ²⁴⁰ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 33.
- ²⁴¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 34.
- ²⁴² Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, p. 13.
- ²⁴³ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 33.
- ²⁴⁴ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 22-23 & 34.
- ²⁴⁵ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 22-23.
- ²⁴⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 26-27 & 28; Exhibit P-2, collection B, vol. 2, tab 1, doc. 1087-B, pp. 104-106.
- ²⁴⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 102-103.
- ²⁴⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 143 & 187.
- ²⁴⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 143-144 & 187.
- ²⁵⁰ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 39-41 & 43.
- ²⁵¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 42-43.

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- ²⁵² Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 43-44.
- ²⁵³ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 49-50.
- ²⁵⁴ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 55-56.
- ²⁵⁵ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 49.
- ²⁵⁶ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 51.
- ²⁵⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 50-51.
- ²⁵⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 84.
- ²⁵⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 144-145.
- ²⁶⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 103-104.
- ²⁶¹ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 24-25.
- ²⁶² Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 85.
- ²⁶³ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 171, paras d) & f) vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 256, paras d) & f).
- ²⁶⁴ See Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 171 & *Privacy Act*, R.S.C., 1985, c. P-21, s. 26.
- ²⁶⁵ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 171 vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 256, paras c)-f).
- ²⁶⁶ Exhibit P-4, Collection D, vol. 6, tab 24, doc. 523, p. 171 & *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ²⁶⁷ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 26-27.
- ²⁶⁸ Exhibit P-6, Collection F, vol. 1, tab 46, doc. 1193, p. 17, s. 37.
- ²⁶⁹ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 178-182 vs Exhibit P-139, tab 3, doc. 1409, pp. 178-180; *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ²⁷⁰ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 164 vs Exhibit P-139, tab 3, doc. 1409, p. 164.
- ²⁷¹ See Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 164 & *Privacy Act*, R.S.C., 1985, c. P-21, s. 26.
- ²⁷² Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, p. 436 vs Exhibit P-139, tab 3, doc. 1409, p. 436.
- ²⁷³ See Exhibit P-139, tab 3, doc. 1409, p. 436 & *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ²⁷⁴ Exhibit P-4, Collection D, vol. 6, tab 25, doc. 524, pp. 534-578 vs Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714; *Privacy Act*, R.S.C., 1985, c. P-21, s. 22(1)(a).
- ²⁷⁵ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 29.
- ²⁷⁶ Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 29-30.
- ²⁷⁷ See: Section 4.6, CFNIS Independence and Impartiality.
- ²⁷⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B.
- ²⁷⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 86.
- ²⁸⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 141.
- ²⁸¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1201; see also Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 142.
- ²⁸² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 145-146.

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- ²⁸³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 142-143.
- ²⁸⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 143.
- ²⁸⁵ Exhibit P-147, tab 2, doc. 1423, p. 28.
- ²⁸⁶ Exhibit P-147, tab 2, doc. 1423, p. 28.
- ²⁸⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 36.
- ²⁸⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 36.
- ²⁸⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 36.
- ²⁹⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 36-37.
- ²⁹¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 38-39.
- ²⁹² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 86.
- ²⁹³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 86.
- ²⁹⁴ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 16 & 19; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 74 & 85-86; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 29-30.
- ²⁹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 70. See, generally, Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ²⁹⁶ Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 16 & 19.
- ²⁹⁷ See Exhibit P-5, Collection E, vol. 4, tab 13, doc. 1220, pp. 344-353; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 196-197.
- ²⁹⁸ Exhibit P-147, tab 1, doc. 1422, p. 33.
- ²⁹⁹ Exhibit P-147, tab 1, doc. 1422, p. 33.
- ³⁰⁰ Exhibit P-147, tab 1, doc. 1422, p. 33.
- ³⁰¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 18.
- ³⁰² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 33-50.
- ³⁰³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 189-190.
- ³⁰⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 9.
- ³⁰⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 10-16.
- ³⁰⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 35-36.
- ³⁰⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 37.
- ³⁰⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 8-9.
- ³⁰⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 38.
- ³¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 189-190.
- ³¹¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 37-38.
- ³¹² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 129.
- ³¹³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 105.
- ³¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 131.
- ³¹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 20-21, 188 & 190.

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- ³¹⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 20-21.
- ³¹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 151.
- ³¹⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 31-32.
- ³¹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 172-173 & 228-229.
- ³²⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 54-55.
- ³²¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 54-55.
- ³²² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 37.
- ³²³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 174.
- ³²⁴ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 37.
- ³²⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 37.
- ³²⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 39-40.
- ³²⁷ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-714; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 41-42.
- ³²⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 42.
- ³²⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 44-45, 47 & 52-53. See also Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 630-713.
- ³³⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 30; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 147; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ³³¹ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B.
- ³³² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 30.
- ³³³ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 14-19, 23-26, 35-37, 39-40, 48-58, 61-68, 70-74, 81-84 & 120-122.
- ³³⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 46 & 49-50.
- ³³⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 129-130, 132-135.
- ³³⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 1, 77, 89-91, 92, 94-97 & 109.
- ³³⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.
- ³³⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 115-116. See also Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 11-15 & 123-129.
- ³³⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 521.
- ³⁴⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 520.
- ³⁴¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 116-118. See also Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 11-15 & 123-129.
- ³⁴² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 3-5, 7-8 & 96-97.
- ³⁴³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 19.
- ³⁴⁴ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 30-32 & 134-135.
- ³⁴⁵ Exhibit P-147, tab 2, doc. 1423, p. 30.
- ³⁴⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 68, 77-80 & 109.

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- ³⁴⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 31 & 135-136.
- ³⁴⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 98-100 & 104-106. See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.
- ³⁴⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 130-132.
- ³⁵⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 135.
- ³⁵¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 59-60.
- ³⁵² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 129.
- ³⁵³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 130-131.
- ³⁵⁴ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ³⁵⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77, 88-89 & 93-97.
- ³⁵⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76, 90 & 93.
- ³⁵⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 76-77.
- ³⁵⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 93-94 & 96.
- ³⁵⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 94.
- ³⁶⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 4-5 & 10-11.
- ³⁶¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 9-10.
- ³⁶² See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ³⁶³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 9.
- ³⁶⁴ Exhibit P-5, Collection E, vol. 6, tab 28, doc. 1261, pp. 1 & 7; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 134.
- ³⁶⁵ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 68-69.
- ³⁶⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 69.
- ³⁶⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 69.
- ³⁶⁸ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 69-70.
- ³⁶⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 648-649, 656-657, 658-660 & 662-663. See also Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 174.
- ³⁷⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 82-83; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 174-175.
- ³⁷¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 175-176; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 44, 46, 49-50, 53-54;
- ³⁷² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 176
- ³⁷³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 176-179. See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 516-517.
- ³⁷⁴ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 136.
- ³⁷⁵ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 98-100, 104-106 & 122-123; Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

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- ³⁷⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 104 & 122-123. See also, Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 129-130.
- ³⁷⁷ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.
- ³⁷⁸ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1201.
- ³⁷⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 110-111 & 137-138; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 198.
- ³⁸⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 110-111.
- ³⁸¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 125-126.
- ³⁸² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 129.
- ³⁸³ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ³⁸⁴ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ³⁸⁵ Exhibit P-147, tab 2, doc. 1423, p. 30.
- ³⁸⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 150.
- ³⁸⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 87-88 & 102-103.
- ³⁸⁸ Exhibit P-147, tab 2, doc. 1423, p. 30.
- ³⁸⁹ Exhibit P-147, tab 2, doc. 1423, p. 30.
- ³⁹⁰ Exhibit P-147, tab 2, doc. 1423, p. 30.
- ³⁹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 202-203.
- ³⁹² Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-C.
- ³⁹³ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 519. See also Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 91.
- ³⁹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 204.
- ³⁹⁵ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 114-115.
- ³⁹⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 522.
- ³⁹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 519.
- ³⁹⁸ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 40-41.
- ³⁹⁹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 41-42.
- ⁴⁰⁰ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 42.
- ⁴⁰¹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 41, 44 & 73.
- ⁴⁰² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 14-27.
- ⁴⁰³ Exhibit P-4, Collection D, vol. 1, tab 5, doc. 004; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 291; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 224-227; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 115-116.
- ⁴⁰⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 32-36.
- ⁴⁰⁵ Exhibit P-161, doc. 1087-O.
- ⁴⁰⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 32-36, 114 & 126-127; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 198-199. See also, Section 4.6, CFNIS Independence and Impartiality.

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- ⁴⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 198-199.
- ⁴⁰⁸ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 109. See Section 4.3, The 2009 PNOK Investigation.
- ⁴⁰⁹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 91-92 & 108-109.
- ⁴¹⁰ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 109.
- ⁴¹¹ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 110.
- ⁴¹² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 110.
- ⁴¹³ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 110-114 & 116.
- ⁴¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 199.
- ⁴¹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 89-90 & 100.
- ⁴¹⁶ Exhibit P-4, Collection D, vol. 1, tab 13, doc. 010-B, pp. 1-2; Exhibit P-4, Collection D, vol. 1, tab 10, doc. 009; Exhibit P-4, Collection D, vol. 1, tab 11, doc. 010. See, generally, Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ⁴¹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 190-191.
- ⁴¹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 190.
- ⁴¹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 190.
- ⁴²⁰ Exhibit P-2, Collection B, vol. 2, tab 2, doc 1087-C, p. 158.
- ⁴²¹ Exhibit P-4, Collection D, vol. 1, tab 13, doc. 010-B, p. 1; Exhibit P-4, Collection D, vol. 1, tab 10, doc. 009; Exhibit P-4, Collection D, vol. 1, tab 11, doc. 010. See, generally, Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ⁴²² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 198.
- ⁴²³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 60-61.
- ⁴²⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 61.
- ⁴²⁵ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 74-80, 157-166 & 168-173; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 171.
- ⁴²⁶ *National Defence Act*, RSC 1985, c N-5, s. 250.21(1).
- ⁴²⁷ *National Defence Act*, RSC 1985, c N-5, s. 250.21(2).
- ⁴²⁸ *National Defence Act*, RSC 1985, c N-5, s. 250.26(1).
- ⁴²⁹ *National Defence Act*, RSC 1985, c N-5, s. 250.27(1).
- ⁴³⁰ *National Defence Act*, RSC 1985, c N-5, s. 250.28(2).
- ⁴³¹ *National Defence Act*, RSC 1985, c N-5, ss. 250.28(1) & 250.29.
- ⁴³² *National Defence Act*, RSC 1985, c N-5, s. 250.31(1).
- ⁴³³ *National Defence Act*, RSC 1985, c N-5, s. 250.38(1).
- ⁴³⁴ Exhibit P-173, doc. 1454, p. 4, s. 4.
- ⁴³⁵ Exhibit P-173, doc. 1454, p. 4, s. 4.
- ⁴³⁶ Exhibit P-173, doc. 1454, p. 8, s. 14 [Emphasis added].
- ⁴³⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 220-221.

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- ⁴³⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 174-175 & Exhibit P-4, Collection D, vol. 13, tab 3, doc. 1150.
- ⁴³⁹ See Exhibit P-4, Collection D, vol. 13, tab 3, doc. 1150. See also Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 2, 3, 4, 5, 7, 13(a), 18, 26, 27 & 28.
- ⁴⁴⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 215-216.
- ⁴⁴¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 216.
- ⁴⁴² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 216.
- ⁴⁴³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 216.
- ⁴⁴⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 218.
- ⁴⁴⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 221-222.
- ⁴⁴⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 217.
- ⁴⁴⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 217.
- ⁴⁴⁸ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 87, 89 & 97-98.
- ⁴⁴⁹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 100.
- ⁴⁵⁰ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 100.
- ⁴⁵¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 100-102.
- ⁴⁵² Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 102.
- ⁴⁵³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 102.
- ⁴⁵⁴ Exhibit P-2, Collection B, vol. 2, tab 2, pp. 156-159.
- ⁴⁵⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 157-158.
- ⁴⁵⁶ Exhibit P-2, Collection B, vol. 2, tab 2, pp. 157-158.
- ⁴⁵⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 135-136.
- ⁴⁵⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 213.
- ⁴⁵⁹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 10.
- ⁴⁶⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 96-97.
- ⁴⁶¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 96-97.
- ⁴⁶² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 97.
- ⁴⁶³ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 138.
- ⁴⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 212.
- ⁴⁶⁵ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 73; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 17, 196-201 & 230-231.
- ⁴⁶⁶ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 90.
- ⁴⁶⁷ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 94-96.
- ⁴⁶⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 206.
- ⁴⁶⁹ Exhibit P-2, Collection B, vol. 2, tab 5, doc. 1087-F, pp. 44-47.
- ⁴⁷⁰ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 136.
- ⁴⁷¹ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 116-118.

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- ⁴⁷² Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 115-116.
- ⁴⁷³ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 522.
- ⁴⁷⁴ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 3.
- ⁴⁷⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 200.
- ⁴⁷⁶ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 296-297.
- ⁴⁷⁷ Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 296.
- ⁴⁷⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 202.
- ⁴⁷⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 121.
- ⁴⁸⁰ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 166.
- ⁴⁸¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 18.
- ⁴⁸² See Exhibit P-5, Collection E, vol. 6, tab 17, doc. 1250, p. 30; Testimony of CWO(ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 215.
- ⁴⁸³ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 109-110.
- ⁴⁸⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 217-218.
- ⁴⁸⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 101.
- ⁴⁸⁶ *National Defence Act*, RSC 1985, c N-5, s. 250.28(2); Exhibit P-173, doc. 1454, p. 13, s. 27.
- ⁴⁸⁷ See, generally, Section 4.2 The Suicide Note Left by Cpl Langridge; Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ⁴⁸⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁴⁸⁹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 333.
- ⁴⁹⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ⁴⁹¹ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 332.
- ⁴⁹² Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 171-172.
- ⁴⁹³ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 206-207 & 209.
- ⁴⁹⁴ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 205-207 & 208-209.
- ⁴⁹⁵ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 519 [Emphasis added].
- ⁴⁹⁶ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 40; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 214-215; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 46.
- ⁴⁹⁷ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 263-264; Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 4.1.3, The 2008 Investigation – The Investigation Plan.
- ⁴⁹⁸ Final Submissions of the subjects of the complaint, pp. 64-65.
- ⁴⁹⁹ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15.
- ⁵⁰⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 79-81.
- ⁵⁰¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 83.
- ⁵⁰² See Exhibit P-119, doc. 1396, pp. 7 & 11-12.
- ⁵⁰³ Exhibit P-119, doc. 1396, p. 11.

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- ⁵⁰⁴ Exhibit P-119, doc. 1396, p. 11.
- ⁵⁰⁵ Exhibit P-119, doc. 1396, p. 11.
- ⁵⁰⁶ Exhibit P-119, doc. 1396, p. 11.
- ⁵⁰⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13.
- ⁵⁰⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33.
- ⁵⁰⁹ See Section 4.3, The 2009 PNOK Investigation.
- ⁵¹⁰ See Section 4.3, The 2009 PNOK Investigation.
- ⁵¹¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 291 and 294.
- ⁵¹² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 291 and 294. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 53-54.
- ⁵¹³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C.
- ⁵¹⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B; Exhibit P-4, Collection D, vol. 9, tab 75; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1023; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 125.
- ⁵¹⁵ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13.
- ⁵¹⁶ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 13(b), 13(d), 13(e), 30, 32(b) & 32(c).
- ⁵¹⁷ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C.
- ⁵¹⁸ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 5.
- ⁵¹⁹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 97.
- ⁵²⁰ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 101.
- ⁵²¹ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 101.
- ⁵²² Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 116-118. See also Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 18-19.
- ⁵²³ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 117-118.
- ⁵²⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 55-56.
- ⁵²⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 55 and 57-58.
- ⁵²⁶ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 94-96.
- ⁵²⁷ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 51.
- ⁵²⁸ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 51.
- ⁵²⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 17.
- ⁵³⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 5-8.
- ⁵³¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 24-26.
- ⁵³² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 10.
- ⁵³³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 174.
- ⁵³⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 14.
- ⁵³⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 51-52. See, generally, Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁵³⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 42-43.

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- ⁵³⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 130.
- ⁵³⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 163-165.
- ⁵³⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 159-161.
- ⁵⁴⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 131.
- ⁵⁴¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 130.
- ⁵⁴² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 133-134.
- ⁵⁴³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 134.
- ⁵⁴⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 170.
- ⁵⁴⁵ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087; Exhibit P-4, Collection D, vol. 9, tab 75, doc. 799; Exhibit P-4, Collection D, vol. 12, tab 75, doc. 1102; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 50-51.
- ⁵⁴⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 38.
- ⁵⁴⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 38.
- ⁵⁴⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 39.
- ⁵⁴⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 39.
- ⁵⁵⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 39.
- ⁵⁵¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 39 and 40-41.
- ⁵⁵² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 39-41; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 53 and 57.
- ⁵⁵³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 53 and 57.
- ⁵⁵⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 57 [Emphasis added].
- ⁵⁵⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 40-41.
- ⁵⁵⁶ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 168-169.
- ⁵⁵⁷ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 169.
- ⁵⁵⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 114 [Emphasis added].
- ⁵⁵⁹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 167.
- ⁵⁶⁰ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 167-168 [Emphasis added].
- ⁵⁶¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 39-40.
- ⁵⁶² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 40.
- ⁵⁶³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 167.
- ⁵⁶⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 168 [Emphasis added].
- ⁵⁶⁵ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 168.
- ⁵⁶⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1025; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 72.
- ⁵⁶⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1025.
- ⁵⁶⁸ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 72.
- ⁵⁶⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1030-1031; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 73-74.

⁵⁷⁰ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1031; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 74.

⁵⁷¹ Exhibit P-4, Collection D, vol. 9, tab 71, doc. 795, p. 1.

⁵⁷² Exhibit P-4, Collection D, vol. 9, tab 71, doc. 795, p. 1.

⁵⁷³ Exhibit P-4, Collection D, vol. 12, tab 69, doc. 1096.

⁵⁷⁴ Exhibit P-4, Collection D, vol. 12, tab 69, doc. 1096.

⁵⁷⁵ Exhibit P-119, doc. 1396, pp. 88-89.

⁵⁷⁶ Exhibit P-119, doc. 1396, p. 88.

⁵⁷⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 69.

⁵⁷⁸ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 200.

⁵⁷⁹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 54.

⁵⁸⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 54.

⁵⁸¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 201; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1370.

⁵⁸² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1370.

⁵⁸³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 237-238.

⁵⁸⁴ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 238.

⁵⁸⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 53.

⁵⁸⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 53.

⁵⁸⁷ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 53; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 55-56; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.

⁵⁸⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 237.

⁵⁸⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 237.

⁵⁹⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 237.

⁵⁹¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 237-238.

⁵⁹² Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 161; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 137.

⁵⁹³ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 161.

⁵⁹⁴ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 161.

⁵⁹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 244.

⁵⁹⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 251.

⁵⁹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 244.

⁵⁹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 251-252 [Emphasis added].

⁵⁹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 243.

⁶⁰⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 243.

⁶⁰¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 243-244.

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- ⁶⁰² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 197-198.
- ⁶⁰³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 197.
- ⁶⁰⁴ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 52; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 53.
- ⁶⁰⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 52; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 237-238.
- ⁶⁰⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 52 [Emphasis added].
- ⁶⁰⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 268; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 27-28.
- ⁶⁰⁸ Exhibit P-6, Collection F, vol. 1, tab 36, doc. 1183, p. 3; Exhibit P-183, tab 42, doc. 1502, p. 1; Exhibit P-52, doc. 1349, p. 3. The current MP policy no longer requires contact to be made every 30 days, but continues to require “regular and continuous contact” be made to discuss assistance requirements and to provide updates: Exhibit P-183, tab 41, doc. 1501, p. 2. The CFNIS SOP remains unchanged: Exhibit P-183, tab 1, doc. 1461, p. 4.
- ⁶⁰⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 58-60 and 91-92.
- ⁶¹⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 57-58.
- ⁶¹¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 237-238.
- ⁶¹² See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 97 and 117-118; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 5-8 and 10; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 222-223, 1348-1350 and 1351-1357; Section 4.3, The 2009 PNOK Investigation.
- ⁶¹³ See Section 4.3, The 2009 PNOK Investigation.
- ⁶¹⁴ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 101 and 116-118; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 174; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087; Section 4.3, The 2009 PNOK Investigation.
- ⁶¹⁵ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 5; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 5-8, 10 and 24-26; Section 4.3, The 2009 PNOK Investigation.
- ⁶¹⁶ See Section 4.3, The 2009 PNOK Investigation; Exhibit P-70, doc. 1358, pp. 3-5; Exhibit P-103; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087.
- ⁶¹⁷ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 101; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 17; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 32.
- ⁶¹⁸ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 14 vs. Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 29-30 and Section 4.3, The 2009 PNOK Investigation.
- ⁶¹⁹ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 94-96 vs. Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 29-30 and Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 280-281.
- ⁶²⁰ See Section 4.3, The 2009 PNOK Investigation; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 32; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 134-135 and 153-154.
- ⁶²¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 64-67.
- ⁶²² Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 64-65; Section 4.3, The 2009 PNOK Investigation.
- ⁶²³ See Section 4.3, The 2009 PNOK Investigation.

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- ⁶²⁴ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 84 and 88.
- ⁶²⁵ See Section 4.3, The 2009 PNOK Investigation.
- ⁶²⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 138.
- ⁶²⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 126 and 138.
- ⁶²⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 126; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 138.
- ⁶²⁹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 126-129.
- ⁶³⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, p. 138; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 151.
- ⁶³¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 127-128.
- ⁶³² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 137-138.
- ⁶³³ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 42-43, 133-134, 160 and 163-165; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088; Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁶³⁴ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁶³⁵ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 145-146.
- ⁶³⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 149 [Emphasis added].
- ⁶³⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 145-146 and 151-152.
- ⁶³⁸ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 130, 159-161 and 163-165; Section 4.4, The 2010 Criminal Negligence Investigation; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 145.
- ⁶³⁹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 144-145, 152-153 and 157-158.
- ⁶⁴⁰ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 147, 151 and 288-289.
- ⁶⁴¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 147-148 and 288-291.
- ⁶⁴² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 289-291.
- ⁶⁴³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 130-131 and 133-134.
- ⁶⁴⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 23.
- ⁶⁴⁵ Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁶⁴⁶ See Section 4.4, The 2010 Criminal Negligence Investigation; Section 4.6, CFNIS Independence and Impartiality; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 224.
- ⁶⁴⁷ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 170; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 217.
- ⁶⁴⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 232-233. See also pp. 217-218.
- ⁶⁴⁹ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1025 and 1031; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 41, 88-93 and 132-133; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 93.
- ⁶⁵⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 68.

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- ⁶⁵¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 65-66.
- ⁶⁵² See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 92-94.
- ⁶⁵³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 150; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 73.
- ⁶⁵⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.
- ⁶⁵⁵ See Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 72; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 237-238; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 54 and 57-58; Exhibit P-4, Collection D, vol. 13, tab 3, doc. 1150, p. 4.
- ⁶⁵⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 55.
- ⁶⁵⁷ Exhibit P-4, Collection D, vol. 9, tab 71, doc. 795, p. 1.
- ⁶⁵⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 23-24.
- ⁶⁵⁹ See Exhibit P-147, tab 2, doc. 1423, pp. 202-208; Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁶⁶⁰ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 248.
- ⁶⁶¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 227 [Translation].
- ⁶⁶² Exhibit P-119, doc. 1396, pp. 88-89. Because Sgt Shannon had not yet been assigned to work on this investigation when he contacted Mrs. Fynes in September 2010, he could not have provided any information: Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115 and 232; Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁶⁶³ Exhibit P-119, doc. 1396, pp. 88-89; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 200; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 69 and 94.
- ⁶⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 70 and 94.
- ⁶⁶⁵ Exhibit P-4, Collection D, vol. 13, tab 3, doc. 1150, p. 4.
- ⁶⁶⁶ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 23-24.
- ⁶⁶⁷ See Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015.
- ⁶⁶⁸ Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 62-63.
- ⁶⁶⁹ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, p. 138.
- ⁶⁷⁰ Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 137-138.
- ⁶⁷¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 23.
- ⁶⁷² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 23-24.
- ⁶⁷³ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 24.
- ⁶⁷⁴ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.
- ⁶⁷⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 53-54.
- ⁶⁷⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 54.
- ⁶⁷⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.
- ⁶⁷⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 239-240.
- ⁶⁷⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 54; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 239-240.

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- ⁶⁸⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 239-240.
- ⁶⁸¹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.
- ⁶⁸² Exhibit P-4, Collection D, vol. 12, tab 68, doc. 1095; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.
- ⁶⁸³ Exhibit P-4, Collection D, vol. 12, tab 68, doc. 1095.
- ⁶⁸⁴ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(d). See also Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁸⁵ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 50-54, 56, 83-84 and 88-90 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 165-166; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 106-107.
- ⁶⁸⁶ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 166-167; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 107-111; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 52 [Translation]. See also Exhibit P-4, Collection D, vol. 1, tab 18, doc. 014, p. 2.
- ⁶⁸⁷ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 88 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 166; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 108.
- ⁶⁸⁸ Exhibit P-4, Collection D, vol. 12, tab 68, doc. 1095.
- ⁶⁸⁹ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1096.
- ⁶⁹⁰ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1100.
- ⁶⁹¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 30.
- ⁶⁹² Exhibit P-2, Collection B, vol. 1, doc. 1087, p. 1198; Exhibit P-147, tab 3, doc. 1424, pp. 64-68; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 225.
- ⁶⁹³ Exhibit P-147, tab 2, doc. 1423, p. 70.
- ⁶⁹⁴ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 24.
- ⁶⁹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 268; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 27-28.
- ⁶⁹⁶ Exhibit P-147, tab 1, doc. 1422, p. 102.
- ⁶⁹⁷ Exhibit P-147, tab 1, doc. 1422, p. 102.
- ⁶⁹⁸ Exhibit P-147, tab 1, doc. 1422, p. 102.
- ⁶⁹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 29.
- ⁷⁰⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 29.
- ⁷⁰¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 29-30.
- ⁷⁰² Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1101; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 113.
- ⁷⁰³ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1; Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, p. 1.
- ⁷⁰⁴ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(e).
- ⁷⁰⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 240 [Emphasis added].

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- ⁷⁰⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 55.
- ⁷⁰⁷ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 227-229; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 21; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 168 and 170.
- ⁷⁰⁸ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 228.
- ⁷⁰⁹ Exhibit P-147, tab 3, doc. 1424, pp. 12-62; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 148-149.
- ⁷¹⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 112.
- ⁷¹¹ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 168 and 170.
- ⁷¹² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 228-229.
- ⁷¹³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 168.
- ⁷¹⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 170.
- ⁷¹⁵ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 171.
- ⁷¹⁶ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015.
- ⁷¹⁷ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 1.
- ⁷¹⁸ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 2.
- ⁷¹⁹ See Section 4.3, The 2009 PNOK Investigation.
- ⁷²⁰ See Section 4.3, The 2009 PNOK Investigation.
- ⁷²¹ See Section 4.3, The 2009 PNOK Investigation.
- ⁷²² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(e); Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 247-248.
- ⁷²³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 247-248.
- ⁷²⁴ See Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 4-5, 97, 101 and 116-118; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 7-8, 10, 17, 24-26 and 174; Section 4.3, The 2009 PNOK Investigation.
- ⁷²⁵ See Section 4.3, The 2009 PNOK Investigation.
- ⁷²⁶ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 3.
- ⁷²⁷ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 3.
- ⁷²⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 170.
- ⁷²⁹ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 218; Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015.
- ⁷³⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 218.
- ⁷³¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 218-219.
- ⁷³² Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 219.
- ⁷³³ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 219.
- ⁷³⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 219.
- ⁷³⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 220.
- ⁷³⁶ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 1 [Emphasis added].

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- ⁷³⁷ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 3.
- ⁷³⁸ See Section 4.4, The 2010 Criminal Negligence Investigation; Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ⁷³⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 23.
- ⁷⁴⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 23-24.
- ⁷⁴¹ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 228-229.
- ⁷⁴² Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 228.
- ⁷⁴³ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 229-230; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 85-86.
- ⁷⁴⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 20.
- ⁷⁴⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 21.
- ⁷⁴⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 21.
- ⁷⁴⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 32(b) & 32(c).
- ⁷⁴⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 32(b); Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 241-242.
- ⁷⁴⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 55.
- ⁷⁵⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 242-243 and 256.
- ⁷⁵¹ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁵² See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁵³ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁵⁴ Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 1.
- ⁷⁵⁵ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 186-187.
- ⁷⁵⁶ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 186.
- ⁷⁵⁷ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁵⁸ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, pp. 1-2.
- ⁷⁵⁹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 32(c); Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 1.
- ⁷⁶⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 256-257.
- ⁷⁶¹ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 257.
- ⁷⁶² See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁶³ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁶⁴ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁶⁵ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁶⁶ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, pp. 1-2.
- ⁷⁶⁷ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 27, 29, 221, 284 and 286.
- ⁷⁶⁸ See Section 4.3, The 2009 PNOK Investigation.
- ⁷⁶⁹ See Section 4.3, The 2009 PNOK Investigation.

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- ⁷⁷⁰ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, p. 2.
- ⁷⁷¹ Exhibit P-4, Collection D, vol. 1, tab 19, doc. 015, pp. 1 and 3.
- ⁷⁷² See Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁷⁷³ Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, pp. 127-128; Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁷⁷⁴ See Section 4.4, The 2010 Criminal Negligence Investigation; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 157 and 183.
- ⁷⁷⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 208-209.
- ⁷⁷⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 209-210.
- ⁷⁷⁷ See, generally, Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact; Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing; Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁷⁷⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 9.
- ⁷⁷⁹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 9.
- ⁷⁸⁰ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 29-31, 38 and 41-42.
- ⁷⁸¹ Exhibit P-4, Collection D, vol. 12, tab 65, doc. 1091, pp. 1-2.
- ⁷⁸² Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 26-27.
- ⁷⁸³ Testimony of Maj Parkinson, Transcript of Proceedings, vol. 18, 8 May 2012, p. 81.
- ⁷⁸⁴ Exhibit P-4, Collection D, vol. 12, tab 65, doc. 1091, p. 1.
- ⁷⁸⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 238-239 and 242; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 29.
- ⁷⁸⁶ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 239.
- ⁷⁸⁷ Exhibit P-84.
- ⁷⁸⁸ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B.
- ⁷⁸⁹ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 29.
- ⁷⁹⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 35-36.
- ⁷⁹¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 247.
- ⁷⁹² Testimony of MCpl Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 187.
- ⁷⁹³ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 4.
- ⁷⁹⁴ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 12 and 29-30.
- ⁷⁹⁵ Exhibit P-181, doc. 1460, pp. 3-6.
- ⁷⁹⁶ Exhibit P-181, doc. 1460, p. 1.
- ⁷⁹⁷ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁷⁹⁸ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 160, 189-190, 193, 204-206 and 233-237.
- ⁷⁹⁹ See, generally, Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13, pp. 2-3.
- ⁸⁰⁰ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 33(b), 33(c) & 33(d), p. 6; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 190 and 236-237.
- ⁸⁰¹ Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, p. 3.

⁸⁰² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 187-188; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 56 and 65-66; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 19-21 [Translation].

⁸⁰³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 188.

⁸⁰⁴ Exhibit P-4, Collection D, vol. 1, tab 10, doc. 009; Exhibit P-4, Collection D, vol. 1, tab 13, doc. 010-B.

⁸⁰⁵ Exhibit P-4, Collection D, vol. 1, tab 10, doc. 009, p. 1.

⁸⁰⁶ Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, pp. 40-41; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 19 [Translation].

⁸⁰⁷ Exhibit P-119, doc. 1396, p. 75; Exhibit P-147, tab 1, doc. 1422, p. 98.

⁸⁰⁸ Exhibit P-147, tab 2, doc. 1423, p. 35; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 269-272.

⁸⁰⁹ Exhibit P-147, tab 2, doc. 1423, pp. 35-43.

⁸¹⁰ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 31-35.

⁸¹¹ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 31-35 vs. Exhibit P-147, tab 2, doc. 1423, pp. 35-43.

⁸¹² Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 32-34 vs. Exhibit P-147, tab 2, doc. 1423, pp. 38-40.

⁸¹³ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 34-35 vs. Exhibit P-147, tab 2, doc. 1423, pp. 40-41.

⁸¹⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 22-23 [Translation].

⁸¹⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 268; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 27-28.

⁸¹⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 268; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 27-28.

⁸¹⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 272 and 290; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 2-5.

⁸¹⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 4-5.

⁸¹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 272 and 290.

⁸²⁰ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A.

⁸²¹ See Section 4.6, CFNIS Independence and Impartiality.

⁸²² See Section 4.6, CFNIS Independence and Impartiality.

⁸²³ Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013, p. 1; Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A.

⁸²⁴ Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 1-2 and 129-130; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 157-160.

⁸²⁵ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.

⁸²⁶ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.

⁸²⁷ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.

⁸²⁸ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.

⁸²⁹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.

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- ⁸³⁰ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸³¹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸³² Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸³³ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸³⁴ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸³⁵ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 273-274.
- ⁸³⁶ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁸³⁷ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 190. See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸³⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33(b), p. 6.
- ⁸³⁹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴⁰ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴¹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴² See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴³ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴⁴ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 147 and 149. See, generally, Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁴⁶ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸⁴⁷ See Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 2.
- ⁸⁴⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 275.
- ⁸⁴⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 138; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 275.
- ⁸⁵⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 116-118.
- ⁸⁵¹ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, p. 2.
- ⁸⁵² Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 189-190 and 193-194.
- ⁸⁵³ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁵⁴ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁵⁵ See, generally, Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ⁸⁵⁶ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 181, 568 and 627; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 98; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 58-59.
- ⁸⁵⁷ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 128-130; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 52-53 and 160; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 62-63; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, pp. 626-628.
- ⁸⁵⁸ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.

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- ⁸⁵⁹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁶⁰ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁶¹ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 204-206.
- ⁸⁶² Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33(c), p. 6.
- ⁸⁶³ See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 67-68; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 71-72; Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁶⁴ Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 45-46; Exhibit P-6, Collection F, vol. 3, tab 4, doc 1323, p. 2. See, generally, Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁶⁵ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁸⁶⁶ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁶⁷ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁶⁸ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁶⁹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 3.
- ⁸⁷⁰ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁷¹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁷² Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4 [Emphasis added].
- ⁸⁷³ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 233-236.
- ⁸⁷⁴ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33(d) p. 6; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 195-196.
- ⁸⁷⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 160.
- ⁸⁷⁶ See Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189.
- ⁸⁷⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 286-287.
- ⁸⁷⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 287.
- ⁸⁷⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 283.
- ⁸⁸⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 283-284.
- ⁸⁸¹ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 47-50 and 57-59 [Translation].
- ⁸⁸² See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ⁸⁸³ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ⁸⁸⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.1.7, The 2008 Investigation – Return of Exhibits; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 217.
- ⁸⁸⁵ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁸⁶ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, p. 5.
- ⁸⁸⁷ Exhibit P-4, Collection D, vol. 1, tab 35, doc. 032, p. 5. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 236-237.

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- ⁸⁸⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 291-292.
- ⁸⁸⁹ Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, p. 230.
- ⁸⁹⁰ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 34 vs. Exhibit P-147, tab 2, doc. 1423, p. 40.
- ⁸⁹¹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁹² Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁹³ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁸⁹⁴ See Section 4.3, The 2009 PNOK Investigation.
- ⁸⁹⁵ See Section 4.3, The 2009 PNOK Investigation.
- ⁸⁹⁶ See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁸⁹⁷ See Section 4.3, The 2009 PNOK Investigation.
- ⁸⁹⁸ Exhibit P-2, Collection B, vol. 2, tab 3, doc. 1087-D; Exhibit P-2, Collection B, vol. 2, tab 4, doc. 1087-E; Section 4.3, The 2009 PNOK Investigation.
- ⁸⁹⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 5.
- ⁹⁰⁰ See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁹⁰¹ See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁹⁰² See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁹⁰³ See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁹⁰⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁹⁰⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁹⁰⁶ Exhibit P-147, tab 2, doc. 1423, pp. 35-43.
- ⁹⁰⁷ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 34-35 vs. Exhibit P-147, tab 2, doc. 1423, pp. 40-41; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 22-23 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 272 and 290; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 2-5.
- ⁹⁰⁸ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹⁰⁹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹¹⁰ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹¹¹ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹¹² Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹¹³ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹¹⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹¹⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹¹⁶ See Section 4.2, The Suicide Note Left by Cpl Langridge.

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- ⁹¹⁷ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹¹⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹¹⁹ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹²⁰ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹²¹ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹²² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 33 p. 6.
- ⁹²³ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 4.
- ⁹²⁴ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁹²⁵ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 269; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 52.
- ⁹²⁶ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 269; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 52.
- ⁹²⁷ Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, pp. 40-41; Exhibit P-119, doc. 1396, p. 75; Exhibit P-147, tab 1, doc. 1422, p. 98; Exhibit P-147, tab 2, doc. 1423, p. 35.
- ⁹²⁸ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 184-185, 264, 272-274 and 315; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, p. 149; Testimony of CWO (Ret'd) Watson, Transcript of Proceedings, vol. 55, 1 October 2012, pp. 149-150, 156-157, 213 and 241; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 161; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 20-21 and 56-57. See also Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁹²⁹ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001.
- ⁹³⁰ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 18; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 3-4 [Translation].
- ⁹³¹ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁹³² See Section 4.5.4, CFNIS Interactions with the Fynes – The 2009/2010 Investigations Interviews, Updates and Briefing.
- ⁹³³ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 94 [Emphasis added].

4.6 CFNIS INDEPENDENCE AND IMPARTIALITY

Introduction

1. The first and most serious group of allegations made in this complaint challenges the CFNIS' ability to conduct independent and impartial investigations.¹ In essence, the Fynes allege the CFNIS members involved in the investigations were not attempting to uncover the truth in an objective and detached manner – and were not capable of doing so – because they were influenced by a desire to protect the interests and reputation of the CF as an institution. The Fynes claim this was the result both of actual influence exerted by members of the CF on the CFNIS members through various interactions or coordinated activities related to the case, and of the CFNIS members' own biases or desire to “protect the uniform.”² They allege the CFNIS members were incapable of being objective by virtue of the very fact they were members of the CF as well as of the Military Police, but also because, in this case, the alleged wrongdoing they were asked to investigate related to actions taken or decisions made or supported by the CF Chain of Command (CoC), as opposed to some isolated act of wrongdoing by an individual CF member.³

2. These allegations are extremely serious. They are the most serious allegations that can be made about any police force or police officer because the ability to investigate allegations to the fullest without external interference or bias is essential to the ability of a police force to fulfill its basic role and retain its exceptional powers. When made about the CFNIS, the allegations raise special concern. The CFNIS is an internal police force in charge of investigating serious and sensitive offences within the military.⁴ Alleging it is not capable of carrying out its investigations without interference by or bias in favour of the military amounts to putting in question its *raison d'être* and its very ability to carry out its core mandate and functions.

3. In this case, the evidence heard by this Commission provides no indication of any overt interference or attempt by CF members to dictate or influence the conduct of the three CFNIS investigations or their ultimate conclusions. There is also no evidence of any bias or desire to protect CF interests in the conduct of the investigations or the conclusions reached. In fact, many of the Fynes' allegations about these issues were not supported by any evidence at all. It is clear the Fynes were not satisfied with the result of the investigations. It is also clear, as detailed elsewhere in this report, there were deficiencies and errors made during the investigations.⁵ The complainants appeared to believe any such errors made or any conclusions reached with which they were not satisfied, were the result of lack of independence or bias. Underlying many of their allegations was an assumption that, because the results of the investigations tended to exonerate the military of any culpability, this was proof these results were intended by the investigators all along. In other words, they mistake outcome for intention. The evidence in this case demonstrates this assumption was faulty. The vast majority of the problems observed during the investigations appear to be entirely unrelated to lack of independence or to bias.

4. There were, to be sure, a few instances giving rise to some concerns about maintaining confidence in CFNIS independence. On the whole, these concerns relate to the fundamental problems that can result when an organization seeks to investigate itself. As an internal police force, the CFNIS will always face additional challenges to demonstrate its independence. These challenges are further heightened in a case like the present, where the allegations of wrongdoing do not relate to isolated behaviour by one or more individuals, but to broader allegations of malfeasance perpetrated or supported by the CoC and the CF as an institution. In such cases, there may inevitably be a residual suspicion the internal police force, because it is part of the very institution it must investigate, will not pursue the investigation as vigorously or will not be as inclined to find wrongdoing. This suspicion may be present regardless of the CFNIS' actual intent or actions. As a result, the CFNIS bears the additional – and perhaps at times unfair – burden of demonstrating absolute probity in all actions related to the conduct of such investigations. Unless the CFNIS is able to demonstrate it conducted its investigation of alleged institutional wrongdoing in an exceptionally scrupulous and above-board manner

in every respect, confidence in its independence can be compromised. In this case, there were some instances where the CFNIS members' conduct fell short of this extremely high standard, and these might well, in turn, fuel suspicion of lack of independence.

5. There is no evidence of any actual impact on the conclusions reached in the investigations. However, in some cases, there were consequences for the CFNIS' interactions with the complainants or with the public, and as such, there was a risk of creating negative perceptions.

6. Because of the importance of maintaining confidence in the police, appearances do matter when it comes to independence, especially where an internal police force is concerned. For this reason, the Commission has identified some of the issues of concern arising in this case with a view to assisting the CFNIS in better addressing such matters in the future. However, it should be kept in mind those concerns are of a fundamentally different nature from those identified in the complainants' allegations. As such, discussion of the concerns should not be viewed in any way as detracting from the Commission's findings that the specific allegations of lack of independence and bias made in this case are unsubstantiated.

Allegations of CFNIS Bias and Lack of Independence

7. The Fynes have alleged, as a general complaint, the three investigations in this case were not conducted in an independent manner, and they have further alleged the CFNIS is not set up with the necessary independence to conduct such investigations.⁶

8. They have also made more specific allegations and raised concerns in testimony about certain conduct or interactions, which they allege demonstrate a lack of CFNIS independence. In particular, they have raised concerns about the use of the CF's BOI and SI investigations in support of the CFNIS investigations and about the sharing of information with those bodies.⁷ They claim the CFNIS "participated in broader CF efforts to provide explanations and justifications in response to the complainants' concerns,"

including by sharing the Fynes' concerns with the CF CoC, participating in public affairs coordination and participating in a CF-wide Task Force constituted to address the case.⁸ They also claim the CFNIS participated in efforts to withhold information from them, alleging the CFNIS' decisions about whether and when to communicate with them and how much information to provide, were dictated or influenced by the CF CoC or legal advisors or by concerns about the CF's litigation interests.⁹

9. The Fynes also allege the CFNIS members involved in the investigations were biased in favour of the CF or Regiment CoC. They allege the investigations were aimed at exonerating the CF of any responsibility rather than objectively uncovering the truth.¹⁰ They claim the CFNIS members selected only information favourable to CF interests and made findings or statements for the purpose of exonerating the CF CoC and attacking Cpl Stuart Langridge's character.¹¹

10. Together, these allegations show the Fynes believe the CFNIS members, intentionally or not, had preconceived ideas about both Cpl Langridge and his Regiment when the first investigation began. As a result, they believe the CFNIS members, at a minimum, refrained from investigating, or at worst, sought to cover-up certain matters or information in an effort to protect the CF's institutional reputation or interests.¹²

11. The Fynes also appear to believe the CFNIS will always seek to "protect the uniform" because of corporate identification with the CF and will be naturally sceptical of any allegations involving wrongdoing by the CoC or by the CF as an institution.¹³ Mr. Fynes testified he believes the CFNIS members have a "default position" to defend the CF as a result of their "military training and being indoctrinated into the ways of the Canadian Armed Forces."¹⁴ He also stated the CFNIS has a default bias "because they are military first and they are police second."¹⁵

12. The subjects of the complaint forcefully denied these allegations.¹⁶ Some were shocked or disappointed to hear such allegations.¹⁷ Others indicated, in no uncertain terms, they thought the allegations were "false" or could not be substantiated, and they insisted CFNIS members would never behave in this manner.¹⁸ WO Ross Tourout

“totally disagreed” with the notion the CFNIS, as an organization, would “work in the interests of the CF”, calling the allegation “discouraging.”¹⁹

13. The CFNIS members took great pride in their independence and denied they would ever let external influences affect their investigations.²⁰ MCpl David Mitchell testified independence is:

[...] something that military police in general and the NIS hold very dear. **We will fight to the death in order to keep that independence intact. Without that, then essentially there is not even a possibility of justice.**

So, at no time was this investigation aimed at exonerating the chain of command or the CF in general. No.”²¹ [Emphasis added]

14. Similarly, PO2 Eric McLaughlin affirmed:

We don’t work for our base commander [...] I answer to my own chain of command, the OC answers to the CO of the NIS and that's a very straight line right up to the VCDS-CDS, as I understand it.

[...] I have never been coerced into doing anything. **At the end of the day, and this is a rule...explained to me from the day I joined the NIS up till this day, the investigation is the priority, always will be.**²² [Emphasis added]

15. LCol Gilles Sansterre testified he is “a policeman first” and noted, although the CFNIS are “loyal to the Canadian Forces,” this loyalty “does not interfere with our honesty and our integrity.”²³

The Conceptual View: What Does Police Independence Mean and Why Is It Important?

16. The basic concept of police independence is related to the need to avoid a “police state” situation where political or Government actors can direct police to investigate their enemies or to refrain from investigating their friends.²⁴ At the same time, there is also a recognition police must be held accountable.²⁵ To achieve this, it has been recognized democratically elected representatives must be able to provide general policy or management guidance to police and must, at times, answer for police actions.²⁶

Otherwise, there would be a danger for a different type of “police state” to emerge, one where police could simply take arbitrary or uncontrolled actions without having to answer to anyone.²⁷

17. Professor Kent Roach provided a paper and testified before this Commission about the concept of police independence. In his view, police independence requires a balancing of competing considerations.²⁸ Police must be held accountable but must also be able to carry out their core law enforcement functions free from political or bureaucratic interference.²⁹ The core functions recognized as requiring independence from arbitrary interference include decisions about the conduct of investigations and the laying of charges: whom to investigate; how much investigation to carry out; when to begin, end or continue an investigation; and whether and when to bring or recommend charges.³⁰ In these functions, police should be guided only by the rule of law and should not receive direction from or exchange detailed information with Government representatives.³¹

18. In the military context, there are additional challenges because the MP are part of the CF.³² On the one hand, the need for the CF to be able to command its members, exchange information, and provide policy and managerial guidance is heightened because of the need to ensure military operations are not compromised.³³ On the other hand, the dangers of improper command influence or interference are also heightened because the MP do not have a separate structure or corporate identity, and they are ultimately subject to the CF CoC.³⁴ The Somalia inquiry provided a chilling lesson of the dangers which can arise when independence is compromised.³⁵ Since then, there has been a growing recognition of the need to protect MP independence.³⁶ The creation of the CFNIS, whose members have always reported directly to the CFPM rather than to CF Commanders, was one of the results of this recognition.³⁷

19. The need to make police independence visible is also heightened in the military context.³⁸ Because the MP are part of the broader CF, in order to maintain public confidence in the military police,³⁹ it is essential they be seen to have the freedom to

conduct their own independent investigations and come to their own independent conclusions.⁴⁰

Specific Allegations or Concerns

THE SUMMARY INVESTIGATION AND THE 2009 INVESTIGATION

20. At the outset of their investigation into the Fynes' allegations of negligence in the designation of Cpl Langridge's PNOK, the CFNIS learned the CF Brigade in charge of Cpl Langridge's Regiment intended to conduct a Summary Investigation (SI) into many of the same issues.⁴¹ Despite an initial attempt by the CFNIS to have the SI stopped because of its potential to hamper the criminal investigation, the SI nevertheless proceeded first.⁴² The CFNIS then reviewed the SI report and evidence as part of its own investigation.⁴³

21. The SI was not neutral in purpose or intent. Its Terms of Reference specified it was being conducted "in anticipation of litigation" to prepare the CF's defence to an eventual lawsuit by the Fynes.⁴⁴ The legal advisor to the SI, LCol Bruce King, had been involved in discussions with the Fynes and their counsel about the potential litigation and its settlement, and he might well have been perceived as acting in an adversarial capacity towards the Fynes in representing the CF's interests.⁴⁵ The legal advisor had also been identified by the CFNIS as a potential suspect in the investigation, although this was likely due to an inaccurate understanding of his role and involvement in the PNOK decision.⁴⁶ After the SI was completed, the CF CoC provided strongly worded comments supporting the appropriateness of all actions taken by the Regiment in this case.⁴⁷ Those comments were reviewed by CFNIS members during their investigation.⁴⁸

22. Under the circumstances, it is clear the CFNIS could not rely on the SI to come to its own conclusions without risking compromising its independence.⁴⁹ The SI was an internal investigation done by the CF to protect its own litigation interests. The CFNIS was asked to investigate allegations of institutional wrongdoing by the CF in connection

with the same facts. If the CFNIS ended up simply adopting the CF investigation's conclusions or, worse, the CF CoC's conclusions and views about the matter, its investigation could not be said to be independent.

23. There are also other, more complex questions raised by this situation. Even if the CFNIS did not adopt the CF's conclusions, could it undermine the CFNIS investigation if it relied for its own purposes on evidence collected by the CF? Could the mere review of these materials cast doubt on the CFNIS' independence? Was the CFNIS' failure to stop the SI from proceeding in the first place the result of a lack of independence?

24. The complainants allege both the review of the SI and the failure to stop it are evidence of lack of independence.⁵⁰

The failure to stop the SI

25. When Maj Daniel Dandurand, the OC for the CFNIS WR Detachment, learned about the Brigade's intent to conduct an SI, he was concerned about the possibility the SI "could taint our criminal investigation."⁵¹ He immediately requested a meeting with the Brigade Commander, Col K.A. Corbould, "[i]n order to determine whether the SI need[ed] to be stopped" in light of the "likely overlap" with the CFNIS investigation.⁵² On November 25, 2009, he wrote to the investigating officer in charge of conducting the SI, Maj Derek Chenette, indicating:

I came to learn of your SI by chance and **I am of the strongest belief that matters being looked into by your team will overlap with our criminal investigation.**

I am meeting with Comd 1 CMBG in the morning to discuss this matter **and all I ask for now is that you do not proceed with any further activity on this SI until we can determine if your activity could taint our criminal investigation.** [...] Once you are back in Edmonton, I think it would be best for us to meet and discuss the way ahead.⁵³ [Emphasis added]

26. Maj Chenette responded he would await word from the Commander before proceeding but noted he could not "afford to lose too many days" if he was instructed to proceed.⁵⁴

27. Maj Dandurand could not recall what was discussed with the Brigade Commander or what was done to address his concerns.⁵⁵ He explained his intent going into the meeting was to ensure the SI would not encroach on the CFNIS investigation.⁵⁶ He could not recall what assurances he received from Col Corbould, if any, but he testified he had no remaining concerns after the meeting and believed his intent had been achieved.⁵⁷ He explained, if he had requested measures to be taken by a CF Commander to protect a criminal investigation and those measures were not forthcoming, he would have flagged the issue to the CO CFNIS immediately.⁵⁸

28. On the basis of this evidence, it appears Maj Dandurand either was satisfied the SI would not proceed or was satisfied it would proceed in a manner that would not impact the CFNIS investigation.⁵⁹

29. As it turns out, the SI proceeded the day after Maj Dandurand's meeting with the Brigade Commander.⁶⁰ It is not known whether Maj Dandurand was aware at the time that the SI proceeded despite his concerns.⁶¹ There is no evidence Maj Dandurand took any additional steps to stop the SI, nor evidence any steps were taken to ensure the SI did not, in fact, encroach on the CFNIS investigation. Maj Dandurand's concerns were never put in writing in any official correspondence to the CF Brigade, and there was no follow-up.

30. In the end, the SI was completed before the CFNIS investigation even began and turned out to be much more extensive than the investigation eventually conducted by the CFNIS. The SI conducted numerous interviews with witnesses who had knowledge relevant to the CFNIS investigation before the CFNIS had a chance to interview those witnesses.⁶² The very first witness interviewed by the SI was one of the main subjects of the Fynes' complaint to the CFNIS.⁶³

31. This created a risk for the integrity of the police investigation. It prevented the CFNIS from getting "first crack" at interviewing key witnesses, as Maj Dandurand thought it should have.⁶⁴ It meant witnesses could be "contaminated" before the CFNIS had an opportunity to speak to them.⁶⁵ From the issues being pursued, the types of questions being asked, or the manner in which the questions were asked, there was a risk

the witnesses could have formed beliefs or understandings about what the CF's position was about the issues or what the CF policies or expected behaviours were in this situation. This, in turn, could affect the witnesses' perceptions, recollection or even willingness to provide information to the CFNIS. The CFNIS' failure to take sufficient steps to stop the SI could create the perception they did not take these risks seriously, or they were unwilling or unable to protect their investigation.

32. While there is no evidence the failure to stop the SI resulted from interference by CF members, it did contribute to creating the impression the CF's investigation was the most important investigation conducted in this case. Because the CFNIS subsequently conducted only a limited investigation, the end result could lead to a perception it was merely "rubberstamping" the CF's more extensive investigation. This was not likely to inspire confidence in the CFNIS' independence.

Review of the SI materials

33. During the course of their investigation, the CFNIS members obtained and reviewed the SI report, the SI Annexes, as well as policy materials gathered during the SI.⁶⁶ The Annexes contained 593 pages of documentary evidence.⁶⁷ They included documents recording the answers provided by the 18 witnesses interviewed during the SI.⁶⁸

34. Sgt Scott Shannon also reviewed a copy of comments made about the SI by the Commanders of the Brigade and Area in charge of Cpl Langridge's Regiment.⁶⁹ These documents included forceful and categorical views by high-ranking members of the CF CoC about some of the matters under investigation by the CFNIS. Col Corbould, the Brigade Commander, indicated he was satisfied the various "possible administrative errors" had not been caused by "intentional neglect" on the part of Regiment staff, and he concluded the matter had been "dwelled into enough" and now considered it "to be closed."⁷⁰ BGen Michael Jorgensen, the LFWA Commander, commented it was not unreasonable to treat Cpl Langridge's common-law spouse as his NOK,⁷¹ and concluded:

[...] any reasonable and objective outside observer would find that Cpl Langridge's post-death administration was properly executed by the CF. To review, the CF acted

correctly in all important issues. [...] clearly, the CF cannot and should not assume responsibility for everything the Fynes believe went wrong.⁷² [Emphasis added]

35. All of the CFNIS members involved in the investigation denied they relied on the SI materials to come to their own conclusions about the complaint.⁷³ Sgt Shannon also insisted he was not influenced by the Brigade and Area Commanders' comments.⁷⁴ There is no evidence otherwise indicating the CFNIS members' conclusions were based on or influenced by the SI, and there is no reason to doubt their testimony on this issue.

36. In light of this, the question before the Commission is whether the mere review of these materials nevertheless raises concerns in terms of CFNIS independence. Was the review of the investigation conducted by the CF about many of the same issues investigated by the CFNIS⁷⁵ liable to create doubts about the independence of the CFNIS investigation? This issue relates to the danger of creating negative perceptions and to the steps necessary to maintain confidence in CFNIS independence. There is cause for concern about this for two reasons.

37. First, if a decision had been made to proceed with charges, the review could have impacted the admissibility of the evidence gathered in the CFNIS' own investigation. LCol Bruce MacGregor, a JAG Legal Officer who acted as the Director of Military Prosecutions for several years,⁷⁶ explained, where witnesses are compelled to provide evidence in a BOI or SI, any evidence obtained by police as a direct result of those statements would likely be found inadmissible in criminal or disciplinary proceedings.⁷⁷ As a result, the best approach is to ensure CFNIS investigators interview witnesses before they give evidence in BOIs or SIs.⁷⁸ Otherwise, there is a risk to "really taint some evidence."⁷⁹ From the evidence, it is not clear the CFNIS members involved in this case understood this risk.⁸⁰ However, the perception they were willing to take this risk could have an impact on overall confidence in the CFNIS' independence.

38. Second, it is not clear the investigation conducted by the CFNIS in this case was sufficiently extensive to provide a tangible demonstration of its independence. Because this case involved allegations of wrongdoing by the CF as an institution, and the CFNIS had reviewed an investigation conducted by the CF to protect its own interests, it was

important for the CFNIS to “take every effort, and be seen to have taken every effort, to make clear that they have reached their own independent law enforcement conclusions.”⁸¹

39. Maj Dandurand had specifically assured the Fynes the information from the SI would not be taken at face value. He had told them the CFNIS would conduct its own interviews with the SI witnesses using its own methods.⁸² This was important because the evidence gathered during the SI would have been shaped by the SI’s purpose, which was to defend the CF’s interest in potential litigation. Indeed, some of the questions asked during the SI could be interpreted as providing “hints” about the appropriate answers or the issues at stake from the CF’s perspective.⁸³ As a result, it was particularly important for the CFNIS investigators to conduct their own interviews in order to be able to show they investigated the matter independently. This was what MCpl Mitchell planned to do.⁸⁴

40. However, the CFNIS ended up interviewing only three fact witnesses compared to the 18 who were interviewed during the SI.⁸⁵ When Sgt Shannon assumed the lead for the investigation, he relied on the documentary record to come to his conclusions and did not interview any fact witnesses.⁸⁶ As a result, none of the members of the Regiment CoC who may have been involved in the PNOK decision, and none of the potential suspects in the investigation were questioned.⁸⁷

41. Because most of the key witnesses were not interviewed separately by the CFNIS, an appearance could be created that the CFNIS relied on the CF’s investigation to come to its conclusions. Although the subjects’ testimony in this hearing has demonstrated this was not the case, the factual investigation they conducted was not sufficiently robust to promote full confidence in their independence. Especially in light of the assurances they had provided to the Fynes, and the fact they had reviewed an investigation conducted by the CF to protect the CF’s own interests, it would have been preferable for them to have conducted a more comprehensive factual investigation, sufficient to put them in a position to demonstrate every aspect was investigated fully and independently by the CFNIS.

Conclusions about the use of the SI during the 2009 Investigation

42. The Commission finds there is no evidence the SI impacted the CFNIS' ultimate conclusions. As such, it cannot be concluded the CFNIS lacked independence simply because it accessed and reviewed this CF investigation. However, there was a risk the CFNIS could be seen as deferring to the CF in allowing it to conduct a much more extensive investigation first. In addition, considering the heightened need to demonstrate allegations of institutional wrongdoing were investigated to the fullest, the limited investigation conducted by the CFNIS after its members reviewed the SI materials could raise concerns in terms of maintaining confidence in its independence.

THE BOI REPORT AND THE 2010 INVESTIGATION

43. A Board of Inquiry (BOI) into the circumstances surrounding Cpl Langridge's death was constituted by the Brigade in charge of Cpl Langridge's Regiment. During the 2010 criminal negligence investigation, the CFNIS reviewed a draft of the BOI report.⁸⁸

44. The BOI was an internal CF investigation.⁸⁹ Its legal advisor was the same legal officer who was involved in discussions with the Fynes' counsel in connection with anticipated litigation and was subsequently appointed as counsel to the SI.⁹⁰ Many of the issues examined during the BOI were directly relevant to the "ultimate issues" the CFNIS was asked to investigate in the 2010 investigation.⁹¹

45. Unlike the SI, the BOI was not conducted for the purpose of advancing CF interests in any anticipated litigation. However, the Fynes were firmly of the view its entire process was biased and aimed at protecting CF interests. They alleged the witness answers were manipulated and suggested the BOI "started from a conclusion, and then made everything fit."⁹² They specifically made the CFNIS aware of those concerns and repeatedly raised them during their meetings and correspondence with the investigators.⁹³

46. The CFNIS investigators obtained only the draft report and not the underlying evidence gathered during the BOI.⁹⁴ They reviewed neither the transcripts of the actual witness testimony at the BOI nor the documentary evidence filed. As a result, they were not in a position to make their own assessment of the evidence and level of probing that

took place during the BOI. They only had access to the BOI's description of the evidence considered relevant to support its conclusions.

47. The complainants allege the use of the BOI report during the 2010 investigation is evidence of the CFNIS' lack of independence.⁹⁵ They are particularly concerned about the interaction between the BOI and the CFNIS.⁹⁶ They believe there was "cross-contamination" between the two organizations.⁹⁷ In essence, their concerns arise from what they perceive as information "going in a circle."⁹⁸ The circle involved the BOI obtaining the 2008 CFNIS investigation report (which the Fynes believed contained biased and incorrect findings⁹⁹), using it to question witnesses and to derive its own conclusions (which the Fynes again believed to be biased and inaccurate¹⁰⁰), and then passing the report back to the CFNIS for use in the 2010 investigation.¹⁰¹ The 2010 investigation was opened in response to the Fynes' specific request for a separate investigation into the negligence they believed was committed by the CF in connection with their son's death.¹⁰² This closed circle would render its status as a separate investigation meaningless.

48. The issue before the Commission is largely similar to the issue raised with respect to the review of the SI materials. If the CFNIS simply adopted the CF's conclusions, its independence could be compromised. Even if the CFNIS did not rely on the CF's conclusions, questions nevertheless would remain about whether sufficient investigative steps were taken to demonstrate its investigation was independent in light of its having conducted a review of the CF's conclusions.

Reliance placed on the BOI report

49. In the 2010 file, the CFNIS was presented with serious allegations of institutional wrongdoing by the CoC of a CF Regiment. It is clear, if it was to conduct an independent investigation of the matter, it could not simply turn around and adopt the CF's own conclusions about its lack of negligence without further probing or questioning.

50. Relying on the BOI's conclusions would be particularly problematic in this case because the Fynes had raised concerns about the process, and the CFNIS had promised to conduct its own investigation.¹⁰³

51. The BOI report also contained several controversial conclusions and findings. The CF Reviewing Authority and the Approving Authority each took issue with some of the findings and questioned whether they were accurate or supported by sufficient evidence.¹⁰⁴

52. One of the reasons cited in the BOI report in support of the conclusion the Regiment had acted appropriately by requiring Cpl Langridge to remain at the base prior to receiving further treatment for his addiction issues, was that, if this had not been done, Cpl Langridge could have committed suicide while at the treatment center.¹⁰⁵ Considering Cpl Langridge did commit suicide precisely during this period, this surprising statement, at a minimum, required further explanation. The issue was directly relevant to the CFNIS' investigation as the CFNIS was asked to investigate whether the Regiment's and the CF medical community's decisions about Cpl Langridge's treatment were negligent and contributed to causing his death.¹⁰⁶

53. It is not within this Commission's mandate to pass judgment on the BOI's conclusions, nor is it the Commission's intent. However, the fact the report contained several controversial or unexplained conclusions and findings, the accuracy of which was being questioned even within the CF, meant it should have been clear to the CFNIS members they needed to make their own assessment of the evidence and conduct their own investigation. Without independently reviewing the BOI evidence, they could not assess, use or rely on the BOI's conclusions.

54. The evidence before the Commission is not entirely clear as to what reliance, if any, was placed on the BOI report in the conduct of the 2010 investigative assessment. Both the investigators involved reviewed the BOI report, but did not specifically explain whether and how it was used in conducting their assessment of the file and reaching their conclusions.¹⁰⁷ Other members involved in supervising the investigation at the Detachment and HQ levels appeared to believe some limited reliance could be placed on

the BOI's conclusions or, at least, on its failure to report any suspicion of criminal activity.¹⁰⁸ However, their testimony did not provide insight as to whether the BOI's conclusions were, in fact, relied on in conducting the assessment in this case. Counsel for the subjects of the complaint argued there was no basis for the CFNIS to conclude the BOI was improper or unreliable but did not make specific submissions about what reliance, if any, was placed on it in this case.¹⁰⁹

55. Further complicating matters, legal advice was obtained in support of the investigative assessment. Because issues of solicitor-client privilege intervened, it was more difficult for the Commission to obtain precise information about exactly what materials were reviewed and relied on.¹¹⁰

56. On the whole, the evidence does not support a conclusion that the CFNIS compromised its independence by adopting the BOI's conclusions. Other materials were reviewed during the 2010 assessment, and the investigators did perform their own analysis of the elements of the offence.¹¹¹ Considering the BOI was included in the materials reviewed, there are questions about the exact source of some of the facts the investigators relied on in making their assessment.¹¹² There is, however, no positive evidence they relied on the facts as found by the BOI to come to their conclusions. As such, it cannot be concluded the allegations of lack of independence resulting from the use of the BOI report are well founded.

57. From the perspective of maintaining confidence in the CFNIS' independence, however, it is of concern that not all CFNIS members appeared to have a clear understanding that relying on the CF's conclusions and findings would be problematic.

Demonstrating independence

58. The review of the BOI report during the 2010 assessment gave rise to a risk the CFNIS could be viewed as simply adopting the CF's conclusions. It is not clear the limited activity undertaken and the limited materials reviewed by the CFNIS in this case were sufficient to dispel this notion and provide the necessary demonstration of the CFNIS' independence.

59. LCol Sansterre testified he would see no issue with CFNIS investigators reviewing information provided during an SI or BOI, but noted they would still have to “come up with their own findings” as the CFNIS “do separate investigations.”¹¹³ He explained:

I would have a problem if **they only relied on the findings of the BOI, didn't do any investigation** to confirm whether they have any suspicion or have any evidence to support the allegations.¹¹⁴ [Emphasis added]

60. In many ways, the CFNIS members involved in the 2010 investigation did precisely what LCol Sansterre stated should be avoided. A BOI report containing findings about the same issues they were asked to investigate was included in the materials they reviewed in support of their investigative assessment, and they conducted no apparent factual investigation of their own to support their conclusions.¹¹⁵

61. Their assessment was not limited to reviewing the BOI report, but the materials they had were limited. Essentially, there were the Fynes' allegations, the 2008 investigation report, and the BOI report.¹¹⁶ To assess whether the allegations required investigation, the CFNIS members had to apply their analysis to a fact scenario. Some of the facts referred to in Sgt Shannon's final presentation about the case were contrary to the Fynes' allegations.¹¹⁷ The source for this understanding of the facts had to come from the materials reviewed. The 2008 investigation report contained a wealth of relevant information. However, many negligence-related issues had not been investigated properly or at all in that case.¹¹⁸ As such, the limited work performed in the 2010 file and the limited materials available left the door open for a perception to arise the CFNIS relied on the BOI's factual findings to support some of its own analysis. The evidence did not positively demonstrate this was actually the case. However, the work done by the CFNIS was also not sufficient to provide a clear demonstration this was not the case. As such, confidence in its independence could be diminished.

62. The Fynes, having raised their own concerns about the BOI process, had been specifically assured an independent investigation would be conducted, and the BOI evidence and witnesses would be revisited.¹¹⁹ It is not surprising their own confidence in the CFNIS' independence was further diminished when they learned the CFNIS did no

investigation and included the BOI's findings – but not the evidence supporting those findings – in the materials reviewed to assess their complaint.

Conclusions about the use of the BOI report during the 2010 Investigation

63. While the evidence is not sufficient to establish the CFNIS' conclusions were based on those of the BOI, the Commission notes a clearer separation between the two processes, and a clearer record of a factual investigation capable of supporting the conclusions reached by the CFNIS, would have assisted in fostering greater confidence in the CFNIS' independence.

CONTACTS BETWEEN THE CFNIS AND THE CF

64. The Fynes make a number of complaints about improper or inappropriate contacts between the CFNIS and other parts of the CF. They allege the CFNIS discussed some of the Fynes' concerns with members of the CF CoC “for the purpose of participating in CF efforts to explain and justify their actions” and not for the purpose of conducting a police investigation.¹²⁰ They also express great concern about the CFNIS' alleged participation in a CF-wide Task Force to handle the Langridge matter, which they believe demonstrates the CFNIS' lack of independence.¹²¹

65. Essentially, these allegations raise questions about whether interference or improper influence was exerted by the CF on the CFNIS. Communication by the CFNIS with other CF organizations is entirely appropriate and expected. General exchange of information and even guidance provided by the CF on broader organizational issues does not compromise CFNIS independence.¹²² Police independence concerns would arise only if the exchanges went further and involved an attempt to direct or influence the conduct of CFNIS investigations or the conclusions reached.¹²³ Concern could also arise if there was evidence the CFNIS was pressured or influenced into adjusting its perspective or activities to advance the CF's interests. No such evidence was presented in this case.

The LFWA meeting

66. On April 16, 2010, Maj Dandurand and other members of the CFNIS Detachment met with members of the CoC for the Brigade (1 CMBG) and Area (LFWA) in charge of Cpl Langridge's Regiment.¹²⁴

67. The meeting was held at LFWA's request. The main purpose was to exchange information about the different CF organizations' responsibility for different aspects of the case.¹²⁵ At the time, the SI was under review at LFWA, the BOI draft report had been submitted to the CDS' office for approval, and the CFNIS' 2009 investigation was ongoing.¹²⁶

68. One of the reasons the LFWA wished to obtain information about the CFNIS investigation was to evaluate its impact on its own activities and, in particular, on the approval process for the BOI at the CDS level.¹²⁷ LFWA wanted to provide a comprehensive information package for the CDS, which would address all of the different investigations.¹²⁸ Prior to the meeting, Maj M.H. (Mike) Hertwig-Jaksch, a member of the LFWA staff, explained:

The G1 LFWA has asked me to arrange a meeting at which we could discuss and assess the impact of the findings of the CFNIS investigation on the Cpl Langridge case as a whole.

As you are aware, the BOI is currently being reviewed at NDHQ. It is known that the Langridge family is already at disagreement over some findings of the BOI. Although the subsequent SI and CFNIS investigation are separate from the BOI, their impact will successively be felt by the Langridge family.

It would be important, therefore, to **manage their expectations in a holistic [sic], rather than piece-meal approach.** In particular, the G1 considers it important that **the CDS be aware of all aspects of the case (incl the SI and CFNIS investigation) when he authors his Approving Authority comments.** That way, he will not be **blind-sided by subsequent developments or be placed in a situation where he would have to correct himself vis-a-vis the family after the fact.**¹²⁹ [Emphasis added]

69. During the meeting, Maj Dandurand provided general information to notify LFWA about the CFNIS investigation but did not discuss the details of the CFNIS investigation.¹³⁰ He explained he was required to "hold back" because of the relationships between the officers being investigated and those he would inform.¹³¹ He advised LFWA

the CFNIS would use “normal channels” to provide notification to the CF CoC once the investigation was concluded.¹³²

70. Maj Dandurand also used this opportunity to raise with LFWA a number of the concerns the Fynes had communicated to him in earlier meetings. These pertained to administrative matters unrelated to the CFNIS investigation or the CFNIS’ law enforcement functions. Maj Dandurand provided detailed information to the Fynes in a subsequent meeting about the issues he had discussed with LFWA.¹³³ They included matters “peripheral” to the criminal investigation such as the condition of Cpl Langridge’s Jeep when it was shipped to the Fynes by the Regiment, missing items in the inventory of Cpl Langridge’s effects prepared by the Regiment, issues raised by the Fynes about the BOI process, and issues surrounding the awarding of the memorial cross to the Fynes.¹³⁴

71. The discussions at the LFWA meeting do not raise any police independence concerns. For the CFNIS to provide information about its investigation to the CF CoC is in line with the legitimate exchange of information described by Prof Roach as compatible with police independence.¹³⁵ The exchanges here were compatible with the briefing protocols in place and did not fall outside the normal exchange of information to be expected in military policing.¹³⁶ There is no evidence indicating there was any pressure on the CFNIS to provide more information than it believed appropriate or to reach certain conclusions. On the contrary, Maj Dandurand provided only general information. No details about the CFNIS investigation were shared, and its integrity was protected.

72. The initial LFWA message did mention an intent to “manage [the family’s] expectations” in a holistic way.¹³⁷ If the CFNIS were seen as participants in a CF-wide approach to managing communications with the complainants or presenting unified CF corporate positions, concerns about maintaining confidence in CFNIS independence could arise.¹³⁸ However, the evidence indicates the CFNIS did not participate in any such CF enterprise.¹³⁹

73. There was nothing inappropriate about the LFWA personnel's concern with the eventual impact of the CFNIS investigation on the BOI approval process. One of the legitimate purposes of information sharing with the military police is to allow the CF to evaluate the impact on all aspects of its activities. It was only natural, and certainly legitimate, for the CF CoC to be concerned about the CDS being blind-sided and to wish to ensure any public pronouncements he made about the case were consistent with the eventual findings of the different investigations.

74. In subsequent correspondence and during his testimony, Maj Dandurand made it clear he shared the concerns about ensuring the CDS was made aware of the CFNIS investigation before making public pronouncements on the case.¹⁴⁰ Those concerns are focused on avoiding embarrassment for the CF and its leadership. They have nothing to do with the interests of the police investigation or any of the CFNIS' law enforcement activities. However, this does not necessarily mean they were improper or constitute evidence of a lack of CFNIS independence.

75. It is inevitable for CFNIS members, who are also part of the broader CF organization, to be aware and supportive of the organization's broader interests. Independence concerns would arise if they allowed such interests to influence the conduct of their investigations or the conclusions reached. There is no evidence this happened in this case. On the contrary, Maj Dandurand wanted the CDS to hold off on making public pronouncements precisely because he believed the results of the CFNIS' 2009 investigation could include findings of wrongdoing by the CF, contrary to what other CF investigations had found. Maj Dandurand in no way suggested he intended to adjust the CFNIS' findings or investigative activities to suit the CF's interests.

76. There was also no impropriety in Maj Dandurand discussing the administrative matters raised by the Fynes with the CF CoC. When they first learned Maj Dandurand had brought their concerns to the CoC's attention, the Fynes were grateful and did not express any concerns about independence or improper contact.¹⁴¹ Yet, they subsequently complained about this same issue before the Commission.¹⁴² In testimony, Mr. Fynes explained one of his concerns related to the fact the CFNIS did not investigate how Cpl

Langridge's Jeep had been damaged yet somehow managed to discuss the issue with the CF CoC.¹⁴³ However, the evidence indicates, at the time of the events, the Fynes had not brought the issue of the damage to their son's Jeep to the attention of the CFNIS for purposes of requesting a police investigation.¹⁴⁴ In any event, it is doubtful such a matter would fall within the CFNIS mandate to conduct "serious and sensitive" investigations.¹⁴⁵

77. Maj Dandurand cannot be faulted for attempting to assist the Fynes by bringing their concerns to the attention of the CoC. One of the matters he raised related to the Fynes' costs for correcting the registration of death for Cpl Langridge and the CF's potential responsibility to cover these costs.¹⁴⁶ This was more closely linked to the issues under investigation in the 2009 file.¹⁴⁷ However, the evidence shows Maj Dandurand kept the discussions with LFWA limited to issues surrounding the administrative and financial aspects of the matter and did not discuss any substantive issues related to the CFNIS investigation.¹⁴⁸ There is no evidence the discussions about this issue resulted in any attempt by the LFWA CoC to influence or interfere with the CFNIS investigation. In fact, the CF Brigade and Area were already well aware of the Fynes' concerns about this issue as this was addressed in the SI.¹⁴⁹

The CF Task Force

78. In August 2010, the VCDS Chief of Staff instructed a CF Task Force be established to address the Fynes' eventual legal action against the CF.¹⁵⁰ The purpose was to ensure the CF adopted a "cohesive approach" to the litigation and the approval process for the BOI report, which was still pending.¹⁵¹ LFWA and staff from the Director of Army Public Affairs were to be involved in the Task Force or, at least, to maintain awareness of the situation.¹⁵²

79. The Fynes believed the CFNIS participated in the CF Task Force and came to view all of the CFNIS' prior and subsequent actions as attempts to advance CF interests or CF corporate positions.¹⁵³ They doubted the CFNIS could investigate their complaints independently and objectively if they were concurrently involved in efforts to protect the CF's reputation and interests in connection with the case. Mr. Fynes testified:

And I know, **and I'm deeply disturbed, that there was a task force in place** involving Public Affairs officers and NIS, et cetera, to deal with the Langridge matter [...]

[...]

The NIS were set up to be independent of a chain of command, they were to be given authority to conduct their internal investigations unhampered and unfettered by any concern for rank or the organizational structure or undue or inappropriate influence.

To see them in lock-step with another entity or other areas of the Canadian Forces whose intention is to protect the brand and to protect the uniform and to manage an affair and protect possibly from litigation, **they have absolutely failed in their mandate.**¹⁵⁴
[Emphasis added]

80. To be sure, for the CFNIS to participate in a Task Force constituted to advance the CF's litigation interests or present the CF's corporate positions to the public, even while it was tasked with investigating alleged institutional wrongdoing by the CF, would be incompatible with the principles of police independence. It is most unfortunate the Fynes were left with the impression the CFNIS was involved.

81. The evidence before the Commission shows the CFNIS did not participate in the Task Force.¹⁵⁵ In fact, when Maj Dandurand learned about it, he specifically told his HQ he was concerned and sought authorization to advise the Task Force about the CFNIS investigations to ensure "there is no possibility of them inadvertently stepping into our lanes."¹⁵⁶ He then advised the individuals involved in the communications about the Task Force that there were ongoing CFNIS investigations and that the CFNIS would have to be consulted before statements were made or inquiries about the case answered.¹⁵⁷

82. From a police independence perspective, there is nothing improper about Maj Dandurand's wish to advise the Task Force about the CFNIS investigations and to ensure the Task Force did not interfere. The evidence suggests this was the CFNIS' only contact with the eventual Task Force.¹⁵⁸

Pressure to conclude the investigations?

83. In February 2011, the Director of the CF's Casualty Support Management Unit, Col Gerard Blais, wrote to the CFNIS DCO, Maj Francis Bolduc, to transmit information received from the Fynes.¹⁵⁹ In this message, he outlined the importance of getting the

CFNIS investigations “signed off as quickly as possible” and the family briefed, in order to avoid a “circular exchange with the family.”¹⁶⁰

84. If the CF attempted to provide direction to the CFNIS about when to conclude its investigations, police independence concerns could arise.¹⁶¹ On the other hand, it is entirely legitimate for the CF to have an interest in knowing about the anticipated timing for the conclusion of CFNIS investigations. It is also to be expected the CF CoC, having an interest in the result of the CFNIS’ investigations, will generally wish to see them completed as early as possible. Most complainants are likely to have similar concerns and this is part of the day-to-day reality of police work. In this case, the Fynes were certainly concerned about the timing, and Col Blais’ inquiries resulted from their complaints about this issue to his staff.¹⁶²

85. In this context, it is clear Col Blais’ comments were not improper. The evidence establishes they were not intended to issue a directive to the CFNIS, to apply pressure or to interfere with the investigations in any way.¹⁶³ They were also not interpreted or perceived by the CFNIS members as pressure to hasten the conclusion of the investigations.¹⁶⁴

Conclusions about information exchange between the CF and the CFNIS

86. The Commission finds the interactions between the CF and the CFNIS do not raise police independence concerns in this case. The Commission saw no evidence indicating improper discussions took place.

RELEASE OF INFORMATION AND COMMUNICATION WITH THE PUBLIC AND THE COMPLAINANTS

87. Many of the Fynes’ allegations of lack of independence relate to the CFNIS’ communications with them or with the media.¹⁶⁵ Essentially, the Fynes allege the CFNIS was involved in direct coordination with the CF, or was influenced by CF interests, in making decisions about the information to release to the public or to the complainants.

88. These complaints do not relate to alleged interference in actual CFNIS investigations or other core law enforcement functions. However, this does not mean police independence concerns cannot arise. If the CFNIS is seen to act in concert with the CF in preparing messages for the public or complainants, or in deciding what information to provide, confidence in its ability to carry out independent investigations can be diminished. In order to be able to carry out its investigations, the CFNIS requires the cooperation of potential complainants and witnesses who may have knowledge of CF wrongdoing. These individuals must be able to come forward with full confidence the CFNIS will act independently.

89. For these reasons, the CFNIS must be able to demonstrate its independence by maintaining a separation from the CF in its communications with the public and, to an even greater extent, with complainants who have brought allegations to its attention.¹⁶⁶

Communication with the complainants

90. The Fynes make a number of complaints about their contacts with the CFNIS and the nature of the information provided to them by the CFNIS. They allege the CFNIS' decisions about what information to provide to them, as well as the timing and format, were influenced directly or indirectly by members of the CF CoC or CF legal advisors or by concerns about CF interests.¹⁶⁷ In particular, they claim this influence caused the CFNIS to withhold information from them; to fail to maintain regular contact with them; to cancel a planned verbal briefing as a direct result of anticipated litigation between them and the CF; and to give insufficient information in the written briefing provided in replacement.¹⁶⁸

Failure to provide updates

91. The Fynes allege the CFNIS' failure to maintain regular contact with them amounted to participation in broader CF efforts to prevent them from communicating with CF members. They believe the lack of contact was related to a "no contact" letter sent to their counsel by CF representatives in connection with anticipated litigation.¹⁶⁹

92. The correspondence was sent on September 21, 2010, by LCdr Gordon Thomson, counsel for the DOJ's Office of the DND/CF Legal Advisor. It reads:

It is on this basis that **I must request that you immediately inform Mrs Fynes not to have any further direct contact with members of the Canadian Forces, Department of National Defence, or Department of Justice with respect to any matters relating to the claims she has demanded from the Crown.** I note that Mrs Fynes has been in contact with several sections of these offices apparently seeking compensation for the claims sought in your firm's demand letter of 16 March 2009. **All further contact with the Crown must be through you or your office to me** unless you formally, and in writing, withdraw as counsel. All sections of the above mentioned organizations have been informed not to have any further direct contact with Mrs Fynes but to address the issues through this office.¹⁷⁰ [Emphasis added]

93. When this letter was sent, there were two CFNIS investigations still ongoing. The CFNIS failed to make any contact with the Fynes between September 2010 and February 2011, despite promises to provide them regular updates about the investigations.¹⁷¹

94. However, the evidence before the Commission has revealed this was unrelated to the CF's correspondence.¹⁷² The CFNIS was not involved in the decision to send this letter, nor were they consulted about it or even aware of it.¹⁷³ Had they known about the letter, it is clear the CFNIS members involved in the investigations would not have viewed it as precluding them from contacting the Fynes in any way.¹⁷⁴ On its face, it is also doubtful the CF's correspondence could be interpreted as seeking to limit the Fynes' contact with the CFNIS, since such contact would not be related to any claims demanded from the Crown.¹⁷⁵

95. While the CFNIS' failure to maintain regular contact with the Fynes was unfortunate,¹⁷⁶ there is no evidence it was the result of CF influence or concern about the CF's interests.

Cancelled briefing

96. In February 2011, the CFNIS offered to provide a verbal briefing to the Fynes about the outcome of the 2009 and 2010 investigations.¹⁷⁷ When the Fynes requested that their lawyer be present at the briefing, CFNIS HQ decided to cancel the briefing and provide a letter instead.¹⁷⁸

97. The Fynes were outraged by this decision. They believed it was made as a direct result of their anticipated litigation with the CF, and they viewed it as a clear instance of the CFNIS being influenced by a desire to protect CF interests.¹⁷⁹ Mr. Fynes testified:

I was astounded by that because if a victim asks the police to investigate potentially a criminal matter and they just refuse to tell them anything as to an outcome or a result or where their investigative processes were, the complainant or the victim is just absolutely left in the dark and then to find out that they're doing -- they're **hiding all of this in fear of possible litigation speaks to protection of the Canadian Forces, it speaks to protection of the image and of the brand**; it doesn't speak to police work and, in my understanding of police work or the independence of police work, to conduct a fair and impartial investigation.¹⁸⁰ [Emphasis added]

98. From the evidence before the Commission, it is clear the decision to cancel the briefing was made because the CFNIS was reluctant to become involved in the civil litigation process.¹⁸¹ This, in itself, does not raise police independence concerns. Although the Commission has found the decision was not appropriate in terms of fulfilling the CFNIS' commitments and obligations to the complainants, this is unrelated to independence, and the CFNIS did have good reasons for not wanting to be pulled into the civil litigation.¹⁸² The question which does arise, from an independence perspective, is whether the reluctance to get involved related to litigation in general or whether it was specifically tied to the fact the litigation involved the CF. If the decision was directly influenced by CF members or by a desire to protect the CF's interests in the litigation, concerns would arise in terms of maintaining confidence in the CFNIS' independence.

99. The evidence shows there was no direct influence or interference by CF members or advisors. The CF was not involved in, and likely not even aware of, the CFNIS' decision to cancel the briefing.¹⁸³

100. The evidence is less clear about the motivation for the decision and whether it could have been related to a desire to protect CF interests as opposed to a general aversion by police for involvement in civil litigation. The decision was made by the CFNIS DCO, Maj Bolduc, in consultation with LCol Sansterre and Maj Dandurand.¹⁸⁴ The explanations provided by Maj Bolduc during his testimony focused solely on the impact of the presence of a lawyer on the conduct of the briefing and on the CFNIS members involved.¹⁸⁵ LCol Sansterre's focus was similar.¹⁸⁶ He was not aware what the

litigation was about and did not express a view about whether the fact of litigation against the CF was a sufficient reason to cancel the briefing.¹⁸⁷ Maj Dandurand shared the same concerns,¹⁸⁸ but he also testified he was concerned about the potential impact on the CF's position in the eventual litigation:

MR. FREIMAN: [...] Why does the NIS care whether there is litigation by an individual against the Canadian Forces?

MAJ DANDURAND: I don't.

MR. FREIMAN: [...] What was it about the fact of litigation that was inhibiting a presentation in the presence of counsel?

MAJ DANDURAND: Because my question at the time that I had posed, having never experienced this before, was; **is it my position as a Canadian Forces Officer to possibly compromise the Canadian Forces' position in preparation for civil litigation** through the process of a discussion that would otherwise perhaps occur during discovery.

MR. FREIMAN: Okay. So, if I understand correctly, your concern was **in your role as a Canadian Forces Officer, not in your role as an NIS investigator?**

MAJ DANDURAND: Correct.¹⁸⁹ [Emphasis added]

101. This illustrates the challenges faced by CFNIS members in maintaining strict independence while also being members of the broader CF organization.¹⁹⁰ In this instance, the dual membership may have created confusion for the CFNIS members about their role. This confusion and the desire to fulfill broader duties as members of the CF are understandable but dangerous. They can compromise the CFNIS' ability to foster confidence in its independence. In his testimony, Prof Roach explained:

[...] it is a challenge with respect to the military police to make sure that when they are within the core of police independence, that is, when they are exercising law enforcement discretion that they **put on their policing hat really to the exclusion of their Canadian Forces hat.**¹⁹¹ [Emphasis added]

102. When it comes to interacting with complainants, CFNIS members should not be wearing their CF hats.

103. The totality of the evidence does not establish the decision to cancel the briefing to the Fynes was motivated by a desire to protect the CF's interests. However, Maj Dandurand's testimony raises the possibility that the need to protect the CF's interests

was one of the factors considered in making the decision. This possibility, and the fact the CFNIS might be believed to have changed its behaviour in interacting with complainants because of the CF's interests, can diminish confidence in CFNIS independence.

Written briefing

104. The Fynes allege the written briefing provided in lieu of the cancelled briefing did not contain sufficient information and claim this was the result of CF influence or CFNIS concern over the CF's interests.¹⁹²

105. There is no evidence to support this allegation. The written briefing did contain insufficient information.¹⁹³ However, this was not the result of an attempt to protect the CF or of influence by CF members.

106. The initial draft for the briefing was prepared by Sgt Shannon, one of the CFNIS members involved in the investigations.¹⁹⁴ The draft letter was reviewed and approved by CFNIS HQ and then sent to the Fynes under Maj Dandurand's signature.¹⁹⁵ The evidence indicates the briefing was not reviewed by anyone outside of the CFNIS before it was sent to the Fynes.¹⁹⁶ The evidence also indicates the reasons for including so little detail in the briefing had nothing to do with the civil litigation or the CF's interests.¹⁹⁷ It was simply the result of Sgt Shannon's attempt to keep the correspondence simple and brief, pursuant to his understanding of the "typical rules" for drafting correspondence.¹⁹⁸

107. While the failure to provide more information in the written briefing was unfortunate for other reasons,¹⁹⁹ it is not evidence of a lack of CFNIS independence.

Joint CFNIS/BOI briefing and Col Blais communications

108. The Fynes allege the CFNIS agreed to participate in a common briefing about its investigations and the BOI.²⁰⁰

109. For obvious reasons, if such a briefing had been contemplated in this case, it could have impacted on the CFNIS' ability to maintain confidence in its independence. However, the Commission found no evidence a common briefing was ever planned or offered. There is also no indication the CFNIS ever agreed or intended to participate in

such a briefing. The only briefing offered to the Fynes by the CFNIS related solely to the CFNIS' own investigations.²⁰¹

110. It appears the Fynes' impression there was a plan to brief them on all major CF investigations at a common briefing may have arisen as a result of their communications with Col Blais, who had been named as the point of contact to answer their questions on behalf of the CF.²⁰² These communications included several discussions relating to the briefings or updates to be provided about the BOI, the SI and the CFNIS investigations.²⁰³ As the issues were discussed together,²⁰⁴ it may have appeared to the Fynes the briefings would also be joined. Fortunately, this impression turned out to be mistaken. However, the communications with Col Blais about CFNIS issues opened the door to creating this confusion about the CFNIS' role and involvement in other CF processes. In this, as well as in other respects, they were problematic in terms of maintaining confidence in CFNIS independence.

111. Col Blais acted as a conduit to provide information to the Fynes.²⁰⁵ He provided answers to a series of their questions about the CF's handling of the case in a single document.²⁰⁶ The answers had been obtained from various CF organizations, including the CFNIS.²⁰⁷

112. The end result of using this process was that information about the CFNIS' ongoing investigations into serious allegations of wrongdoing by the CF was provided to the Fynes through the CF itself and was included alongside responses setting out the CF's own position about the matters under investigation.²⁰⁸ These responses were provided by the CF organizations ultimately responsible for the CF members whose conduct was being investigated.²⁰⁹ This was not likely to assist in bolstering confidence in the CFNIS' independence.

113. Further, the Fynes were told by Col Blais that all responses, including those from the CFNIS, were being vetted by DND legal advisors prior to being provided to the Fynes.²¹⁰ In actual fact, only minor edits were made to the CFNIS answers.²¹¹ The edits did not alter the content of the information.²¹² They were done without the CFNIS' knowledge or consent.²¹³

114. Maj Dandurand testified it caused him “some concern” to learn the CFNIS’ answers were being edited or changed while being transmitted to the family.²¹⁴ Indeed, the CF should not be allowed to modify or influence in any way, however minor, the information provided by the CFNIS to complainants. This type of intervention impacted on the CFNIS’ ability to demonstrate its independence.

115. Overall, it is clear the appointment of Col Blais as a point of contact was only meant to assist the Fynes by simplifying their dealings with the CF. It was also in this spirit that the CFNIS agreed to participate in this process and provide answers through Col Blais about its investigations.²¹⁵ It should be kept in mind the CF is a large organization. The complainants were aware of this from their own experience, and they understood Col Blais would obtain the answers to their questions about the CFNIS investigations directly from the CFNIS.

116. Nevertheless, the global CF response received by the Fynes would not have made it clear to them the CFNIS’ processes were being kept separate, and information about its ongoing investigations was not being freely shared with those under investigation. The impression could have been created that the CFNIS was involved in preparing and presenting a common CF position about the issues even while it was supposed to be investigating them. This was especially the case since the Fynes were told CFNIS information was being vetted by the CF. At a minimum, the global response was liable to send the wrong message about the appropriate separation between the CFNIS and the CF.

Conclusions about communication with the complainants

117. There was no evidence to support allegations of CFNIS lack of independence in its communications with the Fynes. The decision to cancel the verbal briefing and the decision to communicate with the Fynes through Col Blais did, however, impact on the CFNIS’ ability to demonstrate its independence.

118. To avoid such situations in the future, it would be advisable for the CFNIS to maintain its own separate communications with complainants, particularly in cases where there is tension or conflict between the complainants and the CF. The CFNIS, as a police

service, should be mindful of its special status and make its own decisions about whether, when and how to communicate with complainants and about what information to provide.²¹⁶ Concerns over the CF's interests should not impact, nor be seen to impact, the CFNIS' decisions about such matters.

Release of the 2008 investigative file and the ATI process

119. The Fynes allege the CFNIS withheld information about their 2008 investigation into Cpl Langridge's death. They claim an overly redacted copy of the report for the investigation was provided to them without any specific or satisfactory explanation for the redactions.²¹⁷ They allege this was the result of CF influence or concern about the CF's interests.²¹⁸

120. The evidence before the Commission has revealed most of the decisions about the redactions applied to the copies of the 2008 investigation report provided to the Fynes were not made by the CFNIS. They were made by a separate DND organization, the Director of Access to Information and Privacy (DAIP).²¹⁹ This was done pursuant to the usual process in place to address all requests for access to information or documents in the possession of any CF organization, including the MP.²²⁰ This process still applies today.²²¹

121. It is clear there is no sinister intent behind this process. It is simply a delegation of authority to the DAIP to make decisions about the application of access to information and privacy legislation to all requests for the release of DND or CF information.²²² There are similar processes in place in most other Government departments.²²³ However, when applied to decisions about the release of CFNIS information, this process raises police independence concerns.

122. The most important concern is that the process in place does not allow the CFNIS to make final decisions about what information needs to be redacted to protect its ongoing investigations or police methods. The CFNIS can identify such information and recommend it not be released, but it does not have the authority to make the final decision.²²⁴ While, in practice, the CFNIS' recommendations have been followed by

DAIP and no issue has arisen,²²⁵ the framework in place does not give the CFNIS the necessary authority to make final decisions to protect its investigations and law enforcement activities. As such, the process creates risks for the CFNIS' independence as it allows a separate DND organization to make decisions, which could impact on the conduct of its core policing functions.²²⁶

123. Another important concern is the impact on the CFNIS' ability to demonstrate its independence. Pursuant to the process in place, DAIP is free to add more redactions than those recommended by the CFNIS.²²⁷ In such cases, no consultation occurs, and the CFNIS is generally not even aware of the final redactions applied to its reports before they are released.²²⁸

124. This case illustrates the concern well. When the Fynes complained to the CFNIS about the redactions made to the investigation report, the CFNIS members could neither explain nor change the redactions. They could only tell the Fynes those decisions were not made by the CFNIS.²²⁹ DAIP had applied extensive redactions, many difficult to understand or justify, on the basis of its own determination about what information was not necessary or not in the family's interest to receive.²³⁰ Those determinations were made without consulting the CFNIS or the family.²³¹

125. It is incongruous, especially in a case involving allegations of institutional wrongdoing by the CF, for the police force in charge of investigating those allegations to have to tell the complainants the CF or DND is making decisions about what parts of the police report can be disclosed to them. This can create the impression the institutions under investigation have an opportunity to hide information about the investigations from the complainants. The Fynes certainly were under the impression information was being deliberately withheld.²³² While there is no evidence any of the redactions were, in fact, made for the purpose of covering up information or protecting CF interests, and the Commission has found they were not,²³³ the process in place can diminish confidence in CFNIS independence.

126. MP and CFNIS witnesses who testified before the Commission had different views about the impact of the process on CFNIS independence. Some witnesses believed

no concerns arose,²³⁴ while others saw potential issues, at least in terms of maintaining confidence in CFNIS independence, but believed any problems could be addressed in practice by entering into discussions with DAIP on a case-by-case basis.²³⁵

127. There were internal discussions about the possibility of allowing the MP to assume control over the release of its own information, but the issue was never addressed in formal discussions between the MP and CF/DND leaderships.²³⁶ The application of access to information and privacy legislation is complex, and there would be significant resource implications and risk management issues if the MP were to take over decision-making authority over the release of their information.²³⁷ As a result, MP and CFNIS leaderships decided to “pick [their] battles” and did not pursue the issue by way of a formal proposal to CF leadership because it was not seen as giving rise to serious issues in practice.²³⁸ However, the experience in this case shows issues can and do arise.

Conclusions about release of CFNIS information

128. The official process currently in place allows a non-police organization to overrule the redactions recommended by the MP to protect ongoing investigations or police methods. Although this does not appear to have happened in practice, the process itself is not compatible with police independence principles. At a minimum, the MP should have final decision-making authority to refuse to release its information where it believes release could compromise its core law enforcement functions.

129. In order to foster confidence in its independence, it would also be preferable for the MP to have the authority to make its own decisions about the release of its information in all cases.²³⁹ This will be particularly important where the request is made by complainants or victims who have a direct relationship with the MP or CFNIS. The Commission recognizes the difficulties involved for both the MP and the CF/DND. Because of the complexity of the matter and the potential resource implications, high level discussions between the MP and CF/ DND leaderships would be necessary to address the issues.

Public affairs

130. As part of their complaints alleging the CFNIS “participated in broader CF efforts to provide explanations and justifications in response to the complainants’ concerns,” the Fynes take issue with CFNIS participation in public affairs coordination with the CF.²⁴⁰

131. The manner in which messages about the CFNIS’ activities are conveyed to the public can have a significant impact on confidence in CFNIS independence, which can, in turn, impact on the CFNIS’ ability to carry out its policing functions.

132. If the CFNIS is not seen to be in control of the information and messages released about its investigations, if it is believed to be “speaking with one voice” with the military institutions it is charged to investigate, or if the military is believed to control the information provided to the public about CFNIS investigations, confidence in CFNIS independence will be diminished.²⁴¹

Release of CFNIS information to the public: who decides?

133. The evidence in this case has shown, in practice, it was generally the CFNIS who decided what information would be released about its investigations. This information was often released through the CFNIS’ own Media Response Lines (MRLs), which were prepared by the CFNIS Public Affairs Officer (PAO) and approved by the CFPM.²⁴² When information about CFNIS investigations or activities was included in CF MRLs, the CFNIS PAO was consulted.²⁴³

134. The evidence has also shown the CFNIS was consulted and was involved in the coordination of the CF’s public affairs response to the Fynes matter, both after its first investigation was concluded and while its two subsequent investigations were ongoing.²⁴⁴ This, in itself, would not necessarily raise police independence concerns. Exchanging information about what information each organization plans to release is not inappropriate, and there is no indication the CFNIS was obliged even to provide this information in cases where this could compromise an investigation.

135. The problem that can arise with consultation and coordination about public relations is, depending on how the consultations are done, they could risk creating the impression the CF is controlling the message for its police force.

136. In this case, the consultations were extensive. They involved significant time and resources devoted to discussing messages and approach.²⁴⁵ According to the evidence, this was not unusual.²⁴⁶ Coordinated efforts involving the CF and the CFNIS happened “extremely often” in the preparation of media responses.²⁴⁷ One of the goals was to ensure the different sections of the CF, including the CFNIS, did not contradict each other when providing information.²⁴⁸

137. The coordination and consultations in this case occurred among the PAOs for the different CF organizations involved, including the CFNIS PAO.²⁴⁹ While final products required approval by the CFNIS CoC and the CFPM, the process relied entirely on the PAOs to identify and report any issues impacting on CFNIS independence. According to the witness testimony, had there been disagreements between the PAOs about information or lines related to the CFNIS, the CFPM would have been advised, and the issue could have been resolved at that level and discussed with the VCDS if necessary.²⁵⁰

138. However, there was no official framework or policies governing the consultations. While many witnesses spoke of a general practice requiring CF PAOs to consult with the CFNIS before releasing any information about CFNIS investigations or activities,²⁵¹ no one could point to any CF policy or directive formalizing this arrangement.²⁵² Similar to what was done in the ATIP process, issues were dealt with on a case-by-case basis.²⁵³ This meant, although in practice other CF organizations tended to defer to the CFNIS’ decisions about the release of its information most of the time,²⁵⁴ they had no actual obligation to do so. Because this requirement was not formalized, the CFNIS’ ability to make decisions about its messages was not protected.

139. The overall result of this informal consultation and coordination process was that it risked creating the impression the CF was in control of all messages and the CFNIS was participating in delivering a unified message in service of a public relations strategy devised to protect the CF’s interests. This was precisely the impression formed by the

Fynes in this case.²⁵⁵ Although the evidence does not indicate it was, in fact, what the CFNIS did, having clear and transparent policies would minimize the risk of creating such perceptions, which can be seriously damaging to any attempt to foster confidence in CFNIS independence.

Who should be the messenger?

140. Having spokespersons from the CF speak on behalf of the CFNIS can also give rise to concerns in terms of the CFNIS' ability to demonstrate its independence. It is difficult to send the appropriate message about the separation between the CF and the CFNIS if they are seen to speak on each other's behalf.

141. In this case, the appropriate separation was often not maintained. The CFNIS was generally consulted about the information to be released about its investigations, but it was not always the messenger. CFNIS messages were often included in global CF MRLs or public statements and ended up being delivered to the public by CF spokespersons.²⁵⁶ When the CF became aware of the potential for litigation and the case began to attract more media attention, the PAOs for the legal side had "the lead," meaning they were in charge of collating the information from different CF organizations, including the CFNIS, and responding to media inquiries.²⁵⁷ Even the CFPM's official public apology for the failure to disclose the suicide note was not delivered directly but was included in a statement by the CDS made on behalf of the CF as a whole.²⁵⁸

142. The former CFNIS CO, LCol (Ret'd) William Garrick, testified it was not a usual or appropriate practice for the CFNIS to participate in joint briefing packages or media lines with the CF, as the CFNIS would generally do its own media lines.²⁵⁹ Maj Dandurand indicated the CFNIS would generally have the lead on public affairs matters where there are ongoing investigations.²⁶⁰ However, he also testified the appropriateness of including CFNIS messages in CF-wide briefings or MRLs would still be determined on a case-by-case basis.²⁶¹ In this case, the CFNIS did participate in common responses while investigations were ongoing, and it did not always have the lead on the responses.

143. The CFNIS also, on occasion, included messages solely related to protecting the CF's interests or reputation in its own media lines. The "key message" stating "[t]he Department of National Defence and the Canadian Forces care deeply about its personnel and their families and aspires to treat all members of the CF family with respect" was included in CFNIS MRLs, including the draft MRLs prepared following the conclusion of the 2009 and 2010 investigations.²⁶² This message was unrelated to the CFNIS' investigations or activities.²⁶³ As Maj Dandurand testified, it reflected "my Canadian Forces' hat as opposed to my military police hat."²⁶⁴ This is precisely what can cause concern in terms of maintaining confidence in CFNIS independence. For the CFNIS to deliver a general message about the CF's conduct in all cases could give the impression the CFNIS has pre-conceived ideas about the CF and about any allegations of institutional misconduct by the CF it is asked to investigate.

144. From the evidence, it is clear there was no nefarious intent on the part of any of the PAOs or CF and CFNIS CoC members. Joint MRLs and statements were prepared as a matter of course, because the case involved many different CF issues, and efforts were made, in practice, to ensure the CFNIS retained control over messages about its activities, even when the messages were being delivered by the CF. However, in terms of fostering confidence in CFNIS independence, this practice was problematic.²⁶⁵ It risked creating the perception the CFNIS was participating in a coordinated CF effort to convey certain messages.²⁶⁶ Further, it opened the door for messages conveying the CF's own position about the matters under investigation to be included in media lines or public statements alongside messages from the CFNIS, which created a risk the CFNIS would be seen as endorsing the CF's positions even while it was still investigating the issues.

CF comments about matters under investigation

145. Another question before the Commission is whether the CF high command's own separate messages or comments about matters under investigation by the CFNIS can have an impact on confidence in CFNIS independence.

146. In this case, while the CFNIS' 2009 and 2010 investigations were still ongoing, the CDS wrote a letter to the editor, published in the *Edmonton Journal*, which contained comments about some of the issues being investigated.²⁶⁷ He wrote:

The case of Cpl. Stuart Langridge is a tragedy that affects us all. Canadian Forces (CF) personnel who suffer from mental health conditions deserve the best possible care, indeed the same high standards of support as if they suffered physical injury. **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. Last week I apologized for the mishandling of communications with the family of Langridge. **I was not apologizing for the comprehensive medical care he received from some of the finest civilian and military practitioners the country has to offer, nor for the CF's actions to respect and fulfil his last will and wishes.** The CF has a caring medical system focused on supporting and rehabilitating those who serve their country so valiantly, along with the families that support them. We will continue to improve. A death diminishes us all, no matter what the circumstances. It is my duty to care for the sons and daughters of Canada -- a duty I take seriously.²⁶⁸ [Emphasis added]

147. The CFNIS did not participate in preparing or issuing these comments, and the evidence clearly shows the comments had no impact on the CFNIS' conduct of the investigations or the ultimate conclusions reached.²⁶⁹ However, a concern arises in terms of the perception which can be created, because the CFNIS, as an organization internal to the CF, is subject to the CDS' overall authority. As such, there is a potential risk the CDS' comments could be viewed as being made not only on behalf of the CF organization being investigated but also on behalf of the internal police force conducting the investigations. There may even be a risk for the comments to be viewed as either directing or influencing the CFNIS members involved in the investigations.

148. That being said, the CF is entitled to present its own positions to the public about matters under investigation.²⁷⁰ The CFNIS is not responsible for the public comments the CF chooses to make. It does not have the authority to prevent public comment by the CF high command. Nor would it be reasonable to expect such comments to be prohibited in the name of police independence,²⁷¹ especially in a case like this one, where the Fynes made public comments and allegations about the conduct of the CF and its members, and the CF was entitled to respond publicly.²⁷²

149. In fact, if the independence safeguards put in place continue to function properly, it should be expected public comments about matters under investigation by the CF high command will continue to be made from time to time, as the CDS' office will not be aware of the exact scope of each investigation carried out by the CFNIS and may well comment on certain matters without knowing they are under investigation.

150. The best way for the CFNIS to minimize the risk of creating negative perceptions when such comments are made by the CF is to ensure its participation in public relations coordination with the CF is appropriately limited and its messages are delivered separately from any CF messages. If this is done consistently, there will be less risk for the CF's comments to be viewed as being made on behalf of the police force and less confusion about the role and perspectives of the different organizations.

Conclusions about public relations coordination

151. The evidence does not support a conclusion that the CFNIS participated in efforts to present the CF's perspective to the public. There is no evidence the CF exerted any control or influence over the CFNIS' messages, nor is there any evidence the CFNIS modified its messages about its investigations to serve the CF's interests or public relations strategy.

152. However, the coordination that took place, the lack of formal processes to frame the discussions, and the manner in which messages were delivered all contributed to creating perceptions detrimental to maintaining public confidence in CFNIS independence.

153. As suggested by Prof Roach, it would be preferable for consultations about public relations to occur at a higher level.²⁷³ This would help ensure they are more transparent and involve officials who are accountable and have an understanding of the requirements of police independence.²⁷⁴ Having clear policies governing such matters, rather than relying on a general practice, which may or may not be known or adhered to by all CF PAOs, would also provide more effective safeguards.²⁷⁵

154. The CFNIS should deliver its own messages to the public, separately from the CF.²⁷⁶ If the CFNIS is careful not to speak on behalf of the CF and is careful not to allow the CF to speak on its behalf, a clearer demonstration of its independence will be provided.

LEGAL ADVICE

155. In their complaint before this Commission, the Fynes specifically refer to the role of CF legal advisors and allege they participated in influencing the CFNIS' decisions, in particular about their contacts with the complainants.²⁷⁷

156. The basic issue raised by this allegation is whether consultation by the CFNIS of legal advisors who are members of the CF, and who answer to a CoC separate from the Military Police's, raises issues about independence.

157. As Prof Roach explained, if the advice is obtained from military or civilian prosecutors, no concerns are raised since these actors have duties to uphold the rule of law similar to the police's duties.²⁷⁸ If advice was sought from CF legal advisors who are not prosecutors or from DOJ counsel representing the interests of the Government, independence issues could arise, depending on the content of the advice.²⁷⁹

158. There is very little evidence before this Commission about specific legal advice received by the CFNIS in connection with the issues raised in the Fynes' complaint.²⁸⁰ Because of solicitor-client privilege, it cannot be known exactly what advice was obtained and from whom.²⁸¹ However, the evidence has shown the general practice followed by the CFNIS is to obtain legal advice from military prosecutors or from its embedded legal advisor, who is also a member of the JAG's Director of Military Prosecutions.²⁸² There is no indication any derogation from this practice took place in this case. Based on the evidence available, it does not appear any independence concerns arise as a result of any legal advice sought or obtained by the CFNIS.

159. Questions were raised during the hearing about the possibility inappropriate legal consultations might have taken place. In an affidavit filed before the Commission, DND/CF Ombudsman Investigator Patrick Martel stated he was told by the CFNIS

members involved in the 2009 investigation they had received advice from LCol King respecting certain issues relevant to the investigation.²⁸³ LCol King is not a member of the prosecution service.²⁸⁴ He was directly involved in providing advice to the CF about the case in his role as legal advisor to the BOI and the SI, and he was directly involved in representing the CF in litigation discussions with the Fynes' counsel.²⁸⁵ He had also been identified as a potential suspect in the 2009 investigation.²⁸⁶ Had advice been sought from him by the CFNIS during the conduct of the investigation, it certainly could have raised concerns. However, the evidence clearly established no such advice was, in fact, ever sought or obtained.²⁸⁷ It appears Mr. Martel's belief such contact had occurred was simply the result of a misunderstanding.²⁸⁸

CFNIS IMPARTIALITY AND ALLEGATIONS OF SYSTEMIC BIAS

160. The Fynes believe the CFNIS investigations were biased. They make a number of general complaints alleging the investigations were aimed at exonerating the CF and attacking Cpl Langridge's character.²⁸⁹ They also specifically allege the 2008 investigation findings were inaccurate and biased, and they claim the information obtained during that investigation was not selected in an objective and impartial manner.²⁹⁰ They complain the CFNIS members allowed their initial investigation to be "tainted" by meetings with CF members even before attending the scene of Cpl Langridge's death and provided inaccurate information to the ME about Cpl Langridge's disciplinary status.²⁹¹ They further allege inaccurate statements were made about Cpl Langridge's place of residence for the purpose of exonerating the Regiment CoC.²⁹²

161. Having studied a large body of testimony and documentation, the Commission is convinced the totality of this evidence does not support the allegations of bias on the part of the CFNIS members involved in the investigations. Deficiencies in all of the investigations conducted are detailed elsewhere in this report. These deficiencies were, for the most part, related to inexperience, faulty assumptions and inadequate supervision.²⁹³ However, the evidence has shown the CFNIS members all sought to complete their tasks to the best of their ability. Although they did not always succeed, it is clear they had no intent to cover up anything. The Commission saw no evidence

indicating any dishonesty or inappropriate motivations on the part of any of the CFNIS members involved in the investigations.

162. Further, the evidence has revealed many of the events did not happen as the Fynes believed they had.

163. It is clear there was no meeting with members of the LDSH Regiment prior to attending the scene of Cpl Langridge's death.²⁹⁴ Thus, there was no opportunity for the investigation to be tainted as alleged by the Fynes.²⁹⁵ Contrary to the Fynes' belief, there is no evidence the CFNIS members who attended at the scene had any preconceived views about Cpl Langridge, nor were they subsequently influenced by any CF views of Cpl Langridge as a "defaulter."²⁹⁶

164. The information provided to the ME about Cpl Langridge's possible status as a defaulter was also not a manifestation of any bias on the part of the CFNIS members. When they arrived at the base following Cpl Langridge's death, the investigators obtained information from local MP members indicating Cpl Langridge may have been on defaulters²⁹⁷ and then discussed this information with the ME investigator.²⁹⁸ They made it clear the information was not confirmed.²⁹⁹ When the ME investigator inquired about the meaning of the term "defaulters," the CFNIS members provided explanations.³⁰⁰ The ME investigator testified he interpreted this as meaning Cpl Langridge had disciplinary issues and, as a result, mentioned this in his report.³⁰¹ This led to a notation in the ME Certificate indicating Cpl Langridge "had disciplinary issues," to which the Fynes took great offence.³⁰²

165. It is very clear, however, this mention was not the result of any inappropriate action by the CFNIS or its members. It was entirely appropriate for the investigators to provide the ME investigator with all information available to them at the time. They never indicated Cpl Langridge had disciplinary issues, and they made it clear the information about Cpl Langridge potentially having been on defaulters was unconfirmed. The lead investigator subsequently provided clarification to the ME investigator indicating Cpl Langridge was "free to come and go" and not under official "formal custody."³⁰³

166. Similarly, the CFNIS members did not make inaccurate statements about Cpl Langridge's place of residence for the purpose of exonerating the Regiment CoC as alleged by the Fynes.³⁰⁴ During his second meeting with the Fynes, MCpl Mitchell did discuss his belief, based on his initial review of the SI materials, Cpl Langridge resided at the Duty Desk only for a few days after he returned from the hospital until a room could be made available for him in the barracks.³⁰⁵ This information was not accurate. However, it is clear MCpl Mitchell's statements were simply based on an honest misunderstanding and not made with any sinister intentions or bias.³⁰⁶ MCpl Mitchell made it clear during the meeting he intended to verify the information found in the SI materials and was not relying on it to draw conclusions about Cpl Langridge's place of residence or any other issue.³⁰⁷

167. Mrs. Fynes testified she believed there was more discussion about the issue of her son's place of residence than what is found on the recordings of the interview that are in evidence before this Commission.³⁰⁸ However, the evidence has refuted the allegation the recordings of the interview had been tampered with or were incomplete.³⁰⁹ As such, the Commission finds the transcript in evidence contains all of the exchanges with MCpl Mitchell about Cpl Langridge's place of residence. These exchanges do not indicate any bias on MCpl Mitchell's part, nor any intent to misrepresent or conceal information.

168. Likewise, the use of a former address for Cpl Langridge in the "entities" section of the 2008 GO file was not the result of any intention to attack Cpl Langridge's reputation or to exonerate the CF.³¹⁰ The evidence indicates the notation resulted from information previously entered in the system used by the MP.³¹¹

169. It appears the Fynes had doubts about the CFNIS' impartiality from the beginning.³¹² They did not believe CF members could investigate other CF members objectively.³¹³ In some instances, the approaches adopted by CFNIS members during the course of the investigations may have contributed to reinforcing those doubts.

170. One example is the apparent difference in tone and approach for the interviews of higher ranking members of the Regiment during the 2008 investigation.³¹⁴ For interviews with members of a lower rank, the witnesses were addressed by their first name, the

interviews were conducted at the CFNIS Detachment, and the interviews were longer and more detailed.³¹⁵ By contrast, the interviews with the Regimental Sergeant-Major, CWO Douglas Ross, and with the Acting Base Surgeon, Capt Richard Hannah, were shorter and less detailed, the witnesses were addressed as “Sir,” and the interviews were conducted in their offices.³¹⁶

171. Other examples include: the apparent failure of the CFNIS investigators to question, in a more searching, in-depth or critical manner, the decisions or statements made by the Regiment CoC, or as Mr. Fynes put it, the CFNIS’ apparent willingness to accept “cursory explanations [...] without any further inquiry” despite obvious contradictions;³¹⁷ the CFNIS members’ apparent difficulty in understanding and investigating how negligence by the Regiment could have occurred in this case;³¹⁸ the CFNIS’ failure to obtain medical records and interview medical personnel from civilian hospitals, limiting information available about Cpl Langridge’s condition and treatment to military medical records and the views of military medical personnel;³¹⁹ the CFNIS’ formulation of the Concluding Remarks for the 2008 investigation, which were not supported by the evidence, and which the Fynes believed were biased and “spoke to a mind-set that was exculpatory for the military and passing blame to the victim”;³²⁰ and the modification by CFNIS supervisors of the Case Summary for the 2008 investigation to remove most mentions of the investigation of the suicide watch issue, which the Fynes alleged demonstrated the CFNIS was involved in a “cover up.”³²¹

172. These various circumstances might have left the Fynes with the impression the CFNIS members were concerned with maintaining good relations with the chain of command, or “not rocking the boat,” further confirming the Fynes’ initial perception about the CFNIS’ predispositions. However, while these deficiencies in the CFNIS investigations were unfortunate and have been addressed in detail elsewhere in this report,³²² there is absolutely no evidence indicating they were caused by any bias on the part of the investigators.

Conclusion

173. The allegations of bias and lack of independence made in this case are not supported by the evidence. The Commission found no attempt by the CF or its legal advisors to influence the conduct of the CFNIS investigations. The CFNIS was capable of conducting independent investigations in this case and did conduct these investigations. The decisions made by the CFNIS members about the conduct of the investigations, and the ultimate conclusions they reached, were not influenced by the CF or the CF's interests. The subjects of the complaint acted honestly and attempted to conduct impartial investigations to the best of their ability. There is no evidence they ever took or failed to take any investigative step for the purpose of exonerating the CF or attacking Cpl Langridge's character.

174. However, the evidence has also demonstrated some of the events in this case did raise concerns about the CFNIS' ability to demonstrate its independence. In particular, some of the policies and practices in place leave the door open for CF influence to be exercised or for suspicions it has been. To continue to protect their independence and to foster public confidence in the MP, CFNIS and MP leadership must address the issues identified and must ensure policies and practices allow them both to act independently and be seen to act independently.

175. This case, and in particular the allegations of bias and lack of independence made by the Fynes, should be viewed as a caution flag for the CFNIS. Being an internal police force, there will always be a risk the CFNIS will be perceived by complainants as being predisposed to favour CF interests. This risk will be particularly acute where complainants bring forward allegations implicating the CF CoC or challenging the CF's institutional positions. In such cases, complainants are likely to be already significantly suspicious of the CF and its members, as was the case for the Fynes. As such, it will be important for the CFNIS, in order to gain the complainants' trust, to conduct vigorous investigations, which will dispel any suspicion they may be biased or predisposed to advance CF interests.

176. On the basis of the evidence, it appears CFNIS members receive strong indoctrination and training on the need to conduct robust investigations into individual behaviour by CF members regardless of rank or position.³²³ From their testimony before this Commission and the examples they provided, this ethos appears to have been deeply ingrained in the CFNIS members.³²⁴

177. However, it is not as clear the particular importance of conducting especially vigorous investigations into allegations attacking the CF's institutional decisions has been equally ingrained. In order to ensure allegations are brought forward without fear by complainants who are at odds with the CF as an institution, it is important for the CFNIS to be able to demonstrate such allegations will be investigated to the fullest, and official CF decisions will be critically examined and questioned by the CFNIS. In this respect, it can certainly be said the investigations in this case could have been more complete and rigorous.³²⁵ Although this failure did not result from any bias or lack of independence, it did have the impact of further fuelling the Fynes' suspicions, concerns and fears.

¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 1-13, pp. 1-3.

² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 1-2 and 11-13, pp. 1-3; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 196; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85, 89-90, 96-97 and 207-208; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 103-104; Closing Submission of the Complainants, pp. 65 and 79-80.

³ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 2, p. 1; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 200 and 212-213; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 96-97; Closing Submission of the Complainants, pp. 68 and 79-80.

⁴ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 5.

⁵ See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.

⁶ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 1, p. 1.

⁷ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 62; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 139; Closing Submission of the Complainants, pp. 49, 57-60 and 78.

⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 11 and 12, p. 2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85, 96-97 and 207-208; Closing Submission of the Complainants, pp. 65, 72, 85 and Prologue, p. 6.

⁹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13, pp. 2-3. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 86-87, 89-90 and 96-97; Closing Submission of the Complainants, pp. 67-68 and 72-74.

¹⁰ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 1 and 2, p. 1.

¹¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 3, 5 and 8, pp. 1-2.

¹² See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 196-197 and 212; Closing Submission of the Complainants, pp. 28 and 61.

¹³ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 103; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85. See also Closing Submission of the Complainants, pp. 16-17 and 27-28.

¹⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 96.

¹⁵ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 212.

¹⁶ See Final Submissions of the Subjects of the Complaint, pp. 98-100; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 191-192; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 75-78; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, pp. 192-194; Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 309-311 and 318-320; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 282-284, 298-299 and 303; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 268-271; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 173-176; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 154-155; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 196-198; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 12-16; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 88-89; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 203-204; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 95-96. See also Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 343-344.

¹⁷ See Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 193; Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 196-197.

¹⁸ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 319; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 282-283; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 269-270; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 154-155.

¹⁹ Testimony of MWO Tourout, Transcript of Proceedings, vol. 54, 27 September 2012, pp. 196-197.

²⁰ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 15-16; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 65-67; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 262-263; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 95-96 and 102-103; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 155; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 19; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 280-282 and 343-344; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 78.

²¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 75.

²² Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, p. 299.

²³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 16.

²⁴ See Exhibit P-176, doc. 1435, p. 2; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 6-7.

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- ²⁵ Exhibit P-176, doc. 1435, p. 2.
- ²⁶ See Exhibit P-176, doc. 1435, pp. 3 and 7; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 11.
- ²⁷ Exhibit P-176, doc. 1435, pp. 2-3; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 11.
- ²⁸ Exhibit P-176, doc. 1435, pp. 2-3; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 10-11.
- ²⁹ See Exhibit P-176, doc. 1435, pp. 2-3, 7, 10-11 and 13; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 10-11 and 13-14.
- ³⁰ Exhibit P-176, doc. 1435, pp. 7, 10-12 and 14; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 13-14 and 45.
- ³¹ See Exhibit P-176, doc. 1435, pp. 9-14; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 7 and 10-12.
- ³² Exhibit P-176, doc. 1435, p. 3.
- ³³ See Exhibit P-176, doc. 1435, pp. 3 and 36; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 9-11, 17, 19 and 55.
- ³⁴ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 8-10, 16-17, 24 and 57. See also Exhibit P-176, doc. 1435, pp. 22-24 and 35.
- ³⁵ See Exhibit P-176, doc. 1435, pp. 3, 22-23 and 34.
- ³⁶ See Exhibit P-176, doc. 1435, pp. 3 and 46; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 8.
- ³⁷ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 66-68; Exhibit P-176, doc. 1435, pp. 3-4, 24-28 and 33-34.
- ³⁸ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 12-15, 19-22, 24, 29, 36, 39-42, 45 and 57.
- ³⁹ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 12, 22 and 46-47.
- ⁴⁰ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 24 and 39.
- ⁴¹ See Exhibit P-75, tab 2, doc. 1087-K, pp. 3-5; Exhibit P-147, tab 1, doc. 1422, p. 55; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 232-234.
- ⁴² See Exhibit P-147, tab 1, doc. 1422, pp. 53 and 55; Exhibit P-103, p. 3; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 239-240.
- ⁴³ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 427-1023, 1025 and 1037-1040; Exhibit P-70, doc. 1358; Exhibit P-71, doc. 1087-I; Exhibit P-103; Exhibit P-104; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 126-130; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 120-121 and 184.
- ⁴⁴ Exhibit P-75, tab 2, doc. 1087-K, pp. 3 and 5.
- ⁴⁵ See Exhibit P-75, tab 2, doc. 1087-K, p. 3; Exhibit P-4, Collection D, vol. 3, tab 53, doc. 251; Exhibit P-4, Collection D, vol. 11, tab 76, doc. 1000, pp. 10-13, 17-18 and 21-23; Exhibit P-4, Collection D, vol. 4, tab 96, doc. 394; Exhibit P-4, Collection D, vol. 4, tab 63, doc. 361; Exhibit P-4, Collection D, vol. 4, tab 62, doc. 360; Exhibit P-4, Collection D, vol. 4, tab 60, doc. 358; Exhibit P-4, Collection D, vol. 1, tab 48, doc. 045. See also, Testimony of LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 138-139 and 151-153; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 15-16 and 85-86.

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- ⁴⁶ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 28 and 221; Section 4.3, The 2009 PNOK Investigation.
- ⁴⁷ See Exhibit P-102, doc. 1390, pp. 24-25 and 28-30.
- ⁴⁸ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1037 and 1039-1040; Exhibit P-75, tabs 1-5, doc. 1087-J to 1087-N; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 121-124 and 179-180; Exhibit P-102, doc. 1390, pp. 17-30.
- ⁴⁹ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 38-39. See, generally, Exhibit P-176, doc. 1435, pp. 53-54; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 17 and 37.
- ⁵⁰ See Closing Submission of the Complainants, pp. 57-59 and 61.
- ⁵¹ Exhibit P-147, tab 1, doc. 1422, p. 55; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 233-234 and 256.
- ⁵² Exhibit P-147, tab 1, doc. 1422, p. 53.
- ⁵³ Exhibit P-147, tab 1, doc. 1422, p. 55.
- ⁵⁴ Exhibit P-147, tab 1, doc. 1422, p. 55.
- ⁵⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 236-237, 240-241, 251-252 and 255-257.
- ⁵⁶ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, p. 256.
- ⁵⁷ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 256-257.
- ⁵⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 256-257.
- ⁵⁹ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 81-82.
- ⁶⁰ Exhibit P-103, p. 3; Exhibit P-147, tab 1, doc. 1422, pp. 53 and 55; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 239-240.
- ⁶¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 239-240, 251-252 and 255-257.
- ⁶² See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 27 vs. Exhibit P-75, tab 2, doc. 1087-K, pp. 3-5 and Exhibit P-70, doc. 1358, pp. 8-10 and 28-31; Exhibit P-103; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 243-250.
- ⁶³ See Exhibit P-103, p. 3; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 241-243; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 518; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 27 and 286.
- ⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 250-251.
- ⁶⁵ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 105-106.
- ⁶⁶ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 427-1023, 1025 and 1037-1040; Exhibit P-70, doc. 1358; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 126-130; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 120-121 and 184.
- ⁶⁷ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 429-1022; Exhibit P-71, doc. 1087-I; Exhibit P-103; Exhibit P-104; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 127.
- ⁶⁸ See Exhibit P-70, doc. 1358, pp. 3-5; Exhibit P-103; Exhibit P-104.
- ⁶⁹ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 1037 and 1039-1040; Exhibit P-75, tabs 1-5, doc. 1087-J to 1087-N; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 121-124 and 179-180; Exhibit P-102, doc. 1390, pp. 17-30.

⁷⁰ Exhibit P-102, doc. 1390, pp. 28-30.

⁷¹ Exhibit P-102, doc. 1390, p. 24.

⁷² Exhibit P-102, doc. 1390, p. 25.

⁷³ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 126-127; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 167, 171-175, 182-184 and 217; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 61-62; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 110; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 40-41.

⁷⁴ See Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 171-175, 180-182 and 217.

⁷⁵ See Exhibit P-176, doc. 1435, p. 54; Section 4.3, The 2009 PNOK Investigation; Exhibit P-75, tab 2, doc. 1087-K, pp. 3-4; Exhibit P-70, doc. 1358, pp. 8-10 and 28-31.

⁷⁶ Testimony of LCol MacGregor, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 2-5.

⁷⁷ Testimony of LCol MacGregor, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 59-60 and 143.

⁷⁸ Testimony of LCol MacGregor, Transcript of Proceedings, vol. 44, 10 September 2012, pp. 143-144.

⁷⁹ Testimony of LCol MacGregor, Transcript of Proceedings, vol. 44, 10 September 2012, p. 144.

⁸⁰ See Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 42-45; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 182-184.

⁸¹ Exhibit P-176, doc. 1435, p. 54; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 37-38.

⁸² See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 8-10.

⁸³ See, for example, Exhibit P-103, pp. 1, 5 and 6.

⁸⁴ See Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 127-132.

⁸⁵ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 222-223, 1348-1350 and 1351-1357; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 88-93 and 132-133; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 130, 158-160 and 194-197; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 134-136; Section 4.3, The 2009 PNOK Investigation; Exhibit P-70, doc. 1358, pp. 3-5. Of the 18 SI witnesses, approximately 10 to 13 had information relevant to the matters investigated by the CFNIS: see Exhibit P-70, doc. 1358, pp. 3-5 and Exhibit P-103.

⁸⁶ Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 130, 158-160 and 194-197; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 134-136. See, generally, Section 4.3, The 2009 PNOK Investigation.

⁸⁷ See Section 4.3, The 2009 PNOK Investigation.

⁸⁸ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 301-406; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 38 and 171; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 1-3; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 223-224; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 183-184; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 120-121.

⁸⁹ Testimony of Maj Parlee, Transcript of Proceedings, vol. 14, 24 April 2012, pp. 17-18 and 198-199.

⁹⁰ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 302; Exhibit P-4, Collection D, vol. 3, tab 53, doc. 251; Exhibit P-4, Collection D, vol. 11, tab 76, doc. 1000, pp. 10-13, 17-18 and 21-23; Testimony of

LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, p. 143; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 15-16.

⁹¹ See Exhibit P-4, Collection D, vol. 4, tab 25, doc. 323, pp. 3-4; Section 4.3, The 2010 Criminal Negligence Investigation. See, generally, Exhibit P-176, doc. 1435, p. 54.

⁹² Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 131-132; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, p. 77.

⁹³ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 71-72 and 114-115; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 76-78; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 119, 125-126 and 130-132; Exhibit P-4, Collection D, vol. 9, tab 71, doc. 795, p. 1.

⁹⁴ See Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, p. 171; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 23.

⁹⁵ Closing Submission of the Complainants, pp. 49 and 60.

⁹⁶ See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 62.

⁹⁷ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 139.

⁹⁸ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 139.

⁹⁹ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 3, p. 1; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 11-15, 115-118 and 123-129; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 200.

¹⁰⁰ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 71-72 and 114-115; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 76-78; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 119, 125-126 and 130-132; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 136-139; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 76.

¹⁰¹ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 139.

¹⁰² See Section 4.4, The 2010 Criminal Negligence Investigation.

¹⁰³ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42-43, 130 and 133-134.

¹⁰⁴ See Exhibit P-5, Collection E, vol. 5, tab 11, doc. 1233, pp. 525-530 and 534-535.

¹⁰⁵ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 352 and 384.

¹⁰⁶ See Section 4.4, The 2010 Criminal Negligence Investigation.

¹⁰⁷ See Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 171-172; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 1-3; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 183-184; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 115-122, 154-161 and 169-213; Section 4.4, The 2010 Criminal Negligence Investigation.

¹⁰⁸ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 110, 224, 231 and 249; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 225-233 and 238-240 [Translation]. But see Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 149, for a contrary view.

¹⁰⁹ See Final Submissions of the Subjects of the Complaint, pp. 38 and 101-102.

¹¹⁰ See Section 4.4, The 2010 Criminal Negligence Investigation; Section 2.0, The Hearing Process.

¹¹¹ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 171-172; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 1-3; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 183-184; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 120-121.

¹¹² See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 223-224; Section 4.4, The 2010 Criminal Negligence Investigation.

¹¹³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 113.

¹¹⁴ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 113-114.

¹¹⁵ See Section 4.4, The 2010 Criminal Negligence Investigation.

¹¹⁶ See Section 4.4, The 2010 Criminal Negligence Investigation; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 171-172; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, pp. 1-3; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 50, 19 September 2012, pp. 183-184; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 120-121.

¹¹⁷ See Exhibit P-3, Collection C, vol. 1, tab 1, doc. 1088, PDF pp. 127 and 131; Section 4.4, The 2010 Criminal Negligence Investigation.

¹¹⁸ See Section 4.1.2, The 2008 Investigation – Investigating Negligence.

¹¹⁹ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 42-43, 130 and 133-134.

¹²⁰ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 12, p. 2. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 49.

¹²¹ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85, 96-97 and 207-208.

¹²² See Exhibit P-176, doc. 1435, pp. 2-3 and 25; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 10-12 and 17.

¹²³ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 13.

¹²⁴ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 55.

¹²⁵ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 84.

¹²⁶ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 55.

¹²⁷ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 52-55; Exhibit P-102, doc. 1390, pp. 22-26; Exhibit P-147, tab 2, doc. 1423, pp. 32-33.

¹²⁸ Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 83.

¹²⁹ Exhibit P-5, Collection E, vol. 4, tab 1, doc. 1131-B, p. 1.

¹³⁰ See Testimony of Col Hammond, Transcript of Proceedings, vol. 40, 26 June 2012, p. 83; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 68-69.

¹³¹ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 57; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 71-72.

¹³² Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 55.

¹³³ See Exhibit P-5, Collection E, vol. 4, tab 1, doc. 1131-B, p. 1; Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 55-57; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 32-36, 114 and 126-127.

¹³⁴ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 32-36, 114 and 126-127.

¹³⁵ See Exhibit P-176, doc. 1435, pp. 2-3 and 25; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 10-12 and 17.

¹³⁶ See Exhibit P-147, tab 1, doc. 1422, p. 126.

¹³⁷ Exhibit P-5, Collection E, vol. 4, tab 1, doc. 1131-B, p. 1.

¹³⁸ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 35-36.

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- ¹³⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 65-67.
- ¹⁴⁰ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 52 and 57-58; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 68, 77-78, 110 and 255-256.
- ¹⁴¹ Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 32, 34 and 36.
- ¹⁴² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 12, p. 2. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 49.
- ¹⁴³ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 12, p. 2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 48-49 and 202.
- ¹⁴⁴ See Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 81-88; Exhibit P-2, Collection B, vol. 2, tab 2, doc. 1087-C, pp. 14-27 and 43-44; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 33-36.
- ¹⁴⁵ See Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 5.
- ¹⁴⁶ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 33-36.
- ¹⁴⁷ See Section 4.3, The 2009 PNOK Investigation; Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, p. 33.
- ¹⁴⁸ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 90-91.
- ¹⁴⁹ See Exhibit P-70, doc. 1358, pp. 15-17.
- ¹⁵⁰ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 50-51; Exhibit P-147, tab 1, doc. 1422, p. 80.
- ¹⁵¹ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 48 and 50-51.
- ¹⁵² See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 51.
- ¹⁵³ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85, 96-97 and 207-208.
- ¹⁵⁴ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85.
- ¹⁵⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, p. 278 [Translation]. See also Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 280-283 [Translation]; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 19-21 [Translation].
- ¹⁵⁶ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 48; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 86-88 and 252.
- ¹⁵⁷ Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 40.
- ¹⁵⁸ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 278 and 280-283 [Translation]; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 19-21 [Translation].
- ¹⁵⁹ Exhibit P-147, tab 2, doc. 1423, p. 45.
- ¹⁶⁰ Exhibit P-147, tab 2, doc. 1423, p. 45.
- ¹⁶¹ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 45.
- ¹⁶² See Exhibit P-5, Collection E, vol. 5, tab 19, doc. 1241, pp. 120 and 126.
- ¹⁶³ See Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 46 and 51; Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, p. 28.
- ¹⁶⁴ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 44-45 [Translation].

¹⁶⁵ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 10, 11, 12 and 13(a) to 13(e), pp. 2-3. See also Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85; Closing Submission of the Complainants, pp. 65, 70-72, 85 and Prologue, p. 6.

¹⁶⁶ See, generally, Exhibit P-176, doc. 1435, pp. 7, 10-12, 14 and 54-59; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 13-14, 35-36, 39-43 and 45.

¹⁶⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13, pp. 2-3.

¹⁶⁸ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 13(a) to 13(e), pp. 2-3.

¹⁶⁹ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(c), p. 3; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 56 and 64.

¹⁷⁰ Exhibit P-4, Collection D, vol. 10, tab 22, doc. 846.

¹⁷¹ See Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁷² See Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing; Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 237; Testimony of WO (Ret'd) Bonneteau, Transcript of Proceedings, vol. 52, 21 September 2012, pp. 161-162; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 244-245 and 251-252; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, p. 137; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 150 and 157-159.

¹⁷³ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 158; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 244-245; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 17 [Translation].

¹⁷⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 245; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 18 [Translation].

¹⁷⁵ Exhibit P-4, Collection D, vol. 10, tab 22, doc. 846.

¹⁷⁶ See Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁷⁷ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095.

¹⁷⁸ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 54; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 239-240; Exhibit P-4, Collection D, vol. 12, tab 68, doc. 1095. See also, Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁷⁹ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(d), p. 3; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 86-87.

¹⁸⁰ Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 89-90.

¹⁸¹ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 50-54, 56, 83-84 and 88-91 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 165-166; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 106-108; Exhibit P-4, Collection D, vol. 1, tab 18, doc. 014, p. 2. See also, Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁸² See Section 4.5.4, CFNIS Interactions with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁸³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 235-236.

¹⁸⁴ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 49-51 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 219-

220; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 63-65 and 109; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 165.

¹⁸⁵ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 50-54, 56, 83-84 and 88-91 [Translation].

¹⁸⁶ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 165-166.

¹⁸⁷ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 166-167.

¹⁸⁸ See Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 106-108.

¹⁸⁹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 109-110.

¹⁹⁰ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 9-10 and 16-17; Exhibit P-176, doc. 1435, p. 35.

¹⁹¹ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 17.

¹⁹² See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(e), p. 3.

¹⁹³ See Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁹⁴ See Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 225-229; Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁹⁵ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 12-17; Exhibit P-147, tab 2, doc. 1423, p. 70; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1096; Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁹⁶ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 235.

¹⁹⁷ See Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, p. 229; Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

¹⁹⁸ See Testimony of Sgt Shannon, Transcript of Proceedings, vol. 51, 20 September 2012, pp. 225-229.

¹⁹⁹ See Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

²⁰⁰ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 10, p. 2; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 62; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 239; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 56-57 and 83-84.

²⁰¹ See Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 1095; Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 19-21; Section 4.5.4, CFNIS Interaction with the Fynes 2009/2010 Investigations – Interviews, Updates and Briefing.

²⁰² See Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, p. 3; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 19-21 [Translation]; Section 4.5.6, CFNIS Interactions with the Fynes CFNIS Answers to the Col Blais Questions.

²⁰³ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 26-27; Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013; Exhibit P-4, Collection D, vol. 1, tab 31, doc. 028; Exhibit P-4, Collection D, vol. 1, tab 33, doc. 030; Exhibit P-4, Collection D, vol. 1, tab 40, doc. 037; Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, pp. 32-33.

²⁰⁴ See Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013; Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 26-27.

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- ²⁰⁵ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 187-188; Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, p. 41; Exhibit P-147, tab 2, doc. 1423, pp. 45-58. See, generally, Section 4.5.6, CFNIS Interactions with the Fynes CFNIS Answers to the Col Blais Questions.
- ²⁰⁶ Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A.
- ²⁰⁷ See Exhibit P-4, Collection D, vol. 1, tab 10, doc. 009; Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013, p. 29; Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 31-35; Exhibit P-5, Collection E, vol. 5, tab 4, doc. 1226, pp. 40-41; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, p. 19 [Translation]; Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, p. 65; Section 4.5.6, CFNIS Interactions with the Fynes CFNIS Answers to the Col Blais Questions.
- ²⁰⁸ See Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, pp. 1-2, 4 and 5.
- ²⁰⁹ See Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, p. 5 and Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 66-68, indicating responses related to post-death administration issues relevant to the CFNIS' 2009 PNOK Investigation were provided by LFWA, the Area in charge of the LDSH Regiment. See also Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, pp. 1-2, for a response provided by the CF Health Services Group about the medical care received by Cpl Langridge, an issue directly relevant to the CFNIS' 2010 Criminal Negligence Investigation.
- ²¹⁰ See Exhibit P-4, Collection D, vol. 1, tab 16, doc. 013, pp. 30-31; Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 60-61.
- ²¹¹ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 31-34 vs Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, pp. 2-4. See also Testimony of Col Blais, Transcript of Proceedings, vol. 27, 24 May 2012, p. 65.
- ²¹² See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, pp. 31-34 vs Exhibit P-4, Collection D, vol. 1, tab 17, doc. 013-A, pp. 2-4.
- ²¹³ See Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 32-33 [Translation]; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, pp. 17-19.
- ²¹⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 19.
- ²¹⁵ Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 20-21 [Translation].
- ²¹⁶ See Exhibit P-176, doc. 1435, pp. 54-57; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 39-41.
- ²¹⁷ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13(a), p. 3.
- ²¹⁸ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13, pp. 2-3.
- ²¹⁹ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 14, 44-45 and 70-71; Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 63.
- ²²⁰ See Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 8-14, 22-23 and 52; Exhibit P-6, Collection F, vol. 1, tab 46, doc. 1193, p. 10.
- ²²¹ See Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 69-70 and 72; Exhibit P-183, tab 51, doc. 1511.
- ²²² See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, p. 7; Exhibit P-6, Collection F, vol. 1, tab 46, doc. 1193, p. 10.
- ²²³ See *Access to Information Act*, R.S.C., 1985, c. A-1, s. 73; *Privacy Act*, R.S.C., 1985, c. P-21, s. 73.

²²⁴ See Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 65-68; Testimony of Ms. Jansen, Transcript of Proceedings, vol. 24, 17 May 2012, pp. 8-9, 10 and 12-13; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 84.

²²⁵ See Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 67; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 84-85; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 18; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 291-294.

²²⁶ See Exhibit P-176, doc. 1435, pp. 54-57; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 35-36 and 40-41.

²²⁷ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 67.

²²⁸ Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 68.

²²⁹ See Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 14-16; Exhibit P-138, tab 1, doc. 1403, p. 17; Exhibit P-4, Collection D, vol. 1, tab 7, doc. 006, pp. 8-9; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, pp. 104, 107-108 and 122-123. See, generally, Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

²³⁰ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

²³¹ Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

²³² See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 26-27 and 28; Exhibit P-4, Collection D, vol. 1, tab 8, doc. 007, pp. 15-16; Exhibit P-2, collection B, vol. 2, tab 1, doc. 1087-B, pp. 104-106. See, generally, Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

²³³ Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

²³⁴ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 84-85; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, p. 18; Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, p. 72.

²³⁵ See Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 291-294.

²³⁶ See Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 71-73; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 292-293.

²³⁷ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 83-84; Testimony of Maj Wight, Transcript of Proceedings, vol. 23, 16 May 2012, pp. 61 and 73.

²³⁸ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 293-294.

²³⁹ See Exhibit P-176, doc. 1435, pp. 55-57; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 41.

²⁴⁰ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 11, p. 2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85; Closing Submission of the Complainants, p. 65.

²⁴¹ See Exhibit P-176, doc. 1435, pp. 7, 10-12, 14, 54-57 and 59; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 13-14, 35-36, 40-41 and 45.

²⁴² See Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 126-130; Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 41-42; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 63 and 699-701; Exhibit P-147, tab 1, doc. 1422, pp. 111-113. See also Final Submissions of the Subjects of the Complaint, p. 39.

²⁴³ See Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 134-135 and 170-171; Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 38, 40-41 and 54-55;

Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, p. 42; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 1-6, 13, 33, 48, 91-95 and 227; Exhibit P-5, Collection E, vol. 2, tab 17, doc. 1132-B, p. 11; Exhibit P-93, doc. 1378.

²⁴⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 246-351, 442-659, 668-672, 680-688, 697-701, 726-732, 735-744, 768-775, 779-781, 796-798 and 808-810; Exhibit P-93, doc. 1378; Final Submissions of the Subjects of the Complaint, pp. 39-40.

²⁴⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge; Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 246-351, 442-659, 668-672, 680-688, 697-701, 726-732, 735-744, 768-775, 779-781, 796-798 and 808-810; Exhibit P-93, doc. 1378.

²⁴⁶ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 60-62 and 93-94. See also, Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 296-298; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 51.

²⁴⁷ Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, p. 102.

²⁴⁸ Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, p. 103.

²⁴⁹ See Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 295 and 297-298; Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 3-4.

²⁵⁰ See Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 164-165; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, p. 299.

²⁵¹ Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 133-137, 164-165 and 173-174; Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 42-44 and 60; Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 38-39 and 113; Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, p. 61; Testimony of LCol Frei, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 203-204; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 49-51 and 197-198.

²⁵² See Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 133-134; Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, p. 43; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 298-299; Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 19-20.

²⁵³ Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 298-299.

²⁵⁴ See Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, p. 102. But see Testimony of Maj Muralt, Transcript of Proceedings, vol. 31, 7 June 2012, pp. 78 and 89-90.

²⁵⁵ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 11 and 12, p. 2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85; Closing Submission of the Complainants, pp. 65 and 70-72.

²⁵⁶ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 80-81, 158-162, 220, 227, 451-455 and 704-712; Exhibit P-93, doc. 1378.

²⁵⁷ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 276-281, 292, 491, 500-501, 548-550 and 737-739; Testimony of Maj Poulin, Transcript of Proceedings, vol. 27, 24 May 2012, pp. 170-173; Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 54-55.

²⁵⁸ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 256-257, 262, 453-454, 488, 535, 542-543 and 738. See, generally, Section 4.2, The Suicide Note Left by Cpl Langridge.

²⁵⁹ Testimony of LCol (Ret'd) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 61-62.

²⁶⁰ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 254.

²⁶¹ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 255.

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- ²⁶² See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, pp. 697-698; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 200 and 213-214. But note the messages in the 2009/2010 investigations MRL were not delivered to the public: see Testimony of Capt Holder, Transcript of Proceedings, vol. 32, 11 June 2012, pp. 60-62.
- ²⁶³ Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 213-214.
- ²⁶⁴ Testimony of Maj Dandurand, Transcript of Proceedings, vol. 59, 5 October 2012, p. 34.
- ²⁶⁵ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 43 and 46-47.
- ²⁶⁶ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 42.
- ²⁶⁷ See Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 808; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 205-206; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 261.
- ²⁶⁸ Exhibit P-5, Collection E, vol. 1, tab 2, doc. 1132, p. 808.
- ²⁶⁹ See Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 205 and 207-209; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, pp. 261-262. See, generally, Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.
- ²⁷⁰ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 43-44.
- ²⁷¹ See Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 43-44.
- ²⁷² See Final Submissions of the Subjects of the Complaint, p. 40.
- ²⁷³ Exhibit P-176, doc. 1435, p. 59.
- ²⁷⁴ Exhibit P-176, doc. 1435, pp. 57-59 and 61-62; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 55-56.
- ²⁷⁵ Exhibit P-176, doc. 1435, p. 59.
- ²⁷⁶ Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, p. 43.
- ²⁷⁷ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 13, pp. 2-3.
- ²⁷⁸ See Exhibit P-176, doc. 1435, pp. 49-51; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 27-28 and 30-32.
- ²⁷⁹ Exhibit P-176, doc. 1435, pp. 51-52; Testimony of Prof Roach, Transcript of Proceedings, vol. 60, 9 October 2012, pp. 28-30 and 32.
- ²⁸⁰ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 18; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 165. See, generally, Section 4.4, The 2010 Criminal Negligence Investigation.
- ²⁸¹ See, generally, Section 2.0, The Hearing Process.
- ²⁸² See Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 21, 115 and 146-152; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 301-302; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 33, 12 June 2012, pp. 200-203 [Translation]; Testimony of Maj Bolduc, Transcript of Proceedings, vol. 34, 13 June 2012, pp. 1-5 and 95-98 [Translation]; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 10-11 and 220; Exhibit P-6, Collection F, vol. 3, tab 3, doc. 1317, pp. 17-27.
- ²⁸³ Exhibit P-6, Collection F, vol. 1, tab 55, doc. 1292, p. 3.
- ²⁸⁴ See Testimony of LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 113-114.

²⁸⁵ See Exhibit P-75, tab 2, doc. 1087-K, p. 3; Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, p. 302; Exhibit P-4, Collection D, vol. 1, tab 48, doc. 045; Exhibit P-4, Collection D, vol. 3, tab 53, doc. 251; Exhibit P-4, Collection D, vol. 4, tab 60, doc. 358; Exhibit P-4, Collection D, vol. 4, tab 62, doc. 360; Exhibit P-4, Collection D, vol. 4, tab 63, doc. 361; Exhibit P-4, Collection D, vol. 4, tab 96, doc. 394; Exhibit P-4, Collection D, vol. 11, tab 76, doc. 1000, pp. 10-13, 17-18 and 21-23. See also, Testimony of LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 138-139, 143 and 151-153; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 15-16 and 85-86.

²⁸⁶ Exhibit P-2, Collection B, vol. 1, tab 1, doc. 1087, pp. 28 and 221. See, generally, Section 4.3, The 2009 PNOK Investigation.

²⁸⁷ See Testimony of LCol King, Transcript of Proceedings, vol. 25, 22 May 2012, pp. 156-157; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 57, 3 October 2012, pp. 273-274; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 223-228.

²⁸⁸ Testimony of Mr. Martel, Transcript of Proceedings, vol. 41, 27 June 2012, pp. 25 and 27-28.

²⁸⁹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 1, 2 and 3, p. 1.

²⁹⁰ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 3 and 5, p. 1.

²⁹¹ Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegations 6 and 7, p. 2.

²⁹² Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 8, p. 2.

²⁹³ See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.

²⁹⁴ See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 150; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 176. See, generally, Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

²⁹⁵ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 6, p. 2.

²⁹⁶ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 196-197; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 77; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 48, 14 September 2012, p. 193; Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

²⁹⁷ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 155.

²⁹⁸ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 71-72; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 67-68.

²⁹⁹ Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, p. 68.

³⁰⁰ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, p. 71-72; Testimony of Sgt Ritco, Transcript of Proceedings, vol. 47, 13 September 2012, pp. 67-68.

³⁰¹ See Testimony of Dennis Caufield, Transcript of Proceedings, vol. 13, 19 April 2012, pp. 45-46; Exhibit P-6, Collection F, vol. 3, tab 4, doc. 1323, p. 2.

³⁰² See Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 259; Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 7, p. 2; Closing Submission of the Complainants, p. 23; Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, p. 60; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 196-197 and 203-206.

³⁰³ Exhibit P-6, Collection F, vol. 3, tab 4, doc. 1323, p. 3.

³⁰⁴ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 8, p. 2; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 227-229; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 44-47.

³⁰⁵ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 59-61; Exhibit P-70, doc. 1358, pp. 16 and 18.

³⁰⁶ Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 187-192.

³⁰⁷ See Exhibit P-3, Collection C, vol. 1, tab 2, doc. 1088-B, pp. 7-8, 24-26, 62 and 134-135. See also Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 28, 4 June 2012, pp. 191-192.

³⁰⁸ Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 29-31, 38 and 41-42.

³⁰⁹ See Section 4.5.5, CFNIS Interactions with the Fynes – The ‘Stockholm Syndrome’ Comment.

³¹⁰ Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 44.

³¹¹ See Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 94-95.

³¹² See Testimony of Mrs. Fynes, Transcript of Proceedings, vol. 17, 7 May 2012, pp. 103-104; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 196, 200 and 212-213; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 84-85, 89-90, 96-97 and 207-208.

³¹³ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, p. 212; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, p. 96.

³¹⁴ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 95-96; Closing Submission of the Complainants, pp. 16-17.

³¹⁵ See Exhibit P-1, Collection A, vol. 2, tabs 1-5, docs 001-C to 001-G.

³¹⁶ See Exhibit P-1, Collection A, vol. 2, tabs 6 and 7, docs 001-H and 001-I.

³¹⁷ See Testimony of Mr. Fynes, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 95-96 and 119; Closing Submission of the Complainants, pp. 17, 27 and 61. See, generally, Section 4.1.2, The 2008 Investigation – Investigating Negligence, for a discussion of the CFNIS’ apparent acceptance of the statements made by CWO Ross and Capt Hannah about the conditions put in place for Cpl Langridge and the lack of a suicide watch, and Sections 4.3 and 4.4, The 2009 PNOK Investigation and The 2010 Criminal Negligence Investigation, for a discussion of the CFNIS’ failure to interview members of the Regiment CoC about the allegations.

³¹⁸ See Section 4.3, The 2008 Investigation – Investigating Negligence; Section 4.4, the 2010 Criminal Negligence Investigation.

³¹⁹ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 5, p. 1; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 209-210; Section 4.1.2, The 2008 Investigation – Investigating Negligence.

³²⁰ See Exhibit P-6, Collection F, vol. 1, tab 5, doc. 1151, Allegation 3, p. 1; Testimony of Mr. Fynes, Transcript of Proceedings, vol. 42, 5 September 2012, pp. 199-200; Exhibit P-2, Collection B, vol. 2, tab 1, doc. 1087-B, p. 117; Section 4.1.4, The 2008 Investigation – The Concluding Remarks.

³²¹ See Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping; Closing Submission of the Complainants, pp. 19-20 and 28.

³²² See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.

³²³ Testimony of LCol Delaney, Transcript of Proceedings, vol. 15, 25 April 2012, pp. 10-13; Testimony of Col Lander, Transcript of Proceedings, vol. 43, 6 September 2012, pp. 280-282; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, pp. 13-15; Testimony of LCol (Ret’d) Garrick, Transcript of Proceedings, vol. 56, 2 October 2012, pp. 102-103.

³²⁴ Testimony of WO Bigelow, Transcript of Proceedings, vol. 46, 12 September 2012, pp. 310-311 and 318-319; Testimony of PO2 McLaughlin, Transcript of Proceedings, vol. 49, 18 September 2012, pp. 282-284 and 298-299; Testimony of WO (Ret’d) Bonneteau, Transcript of Proceedings, vol. 52, 21 September

2012, pp. 173-175; Testimony of WO Hart, Transcript of Proceedings, vol. 53, 24 September 2012, pp. 154-155; Testimony of Maj Dandurand, Transcript of Proceedings, vol. 58, 4 October 2012, p. 55; Testimony of Sgt Mitchell, Transcript of Proceedings, vol. 29, 5 June 2012, p. 78.

³²⁵ See Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 4.3, The 2009 PNOK Investigation; Section 3.3, The 2010 Criminal Negligence Investigation.

V. FINDINGS

5.0 FINDINGS

Allegations Relating to Independence and Impartiality

- 1. The NIS investigations were not conducted in an independent and impartial manner. NIS lacks the independence, on a structural level, to conduct such investigations.*

The Commission finds this allegation to be UNSUBSTANTIATED.

The Commission saw no evidence supporting this allegation. The Commission has identified deficiencies in all three investigations conducted in this case.¹ However, there is no evidence any of these deficiencies were the result of lack of independence or bias on the part of the CFNIS members involved or the CFNIS as an institution.² Rather, the deficiencies largely resulted from inexperience, faulty assumptions and inadequate supervision.

The evidence provides no indication of any interference or attempt by CF members to dictate or influence the conduct of the three CFNIS investigations or their ultimate conclusions. There is also no evidence of any bias or desire to protect CF interests having influenced the conduct of the investigations or the conclusions reached.³

The Commission has noted some of the events in this case did raise concerns about maintaining confidence in the CFNIS' independence. In particular, the failure of the CFNIS members involved in the 2009 and 2010 investigations to conduct more extensive investigations, after they had obtained and reviewed the CF's internal investigations into the same matters, could impact on the CFNIS' ability to demonstrate its independence.⁴ However, the evidence did not demonstrate the review of the CF investigations actually impacted the conduct of the investigations or the conclusions reached.⁵

There was no evidence indicating the CFNIS, as an institution, lacked the independence to conduct the investigations.⁶ However, some of the policies and processes in place give

rise to concerns about the CFNIS' ability to maintain its independence. In particular, it was found the CFNIS does not have final decision-making authority to refuse to release information that might impact on ongoing investigations or police methods.⁷ However, there is no evidence information that could compromise CFNIS investigations or methods was in fact released despite the CFNIS' objection.⁸ As such, there is no evidence the policies and processes impacted on CFNIS independence in practice.

2. The 2008, 2009 and 2010 investigations were aimed at exonerating the Lord Strathcona's Horse (Royal Canadians) regiment (LDSH) Chain of Command and the Canadian Forces (CF) more generally of any responsibility for their failure to prevent Cpl Langridge's death and for the manner in which the complainants were subsequently treated.

The Commission finds this allegation to be UNSUBSTANTIATED.

There is no question all three investigations were incomplete and left many questions unanswered.⁹ However, there is no evidence these deficiencies were caused by any bias on the part of the members involved, nor that the investigations were aimed at exonerating anyone.¹⁰ In order to reach a contrary conclusion, the Commission would be required to find there was a conspiracy commencing with the front line investigators up to the highest ranking CFNIS members. Such planning and thought processes were not presented in any fashion in this case.¹¹

On the contrary, the evidence shows the CFNIS members all sought to complete their tasks to the best of their ability. There is no evidence indicating any dishonesty or inappropriate motivations on the part of any of the CFNIS members involved in the investigations.¹² Further, the evidence reveals many of the events that led the complainants to believe the investigations were biased, did not, in fact, happen as the complainants believed they had.¹³

3. The 2008 Sudden Death investigation report contained findings that were inaccurate, that the investigator was not qualified to make, and that were aimed at attacking Cpl Langridge's character and exonerating CF members of any wrongdoing or liability.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The Commission finds the Concluding Remarks for the 2008 investigation contained information that was inaccurate or not supported by the evidence uncovered during the investigation. They contained a statement indicating Cpl Langridge's addiction issues had caused him to suffer from mental health issues, which the investigator was not qualified to make, and which was not supported by the evidence.¹⁴ The revised Concluding Remarks authored by the supervisors for the 2008 investigation continued to include information not supported by the evidence about Cpl Langridge's mental health and addiction issues.¹⁵ The Concluding Remarks also included a comment indicating Cpl Langridge's death occurred despite the structure and support provided by his Unit. This conclusion was not supported by the evidence and may well have been inaccurate.¹⁶

However, there is no evidence the statements were aimed at attacking Cpl Langridge's character or at exonerating CF members. On the contrary, the evidence indicates the CFNIS members involved had no improper motivations or bias and no intent to attack Cpl Langridge's character or exonerate the CF.¹⁷

The Commission notes the Concluding Remarks were modified in 2010 following the Fynes' complaints during meetings with CFNIS members.¹⁸ In recognition of the great distress these Concluding Remarks caused the complainants, all objectionable statements were removed. However, there was no recognition by the CFNIS or its members that the original Remarks were inaccurate or unsupported by the evidence.¹⁹

4. The 2008 Sudden Death investigation was overly intrusive in light of its initial aim of determining the cause of death. Obtaining and including in the file Cpl Langridge's medical records was unnecessary for this purpose.

The Commission finds this allegation to be UNSUBSTANTIATED.

The Commission is satisfied it was both relevant and necessary for the purposes of this investigation to obtain Cpl Langridge's medical records.

Those records had relevance to the sudden death investigation. They could be used to confirm suicide as the most likely cause of death because they contained information about Cpl Langridge's mental health issues and past suicide attempts.²⁰

The records were especially relevant to the investigation of potential negligence, which was also one of the stated goals set out in the Investigation Plan for the 2008 investigation.²¹ In this respect, the Commission has, however, found the investigation conducted into potential negligence was incomplete, and the medical records obtained were insufficient.²²

The CFNIS members cannot be faulted both for doing too much and for not doing enough. The Commission has found more should have been done to investigate negligence but finds there is no support for the allegation the investigation was overly intrusive.

5. When they did start to examine the issue of the underlying causes of Cpl Langridge's suicide in the 2008 investigation, NIS investigators failed to pursue this examination in a complete and unbiased manner. The investigators were selective in the information they obtained and included, and their selection was not objective or impartial. The conclusions drawn by the investigators were based on incomplete facts which contained numerous contradictions and discrepancies.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The Commission has found there was no bias on the part of the CFNIS members involved in the investigation. There is no evidence they selected information in a manner that was not objective or impartial.²³

However, the evidence does reveal many aspects of the investigation were incomplete. Both in terms of investigating the cause of death and investigating potential negligence, the evidence reveals many obvious investigative steps were not taken and many clearly relevant documents were not obtained.²⁴ Hence, Cpl Langridge's parents and common-law spouse were never interviewed; Cpl Langridge's medical records from civilian hospitals were never obtained; medical personnel from civilian hospitals and key care providers from the military medical community were not interviewed; members of Cpl Langridge's CoC were not interviewed; the activities and whereabouts of Cpl Langridge during the days immediately preceding his death were not ascertained; and, the authenticity of his suicide note was never confirmed or investigated.²⁵ Other steps directly relevant to ruling out foul play, including such obvious matters as confirming the lack of access to Cpl Langridge's room by a third person, were also not pursued.²⁶

These deficiencies were the result of poor planning and poor execution of the investigation as well as inadequate supervision. The Investigation Plan, in particular, was especially inadequate, and there was no intervention by supervisors to correct the situation.²⁷

In terms of the conclusions drawn, there was sufficient evidence to support ruling out foul play at an early point in the sudden death investigation. As such, despite other deficiencies in this aspect of the 2008 investigation, it cannot be found the conclusions were based on incomplete facts.²⁸ However, the contradictions and discrepancies in the facts relevant to potential negligence were not sufficiently investigated.²⁹ Insofar as there were conclusions drawn in this regard, they were based on incomplete facts.³⁰

6. The NIS investigators in the 2008 Sudden Death investigation met with CF members from the LDSH regiment prior to attending the scene. They were influenced by these meetings and discussions and this tainted the remainder of their investigation.

The Commission finds this allegation to be UNSUBSTANTIATED.

There is no evidence whatsoever to support this allegation. On the contrary, the evidence reveals the CFNIS investigators did not meet with members of the LDSH Regiment prior to attending the scene.³¹ Their investigation was not “tainted” by any such meeting or by any other event or discussions.³²

When the CFNIS investigators arrived at the Base, they attended the MP guardhouse. There, they met with local MP members and, subsequently, with the ME investigator.³³ At the scene, they also interacted with first responders including MP members and Base Firefighters.³⁴ They met with LDSH members only after attending at and processing the scene and only for the legitimate purposes of conducting interviews in support of their investigation or discussing administrative matters related to Cpl Langridge’s property.³⁵

As can be expected during the initial phases of any investigation, the CFNIS investigators encountered rumours and other unconfirmed information about Cpl Langridge and his last days in the course of their early interactions with MP members and witnesses. However, it is clear they recognized the speculative and fragmentary nature of such statements, and attempted, albeit without great success, to discern what, if any, truth lay behind them.³⁶

7. NIS members involved in the conduct of the 2008 Sudden Death investigation provided inaccurate information to the Alberta Medical Examiner (ME) about whether Cpl Langridge was the subject of disciplinary action in the CF. This resulted in an inaccurate mention on the ME certificate that Cpl Langridge had “disciplinary issues.” NIS refused to make any attempt to have this inaccuracy corrected.

The Commission finds this allegation to be UNSUBSTANTIATED.

The evidence before the Commission has revealed the CFNIS investigators were not, in fact, responsible for the comment included in the ME Certificate. The information they provided to the ME investigator was accurate. When they provided preliminary or unconfirmed information, they specified the information had not been verified, and they offered further clarification when they obtained additional information.³⁷

The mention of disciplinary issues included in the ME certificate was the result of the ME Investigator's own interpretation and not of statements made by the CFNIS members.³⁸ As such, the CFNIS cannot be faulted for not volunteering to provide assistance to the complainants in having the Certificate corrected. The complainants should have pursued this issue directly with the Office of the Alberta Medical Examiner.

8. The NIS and its members made inaccurate statements about where Cpl Langridge was residing immediately prior to his death. Those statements were aimed at exonerating the LDSH Chain of command of any responsibility and were examples of NIS participation in broader efforts by the CF to exonerate themselves from any responsibility.

The Commission finds this allegation to be UNSUBSTANTIATED.

The evidence reveals, during an interview with the complainants, one CFNIS member did discuss his belief – based on an initial review of the materials – Cpl Langridge did not reside in the Defaulters' room at the time of his death.³⁹ This information was not accurate.⁴⁰ However, it is clear the statements were based on an honest misunderstanding, and the member made it clear he intended to verify the information.⁴¹

There were also inaccuracies in some of the notations about Cpl Langridge's address included in the 2008 investigative file. The evidence shows these statements were in the nature of clerical errors.⁴²

None of the statements made were aimed at exonerating the Regiment of responsibility, nor were they examples of CFNIS participation in any efforts to exonerate the CF from responsibility.⁴³ In fact, the Commission has found no evidence of participation by the CFNIS in any such efforts.⁴⁴

9. NIS members commented, during a meeting with the complainants, that a statement made by their Assisting Officer indicating that the complainants were "deceived, misled and intentionally marginalized in their dealings with DND and the CF" was

likely the result of Stockholm syndrome. This demonstrated a previously-held view by NIS members that any views critical of the CF must be wrong. Such views prevented NIS members from conducting independent investigations into the actions of CF members.

The Commission finds this allegation to be UNSUBSTANTIATED.

The CFNIS members adamantly denied making any comment related to ‘Stockholm syndrome’.⁴⁵ The evidence before this Commission provides no confirmation of any such comment having been made.⁴⁶ The recording for the meeting when the comment was alleged to have been made contains no trace of it.⁴⁷ The recording was submitted to expert analysis by the Commission as a result of allegations by the complainants that the recording had been altered. That analysis confirms the recording was not altered.⁴⁸

10. NIS agreed to participate in an intended briefing that was offered to the complainants by the CF and that was to include information about the CF Board of Inquiry, as well as about the CFNIS investigations. NIS failed to preserve its independence by failing to ensure that its police investigations were kept separate and distinct from other internal CF processes.

The Commission finds this allegation to be UNSUBSTANTIATED.

The Commission found no evidence a common briefing about the CFNIS investigations and the CF’s BOI was ever planned or offered to the complainants. The evidence reveals the only briefing offered to the complainants by the CFNIS related solely to the CFNIS’ own investigations.⁴⁹

It appears the complainants’ impression there was a plan to provide a common briefing may have arisen as a result of their communications with Col Blais, who had been named as the point of contact to answer their questions on behalf of the CF.⁵⁰ These communications included several discussions relating to the briefings or updates to be

provided about the BOI and the CFNIS investigations. As the issues were discussed together, it may have appeared to the complainants the briefings would also be joined.⁵¹

Although the Commission has found there was no plan to provide a joint briefing, it also finds the communications with Col Blais about CFNIS issues opened the door to creating confusion about the CFNIS' role and were problematic in terms of maintaining confidence in CFNIS independence.⁵²

11. NIS participated in broader CF efforts to provide explanations and justifications in response to the complainants' concerns, instead of conducting independent investigations in response to those concerns.

The Commission finds this allegation to be UNSUBSTANTIATED.

This allegation related to the complainants' concerns about CFNIS participation in public affairs coordination with the CF. The evidence does not support a conclusion the CFNIS participated in efforts to present the CF's perspective to the public. There is no evidence the CF exerted control or influence over the CFNIS' public messages, nor is there any evidence the CFNIS modified its messages about its investigations to serve the CF's interests or public relations strategy.⁵³ In addition, the evidence indicates the CFNIS did not participate in a CF-wide Task Force constituted to advance the CF's interests in civil litigation or to present the CF's positions to the public.⁵⁴

However, the CFNIS did participate in extensive public relations coordination involving other CF organizations. While the CFNIS generally retained control over the information released about its investigations and activities, the evidence reveals there were no formal policies or processes in place to protect the CFNIS' independence in terms of its authority over the release of its information.⁵⁵ This gives rise to concerns about maintaining confidence in CFNIS independence. The Commission has noted that having clear policies governing such matters, rather than relying on a general practice which may or may not be known or adhered to by all CF PAOs, would provide more effective safeguards.⁵⁶

The evidence also reveals the CFNIS, in this case, often participated in preparing joint media response lines or public statements with other CF organizations.⁵⁷ This was done because the case raised issues of concern to many different CF organizations. CFNIS messages were, at times, delivered by CF spokespersons, and messages related to the CF's interests were, at times, included in the CFNIS' own media lines.⁵⁸ This risked creating confusion and impacted the CFNIS' ability to demonstrate its independence.⁵⁹

When the CF high command commented on the matter while it was still under investigation, because the CFNIS had not been careful to keep its public messages separate from those of the broader CF, there was a risk of creating an impression the CFNIS might be influenced by the positions taken by members of the CF CoC.⁶⁰ The Commission has found the CFNIS does not have authority to prevent comment by the CF about matters it is investigating.⁶¹ However, the CFNIS can contribute to fostering greater confidence in its independence by keeping its own messages separate, not speaking on behalf of the CF, and not allowing the CF to speak on its behalf.⁶²

12. Concerns raised by the complainants in discussions with CFNIS members (particularly, concerns about damages to Cpl Langridge's vehicle while in CF custody) were discussed by NIS members with non-MP members of the CF (in particular, Land Forces Western Area). This was done for the purpose of participating in CF efforts to explain and justify their actions and not for the purpose of conducting an independent investigation.

The Commission finds this allegation to be UNSUBSTANTIATED.

The evidence before the Commission shows no inappropriate discussions took place between the CFNIS members and the LFWA CoC. The discussions that did take place were limited to legitimate information-sharing, and no details about the CFNIS investigation were provided.⁶³

There was no impropriety in discussing the complainants' administrative concerns with the LFWA CoC. These concerns were unrelated to the CFNIS investigation or mandate

and were brought to the CF's attention in an effort to assist the complainants.⁶⁴ When they initially learned about these efforts, the complainants were grateful and did not express any concerns about lack of CFNIS independence or improper contacts with the CF.⁶⁵ There is no evidence the discussions about these matters involved any attempt by the LFWA CoC to influence or interfere with the CFNIS investigation, let alone that this was the result.⁶⁶

There is also no evidence the discussions were related to CFNIS participation in any CF efforts to explain or justify the CF's actions. The LFWA CoC's concern to ensure the CDS was aware of all ongoing investigations prior to issuing public comments was legitimate.⁶⁷ The CFNIS Detachment OC's own individual concern about the same issue was unrelated to the interests of the police investigation, but the evidence reveals it had no impact on the conduct of the investigations or the conclusions reached.⁶⁸

13. NIS and its members failed to provide adequate and timely information to the complainants. NIS participated in broader Canadian Forces efforts to withhold information from the complainants. NIS members allowed non-MP members of the CF, including CF legal advisers, to influence or dictate their decisions about the type of information provided to the complainants and the manner in which this information would be provided. NIS members allowed a broader CF concern over potential litigation between the complainants and the CF to dictate or influence their decisions about the information to be provided to the complainants and the manner in which that information would be provided. In particular:

a) NIS improperly withheld information from the complainants about its 2008 Sudden Death investigation by providing a copy of the report which contained numerous redactions having no justification in law or privacy protection. The complainants were provided with an incomplete file with no specific or satisfactory explanation for withholding information.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The evidence has revealed many of the redactions applied to the copies of the 2008 investigation report provided to the complainants were difficult to understand or justify.⁶⁹ The complainants were not provided with satisfactory explanations for the redactions.⁷⁰ Many of the redactions were applied by a separate DND organization, the DAIP, while others resulted from the MP's own failure to include certain information when compiling the file.⁷¹

The redactions applied are of concern, and what the evidence has revealed about the process in place for the release of CFNIS information also raises concerns.⁷² In particular, the fact the CFNIS does not have final decision-making authority to refuse to release information which may compromise its ongoing investigations or disclose police methods, can have an impact on the CFNIS' ability to maintain and protect its independence.⁷³ While this has not happened in practice, the existing process is of concern. In addition, delegating decisions about redactions to be applied to CFNIS information also raises concerns in terms of maintaining confidence in the CFNIS' independence.⁷⁴

However, the evidence does not support a conclusion the redactions were an attempt by the CFNIS or its members to withhold information from the complainants.⁷⁵ There is also no evidence of CFNIS participation in any broader CF efforts to withhold information from the complainants in connection with the release of this report, nor of any concerns about the CF's litigation interests having influenced decisions about the information released.⁷⁶ While the CFNIS did allow non-MP members of the DND, namely the office of the DAIP, to make decisions about the release of the information contained in its investigative file, this was done pursuant to the process in place for the release of information and not with any improper intent or motivation.⁷⁷

- b) NIS members failed to provide regular updates to the complainants as promised. Communication was irregular and contained unexplained gaps of many months.***

The Commission finds this allegation to be SUBSTANTIATED.

The evidence reveals the CFNIS members involved failed to provide timely and adequate information to the complainants throughout the course of all three investigations conducted. The complainants were never updated or briefed about the 2008 investigation until over a year after it was concluded.⁷⁸ They were never provided with an explanation of the reasons for the CFNIS' failure to disclose Cpl Langridge's suicide note to them in a timely manner.⁷⁹

When they did receive a briefing about the 2008 investigation, the complainants were provided general information and justifications but no specific information answering their questions. Commitments to provide information at a later date were not honored.⁸⁰

During the 2009 and 2010 investigations, the complainants were not provided with the regular updates they had been specifically promised by the CFNIS members. A limited number of updates were initially provided, but then a period of five months elapsed without any update or contact.⁸¹ Even when they did receive updates, the complainants were given no substantive information about the investigations. In particular, the CFNIS members made numerous promises and commitments to the complainants about how the investigations would be conducted. The investigations were not conducted as promised, and the CFNIS members never advised the complainants about the change in approach.⁸²

The Commission finds there was no acceptable justification for the failure to provide regular updates and substantive information to the complainants. The Detachment OC assumed responsibility for providing updates and information in connection with the 2009 and 2010 investigations but did not ensure they were, in fact, provided.⁸³

- c) *NIS acquiesced and participated in an effort by the CF to prevent the complainants from communicating with CF members. The complainants received a letter advising them that, in light of anticipated litigation, they were not to communicate directly with any member of the CF. No exception was made to allow the complainants to communicate with the NIS members*

investigating their complaints and NIS members in fact did not contact the complainants during this period.

The Commission finds this allegation to be UNSUBSTANTIATED.

While the CFNIS' failure to maintain contact with the complainants and provide them with information was serious, the Commission has found no evidence it was the result of influence by CF members or legal advisors. As well, the Commission has found it was not motivated by concern over the CF's litigation interests. There is also no evidence the CFNIS participated in any CF efforts to withhold information from the complainants or to prevent the complainants from communicating with the CF.⁸⁴

The evidence reveals the "no contact" letter sent by CF legal representatives in September 2010 had no impact on the CFNIS' interactions with the complainants.⁸⁵ The CFNIS was not involved in the decision to send this letter, nor were they consulted about it or even aware of it. Had they known about the letter, the evidence indicates the CFNIS members would not have viewed it as precluding them from contacting the complainants. On its face, it is also doubtful the CF's correspondence could fairly be interpreted as seeking to limit or limiting the complainants' contact with the CFNIS.⁸⁶

d) NIS cancelled a planned verbal briefing on the 2009 and 2010 investigations that was to be provided to the complainants. This decision was made because the complainants requested that their lawyer attend the briefing as an observer. In cancelling a briefing about the police investigations because of potential litigation between the complainants and the CF, the NIS failed to act independently.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The Commission finds the CFNIS did cancel a verbal briefing initially offered to the complainants because they requested their lawyer be present as an observer. This decision

was made by the CFNIS DCO, but two of the subjects of the complaint, the CFNIS CO and the Detachment OC, participated in the decision.⁸⁷

The Commission finds the decision to cancel the briefing was not appropriate. The CFNIS members had obligations to provide information to the complainants, particularly in light of the commitments they had made to them and the CFNIS' poor track record for maintaining contact during the investigations. Their desire not to become involved in the civil litigation process, while understandable, was not a sufficient or acceptable reason to fail to honor their obligations and commitments to the complainants in this case.⁸⁸

There is no evidence the decision to cancel the briefing was influenced or dictated by non-MP CF members.⁸⁹ Because of solicitor-client privilege, it cannot be known what advice, if any, was obtained from CF legal advisors when the decision was made.⁹⁰ However, the evidence indicates no concerns arise in this respect as the CFNIS generally obtains advice only from members of the military prosecution service, and this does not raise police independence concerns.⁹¹

The evidence before the Commission does not conclusively refute the possibility that concern over the CF's litigation interests may have influenced the decision to cancel the briefing. The evidence is not conclusive as to whether consideration of the specific fact the CF was involved in the litigation played a part in the decision, although the testimony of at least one of the subjects of the complaint did indicate the CF's litigation interests may have been a factor considered in the decision.⁹² While this is not sufficient to conclude the CFNIS failed to act independently, it does raise concerns about its ability to maintain confidence in its independence.⁹³

- e) *The written briefing provided to the complainants by NIS in May 2011 in replacement for the planned verbal briefing did not contain sufficient information to answer the complainants' questions.*

The Commission finds this allegation to be SUBSTANTIATED.

The evidence reveals the information contained in the written briefing provided to the complainants was inadequate and insufficient to answer the complainants' questions.

The decision to provide a letter instead of a verbal briefing was, by its very nature, bound to result in the complainants receiving less information. Further, the letter, as drafted, provided no information about the rationale for the conclusions reached in the two investigations.⁹⁴ The letter failed to honour the commitment made by the CFNIS members to the complainants that full justification would be provided if a decision was made not to proceed with charges. The letter also contained no information about the investigative steps taken in the 2009 and 2010 investigations and, as such, failed to inform the complainants the investigations did not proceed as earlier promised by the CFNIS members.⁹⁵ Some of the information contained in the letter was inaccurate and some of the characterizations of the nature and scope of the activity undertaken were potentially misleading.⁹⁶

Nevertheless, there is no evidence this was the result of CF influence or was motivated by concern over the CF's interests.⁹⁷

Allegations Relating to Insufficient Investigation or Failure to Investigate

14. The investigations conducted by CFNIS were inadequate. The investigations failed to properly address the issues to be investigated. NIS members failed to investigate other issues, and failed to provide an appropriate response to the complainants with respect to the concerns they specifically brought to their attention.

The Commission finds this allegation to be SUBSTANTIATED.

The Commission has identified significant deficiencies in all three investigations conducted.⁹⁸ In each case, the CFNIS members failed to identify and/or investigate

significant issues properly or at all. Irrelevant investigative avenues or steps were pursued while relevant ones were not. Supervisors failed to intervene to correct misconceptions or inadequate approaches taken by the investigators. Instead, at times, they directed relevant investigative steps not be taken.⁹⁹

15. NIS failed to properly investigate in a timely manner the potential criminal or service offences committed by members of the LDSH Chain of Command and other CF members prior to Cpl Langridge's death. Conduct requiring further investigation, follow-up and analysis was uncovered during the 2008 investigation and was specifically brought to the attention of the NIS by the complainants. This conduct was not adequately investigated.

The Commission finds this allegation to be SUBSTANTIATED.

During the 2008 investigation, the CFNIS investigators obtained or had the means of obtaining information regarding Cpl Langridge's last weeks including the regimental response to his distress and the medical treatment he received. This information suggested an investigation was required to determine whether there were instances of negligence, which could have contributed to Cpl Langridge's death.¹⁰⁰

The CFNIS members involved in the 2008 investigation did not consider any potential offences beyond the possibility Cpl Langridge might have been under a defective suicide watch when he died. They failed to investigate even this question adequately, and they failed to recognize and therefore failed to investigate all other relevant negligence-related issues.¹⁰¹ They failed to interview many important witnesses and also failed to obtain relevant records and evidence. As a result, key questions were never investigated, and easily accessible evidence was never gathered.¹⁰²

In 2010, the complainants specifically requested an investigation be conducted into alleged criminal negligence in relation to Cpl Langridge's death.¹⁰³ Despite assurances made to them these allegations would result in an extensive investigation, the CFNIS members involved in the 2010 investigation did not gather any new evidence or

undertake any investigative steps.¹⁰⁴ Instead, the preliminary assessment they conducted relied largely on the flawed and inadequate 2008 investigation despite the concerns specifically brought to the CFNIS' attention by the complainants about that investigation.¹⁰⁵

The Commission finds the CFNIS failed to investigate the negligence-related issues adequately both in 2008 and 2010 and failed to conduct the follow-up investigation and inquiries, which would have been necessary as a result of the information uncovered during the 2008 investigation and the allegations brought forward by the complainants.

16. NIS failed to investigate the potential service offences committed by CF members in the application of (or failure to apply) suicide prevention policies in Cpl Langridge's case. NIS failed to investigate what policies were applicable and whether they were followed. In particular, NIS failed to investigate whether a requirement existed for the CF to conduct a Summary Investigation for each instance of attempted suicide by a member and whether this was in fact done in Cpl Langridge's case.

The Commission finds this allegation to be SUBSTANTIATED.

Although the evidence is clear Cpl Langridge's suicidal ideation was known by the base medical community and the LDSH CoC prior to his death, at no point did any of the subjects of the complaint investigate the existence or application of suicide prevention policies with respect to Cpl Langridge.¹⁰⁶

Relevant policies or orders directed base commanders and COs to develop and implement intervention plans to provide for a rapid, coordinated and effective response to reports of suicidal behaviour. The CFNIS members involved in the 2008 and 2010 investigations did not investigate whether this imposed a duty to develop and implement such a plan, nor whether the LDSH had developed the necessary intervention plans.¹⁰⁷ The CFNIS members also did not investigate whether any offences could result from the failure to conduct an SI after each of Cpl Langridge's suicide attempts, despite CF orders requiring

this to be done and despite evidence the LDSH CoC and the base medical community were aware of several suicide attempts for which no SI was conducted.¹⁰⁸

17. In the conduct of the 2008 Sudden Death investigation and the subsequent 2010 Criminal Negligence investigation, NIS members failed to conduct the necessary follow-up and analysis to resolve conflicts and discrepancies in the information obtained, including in relation to the alleged “suicide watch” (or lack thereof) conducted prior to Cpl Langridge’s death.

The Commission finds this allegation to be SUBSTANTIATED.

In the course of the 2008 investigation, the CFNIS members received contradictory information about a potential suicide watch having been planned or conducted for Cpl Langridge. They also received conflicting information about the purpose of the conditions imposed on Cpl Langridge and whether they constituted a suicide watch.¹⁰⁹

The Commission finds the inquiries made by the CFNIS members about this issue were not focused or adequate. Many critical questions were left unanswered or were not thoroughly addressed. Contradictions in the evidence arose, and the CFNIS members failed to probe the witnesses critically, assess the evidence, and conduct the necessary follow-up inquiries.¹¹⁰ As a result, relevant evidence was never obtained, and relevant questions were never answered.

The CFNIS members conducting and supervising the 2010 investigation similarly failed to conduct the necessary follow up and analysis. Because they conducted no investigation at all, they did not gather any evidence or information that might have assisted in resolving the contradictions and discrepancies in the information available.¹¹¹ The limited analysis conducted did not address the relevant issues or answer the relevant questions.¹¹²

18. The activity undertaken by the NIS investigators in the 2008 Sudden Death investigation had no clearly defined and understood purpose. NIS investigators failed to produce a report that provided a

satisfactory explanation for the issues they undertook to investigate. NIS failed to provide clarity for its own personnel and for the complainants about what those issues were.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The CFNIS members who conducted and supervised the 2008 investigation did not exhibit a strong working understanding of the basic purpose and process for conducting a sudden death investigation. They did not have an adequate understanding of the role of the ME and how it related to their own role.¹¹³

The investigators understood the ultimate goal of the investigation was to rule out foul play. However, they did not appear to have a clear understanding of what was required to achieve this goal.¹¹⁴

The CFNIS members failed to assess the death scene and the evidence critically, and they failed to adjust their approach based on what the evidence revealed.¹¹⁵ They did not appreciate or assess the abundant evidence indicating Cpl Langridge's death was the result of suicide, and they did not take into consideration the opinion of the ME Investigator at the scene.¹¹⁶ They failed to make note of significant information available at the scene and they failed to gather, preserve, and protect from contamination evidence that would have been significant and even essential if the possibility of foul play became a realistic suspicion.¹¹⁷

By March 19, 2008, it would have been appropriate, in view of the evidence gathered, to determine Cpl Langridge had not died as the result of homicide.¹¹⁸ Instead, the CFNIS members placed undue emphasis on the need to "keep an open mind" throughout the entirety of the investigation. As a result, the determination there was no foul play involved in the death was unnecessarily delayed.¹¹⁹

While generally complete, the police notes and SAMPIS entries made in the course of the 2008 investigation did not provide sufficient information about important decisions made and did not provide a clear picture of the issues under investigation or the conclusions reached regarding each of these issues.¹²⁰

19. NIS failed to properly investigate in a timely manner the potential service offences committed by members of the CF in designating Cpl Langridge's former partner as next-of-kin. Facts requiring further investigation, follow-up and analysis were specifically brought to the attention of the NIS by the complainants and were not adequately investigated, including facts relating to CF interactions with the funeral director and with the complainants about the Registration of Death documents and facts relating to Cpl Langridge's missing paperwork located after his death.

The Commission finds this allegation to be SUBSTANTIATED.

The evidence reveals numerous serious deficiencies in the 2009 investigation conducted by the CFNIS.¹²¹

The investigation largely proceeded on the basis of faulty and untested assumptions. The allegations were never properly identified nor understood.¹²² Relevant questions were not asked or answered in the investigation. No conclusions were reached about who made the PNOK decision and on what basis.¹²³ Other relevant issues related to the role of the executor, the registration of death, the misplaced paperwork and the involvement of a JAG officer in the PNOK decision-making process were never explored.¹²⁴

A fundamental flaw in the investigation was the total failure to seek legal advice. The issues raised in addressing the PNOK allegations were numerous and of considerable complexity encompassing questions of military, provincial and case law.¹²⁵ The conclusions reached were based on the lead investigator's own understanding of legal norms and principles.¹²⁶ The investigator involved had no legal training and did not have the expertise necessary to be able to draw legal conclusions with respect to the investigation.¹²⁷ It should have been apparent to all CFNIS members involved that legal advice was required.

The investigation into the facts of the complaint also suffered from other shortcomings. Sources of evidence were unduly limited by the failure to conduct interviews with fact

witnesses.¹²⁸ Assumptions were made which were not supportable on the actual facts.¹²⁹ Members of the Regiment CoC involved in the PNOK decision were never interviewed.¹³⁰ The issues of Cpl Langridge's marital status and the complainants' input into the funeral arrangements were not adequately investigated.¹³¹

Throughout the investigation, supervisors were not sufficiently informed or aware of the issues being investigated. They provided limited input and did not intervene to correct the investigators' faulty assumptions or ensure a legal opinion was obtained before legal conclusions were drawn.¹³²

20. In the conduct of the 2009 PNOK investigation, NIS members failed to investigate the actual issue that they had been asked to investigate: whether service offences were committed in appointing Cpl Langridge's former common law partner as next-of-kin for purposes of arranging the funeral. By focussing only on whether or not Cpl Langridge's former partner still qualified as his common law spouse under CF policies, NIS members failed to answer the actual question brought to them for investigation.

The Commission finds this allegation to be SUBSTANTIATED.

The Commission finds the CFNIS members failed to identify the central issue of the complaint. Because the lead investigator involved focused his investigation very narrowly only on the issue of whether Ms. A was Cpl Langridge's common-law spouse at the time of his death, the entitlements associated with being recognized as NOK, particularly in relation to funeral planning, were not investigated.¹³³

Although the complaint lacked clarity, and although it was, in part, based on faulty assumptions as well, the complainants were ultimately concerned the role of planning the funeral had been given to someone who was not entitled. The CFNIS failed to investigate this issue.¹³⁴

Although not noted in the investigation plan, an allegation about funeral planning was considered. However, the investigation of this allegation focused only on the complainants' participation in funeral planning and still missed the central issue of who should have been entitled to plan the funeral.¹³⁵

As a result, the CFNIS failed to answer the actual question brought to them for investigation.¹³⁶

21. NIS failed to investigate or refer to the police of competent jurisdiction for investigation the potential criminal or service offences committed by Cpl Langridge's former partner and the two CF members who accompanied her during her visit to the funeral director. Conduct which required further investigation, follow-up and analysis (including conduct which may have amounted to fraud in the provision of false information for the purpose of obtaining benefits) was specifically brought to the attention of the NIS by the complainants and was not adequately investigated.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

The CFNIS did not conduct an investigation into the attendance at the funeral home by CF members or Ms. A. The Commission finds, while reasons of jurisdiction justify not investigating Ms. A's involvement, it is not clear there would have been a jurisdictional bar to investigating the actions of the CF members who attended at the funeral home.¹³⁷

In addition, the Commission finds it would have been a best practice to advise the complainants the CFNIS did not intend to investigate some of their allegations or refer them to other law enforcement agencies. The CFNIS should then have provided the complainants with information about other agencies that may have been able to investigate their complaints.¹³⁸

22. *NIS failed to investigate, follow up, or provide a response to the complainants with respect to the concerns they raised about how Cpl Langridge's vehicle was damaged while in CF custody.*

This allegation was withdrawn by the complainants during the hearing.

23. *NIS failed to investigate, follow up or provide a response to the complainants with respect to the concerns they raised about damage done to Cpl Langridge's blackberry and computer while in NIS and CF custody.*

This allegation was withdrawn by the complainants during the hearing.

24. *NIS failed to investigate, follow up or provide a response to the complainants with respect to the concerns they raised about the information they obtained from Rogers telephone indicating that someone was accessing the internet from Cpl Langridge's blackberry after his death.*

This allegation was withdrawn by the complainants during the hearing.

Allegations Relating to Professionalism and Competence

25. *The CFNIS members involved in the investigations lacked the necessary skills, professionalism and competence to conduct these investigations and to resolve the issues brought to their attention by the complainants.*

The Commission finds this allegation to be SUBSTANTIATED.

The evidence reveals the CFNIS WR Detachment members involved in the investigations, including those involved in providing supervision and oversight for the

investigations, did lack the necessary skills and, at times, the competence to carry out their duties. The evidence shows this was mostly due to lack of adequate experience, particularly with respect to the conduct of sudden death investigations.¹³⁹

Some of the deficiencies in the investigations were sufficiently egregious to put in question the skills and professionalism of the members involved. Examples of this type of conduct include: the supervisors' direction not to interview Cpl Langridge's parents and common-law spouse in the 2008 investigation;¹⁴⁰ the failure of the members involved to understand the legal requirements applicable for conducting searches and seizures;¹⁴¹ the failure to disclose the suicide note;¹⁴² the failure to seek legal advice in the 2009 investigation;¹⁴³ and the inordinate amount of time taken to complete the 2009 and 2010 investigations.¹⁴⁴

The evidence also reveals numerous instances of lack of professionalism on the part of the CFNIS members. The failure to take steps to ensure Cpl Langridge's suicide note was provided to the complainants when its existence was revealed to the BOI; the failure to provide an immediate and unqualified apology to the complainants; the failure to provide the complainants with an explanation regarding the reasons for the late disclosure; and the failure to put in place clearly understood processes and policies for the timely disclosure of suicide notes in the future, were prime examples.¹⁴⁵ The general conduct of the CFNIS members in interacting with the complainants, including the failure to fulfil commitments and the failure to provide timely and accurate information, also constitutes a deficiency of professionalism.¹⁴⁶

While many of the deficiencies observed in the conduct of the CFNIS members were the result of inexperience and honest mistakes or misunderstandings, there was a lack of professionalism displayed in the failure of the CFNIS members involved, particularly those in leadership or supervisory positions, to step forward, take responsibility, and appropriately correct the situation when serious mistakes were revealed.

26. NIS failed to advise the complainants of the existence of a suicide note left for them by Cpl Langridge and failed to provide the note until many months after Cpl Langridge's death and after the

investigation was concluded. NIS never came forward to reveal the existence of the note, which was learned by the complainants through other means. Once the complainants were advised, NIS failed to send the original note until the complainants made a specific request.

The Commission finds this allegation to be SUBSTANTIATED.

The evidence confirms the CFNIS failed to disclose Cpl Langridge's suicide note to the complainants at any time during the 2008 investigation. There is no evidence early disclosure of the existence and content of the note and, in particular, of the funeral wishes it contained could have caused any jeopardy to the investigation.¹⁴⁷ In fact, in the early days of the investigation and well before Cpl Langridge's funeral, sufficient evidence had already been gathered as a practical matter to rule out foul play.¹⁴⁸

It is clear there were never any reasons to suspect foul play in this case. The conduct of the investigation reveals the CFNIS members were not actively investigating suspicions of foul play but were simply refraining from drawing a final conclusion until confirmation was obtained from the ME as to the cause of death.¹⁴⁹ This was not sufficient reason to withhold disclosure of the information contained in the suicide note to Cpl Langridge's family.¹⁵⁰ Moreover, the evidence has revealed there was no basis for reasonable suspicion about the authenticity of the note and, indeed, no steps were ever taken to confirm it.¹⁵¹

The evidence also confirms the CFNIS did not come forward to reveal the existence of the suicide note at any time after the investigation was concluded.¹⁵² When the BOI inquired about the existence of a suicide note, the CFNIS members took no steps to ensure it was disclosed to the family.¹⁵³ When the BOI disclosed the existence of the note to the complainants, the CFNIS initially resisted their request to obtain the original suicide note.¹⁵⁴ There was no rational justification for this response, which only increased the distress caused to the complainants as a result of the failure to disclose their son's suicide note to them.

The Commission finds the failure to disclose the suicide note for over 14 months after the death shocking and beyond comprehension.

Once the failure was discovered, the evidence reveals the CFNIS members failed to provide an immediate and unqualified apology to the complainants.¹⁵⁵ The CFNIS members also failed to make the necessary inquiries to discover the actual reasons the note had not been disclosed.¹⁵⁶ As a result, they were unable to provide the complainants with a real explanation, and some of the information they provided to the complainants, the public and other members of the CF, was not entirely accurate.¹⁵⁷

The CFNIS members failed to put in place sufficient measures to ensure this type of failure does not happen again.¹⁵⁸ The modification of written policies and procedures took an excessively long time to complete, and current policies are insufficient to address the issue and, in particular, to ensure funeral wishes are disclosed to families in a timely manner.¹⁵⁹ While CFNIS leadership did provide verbal directives and conduct case-by-case monitoring in an effort to avoid similar incidents, the CFNIS members failed to develop and disseminate within the organization an appropriate understanding of the criteria to be used to determine when suicide notes should be disclosed and released.¹⁶⁰

27. NIS members failed to promptly cut down Cpl Langridge and show respect for his body once they arrived at the scene.

The Commission finds this allegation to be UNSUBSTANTIATED.

The evidence demonstrates the CFNIS members present at the death scene showed no disrespect to Cpl Langridge's body. The expert evidence heard by the Commission confirms police attending at a death scene should not move or disturb the body unless absolutely necessary.¹⁶¹ The evidence also establishes the sole authority to move or remove Cpl Langridge's body belonged to the Alberta Medical Examiner. The practice of the Alberta ME's office was not to lower a body until they were ready to remove it from the scene.¹⁶² The expert evidence also shows it would have been improper to attempt to cover the body in any way prior to removal.¹⁶³ There is no evidence Cpl Langridge's

body was made into a spectacle. To the contrary, appropriate steps were taken to ensure the body could not be viewed by passersby.¹⁶⁴

The Commission cannot conclude the time that elapsed between the discovery of Cpl Langridge's body and the removal of his body from the scene was unreasonable. The evidence establishes the time taken was not outside the reasonable range even if some of the steps taken by the CFNIS investigators to document the scene prior to the removal of the body were not strictly necessary.¹⁶⁵ The investigators were inexperienced and this caused some delay, but they acted in good faith to do what they believed was necessary in order to preserve potential evidence.¹⁶⁶ The ME Investigator agreed, in the spirit of cooperation, to wait until the CFNIS investigators had documented the scene before moving Cpl Langridge's body but could have hastened the removal if it had been necessary.¹⁶⁷

28. NIS failed to dispose of the seized exhibits when closing the Sudden Death investigation in July 2008 and failed to have the items returned to the complainants in a timely manner.

The Commission finds this allegation to be SUBSTANTIATED.

The evidence shows the CFNIS members took no steps to have the seized exhibits disposed of at the conclusion of the investigation. Because there were no adequate processes in place at the Detachment, disposal of exhibits did not generally proceed in a timely manner and was, in fact, often delayed for years.¹⁶⁸ In this case, it was only because the lead investigator received a request from the Director of Estates in October 2008 that steps were eventually taken to return the exhibits.¹⁶⁹ A letter requesting authority for disposal was then promptly sent to the Regiment CO, but almost three more months elapsed before a response was received.¹⁷⁰ Once it was, the items were promptly returned to the Regiment.¹⁷¹ Additional delays in having the items returned to the complainants by the Regiment related to communications between the Regiment and the complainants and were unrelated to any action taken by the CFNIS members.¹⁷²

Based on the policies in place at the time, it was reasonable for the CFNIS members involved to send a request for disposal authority.¹⁷³ However, the Commission notes the policies were confusing and difficult to understand, and clarification would be appropriate in this respect.¹⁷⁴ In particular, where items are no longer needed for an investigation or, at the latest, when a death investigation is concluded and no charges are anticipated, items should be returned immediately.¹⁷⁵

29. *NIS members failed to complete the 2009 PNOK and the 2010 Criminal Negligence investigations within a reasonable time.*

The Commission finds this allegation to be SUBSTANTIATED.

The specific allegations forming the basis of the 2009 investigation were unusual, and the members had to contend with changes of personnel during the investigation due to deployment or reassignment.¹⁷⁶ However, 535 days to complete the investigation is simply not reasonable. There were long periods of delay in which nothing was accomplished and the investigation seemed to stagnate.¹⁷⁷ It was the responsibility of the supervisors to ensure the investigation continued to move forward and was completed in a reasonable time. In this investigation, this responsibility fell particularly on the shoulders of the OC, who led the file at its outset and was ultimately responsible for the conduct of the file. While personal circumstances may have prevented him from being able to fully engage in the latter stages of the investigation, this does not excuse the inordinate amount of time it took to complete the investigation.¹⁷⁸

The time taken to complete the 2010 is similarly unreasonable. In fact, throughout most of the period when the investigation remained open, absolutely nothing was done to investigate the allegations, review the materials available or perform any analysis.¹⁷⁹ The evidence indicates a decision had been made to conclude the 2010 investigation as early as August 2010.¹⁸⁰ The decision to keep the investigation open in case new information came to light in the 2009 investigation or in order to provide a common briefing to the complainants was simply not reasonable.¹⁸¹ The two investigations were not factually related. As such, there was no reason to expect relevant evidence could be uncovered during the 2009 investigation. Further, the conclusion of the 2010 investigation should

not have been delayed for the sole purpose of providing a common briefing to the complainants, especially considering the briefing, in fact, never took place.¹⁸²

30. *NIS members failed to provide their written briefing within a reasonable time after the verbal briefing on the 2009 and 2010 investigations was cancelled in February 2011.*

The Commission finds this allegation to be SUBSTANTIATED.

After the CFNIS made the decision to cancel the verbal briefing initially offered to the complainants, a delay of over two months elapsed before they were provided with the written briefing promised in replacement.¹⁸³ The evidence reveals no acceptable justification for this delay. The draft briefing was prepared and approved by CFNIS HQ in early March 2011, but the letter was not signed and sent by the OC until late April 2011.¹⁸⁴ While this may, in part, be explained by some personal issues impacting on the availability of the OC, the Commission has heard no evidence to explain why other members of the Detachment could not have attended to this matter.¹⁸⁵

31. *The NIS members involved in the investigations lacked the experience and training necessary to perform these investigations. They did not appear to have knowledge of the appropriate steps to take and appeared paralysed in any ability to take initiative.*

The Commission finds this allegation to be SUBSTANTIATED.

The evidence reveals the CFNIS members involved in the investigations had only limited field experience related to the investigation of sudden deaths in a domestic context.¹⁸⁶

The lack of experience of the members involved in the 2008 Sudden Death investigation was particularly striking. The lead investigator had never previously conducted a death investigation or attended a death scene.¹⁸⁷ His immediate supervisor had also never been involved in conducting or supervising a death investigation.¹⁸⁸ The other members of the investigative team had limited experience with death investigations in a domestic context.¹⁸⁹

Many of the deficiencies observed in the 2008 investigation were a direct result of the lack of experience of the members involved. From the outset, the investigation lacked focus, clear objectives, or a meaningful plan. In the name of keeping an open mind, the members did not form or test hypotheses and lacked the flexibility and judgment to respond appropriately to new information or address, in a critical fashion, ambiguity and contradictions in the evidence.¹⁹⁰ The members did not appear to understand how to properly handle seized items, including the suicide note.¹⁹¹ The supervisors failed to provide appropriate supervision and guidance to the investigators.¹⁹²

Neither the very serious deficiencies in the sudden death investigation identified by the Commission, nor the lack of experience which led to them, were recognized as problems by the CFNIS witnesses, including members of the CoC who testified before the Commission. There is no evidence these problems have been addressed by the CFNIS.¹⁹³

The evidence shows the problems encountered were not the result of lack of training. The CFNIS members received appropriate formal training to conduct criminal investigations, including training relevant to the processing of death scenes.¹⁹⁴

With respect to the 2009 and 2010 investigations, because the nature of the allegations and the investigations to be conducted were not common or usual, it is not surprising most of the members had limited experience in conducting similar investigations.¹⁹⁵ Unlike the situation for the 2008 Investigation, however, it cannot be concluded the deficiencies in these two investigations were caused by lack of experience.

32. NIS reports contained inaccurate factual statements. In particular:

- a) The 2008 investigation report contained incorrect facts, including an account of a suicide attempt and hospitalization of Cpl Langridge, whereas hospital records show he was not hospitalized during this period and the MP making the statement took no notes about the incident. The inaccurate factual**

statements were not re-examined by NIS members when the complainants brought new facts to their attention.

The Commission finds this allegation to be SUBSTANTIATED IN PART.

Many of the statements contained in the 2008 report simply recorded the information received by the investigators.¹⁹⁶ While this information was not always accurate, the CFNIS members cannot be faulted for reporting what they learned. On the contrary, this is a necessary part of police work. The example listed in this allegation refers to information provided to the CFNIS by Sgt Murrin of the local MP. The Commission finds this information was accurately reported by the investigators.¹⁹⁷ While some aspects of it may have been incorrect or questionable, it is clear the suicide attempt referred to did, in fact, occur.¹⁹⁸ This information was not an example of inaccurate information included in the report by the CFNIS members.

However, the Commission finds the report did contain other information that was inaccurate because it was not adequately recorded by the investigators. In particular, some of the interview summaries prepared by the CFNIS members did not accurately reflect the information received, including inaccurate notations indicating Cpl Langridge had attempted suicide in 2003, and indicating Sgt Hiscock had stated there was no suicide watch for Cpl Langridge.¹⁹⁹ While these were clearly the result of unintentional errors, poor recordkeeping could be observed in many instances, and this had an impact on the information available to supervisors reviewing the entries as well as on the information ultimately provided to the CF CoC when the investigation was concluded.²⁰⁰

b) The written briefing for the 2009 and 2010 investigations incorrectly stated that both of the investigations had been opened at the request of the complainants.

The Commission finds this allegation to be UNSUBSTANTIATED.

The information contained in the written briefing was not inaccurate. The evidence reveals there was a lack of clarity as to the identity of the complainant within the 2009

investigative file.²⁰¹ However, the evidence also reveals the CFNIS members involved in the investigation generally viewed the Fynes as the true complainants while they viewed the Ombudsman's investigator as a "third party complainant" or a conduit for the Fynes' complaint.²⁰² The Commission finds this approach was reasonable.

The statements made in the written briefing did not misrepresent the situation. The letter did not purport to identify the Fynes as the sole complainants. It only stated they had made verbal allegations and noted the investigation focused on those allegations.²⁰³ This statement was accurate.

- c) *The statement in the 2009 investigation written briefing that the NDA trumps all provincial law was inaccurate.*

The Commission finds this allegation to be SUBSTANTIATED.

The Commission finds the unqualified statement included in the written briefing was inaccurate in the context of this investigation. Whether federal law (in this case the *National Defence Act*) will prevail over provincial law in specific circumstances depends on a number of factors, which were not considered by the CFNIS members.²⁰⁴ Provincial law should not have been dismissed out of hand in this case, and it may well have been relevant to answer some of the questions under investigation.²⁰⁵ In order to clarify the situation, a legal opinion was necessary.

However, the Commission notes the statement included in the briefing was not intended to mislead the complainants.²⁰⁶ It accurately reported the legal theory adopted during the investigation. It was inaccurate because of a failure in the legal analysis, not because of a failure to provide information to the complainants.

- 33. *Inaccurate rationales were provided by NIS members to explain or justify the actions taken by NIS. In particular:*

- a) *NIS members, during a meeting with the complainants, justified the NIS decision not to provide the suicide note sooner on the basis that it had to be kept in case of appeals.*

The Commission finds this allegation to be UNSUBSTANTIATED.

The Commission has reviewed the transcripts for the three CFNIS interviews with the complainants and has heard evidence from the members involved in the meetings. The Commission finds there was no discussion related to the possibility of appeals during any of the meetings.²⁰⁷ While the CFNIS members did, at times, take the position it was legitimate not to disclose the existence of the suicide note to the complainants early in the investigation, and, in particular, prior to the funeral, there is no evidence they ever referred to the possibility of appeals to justify the failure to disclose the note for 14 months.²⁰⁸

In a response provided to the Fynes through Col Blais, the CFNIS members did refer to a policy providing for the retention of exhibits to provide for an appeal period.²⁰⁹ However, this reference was not included in the response directly addressing the failure to disclose the suicide note.

- b) NIS members inaccurately stated that the responsibility for failing to promptly cut down Cpl Langridge's body rested with the Alberta Medical Examiner.*

The Commission finds this allegation to be UNSUBSTANTIATED.

The Commission finds the CFNIS members accurately described the legal authority to make decisions for the removal of Cpl Langridge's body.²¹⁰ In this respect, they correctly stated the authority rested solely with the Alberta ME.²¹¹ However, the Commission has also noted the responses provided to the complainants about this issue were not entirely accurate. By focusing solely on the legal authority to make the decision, the responses implied the CFNIS investigators played no part in delaying the removal of Cpl Langridge's body.²¹² This was not consistent with the facts. While the CFNIS did not have authority to make the decision, the evidence has revealed it was because of a request by the CFNIS investigator that the ME investigator waited a longer period prior to removing Cpl Langridge's body.²¹³

- c) *NIS members took the position that it was not their responsibility if the ME overheard things during the processing of the scene and made his inaccurate comment about the disciplinary issues on that basis.*

The Commission finds this allegation to be UNSUBSTANTIATED.

The evidence reveals the CFNIS investigators were not, in fact, responsible for the comment included in the ME Certificate.²¹⁴ The statements made by the CFNIS members about this issue were accurate.²¹⁵

- d) *NIS members advised the complainants that, under MP policies, they were allowed to retain the exhibits for a period of one year to provide for an appeal period.*

The Commission finds this allegation to be SUBSTANTIATED IN PART.

In a response provided to the complainants to explain the failure to return the exhibits in a timely manner after the 2008 investigation, the CFNIS members did make reference to a policy providing for a retention period for the time during which an appeal may be launched.²¹⁶ Like many of the other policies referred to in the response, this policy had no application to this case as no charges had been brought.²¹⁷

The response provided no explanation about the reasons for not returning the exhibits earlier. By referring to all of the policies related to the return of exhibits, including the one about the appeal period, the response implied these policies were the reason the exhibits were not returned immediately upon the conclusion of the investigation.²¹⁸ This was not an accurate explanation.

¹ See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.

² See Section 4.6, CFNIS Independence and Impartiality.

³ See Section 4.6, CFNIS Independence and Impartiality.

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- ⁴ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶ See, generally, Section 4.6, CFNIS Independence and Impartiality.
- ⁷ See Section 4.6, CFNIS Independence and Impartiality.
- ⁸ See Section 4.6, CFNIS Independence and Impartiality.
- ⁹ See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰ See Section 4.6, CFNIS Independence and Impartiality.
- ¹¹ See, generally, Section 4.6, CFNIS Independence and Impartiality.
- ¹² See Section 4.6, CFNIS Independence and Impartiality.
- ¹³ See Section 4.6, CFNIS Independence and Impartiality.
- ¹⁴ See Section 4.1.4, The 2008 Investigation – The Concluding Remarks.
- ¹⁵ See Section 4.1.4, The 2008 Investigation – The Concluding Remarks.
- ¹⁶ See Section 4.1.4 The 2008 Investigation – The Concluding Remarks; 4.1.2 The 2008 Investigation – Investigating Negligence.
- ¹⁷ See Section 4.6, CFNIS Independence and Impartiality.
- ¹⁸ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ¹⁹ See: Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing
- ²⁰ See Section 4.1.1 The 2008 Investigation – Investigating the Sudden Death.
- ²¹ See Section 4.1.3, The 2008 Investigation – The Investigation Plan.
- ²² See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ²³ See Section 4.6, CFNIS Independence and Impartiality.
- ²⁴ See Section 4.1.1 The 2008 Investigation – Investigating the Sudden Death; 4.1.2 The 2008 Investigation – Investigating Negligence.
- ²⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ²⁶ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ²⁷ See Section 4.1.3, The 2008 Investigation The Investigation Plan.
- ²⁸ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ²⁹ See Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ³⁰ See Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ³¹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.6, CFNIS Independence and Impartiality.
- ³² See Section 4.6, CFNIS Independence and Impartiality.
- ³³ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ³⁴ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ³⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.

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- ³⁶ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; 4.1.2, The 2008 Investigation – Investigating Negligence.
- ³⁷ See Section 4.6, CFNIS Independence and Impartiality
- ³⁸ See Section 4.6, CFNIS Independence and Impartiality
- ³⁹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁴⁰ See Section 2.0, Narrative; Section 4.1.2, The 2008 Investigation – Investigating Negligence.
- ⁴¹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁴² See Section 4.6, CFNIS Independence and Impartiality.
- ⁴³ See Section 4.6, CFNIS Independence and Impartiality.
- ⁴⁴ See, generally, Section 4.6, CFNIS Independence and Impartiality.
- ⁴⁵ See Section 4.5.5, CFNIS Interactions with the Fynes – The Stockholm Syndrome Comment.
- ⁴⁶ See Section 4.5.5, CFNIS Interactions with the Fynes – The Stockholm Syndrome Comment.
- ⁴⁷ See Section 4.5.5, CFNIS Interactions with the Fynes – The Stockholm Syndrome Comment.
- ⁴⁸ See Section 4.5.5, CFNIS Interactions with the Fynes – The Stockholm Syndrome Comment.
- ⁴⁹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁰ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵¹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵² See Section 4.6, CFNIS Independence and Impartiality.
- ⁵³ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁴ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁵ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁶ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁷ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁸ See Section 4.6, CFNIS Independence and Impartiality.
- ⁵⁹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁰ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶¹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶² See Section 4.6, CFNIS Independence and Impartiality.
- ⁶³ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁴ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁵ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁶ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁷ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁸ See Section 4.6, CFNIS Independence and Impartiality.
- ⁶⁹ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.
- ⁷⁰ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report.

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- ⁷¹ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Section 4.6, CFNIS Independence and Impartiality.
- ⁷² See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Section 4.6, CFNIS Independence and Impartiality.
- ⁷³ See Section 4.6, CFNIS Independence and Impartiality.
- ⁷⁴ See Section 4.6, CFNIS Independence and Impartiality.
- ⁷⁵ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Section 4.6, CFNIS Independence and Impartiality.
- ⁷⁶ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Section 4.6, CFNIS Independence and Impartiality.
- ⁷⁷ See Section 4.5.2, CFNIS Interactions with the Fynes – Obtaining the 2008 Investigation Report; Section 4.6, CFNIS Independence and Impartiality.
- ⁷⁸ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact; Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁷⁹ See Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact; Section 4.2, The Suicide Note Left by Cpl Langridge.
- ⁸⁰ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ⁸¹ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁸² See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁸³ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁸⁴ See, generally Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁵ See Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁶ See Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁷ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing; Section 4.6, CFNIS Independence and Impartiality.
- ⁸⁸ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁸⁹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁹⁰ See Exhibit P-5, Collection E, vol. 1, tab 1, doc. 1131, p. 18; Testimony of LCol Sansterre, Transcript of Proceedings, vol. 61, 10 October 2012, p. 165; Section 4.6, CFNIS Independence and Impartiality.
- ⁹¹ See Section 4.6, CFNIS Independence and Impartiality.
- ⁹² See Section 4.6, CFNIS Independence and Impartiality.
- ⁹³ See Section 4.6, CFNIS Independence and Impartiality.
- ⁹⁴ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁹⁵ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.

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- ⁹⁶ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ⁹⁷ See Section 4.6, CFNIS Independence and Impartiality.
- ⁹⁸ See Section 4.1, The 2008 Investigation; Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.
- ⁹⁹ See Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ¹⁰⁰ See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ¹⁰¹ See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ¹⁰² See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ¹⁰³ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁴ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁵ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁶ See Section 4.1.2, The 2008 Investigation Investigating Negligence; 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁷ See Section 4.1.2, The 2008 Investigation Investigating Negligence; 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁸ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁰⁹ See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ¹¹⁰ See Section 4.1.2, The 2008 Investigation Investigating Negligence.
- ¹¹¹ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹¹² See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹¹³ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁴ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁵ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁶ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁷ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁸ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹¹⁹ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death.
- ¹²⁰ See Section 4.1.3, The 2008 Investigation – The Investigation Plan; 4.1.4, The 2008 Investigation – The Concluding Remarks; 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ¹²¹ See Section 4.3, The 2009 PNOK Investigation.
- ¹²² See Section 4.3, The 2009 PNOK Investigation.
- ¹²³ See Section 4.3, The 2009 PNOK Investigation.
- ¹²⁴ See Section 4.3, The 2009 PNOK Investigation.
- ¹²⁵ See Section 4.3, The 2009 PNOK Investigation.
- ¹²⁶ See Section 4.3, The 2009 PNOK Investigation.
- ¹²⁷ See Section 4.3, The 2009 PNOK Investigation.

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- ¹²⁸ See Section 4.3, The 2009 PNOK Investigation.
- ¹²⁹ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁰ See Section 4.3, The 2009 PNOK Investigation.
- ¹³¹ See Section 4.3, The 2009 PNOK Investigation.
- ¹³² See Section 4.3, The 2009 PNOK Investigation.
- ¹³³ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁴ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁵ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁶ See Section 4.3, The 2009 PNOK Investigation; Section 4.5.4, CFNIS Interactions with the Fynes: 2009/2010 Investigations – Interviews, Updates and Briefing.
- ¹³⁷ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁸ See Section 4.3, The 2009 PNOK Investigation.
- ¹³⁹ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background; Section 4.1.9, The 2008 Investigation – The Consequences of Inexperience.
- ¹⁴⁰ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ¹⁴¹ Section 4.1.6, The 2008 Investigation – Search Warrants.
- ¹⁴² Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁴³ Section 4.3, The 2009 PNOK Investigation.
- ¹⁴⁴ Section 4.3, The 2009 PNOK Investigation; Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁴⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁴⁶ See Section 4.5, CFNIS Interactions with the Fynes.
- ¹⁴⁷ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁴⁸ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁴⁹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁵⁰ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵¹ See Section 4.2, The Suicide Note Left by Cpl Langridge; 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁵² See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵³ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.5.1, CFNIS Interactions with the Fynes – Early Contact.
- ¹⁵⁶ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵⁷ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁵⁹ See Section 4.2, The Suicide Note Left by Cpl Langridge.

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- ¹⁶⁰ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁶¹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶² See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶³ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶⁴ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶⁵ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶⁶ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶⁷ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ¹⁶⁸ See Section 4.1.7, The 2008 Investigation – Return of Exhibits; Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁶⁹ See Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ¹⁷⁰ See Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ¹⁷¹ See Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ¹⁷² See Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ¹⁷³ See Section 4.1.7, The 2008 Investigation – Return of Exhibits.
- ¹⁷⁴ See Section 4.1.7, The 2008 Investigation – Return of Exhibits; Section 6.0, Recommendations.
- ¹⁷⁵ See Section 6.0, Recommendations.
- ¹⁷⁶ See Section 4.3, The 2009 PNOK Investigation.
- ¹⁷⁷ See Section 4.3, The 2009 PNOK Investigation.
- ¹⁷⁸ See Section 4.3, The 2009 PNOK Investigation.
- ¹⁷⁹ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁸⁰ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁸¹ See Section 4.4, The 2010 Criminal Negligence Investigation.
- ¹⁸² See Section 4.5.4, CFNIS Interaction with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ¹⁸³ See Section 4.5.4, CFNIS Interaction with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ¹⁸⁴ See Section 4.5.4, CFNIS Interaction with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ¹⁸⁵ See Section 4.5.4, CFNIS Interaction with the Fynes, 2009/2010 Investigations – Interviews, Updates and Briefing.
- ¹⁸⁶ See Section 4.1.9, The 2008 Investigation – The Consequences of Inexperience.
- ¹⁸⁷ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹⁸⁸ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹⁸⁹ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹⁹⁰ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death; Section 4.1.2, The 2008 Investigation Investigating Negligence.

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- ¹⁹¹ See Section 4.1.1, The 2008 Investigation Investigating the Sudden Death; Section 4.2, The Suicide Note Left by Cpl Langridge.
- ¹⁹² See Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ¹⁹³ See Section 4.1.9, The 2008 Investigation – The Consequences of Inexperience.
- ¹⁹⁴ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹⁹⁵ See Section 4.0, The Subjects of the Complaint: Role, Involvement and Background.
- ¹⁹⁶ See, generally, Section 4.1.5, The 2008 Investigation – Recordkeeping and Supervision.
- ¹⁹⁷ See Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 3.0, The Narrative; Exhibit P-1, Collection A, vol. 1, tab 1, doc. 001, p. 248; Testimony of Sgt Murrin, Transcript of Proceedings, vol. 10, 16 April 2012, pp. 182-213.
- ¹⁹⁸ See Section 4.1.2, The 2008 Investigation – Investigating Negligence; Section 3.0, The Narrative
- ¹⁹⁹ See Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ²⁰⁰ See Section 4.1.5, The 2008 Investigation – Supervision and Recordkeeping.
- ²⁰¹ See Section 4.3, The 2009 PNOK Investigation; Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰² See Section 4.3, The 2009 PNOK Investigation; Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰³ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰⁴ See Section 4.3, The 2009 PNOK Investigation; Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰⁵ See Section 4.3, The 2009 PNOK Investigation; Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰⁶ See Section 4.5.4, CFNIS Interactions with the Fynes, 2009 and 2010 Investigations – Interviews, Updates and Briefing.
- ²⁰⁷ See Section 4.2, The Suicide Note Left by Cpl Langridge.
- ²⁰⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge; Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing.
- ²⁰⁹ See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹⁰ See Section 4.5.3, CFNIS Interactions with the Fynes – The November 2009 Briefing; Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹¹ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ²¹² See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹³ See Section 4.1.1, The 2008 Investigation – Investigating the Sudden Death.
- ²¹⁴ See Section 4.6, CFNIS Independence and Impartiality.
- ²¹⁵ See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹⁶ See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹⁷ See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.
- ²¹⁸ See Section 4.5.6, CFNIS Interactions with the Fynes – CFNIS Answers to the Col Blais Questions.

VI. RECOMMENDATIONS

6.0 RECOMMENDATIONS

I. Investigative Deployments for Sudden Deaths

There is no substitute for experience in the conduct of sudden death investigations. The evidence before the Commission suggests a lack of relevant domestic experience for the Canadian Forces National Investigation Service (“CFNIS”) in the investigation of sudden deaths. In order to allow the CFNIS to gain the requisite domestic experience, while ensuring that in the interim, investigations of sudden deaths on Defence Establishment¹ property are conducted under the direction of appropriately experienced lead investigators, **the Commission recommends:**

- 1. The Canadian Forces Provost Marshal (CFPM) direct appropriate protocols be entered into with federal, provincial or municipal police agencies, to ensure ongoing opportunities for CFNIS investigators to gain sufficient field experience in sudden death investigations to qualify as lead investigators for CFNIS sudden death investigations, such experience consisting of active and significant involvement in a minimum of 15 sudden death investigations.**
- 2. The CFPM direct the existing Military Police Policy and Technical Procedure (MPPTP) Chapter 7, Annex I² (or corresponding MP Order) dealing with sudden death investigations, be amended to permit the assignment of federal, provincial or municipal police investigators as lead investigators for sudden death investigations occurring on Defence Establishment property.**
- 3. The CFPM direct all sudden death investigations on Defence Establishment property be led by experienced federal, provincial or municipal police investigators until such time as sufficient numbers of CFNIS investigators possess the necessary field experience in sudden death investigations to qualify as lead investigators.**
- 4. The CFPM direct protocols and agreements be established with the federal, provincial or municipal police agencies to secure their agreement to provide lead investigators for the investigation of sudden deaths on Defence Establishment property.**

II. Policies, Orders and Directives: Documentation Reviews

Expert evidence from federal, provincial and municipal officers before this Commission demonstrates that many of the CFNIS policies, orders and directives currently in place are inadequate to deal with issues arising from sudden deaths. Some are inconsistent with one another; others are insufficiently detailed or explicit; and others still do not represent best practices.

The Commission recommends:

- 5. With respect to policies, orders and directives in general,**
 - a) The CFPM direct all existing Military Police (MP) and CFNIS policies, orders, directives and Standard Operation Procedures (SOPs) related, directly or indirectly, to sudden death investigations, be reviewed for consistency and compatibility with other existing orders, policies, directives and SOPs, and necessary adjustments be made to ensure such consistency;**
 - b) The CFPM direct that all new MP and CFNIS policies, directives, orders and SOPs be the subject of a similar review for consistency before adoption;**
 - c) The CFPM direct ongoing review of MP and CFNIS orders, policies, directives and SOPs related to sudden death investigations, including comparison to best practices by other Canadian police services, to ensure continuing consistency with recognized best practices;**

- 6. With respect to specific policies, orders and directives:**
 - a) the CFPM direct deletion from MPPTP Chapter 7, Annex I, section, “Death”, paragraph 1 (or corresponding MP Order) of the following sentence:**
 - b. All deaths will be handled IAW [in accordance with] the same stringent standards as homicide.³*
 - b) the CFPM direct replacement of the deleted extract with a provision stating:**
 - i. all instances of sudden or unexplained death or of human remains being found on Defence Establishment property be approached initially as potential homicides until reasonably determined otherwise;**

- ii. for deaths for which foul play has not been reasonably ruled out, and for deaths determined in fact to be homicide, stringent procedures designed to collect and safeguard evidence to preserve its integrity and continuity continue to be applied;
 - iii. for deaths reasonably determined not to be potential homicides, different investigative procedures, including turning over various investigative responsibilities to provincial coroners or medical examiners (ME), will be appropriate.
- c) the CFPM direct the addition of the above provision in CFNIS SOP 237.⁴
- d) the CFPM direct deletion of the portion of MPPTP Chapter 7, Annex I, section, “Suicide and Attempted Suicide” (or corresponding MP Order), stating:

*Administrative details (previous attempts, possible causes, marital status, alcohol or drug dependencies, etc.) need not be actively pursued and should only be reported if they are offered unsolicited to MP. It must be recognized that a Board of Inquiry or Summary Investigation designed to determine the administrative details will be initiated and will report relevant facts to the appropriate departmental authority.*⁵
- e) The CFPM direct replacement of the deleted extract, consistent with CFNIS SOP 237, with a provision instructing investigators to:

*gain a comprehensive understanding of the background of the deceased, including medical and psychological state, (medication or alcohol consumption)*⁶
- f) the CFPM direct deletion in clause 3 of the “General Statement” section of CFNIS SOP 237, of the following:

*Do not make assumptions or lose evidence based on misconceptions or inexperience.*⁷
- g) The CFPM direct replacement of the deleted extract with a new section:
 - i. cautioning investigators against making hasty assumptions;

- ii. **affirming the investigative propriety of formulating hypotheses to be tested against the facts and evidence as discovered;**
 - iii. **cautioning investigators to bear in mind at all times the need to preserve the integrity and continuity of evidence until its potential relevance has been reasonably ruled out.**
- h) **the CFPM direct deletion from clause 11 in the “Action” section of CFNIS SOP 237, of the following extract:**

Where there is no suspicion of foul play, you are generally permitted to act under the authority of the respective Province’s Coroners Act. The relevant act will typically authorize the investigator to exercise any power of the Coroner, including possession of the body, entering and inspecting any place where the body is or from which it was removed. Investigators under this authority are generally permitted access to the location the deceased was prior to death, to inspect and extract information from any record or writing relating to the deceased, or seize anything that you have reasonable grounds to believe is material to the investigation.⁸

- i) **the CFPM direct replacement of the deleted extract with a provision consistent with the law and jurisprudence in each province setting out the powers, if any, for MP to act under the authority of that jurisdiction’s *Coroners Act* or equivalent.**

III. Supervision

The evidence before this Commission demonstrates inconsistent and in some cases inadequate supervision. Meaningful supervision requires an informed understanding of the issues under investigation in order to provide meaningful feedback to the investigators, as well as diligent supervisory follow-up on issues of concern to ensure allegations have been properly and fully investigated.

The Commission recommends:

- 7. The CFPM direct policies and practices with respect to supervision be put into effect stating:**

- a) **investigations involving complex facts or allegations require active, informed and involved supervision;**
- b) **where an investigation is led by an investigator with limited experience in the specific type of investigation being undertaken, the Case Manager must have significant experience in such investigations;**
- c) **in all cases involving complex facts or allegations, Senior MP advisors must be alert to possible gaps in experience by investigators or Case Managers and must manage resources, including human resources, accordingly;**
- d) **supervisors are to record in the General Occurrence (GO) file any directions given with respect to the conduct of an investigation, including the reasons for those directions.**

IV. Return of Property and Evidence

The evidence before this Commission demonstrates there was no well understood process in place at CFNIS WR Detachment for the return of property and evidence, and that policies dealing with these matters were incoherent and lacking in clarity, with the result that return of property and evidence was delayed beyond what was reasonably necessary.

The Commission recommends:

- 8. **The CFPM direct that seized property and evidence no longer required for investigations be returned to the rightful owners and/or disposed of in a timely manner, pursuant to the following principles:**
 - a) **property or evidence is to be returned to its rightful owner or otherwise disposed of when it is no longer needed for investigative purposes;**
 - b) **in sudden death investigations, property or evidence is no longer needed for investigative purposes when the death is reasonably determined not to have been a homicide, and/or there is no reasonable prospect of a criminal or service charge being laid;**
 - c) **in sudden death investigations, property or evidence is no longer needed for investigative purposes at the latest at the conclusion of the investigation, where a determination has been made that**

no criminal or service charges will be laid in connection with the death;

- d) in cases where a determination has been made that no charges will be laid in connection with the death, property and evidence no longer needed for investigative purposes in relation to a sudden death is to be returned immediately with no waiting period and with no disposal authority needing to be sought;**
- e) the policy with respect to return of suicide notes should be in accordance with recommendations 11 to 13.**

- 9. The CFPM direct amendment of the applicable portions of MPPTP Chapter 7⁹ and Chapter 7, Annex C¹⁰ (or corresponding MP Order(s)), CFNIS SOP 208,¹¹ CFNIS SOP 237¹² and CF MP GP Order 2-391¹³ and its relevant annexes, in accordance with the principles set out in this recommendation.**
- 10. The CFPM direct every CFNIS Detachment establish clear processes and allocate the necessary resources for the timely return of exhibits by ensuring investigators are responsible to make notations in the file once exhibits are no longer required for the investigation, and that a designated person is responsible for ensuring the exhibits are then returned immediately, with clear timelines established and supervisors monitoring the process.**

V. Suicide Notes

A prominent place in the PIH hearings was occupied by the issue of the failure by the CFNIS to ensure timely disclosure of the existence of a suicide note in this case and to provide it to the family. The evidence discloses serious efforts have been made to improve policy and practice on this topic, but further policy clarity and practical guidance are still needed.

The Commission recommends:

- 11. The CFPM direct the review and revision of Clause 21 of CFNIS SOP 237 dealing with Sudden Death,¹⁴ by including a revision within the SOP that provides for a stand-alone clause ensuring there is greater clarity relative to the release of suicide notes found at the scene of a suicide or in the course of a sudden death investigation.**

12. **The CFPM direct the section dealing with suicide notes found at the death scene or in the course of a sudden death investigation be revised, the revision to be focused on protocols for ensuring the apparent wishes of the deceased soldier be brought to the attention of the family or other most appropriate person prior to the soldier’s funeral.**
13. **The CFPM direct that, in drafting the new provision, the following principles are to be reflected:**
 - a) **The default position should always favour early disclosure of the existence and contents of suicide notes. Disclosure should only be delayed where there is a compelling reason to do so, based on concrete facts and evidence and not on abstract possibilities.**
 - b) **The criteria for determining the timing of disclosure should not be whether it has been determined the death was suicide. Instead, the question should be whether there is any actual, realistic reason to suspect foul play or to have doubts about the authenticity of the note.**
 - c) **Where there is a realistic suspicion of foul play, the criterion for determining whether the suicide note can be disclosed should be whether disclosure could harm the investigation. If a realistic harm cannot be identified, the suicide note should be disclosed.**
 - d) **Where questions about authenticity of the suicide note are invoked as a reason to delay disclosure, testing must be conducted to confirm authenticity.**
 - e) **Where funeral wishes or other time-sensitive information is contained in the suicide note, this should be taken into account in the determination. In such cases, if suspicion does exist and disclosure is delayed as a result, all available measures should be taken to conduct testing of the suicide note immediately. While it may not be possible to obtain absolute confirmation of the suicide note’s authenticity prior to the funeral, preliminary testing such as handwriting comparison could provide at least the necessary indications to determine whether the level of suspicion is sufficient to deprive a family of the opportunity to fulfill what may well be their loved one’s last wishes.**
 - f) **A desire to protect the family from potential “harm” that could result from early disclosure of a suicide note, if it was later discovered the suicide note was not authentic, is not sufficient reason to delay disclosure. If no realistic harm to the investigation could result from disclosure, the proper procedure will be to disclose the existence and contents of the suicide note**

to the family, and to advise them final confirmation of the cause of death or authenticity of the suicide note has not yet been obtained. Under such circumstances, families should be allowed to make their own decisions about whether to honour any wishes contained in the suicide note.

- g) Once the family has received a copy of the suicide note, the CFNIS may need to retain the original for a certain period of time. The level of suspicion required to justify retaining the original will not be as great as what would be required to justify not telling the family about the suicide note at all. If releasing the original could hinder the investigation – including by making it unavailable for testing or use as evidence if subsequent information revealed this was necessary – there will be justification for not proceeding immediately.**
- h) In all cases, the original suicide note should be returned to the family at the end of the investigation, unless court proceedings justify retaining it longer.**

VI. Interactions with Complainants and Families

Briefings to complainants or families should always be conducted with a view to addressing the needs of the complainants or of the families of deceased soldiers who are the subject of sudden death investigations.

The Commission recommends:

- 14. The CFPM direct CFNIS briefings to families at the end of a sudden death investigation contain meaningful, substantive information that addresses the main points covered in the investigation and answers the family's questions. Where questions cannot be addressed immediately, there must be follow up to provide substantive responses.**
- 15. The CFPM direct family briefing presentations be conducted, not by means of PowerPoint presentations or similar formal formats, but rather in an interactive, less formal manner that addresses the facts and findings from the point of view of the family and is geared to its perspective.**
- 16. The CFPM direct the portion of CFNIS SOP 237 dealing with Sudden Death – Next of Kin Briefings,¹⁵ be amended to specify that the lead investigator, or a person involved in the investigation having full**

- knowledge of all aspects of the investigation, must attend at a family briefing along with the other designated personnel.
17. The CFPM direct the portion of CFNIS SOP 237 dealing with Sudden Death – Next of Kin Briefings,¹⁶ be amended to delete the provision requiring the Assisting Officer (AO) to attend at family briefings, and to replace it with a provision providing the family with a choice as to whether the AO will attend.
 18. The CFPM direct these procedures for briefings with respect to sudden death investigations also be followed for briefings to victims or complainants in relation to any other CFNIS investigation, where briefings are provided.
 19. The CFPM direct that, in addition to the two briefings provided for in the Sudden Death SOP, the CFNIS provide ongoing contact, information and services for the family of the deceased in death investigations and for complainants in other investigations. Contact and services should be at least at the same level as services provided to victims pursuant to applicable victim services policies (i.e. MPPTP Chapter 5, Annex F¹⁷ (and corresponding MP Orders); CFNIS SOP 204;¹⁸ and CF MP GP Order 2-915¹⁹ and its relevant annexes).
 20. The CFPM direct that, in cases where MP decides not to investigate complaints (or ancillary complaints), the complainant must be informed promptly of the decision not to investigate, as well as of any other methods for potential recourse (such as contacting civilian law enforcement authorities) so as to allow the complainant to pursue such alternatives in a timely manner.
 21. The CFPM direct that MP investigators not make commitments or specific representations to complainants as to the approach or steps to be taken in an investigation. Where, however, such commitments or representations are made, the complainants must be advised of any change in the actual approach or steps taken.

VII. Investigative Plans

The evidence before this Commission suggests Investigation Plans (IP) are vital both as a planning tool for investigators and as a means to provide information on ongoing investigations to supervisors and the chain of command.

The Commission recommends:

- 22. The CFPM direct the establishment of a policy, directive or order with respect to IP:**
 - a) to require the IP to set out the investigative steps necessary to determine each of the issues requiring investigation, as well as the link between the proposed steps and relevant issues;**
 - b) to require all allegations that investigators believe merit investigation be specifically identified in the IP;**
 - c) to specify the notation “completed” in the IP should be used only to indicate the relevant question has been answered; and**
 - d) to specify where the evidence relevant to an investigative step is inconclusive a notation is to be made as to whether the issue will be pursued further along with an indication of the reasons for the decision.**

VIII. Interviews with Witnesses and Complainants

Interviews with witnesses or complainants must be meticulously documented to avoid subsequent possible controversy or confusion.

The Commission recommends:

- 23. The CFPM direct that, where feasible, all CFNIS interviews with witnesses or potential complainants be recorded in full by audio or audio-visual means.**
- 24. The CFPM direct complex allegations or complaints made to MP investigators be specifically reviewed with the complainants in order to ensure the essence of the allegation is understood, with the investigator verifying with the complainant whether a complaint is being made and what it is about.**

IX. Search Warrants

The Commission is alarmed by the evidence of incomplete or defective understanding of the law of search and seizure applicable to MP that emerged through testimony.

The Commission recommends:

- 25. The CFPM direct a review of training offered and demonstrated knowledge required for MP personnel with respect to the law of search and seizure related to police powers.**
- 26. The CFPM direct mandatory training with respect to police powers of search and seizure including:**
 - a) the information required to obtain judicial search warrants;**
 - b) powers of consensual search;**
 - c) powers of warrantless search and the circumstances when such powers can be exercised;**
 - d) powers of search and seizure under Provincial legislation related to sudden death investigation, including under *Coroners Acts* or equivalents;**
 - e) powers of search and seizure under the *National Defence Act*, including powers of a Commanding Officer to issue warrants in connection with the *Code of Discipline*.**

X. Investigator Continuity During Investigations

Lack of continuity in complex investigations poses significant challenges to effective and timely investigation.

The Commission recommends:

- 27. The CFPM direct that where a new MP Investigator assumes responsibility for an ongoing investigation:**
 - a) a full face-to-face briefing be conducted with the investigator by the departing investigator;**
 - b) prior to such briefing, the departing investigator conduct a detailed file review to ensure all documentation the new investigator may reasonably be expected to require is readily accessible;**
 - c) where special circumstances make the departing investigator unavailable, the briefing and/or file review be conducted by the departing investigator's direct supervisor.**

XI. Recordkeeping: General Occurrence Files and SAMPIS

Investigations depend on meticulous and accurate recordkeeping, both for the integrity of the investigation itself and for possible use of evidence and information for various judicial and/or regulatory purposes.

The Commission recommends:

- 28. The CFPM direct the CFNIS to ensure all significant investigative steps be accurately recorded in the GO file, including but not limited to:**
 - a) all documents obtained in the course of the investigation, as well as the source of the documents;**
 - b) a list of any documents related to the law reviewed by investigators, including, CF policy documents, orders, legislation or case law, as well as copies of such documents;**
 - c) any evaluation or summary of the documents prepared by investigators;**
 - d) a notation of any documents of particular relevance or importance to the investigation;**
 - e) a summary of any command team briefings and briefing material, including PowerPoint presentations used in the meeting;**
 - f) a notation of any decisions or conclusions that were reached based on the meeting;**
 - g) a notation of any direction that was given as a result of the meeting.**
- 29. The CFPM direct that complainants in an investigation be clearly identified in SAMPIS from the outset of the investigation.**
- 30. The CFPM direct where circumstances surrounding a sudden death give rise to the possibility of criminal charges or charges under the *Code of Discipline*, including charges arising from negligence, such matters be investigated separately and a separate GO file be created for investigative purposes.**
- 31. In order to ensure investigative assessments (also known as “preliminary investigations”) are detailed and comprehensive, the CFPM direct the amendment of MPPTP Chapter 2, Annex H²⁰ (and**

- corresponding MP Orders) and SOP 238²¹ to require investigators to record in detail the steps taken in reaching a conclusion about whether a complaint requires further investigation, the facts considered in reaching the conclusion, and the sources for those facts.
32. The CFPM prohibit the practice of making unattributed or misattributed modifications to GO file entries, and prohibit in particular the existing practice of supervisors amending and/or altering GO file documents created by subordinates without notation in the file indicating the change in authorship of the document.
 33. The CFPM direct engagement by the MP with SAMPIS software vendor, Versaterm, to design and implement a version control/revision control system by which SAMPIS preserves the original version of all entries made in a GO file and tracks and logs in detail any and all changes made to each entry.
 34. The CFPM direct engagement by the MP with Versaterm to customize the SAMPIS system and/or to develop policies and procedures to minimize the possibility of inadvertent incomplete disclosure of a GO file. The systems or policies developed should provide:
 - a) each printout of a GO file that is disclosed includes all documents on the file, with any redacted pages or entries being identified, and the total number of pages for all information available in the file being disclosed;
 - b) each printout of a GO file that is disclosed includes a notation of the date when each entry was created, as recorded in the system.
 35. The CFPM direct MP participation in collaboration between Versaterm and other police clients, including joining user groups and advisory committees, in order to help guide the development of future SAMPIS product enhancements to meet developing needs and trends in policing and public safety.

XII. MP Use of Canadian Armed Forces Investigations

The Canadian Armed Forces (CAF) conducts its own administrative investigative proceedings in connection with sudden deaths, suicides and attempted suicides of its members. Use by MP investigators of materials from such administrative proceedings carries with it serious risks for MP investigations.

The Commission recommends:

- 36. The CFPM direct policy guidance and training for MP investigators on the challenges and pitfalls of utilizing any materials from CAF investigations, including Boards of Inquiry (BOI) and Summary Investigations (SI).**
- 37. The CFPM direct that such training and guidance:**
 - a) alerts MP investigators to the risks of reviewing statements previously obtained under compulsion, including the risk that any statements subsequently obtained by the MP may be found inadmissible in eventual prosecutions;**
 - b) reminds MP investigators that facts uncovered in CAF investigations can never form the basis for an investigative assessment and that investigative assessments must be based either on the facts alleged by complainants or on the facts uncovered by the MP through preliminary investigation or prior related MP investigations;**
 - c) caution MP investigators that where materials or conclusions from CAF investigations have been reviewed, MP conclusions must nevertheless be based on their own investigation of the case.**

XIII. Media Relations Matters Affecting Both CAF and MP

Police independence in a CAF context requires not only MP independence in fact, but also public perception of such independence. Public relations and media communications initiatives where both CAF and MP are involved present challenges for which clearer policies and procedures are necessary.

The Commission recommends:

- 38. The CFPM direct policy guidance be provided for MP members with respect to media and public relations practices, to safeguard both the fact and the perception of police independence.**
- 39. The CFPM direct such policy guidance be based on the following principles:**

- a) **all MP contact with the media, formulation of media lines and release of public statements are to be separate from CAF public releases and formulation of media lines;**
 - b) **MP personnel are not to participate in joint statements or media lines with the CAF;**
 - c) **MP media lines or public statements are not to include CAF messages;**
 - d) **where MP personnel are present during media conferences or similar public events, questions regarding MP matters must be answered only by MP representatives.**
- 40. The CFPM direct discussions with appropriate CAF officials, aimed at establishing a framework protocol for media and public relations on topics where both MP and CAF are involved.**
- 41. The CFPM direct the framework protocol include the following principles:**
- a) **only the MP has authority for release of information about its activities and investigations;**
 - b) **all media questions regarding MP matters raised during CAF media events are to be referred to MP representatives and vice versa;**
 - c) **MP messages are not to be included in CAF media lines or public statements and vice versa;**
 - d) **consultations between CAF and MP on a media relations matters are to occur between the CFPM and Vice Chief of Defence Staff or their direct delegates.**

XIV. The ATIP Process

Lack of clarity regarding roles and responsibilities in the Access to Information and Privacy (ATIP) request process, as generally governed by the *Access to Information Act*²² and the *Privacy Act*,²³ may have a negative impact on the perception of police independence in terms of release of information connected with MP investigations. It may also impact the MP's ability to protect the integrity of its investigations.

The Commission recommends:

- 42. The CFPM enter into immediate discussions with the Minister of National Defence and other appropriate DND and/or CAF officials to ensure the MP receive full delegation of ATIP powers, duties or functions over MP documents and information in order to have final decision-making authority to refuse the release of information that may impact on ongoing investigations or police methods as well as final decision-making authority to release information according to legislation.**
- 43. The CFPM direct training for all MP members regarding the ATIP process as it relates to MP-generated information or documents.**

XV. Independent Counsel for Subjects at PIH Proceedings

The experience at this PIH confirms the Commission's experience in previous PIH proceedings that the joint representation by Government counsel of the subjects of a complaint along with numerous other individuals and institutions connected with the CAF and with Government, is problematic. It creates issues from a practical/logistical point of view, in terms of an appearance of fairness and in terms of protecting public confidence in the integrity of the PIH process. The interests of the subjects will not necessarily be aligned or be perceived to be aligned with the interests of the CAF, Government and military witnesses or institutional Government clients also being represented by Department of Justice (DOJ) lawyers.

The Commission recommends:

- 44. The CFPM direct negotiations be entered into with appropriate Government officials, including the Treasury Board of Canada and, if appropriate, the DOJ, to allow the subject(s) of a complaint to be indemnified for reasonable legal fees incurred in retaining independent (private) legal counsel for PIH proceedings.**

XVI. Waiver of Privilege

The Commission recognizes the common law privilege with respect to non-disclosure of solicitor-client communications is nearly absolute. However, the Commission is also aware that this privilege may be waived by a client. The position of the Government of Canada is that only the Minister of National Defence is the “client” with respect to all information and communications with a legal component exchanged by or with members of the MP and the CAF and that only the Minister can claim or waive privilege. Especially where a blanket claim of privilege is asserted, this can block access by the Commission to material that was or ought to have been before the MP or the CFNIS as part of their investigations and thus can compromise the Commission’s ability to exercise its statutory oversight mandate.

The Commission recommends:

- 45. The CFPM recommend to the Minister of National Defence, where claims of solicitor-client privilege are made over communications relevant to the subject matter of a PIH, to enter into an arrangement with the Commission to allow the Commission to access and review the materials, while otherwise keeping them confidential, in order to allow the Commission to discharge its oversight mandate. Such agreement could include, where appropriate, the hearing of evidence relevant to matters covered by the privilege claim in *in camera* proceedings.**
- 46. The CFPM recommend to the Minister of National Defence:**
 - a) to consider potential claims of solicitor-client privilege on a case-by-case basis;**
 - b) to consider waiving privilege over communications relevant to the subject matter of a PIH, except where the privilege relates to the legal interests of the subjects of the complaint;**
 - c) where the privilege relates to the legal interests of the subjects of the complaint, to delegate the decision to claim or to waive privilege to the subjects of the complaint.**

¹ *National Defence Act*, R.S.C., 1985, c. N-5, s. 2(1), “defence establishment”; Exhibit P-183, tab 3, doc. 1463, pp. 1 and 3.

² Exhibit P-148, tab 3, doc. 1428, pp. 1-5.

³ Exhibit P-148, tab 3, doc. 1428, p. 1.

⁴ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B.

⁵ Exhibit P-148, tab 3, doc. 1428, p. 4.

⁶ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 12.

⁷ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 9.

⁸ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 13.

⁹ Exhibit P-6, Collection F, vol. 1, tab 41, doc. 1188, p. 5.

¹⁰ Exhibit P-6, Collection F, vol. 1, tab 42, doc. 1189, pp. 12-16.

¹¹ Exhibit P-53, doc. 1350, pp 5-6.

¹² Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, p. 15.

¹³ Exhibit P-183, tab 12 doc. 1472.

¹⁴ Exhibit P-5, Collection E, vol.6, tab 13, doc. 1246-B, p. 15.

¹⁵ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 14-15.

¹⁶ Exhibit P-5, Collection E, vol. 6, tab 13, doc. 1246-B, pp. 14-15.

¹⁷ Exhibit P-6, Collection F, vol. 1, tab 35, doc. 1183, pp. 2-3.

¹⁸ Exhibit P-52, doc. 1349, pp. 2-3.

¹⁹ Exhibit P-183, doc. 1501, pp. 1-3.

²⁰ Exhibit P-6, Collection F, vol. 1, tab 33, doc. 1180, pp. 1-8.

²¹ Exhibit P-54, doc. 1352, pp. 1-3.

²² *Access to Information Act*, R.S.C., 1985, c. A-1.

²³ *Privacy Act*, R.S.C., 1985, c. P-21.

VII. THE MILITARY POLICE RESPONSE

7.0 THE MILITARY POLICE RESPONSE

1. The Military Police has provided a 90-page Notice of Action in response to the Commission's Interim Report. The Interim Report had been issued on May 1, 2014. The Notice of Action was received more than seven months later, on December 16, 2014.

2. In September 2014, the Commission was advised the Notice of Action was ready. However, the Military Police delayed issuing it because it wished to provide a briefing to the Senior Chain of Command of the Canadian Armed Forces (CAF) about its contents prior to its distribution.¹ In December 2014, the Military Police suggested delaying the Notice of Action further, this time in order to brief the Minister.² The Commission expressed its strong objection to this further delay.³ The Notice of Action was eventually issued shortly after.

3. Soon after the Notice of Action was issued, the Commission was advised the Military Police would not allow it to be included in the Commission's Final Report or otherwise published.⁴ The Military Police indicated the Notice of Action was to remain designated as "Protected B" and could not be disclosed to the public along with the Commission's Final Report.⁵ Despite the Commission's strong objection and its attempt to seek clarification of the reasons for this unprecedented position, the Military Police remained steadfast in its refusal to permit publication of the Notice of Action.⁶ As a result, very little can be said here about the contents of the Notice of Action. The purpose of the statutory requirement for the Military Police to provide the Notice of Action therefore cannot be achieved.

4. The Notice of Action is part of a broader statutory scheme creating independent civilian oversight for the Military Police. Rather than mandating the Military Police to follow binding recommendations, this scheme operates by imposing an obligation on the Military Police to explain to the parties in the case, to the Commission, to the Minister and, in the case of a Public Interest Hearing, to the public, what actions it will take to address the issues and the reasons for failing or refusing to take action, should it choose not to act on any of the Commission's findings or recommendations. This obligation is

meant to achieve the twin goals of accountability and transparency, which are essential for meaningful independent oversight.⁷ The Notice of Action is the means by which the Military Police has to answer to the Commission, to the parties, and to elected officials for its decisions. In a public interest case, it is also the means by which the public can be reassured that the oversight regime operates as it is meant to, and that any concerns are being appropriately addressed, or at least that it can be informed as to what is or is not being done and why.

5. The decision to prevent the publication of the Notice of Action in this case frustrates the fundamental goals of independent civilian oversight. The actual content of the Notice of Action, which the Commission has reviewed, is also not consistent with the purpose of oversight, as the Notice of Action largely fails to provide meaningful responses to the Commission's findings and recommendations and, in many cases, provides no response at all.

6. Because the Commission cannot reproduce the text of the Notice of Action, it is not possible to elaborate on the numerous issues it raises, both in terms of the few substantive responses it provides and in terms of the apparent refusal to provide responses. For this reason, the Commission has taken the necessary legal action to ensure the Notice of Action can eventually be made public. Once the Court delivers its final decision, the Commission will publish, in a manner and to an extent consistent with the Court's reasons, a more detailed chapter outlining the specific concerns raised by the text of the Notice of Action. In the meantime, the Commission can only publish the following general comments.

The Notice of Action

7. The Notice of Action rejects some 70% of the Commission's recommendations. A small number of the responses, amounting to less than 20% of the total, do so directly, by taking issue with the substance of the recommendations and indicating, albeit not always clearly or directly, that the recommendations will not be implemented.⁸ The recommendations that are rejected in this manner are:

- The Commission's main recommendations to have sudden death investigations on defence establishment property led by experienced civilian police investigators until CFNIS members acquire sufficient field experience in the conduct of such investigations through secondments with civilian police forces;⁹
- All of the Commission's recommendations relating to media relations matters affecting both the CAF and the MP, including the recommendations to put in place MP policies and to establish protocols with the CAF to ensure that public statements and responses of the MP and the CAF are kept separate;¹⁰
- The recommendation to enter into negotiations with appropriate Government officials to ensure that Military Police members who are the subject of a complaint can be compensated for the cost of retaining independent legal counsel to represent them in Public Interest Hearings;¹¹
- All of the Commission's recommendations relating to the waiver of solicitor-client privilege in cases where privilege claims can compromise the Commission's access to relevant information and its ability to exercise its statutory oversight mandate, including the recommendation to delegate to the subjects of complaints the decision to waive or claim privilege where the privilege invoked relates to their own legal interests;¹² and
- The recommendation to direct that complex allegations or complaints be specifically reviewed with the complainants to ensure the essence of the allegation is understood, with the investigator verifying with the complainant whether a complaint is being made and what it is about.¹³

8. Many of the reasons provided for rejecting these recommendations, where reasons are provided at all, raise their own substantive concerns in terms of an apparent lack of understanding or acknowledgement of the findings made and underlying issues identified in the recommendations. However, these concerns cannot be discussed without a more detailed review of the actual text of the responses. Since the Commission cannot engage

in this discussion here, it can only state that it does not accept the reasons provided for rejecting many of its most important substantive recommendations.

9. Approximately 30% of the responses in the Notice of Action accept the Commission's recommendations. However, this acceptance is not always complete or unqualified, and many of these "positive" responses raise serious concerns in their failure to acknowledge the substantive deficiencies identified in the findings. Again, because the text of the Notice of Action cannot be published, these concerns cannot be discussed further here.

10. Of the recommendations that are fully accepted without qualification and without raising further issues, one relates to a very general principle that is being agreed to without an accompanying commitment in other responses to concrete actions by which this principle will be put into effect. The others relate to more minor or technical issues. The fully accepted recommendations are:

- The Commission's recommendations to review all existing and new policies on sudden death investigations for consistency with other policies;¹⁴
- The recommendation to review sudden death investigations policies for consistency with best practices, including comparison to best practices by other police services;¹⁵
- The recommendation to add to the relevant CFNIS Standard Operating Procedure (SOP) a stand-alone clause related to the release of suicide notes found at the scene of a suicide or in the course of a sudden death investigation;¹⁶
- The recommendation to direct that the revision of the SOP section dealing with suicide notes be focused on protocols for ensuring the apparent wishes of the deceased soldier be brought to the attention of the family or other most appropriate person prior to the soldier's funeral;¹⁷

- The Commission's three recommendations to ensure adequate briefings and file transfers are provided when a new investigator assumes responsibility for an ongoing investigation;¹⁸
- The recommendation that all documents obtained in the course of an investigation, as well as the source of the documents, be accurately recorded in the General Occurrence (GO) file for the investigation;¹⁹
- The recommendation to prohibit the practice of making unattributed or misattributed modifications to GO file entries;²⁰
- All of the Commission's recommendations that the Military Police engage with SAMPIS software vendor, Versaterm, to request various modifications to the system in order to ensure complete records are kept and to minimize the risk of inadvertent incomplete disclosure of GO files, as well as the more general recommendation to participate in collaboration between Versaterm and other police clients to help guide the development of future SAMPIS product enhancements.²¹

11. In addition, the more substantive recommendation related to the ATIP process and the Military Police's authority to make decisions about the disclosure of its information²² also appears to be accepted, at least in principle, but the language used in the Notice of Action remains somewhat non-committal.

12. All other responses in the Notice of Action provide no answer as to whether the recommendations will be implemented. More than half of the total number of responses to the recommendations amount to no more than a statement that the Military Police will research the issues and/or consider the recommendations. This failure to provide any information as to what will be done about the recommendations can only be taken as a rejection of those recommendations, since no commitment at all is provided to implementing them. If these responses were not taken as rejections, then there would be no obligation for the Military Police to explain the failure to implement the

recommendations, and they would disappear from the oversight regime created by the *National Defence Act*.

13. Even the few responses that otherwise reject the recommendations more directly also often fail to provide meaningful answers. Those responses often sidestep some of the most important issues raised by the Commission or fail to provide information about what it is the Military Police plans to do instead of implementing the recommendations. Many are also expressed in language that avoids stating the rejection in clear and direct terms.

14. The responses to the Commission's findings also generally provide no indication as to the position of the Military Police with respect to the findings, or as to whether the deficiencies identified in the Interim Report are acknowledged as deficiencies. Out of 39 responses, only one, the response to the finding that the CFNIS members failed to complete the 2009 and 2010 investigations within a reasonable time,²³ fully acknowledges the deficiencies and discusses measures taken to address them. The other responses do not indicate either agreement or disagreement with the findings. In a few cases, this is not problematic given that the underlying allegations were unsubstantiated and no further comment was required.²⁴ In most cases, however, this non-committal approach is highly problematic, as a response to the findings was required, and the comments included in the Notice of Action fall short of providing one. In response to many of the findings related to deficiencies in the investigations, the Military Police proposes to have the investigations assessed by another police force. In other responses, the Notice of Action includes comments that tend to indicate the deficiencies identified by the Commission have not been recognized or understood by the Military Police, or that raise their own substantive concerns. Because the text of the Notice of Action cannot be published, these concerns cannot be discussed here.

15. A review of the responses to the recommendations and findings found in the Notice of Action leaves open to question whether the Military Police in fact sees there was anything seriously wrong in the investigations and events under review. Instead, the Commission is left with many of the same concerns expressed in the Interim Report to begin with and, in some cases, these concerns are even magnified. However, without the

ability to publish the Notice of Action and to discuss its contents in detail, the Commission is prevented for elaborating further on these serious concerns.

16. On the whole, the Notice of Action is, for the most part, not in fact a response to the Interim Report. Contrary to s. 250.51 of the *National Defence Act*,²⁵ which sets out the information to be included in the Notice of Action, the Notice of Action provided in this case does not notify the Commission or the Minister of the “action that has been or will be taken with respect to the complaint”, except perhaps to indicate that very little action has been taken, and that it is not known what additional action will or will not be taken.

A Rejection of Oversight

17. Independent civilian oversight of the police and properly administered systems for the review of complaints about police conduct serve many important purposes. They assist the police in identifying and correcting deficiencies in practices and procedures; they promote public confidence and trust in the police; they ensure police accountability; and, provided they can operate in a sufficiently transparent manner, they safeguard public confidence in the legitimacy of the process for regulating and overseeing the conduct of the police.²⁶

18. The regime of independent civilian oversight established for the Military Police in the *National Defence Act* operates by imposing an obligation on the Military Police to subject its decisions about what actions it will take in response to complaints, and the reasons for those decisions, to scrutiny by the public and elected officials. The *National Defence Act* does not grant the Commission the power to make binding recommendations or to order the Military Police to make changes or to take action. Instead, the Commission’s Interim Report setting out its findings and recommendations about the complaint is transmitted to the Minister of National Defence, the Chief of the Defence Staff, the Judge Advocate General and the Canadian Forces Provost Marshal (CFPM).²⁷ The CFPM, who is the head of the Military Police, then has the obligation to review the complaint in light of the Commission’s findings and recommendations²⁸ and to provide a

Notice of Action to the Minister of National Defence and to the Commission setting out “any action that has been or will be taken with respect to the complaint.”²⁹ Once the Notice of Action has been received and considered, the Commission prepares its Final Report and provides it to the Minister, the Deputy Minister, the Chief of the Defence Staff, the Judge Advocate General, the CFPM, the complainants, the subjects of the complaint and, in the case of a Public Interest Hearing, the public.³⁰

19. The Act specifically stipulates that, where the CFPM decides not to act on any of the findings or recommendations included in the Commission’s Interim Report, the Notice of Action must set out the reasons for not so acting.³¹ Hence, while the statute leaves the ultimate decision as to the actions to be taken in the hands of the Military Police, it also imposes a mechanism by which the Military Police must answer for its decisions, actions, or lack of action, to the Minister, to the Commission, and ultimately to the parties involved and to the public. This accountability is achieved by imposing an obligation on the Military Police to state what it will do and to explain why. Accountability cannot be achieved where what is being done is not revealed.

20. In that sense, the refusal to publish the Notice of Action can be seen as a rejection of the very principles of independent civilian oversight and as an attempt by the Military Police to avoid accountability and excuse itself from having to explain to anyone, except perhaps the military itself, whether it recognizes the failures identified in this Hearing and what, if anything, it plans to do to address their underlying causes.

21. The content of the Notice of Action itself also has the effect of circumventing the operation of the oversight regime, even for those – like the Commission and the Minister – who did receive the text of the Notice of Action.

22. The majority of the responses to the Commission’s recommendations essentially state the Military Police will consider the recommendations. One would expect the Military Police would in every case consider all the recommendations arising from a Public Interest Hearing. The purpose of a Notice of Action is to report on the result of the recommendations and the findings having been considered, not to state that they will be considered at some indefinite future date.

23. In the present case, the Notice of Action generally does not provide any indication of the Military Police's position on the recommendations, even on more general principles, let alone any intent to follow them. It is not the case that the Military Police provides substantive information about its views, but leaves the more detailed aspects to be determined after further research and consideration. There is for the most part simply no information. By not saying what will be done about practically all of the findings and most of the recommendations, the Military Police is failing to provide the basic information meant to be included in the Notice of Action.

24. The responses in the Notice of Action essentially push back the time when decisions will be made about the recommendations and, in that way, remove these decisions from the accountability provided for in the oversight regime. By not providing a clear answer one way or the other as to whether the recommendations and findings are accepted and what will be done about them, the Military Police is also effectively extracting itself from the obligation to provide explanations for not acting on the findings or recommendations. If and when the Military Police does make decisions about policies and training with respect to the matters raised in the Commission's recommendations and findings, there will be no process and certainly no requirement for the Commission or the Minister to be informed. There will be no requirement for the Military Police to provide explanations if some of the recommendations are not implemented or if some of the findings are not acted on. This is clearly contrary to the statute that created this oversight regime. The Military Police's decisions cannot be assessed by the Commission or the Minister because they are for the most part not revealed, and as a result not explained or justified.

25. The decisions clearly cannot be assessed at all by the complainants, the subjects of the complaint or the public, because the Military Police's position opposing the publication of the Notice of Action means the parties and the public are not even provided with a copy of the incomplete and unsatisfactory responses found in the Notice. The decision to prevent the publication of the Notice of Action effectively ensures that the complainants and the public will never be informed at all as to what will or will not be done. By definition, they are hence not being provided with any explanation or

justification for the decisions made, as they are not even being told in any way what those decisions are. They are also prevented from being shown and from being able to assess how the words used in the Notice of Action amount to a rejection of oversight by the Military Police.

26. The responses in the Notice of Action indicating another police force will be consulted to assess the investigations operate in a similar manner to subvert the purpose of oversight. They transform what is meant to be an exercise of public accountability into a private consultation. The Military Police is in effect looking for a second opinion as to whether there were any deficiencies in its investigations. There is no plan to disclose this second opinion or to provide any further information about what may in fact be done with respect to the Commission's findings, not even to the Commission itself or to the Minister, let alone to the parties or the public. As a result, no response is provided about the findings, and both the parties and the public (as well as, of course, the Commission) will be kept in the dark and will have no means of assessing what, if anything, may eventually be done about any of the deficiencies.

27. The lack of substantive answers in the Notice of Action is particularly disconcerting in light of the time it took to provide it. It is difficult to understand why, after taking more than seven months to review the Commission's Interim Report and to prepare its Notice of Action, the Military Police largely cannot provide answers beyond stating that it will consider the recommendations. The Military Police delayed issuing of the Notice of Action in order to brief the Senior Chain of Command of the CAF.³² Three full months elapsed between the time when the Military Police first advised the Commission the Notice of Action was ready and the time when it was finally provided.³³ Yet, the Military Police apparently did not use this time to consider and to come to conclusions about the recommendations so as to provide meaningful answers.

28. This is particularly shocking when it comes to the responses to the policy recommendations relating to the disclosure of suicide notes. According to the public statements made when the failure to disclose Cpl Langridge's suicide note was discovered, and to the testimony heard about this issue during the Hearing, the CFNIS

began working on revising its procedures for the disclosure of suicide notes in June 2009.³⁴ Yet, in December 2014, the Military Police was still not able to tell the Commission what those policies and procedures will be.³⁵

29. Many of the others recommendations and findings for which the Military Police provides no answer also relate to areas where, in the Commission's view, the deficiencies were serious, obvious and inexcusable. The Commission identified clear, often egregious deficiencies in the interactions by the Military Police with the Fynes throughout the investigations under review, including: the repeated failure to provide them with substantive information and answers to their legitimate questions;³⁶ the failure to fulfill commitments made to them;³⁷ the failure to provide appropriate explanations and apologies once the failure to disclose the suicide note was discovered;³⁸ and the failure to take steps to return exhibits because there were no processes in place to deal with them.³⁹ Yet, years after the events and over seven months after receiving the Commission's Interim Report, the Military Police still cannot provide any information about what it plans to do about these issues, and has still yet to respond even to simple recommendations like providing substantive information during family briefings,⁴⁰ or putting in place the necessary processes and resources at CFNIS Detachments to attend to the return of exhibits.⁴¹ There is still no response in the Notice of Action to some of the most serious factual findings on these matters.⁴² In particular, the Military Police provides no acknowledgement or answer to the serious finding of lack of professionalism on the part of those in supervisory and leadership positions who did not step forward, take responsibility, provide adequate explanations and apologies, or correct what needed to be corrected.⁴³

A Failure to Learn Lessons

30. Throughout the events under review, the Commission often observed instances where the Military Police and its members had apparent difficulty in recognizing their own shortcomings and deficiencies and were unable to take timely action to address them. Seemingly set on justifying their actions or to preserve a positive image in the eyes of the complainants or of the public at large, MP members often proceeded to make

matters worse by failing to provide timely, accurate and straightforward answers to the family and to the public, and by failing or refusing to modify a misguided approach.⁴⁴ The Military Police often made statements that appeared to respond to the concerns, while taking few if any steps to actually address them. This was especially true in the official response to the suicide note issue, where the organization promised to take remedial steps but then proceeded to devote very little attention to the matter, either in terms of the revision of internal procedures or in terms of the explanations and any apologies provided to the complainants and to the public.⁴⁵ Indeed, this pattern can be seen in substantially all of the interactions between the Military Police and the Fynes. The Military Police repeatedly sought to appease the Fynes by making what turned out to be empty promises and gestures and by providing vague explanations, but failed to take substantive steps to address the concerns.⁴⁶

31. The response to this report can be seen in the same light. The Military Police flatly refuses to allow the Fynes or the public at large to even see the response. The response itself says very little of substance about the actual issues identified. Even as it rejects the vast majority of the recommendations, the rejection is couched in language that avoids meeting the issues head on or providing direct answers. Responses may on the surface give an impression that issues are taken seriously and will be addressed, but they stop short of acknowledging the deficiencies identified in the Interim Report or of agreeing to specific remedial action capable of repairing the deficiencies.

32. Overall, the Military Police response demonstrates an unwillingness or inability by the Military Police to recognize and address its own shortcomings. If any further proof were necessary of the need for independent oversight, it would be provided by the apparent inability of the Military Police to deal effectively with its own shortcomings, both during the underlying events and in its response to the Commission's findings and recommendations arising from those events. This makes the Military Police's apparent reluctance substantively to accept external oversight all the more troubling.

¹ See Section 2.0, The Hearing Process.

² See Section 2.0, The Hearing Process.

³ See Section 2.0, The Hearing Process.

⁴ See Section 2.0, The Hearing Process.

⁵ See Section 2.0, The Hearing Process.

⁶ See Section 2.0, The Hearing Process.

⁷ See, generally, *Canada (Attorney General) v Amnesty International Canada*, 2009 FC 918, [2010] 4 FCR 182 at para 79; Hon. Justice Wallace T. Oppal, *Closing the Gap: Policing and the Community*, Commission of Inquiry into Policing in British Columbia (British Columbia, 1994), at p. xxv, xxxi & 1-2; Canada – Minister of National Defence, *Report of the Special Advisory Group on Military Justice and Military Police Investigation Services*, presented to the Minister of National Defence on 14 March 1997 (Ottawa: National Defence, 1997) at p. 82-83 (The Dickson Report); The First Independent Review by the Right Honourable Antonio Lamer P.C., C.C., C.D. of the provisions and operation of Bill C-25, *An Act to amend the National Defence Act and to make consequential amendments to other Act*, as required under section 96 of Statutes of Canada 1998, c.35 (3 September 2003) at p. 77; Gwen Boniface, Commissioner, Ontario Provincial Police, *Police Leaders' Perspective on Accountability, Building Ethical Frameworks and Civilian Oversight*, presentation to Canadian Association for Civilian Oversight of Law Enforcement, 25 June 2004; *House of Commons Debates*, 36th Parl, 1st Sess, No. 77 (19 March 1998) at 1715 & 1724 (Hec Clouthier).

⁸ The Commission's 46 main recommendations were often divided into several parts, leaving a total of 96 recommendations to be addressed in the Notice of Action. 18 of the 96 responses express a direct rejection of the recommendations.

⁹ See Section 6.0, Recommendations 1 to 4.

¹⁰ See Section 6.0, Recommendations 39-41.

¹¹ See Section 6.0, Recommendation 44.

¹² See Section 6.0, Recommendations 45-46.

¹³ See Section 6.0, Recommendation 24.

¹⁴ See Section 6.0, Recommendations 5a & 5b.

¹⁵ See Section 6.0, Recommendation 5c.

¹⁶ See Section 6.0, Recommendation 11.

¹⁷ See Section 6.0, Recommendation 12.

¹⁸ See Section 6.0, Recommendations 27a-c.

¹⁹ See Section 6.0, Recommendation 28a.

²⁰ See Section 6.0, Recommendation 32.

²¹ See Section 6.0, Recommendations 33-35.

²² See Section 6.0, Recommendation 42.

²³ See Section 5.0, Finding 29.

²⁴ See Section 5.0, Findings 6, 7, 8, 9, 12, 13c, 27, 32b and 33c.

²⁵ R.S.C., 1985, c. N-5.

²⁶ See *Canada (Attorney General) v. Amnesty International Canada*, 2009 FC 918 at para 79; *Canada (Royal Canadian Mounted Police Public Complaints Commission) v. Canada (Attorney General)*, 2004 FC 830 at para 39; Hon. Dennis R. O'Connor, *A New Review Mechanism for the RCMP's National Security Activities*, Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar (Ottawa, 2006), at p. 473; Hon. Patrick Lesage, Q.C., *Report on the Police Complaints System in Ontario*, April 22, 2005, at p. 57-58; Hon. Justice Wallace T. Oppal, *Closing the Gap: Policing and the Community*, Commission of Inquiry into Policing in British Columbia (British Columbia, 1994), at p. xxv, xxxi & 1-2; Canada – Minister of National Defence, *Report of the Special Advisory Group on Military Justice and Military Police Investigation Services*, presented to the Minister of National Defence on 14 March 1997 (Ottawa: National Defence, 1997) at p. 82-83 (the Dickson Report); The First Independent Review by the Right Honourable Antonio Lamer P.C., C.C., C.D. of the provisions and operation of Bill C-25, *An Act to*

amend the National Defence Act and to make consequential amendments to other Act, as required under section 96 of Statutes of Canada 1998, c.35 (3 September 2003) at p. 77-78; Gwen Boniface, Commissioner, Ontario Provincial Police, *Police Leaders' Perspective on Accountability, Building Ethical Frameworks and Civilian Oversight*, presentation to Canadian Association for Civilian Oversight of Law Enforcement, 25 June 2004; National Institute of Justice, *Citizen Review of Police: Approaches and Implementation*, U.S. Department of Justice, (Washington DC, March 2001), at p. 7-12; *House of Commons Debates*, 36th Parl, 1st Sess, No. 77 (19 March 1998) at 1715 & 1724 (Hec Clouthier).

²⁷ See *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.48.

²⁸ *National Defence Act*, R.S.C., 1985, c. N-5, ss. 250.49(1).

²⁹ *National Defence Act*, R.S.C., 1985, c. N-5, ss. 250.51(1).

³⁰ See *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.53.

³¹ *National Defence Act*, R.S.C., 1985, c. N-5, ss. 250.51(2).

³² See Section 2.0, The Hearing Process.

³³ See Section 2.0, The Hearing Process.

³⁴ See Section 4.2, The Suicide Note Left by Cpl Langridge.

³⁵ See Section 6.0, Recommendations 13a-h, which did not receive a response in the Notice of Action.

³⁶ See Section 4.5, CFNIS Interactions with the Fynes.

³⁷ See Section 4.5, CFNIS Interactions with the Fynes.

³⁸ See Section 4.2, The Suicide Note Left by Cpl Langridge & Section 4.5, CFNIS Interactions with the Fynes.

³⁹ See Section 4.1.7, Return of Exhibits.

⁴⁰ See Section 6.0, Recommendation 14.

⁴¹ See Section 6.0, Recommendation 10.

⁴² See Section 5.0, Findings 13b, 13d, 13e, 25 and 26.

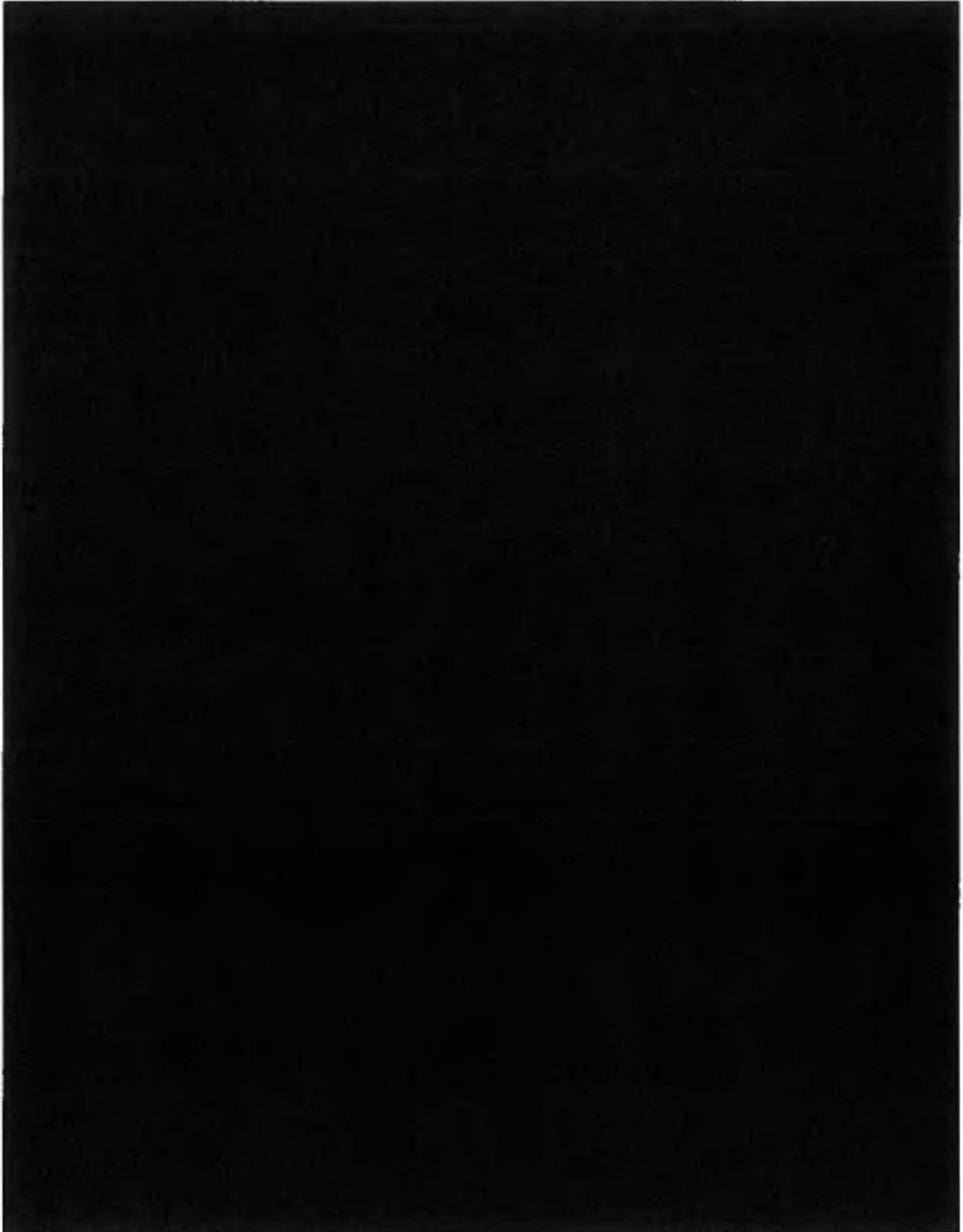
⁴³ See Section 5.0, Finding 25.

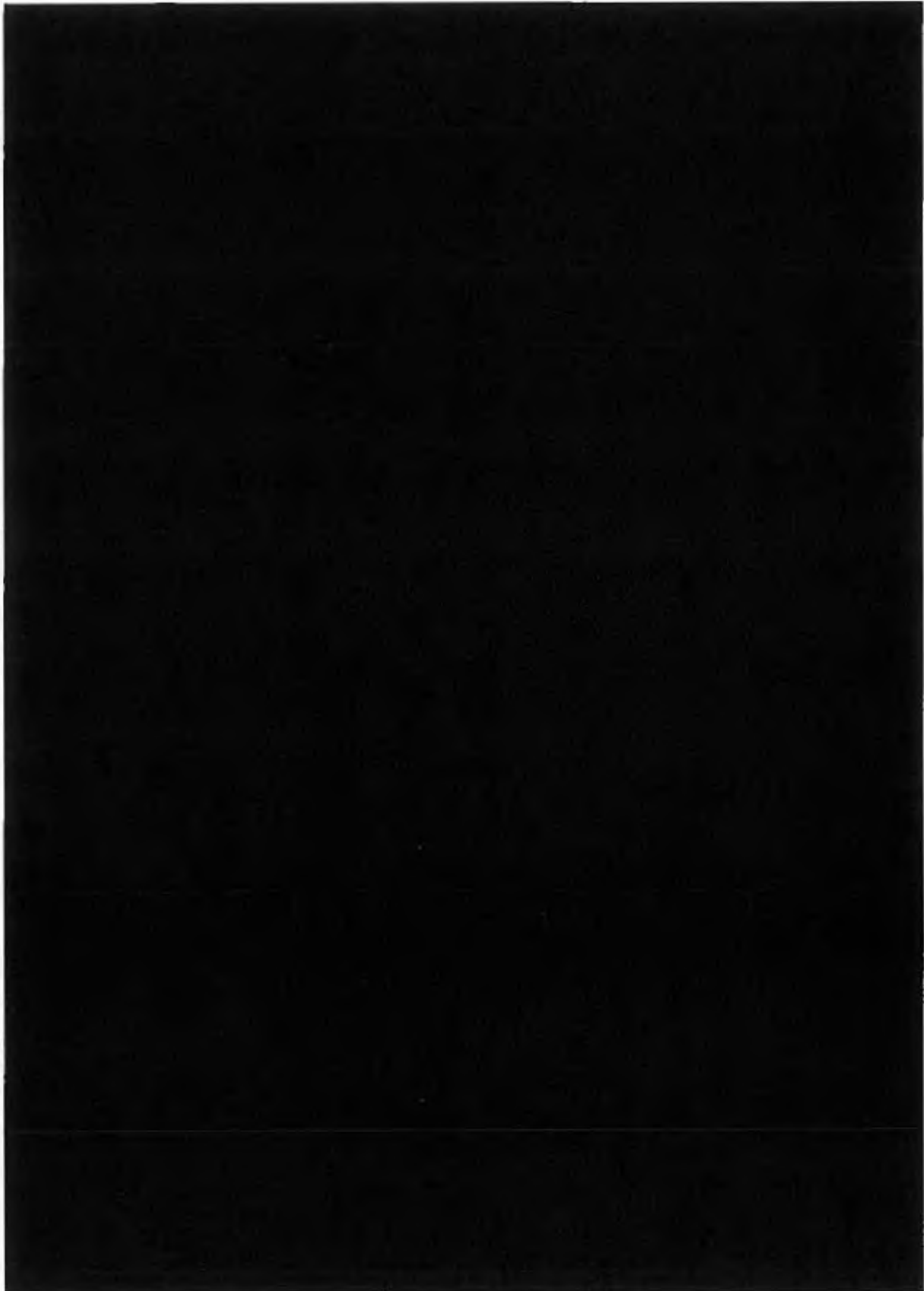
⁴⁴ See Section 4.2 The Suicide Note Left by Cpl Langridge & Section 4.5 CFNIS Interactions with the Fynes.

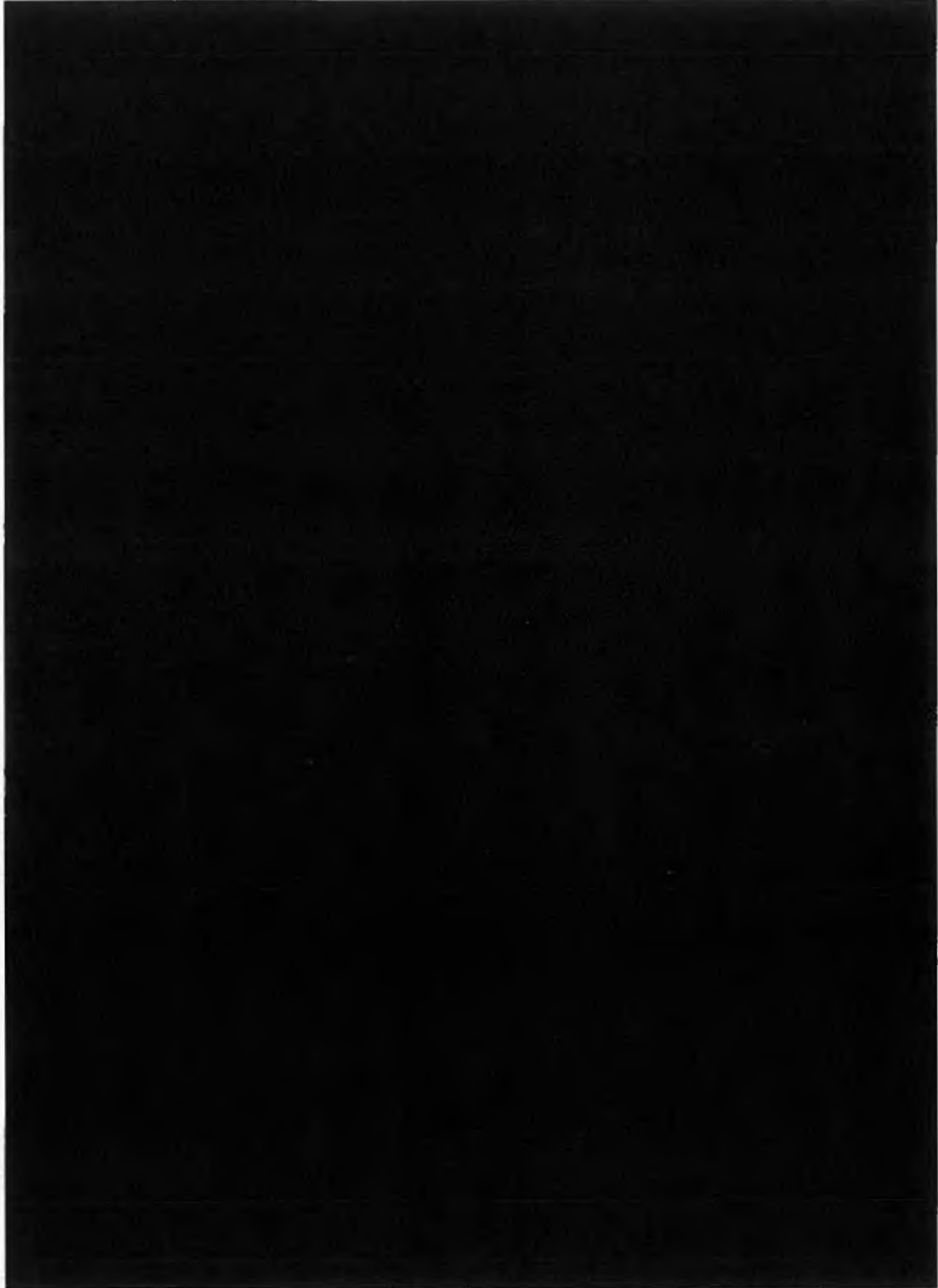
⁴⁵ See Section 4.2, The Suicide Note Left by Cpl Langridge.

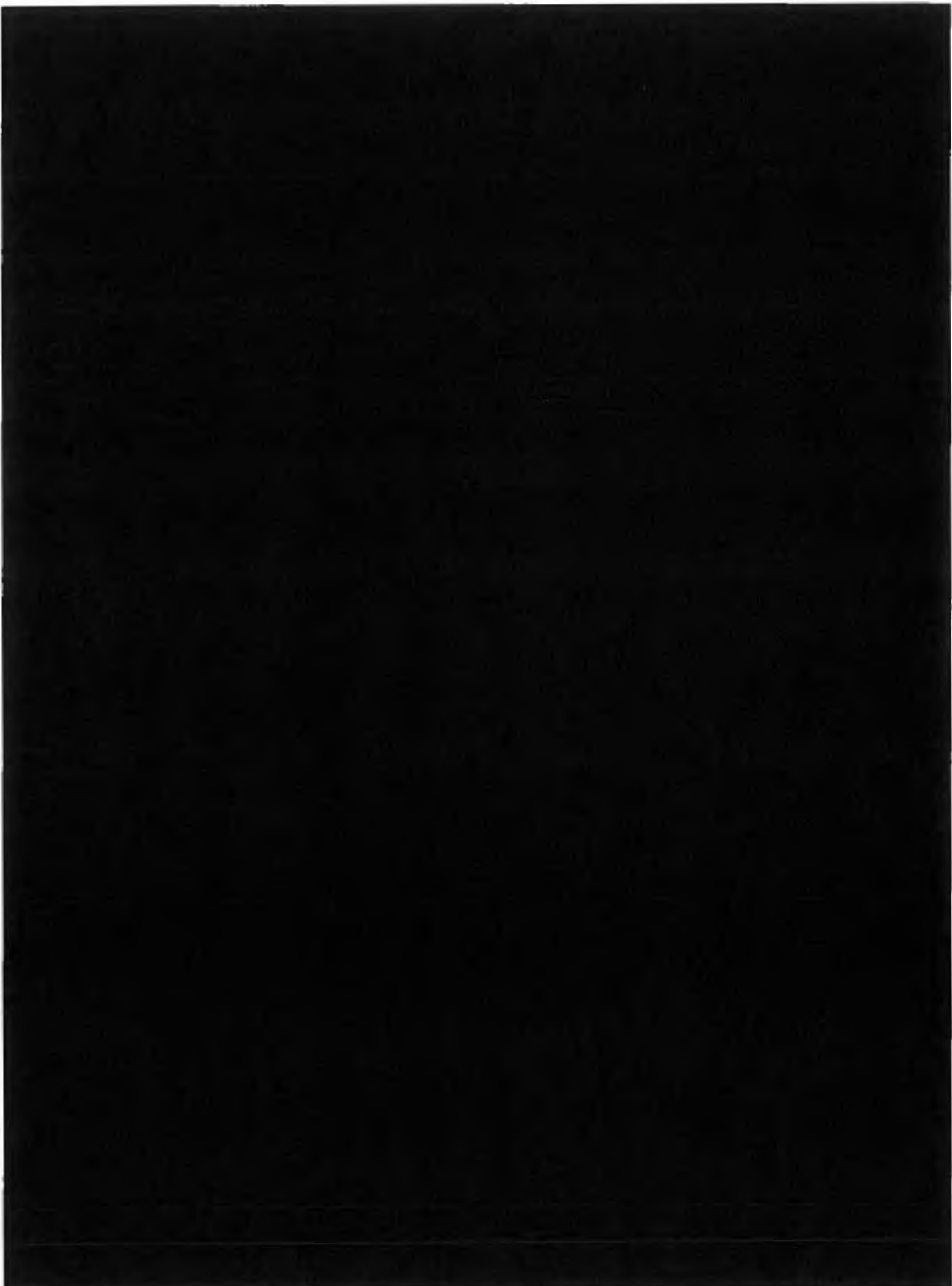
⁴⁶ See Section 4.5, CFNIS Interactions with the Fynes.

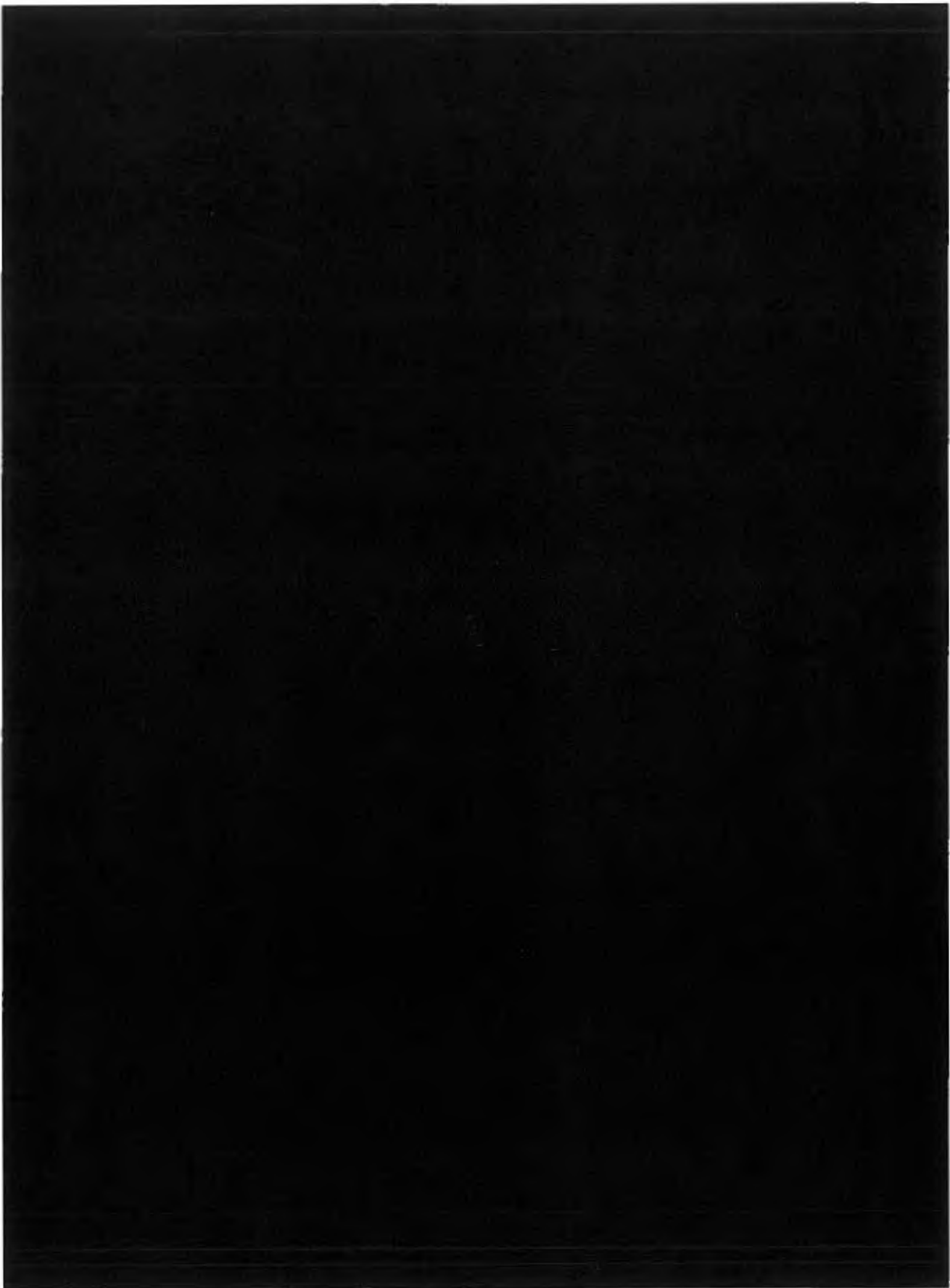
7.1 THE NOTICE OF ACTION

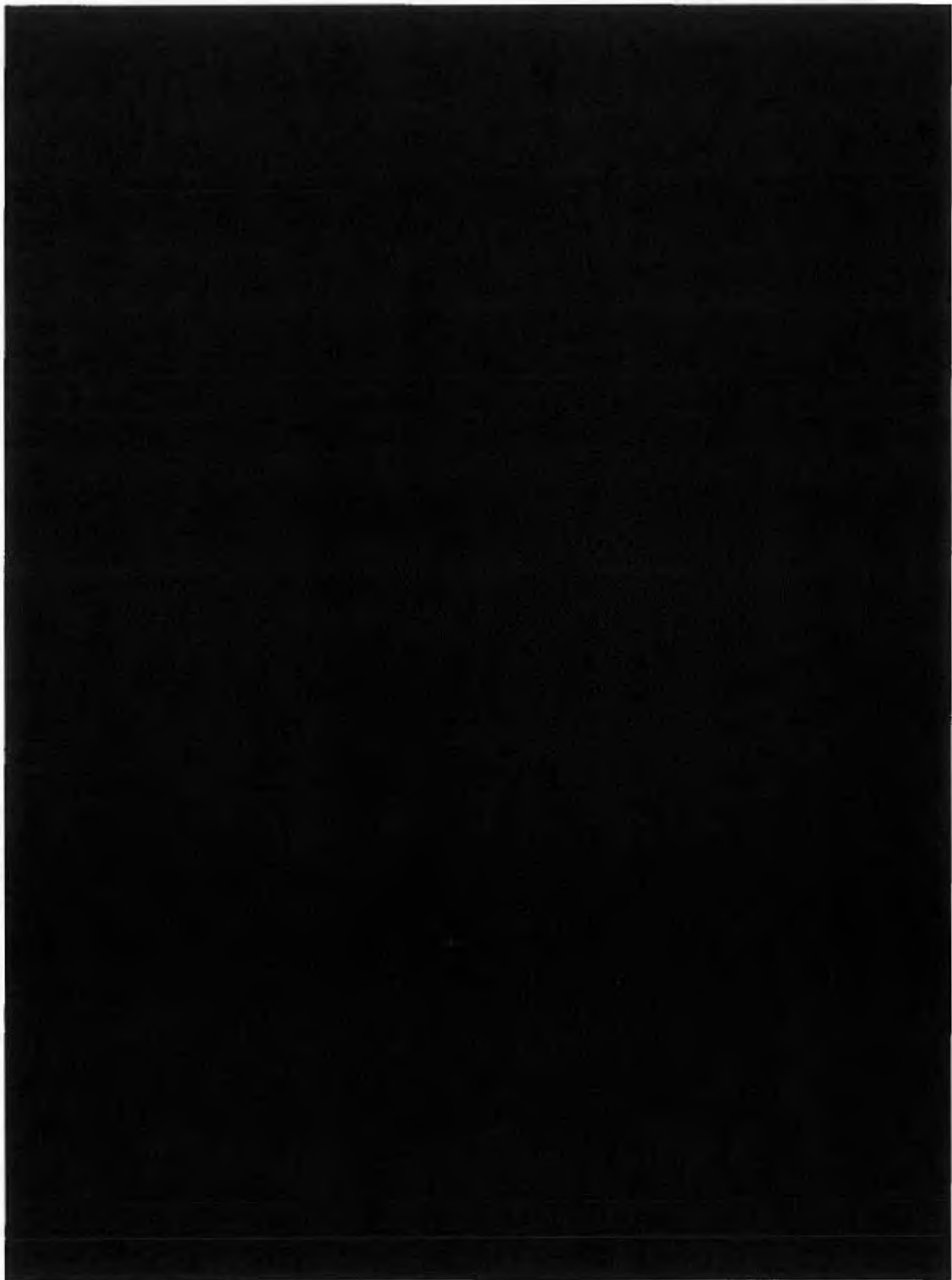


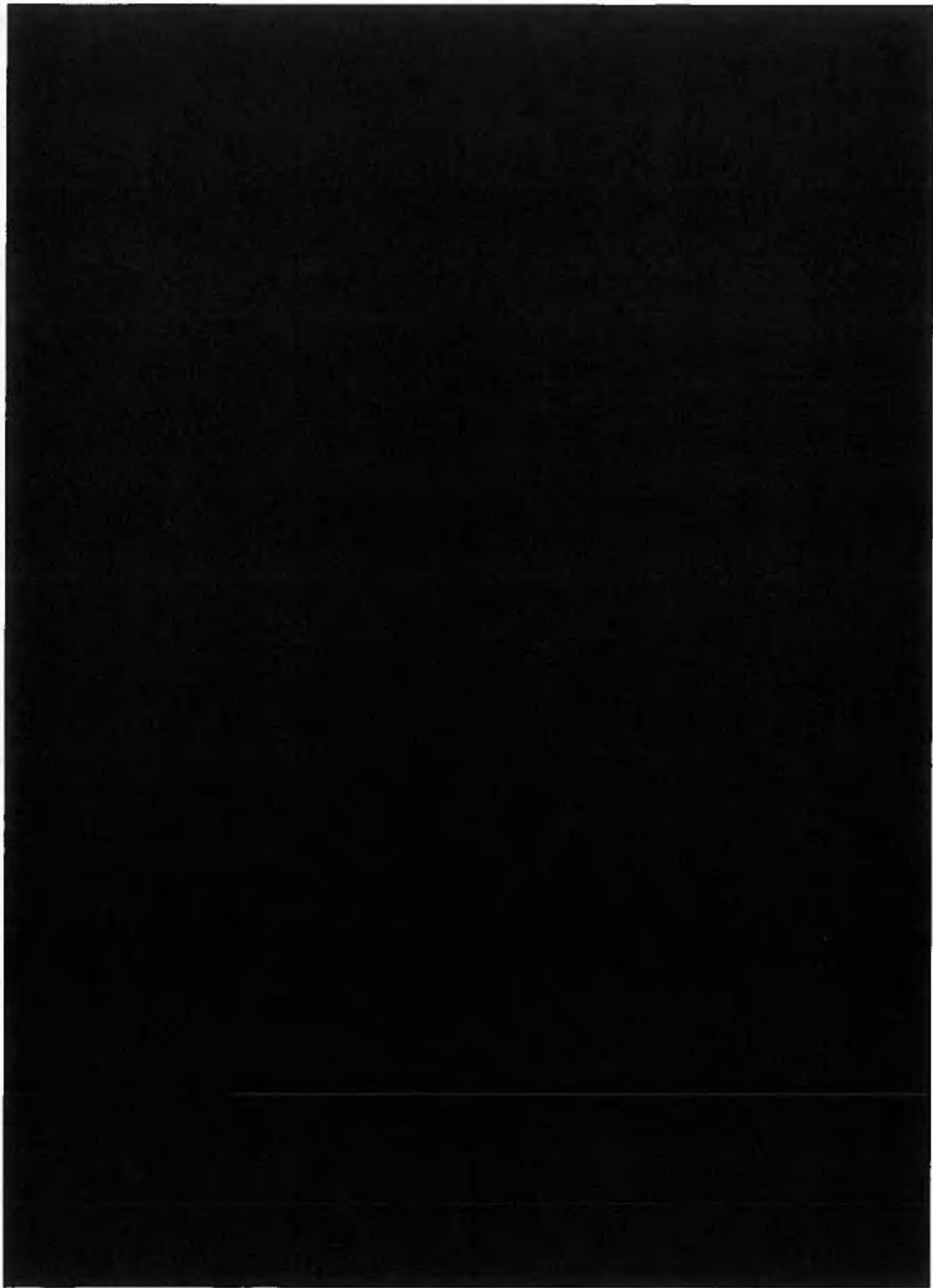


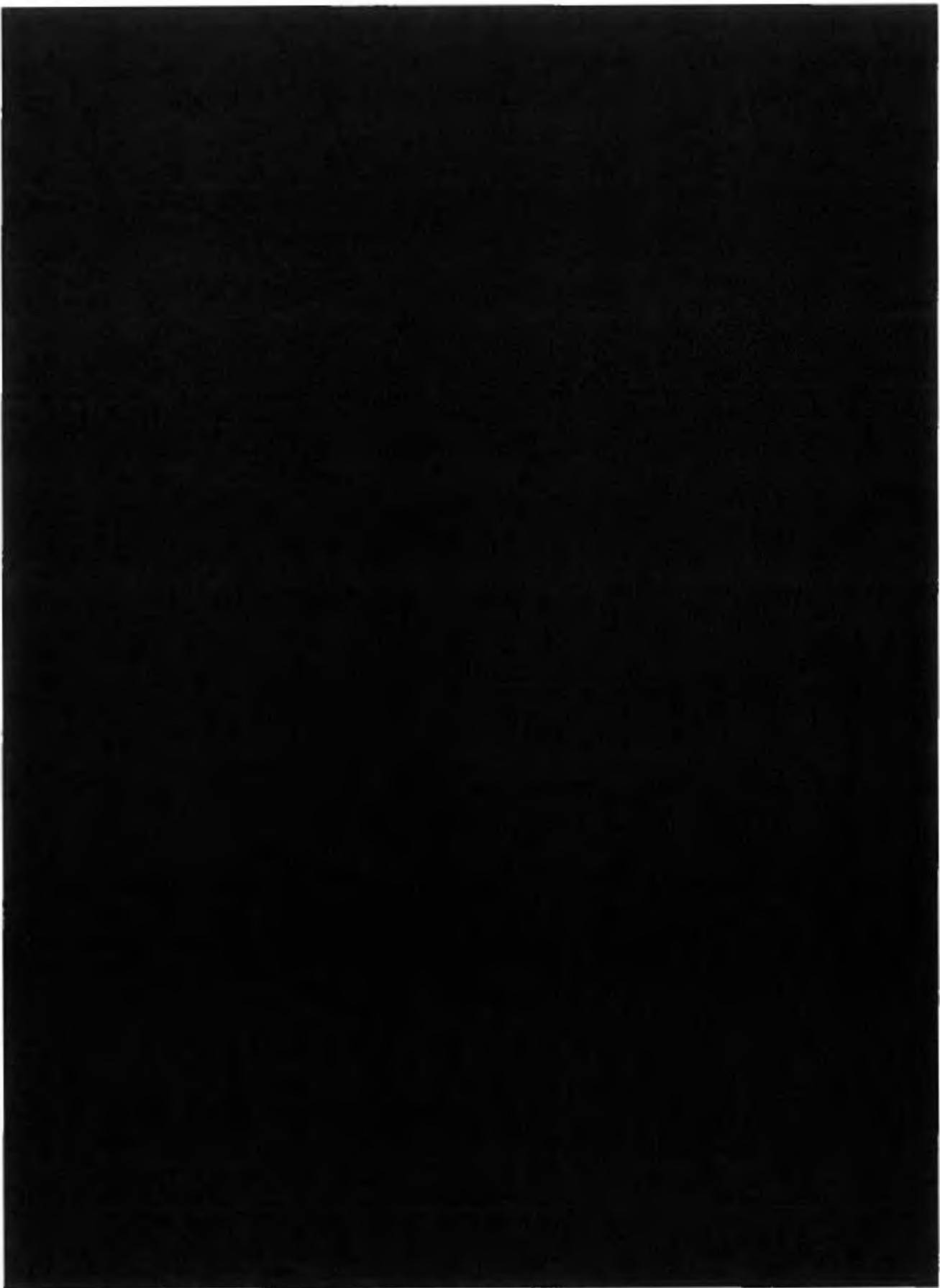


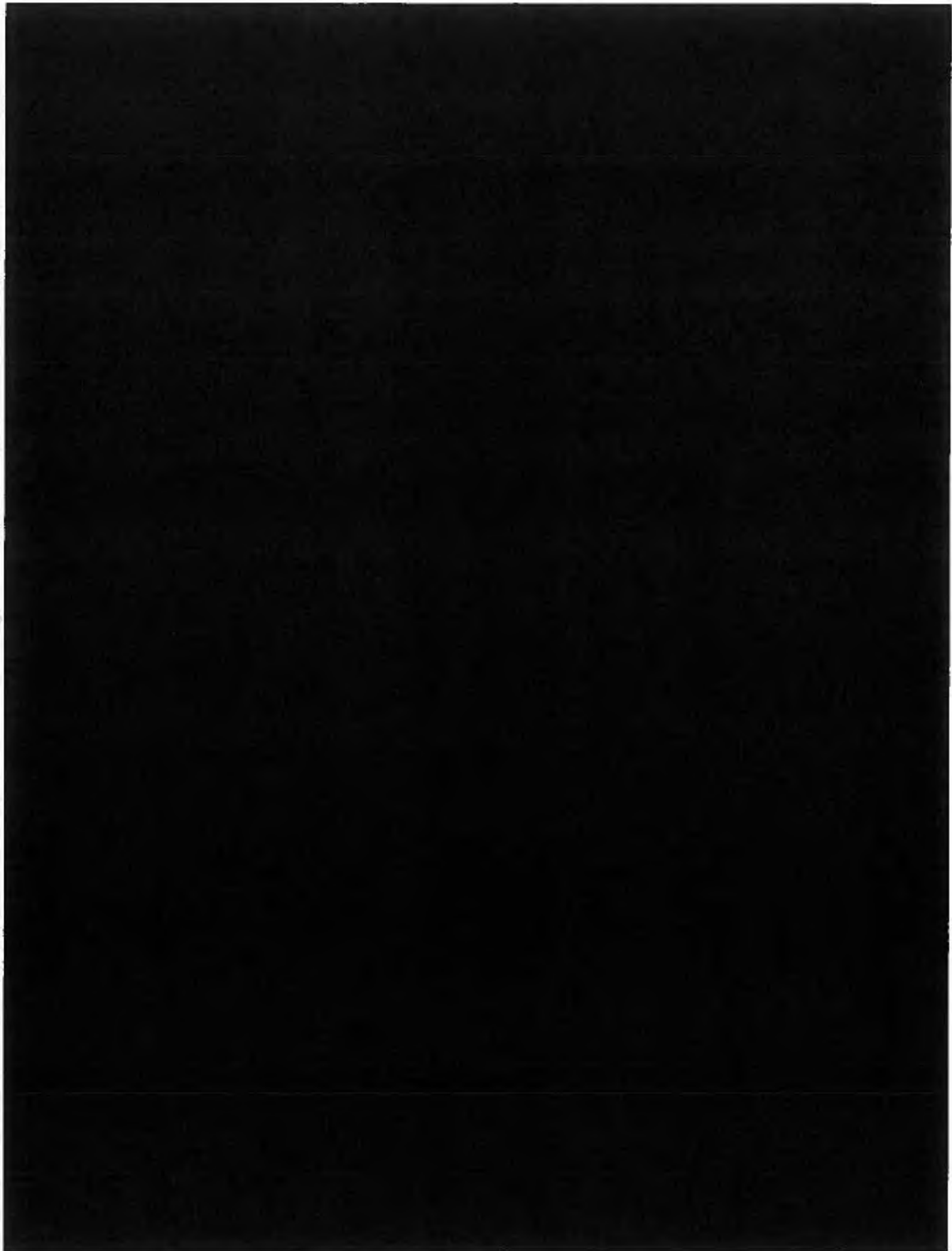




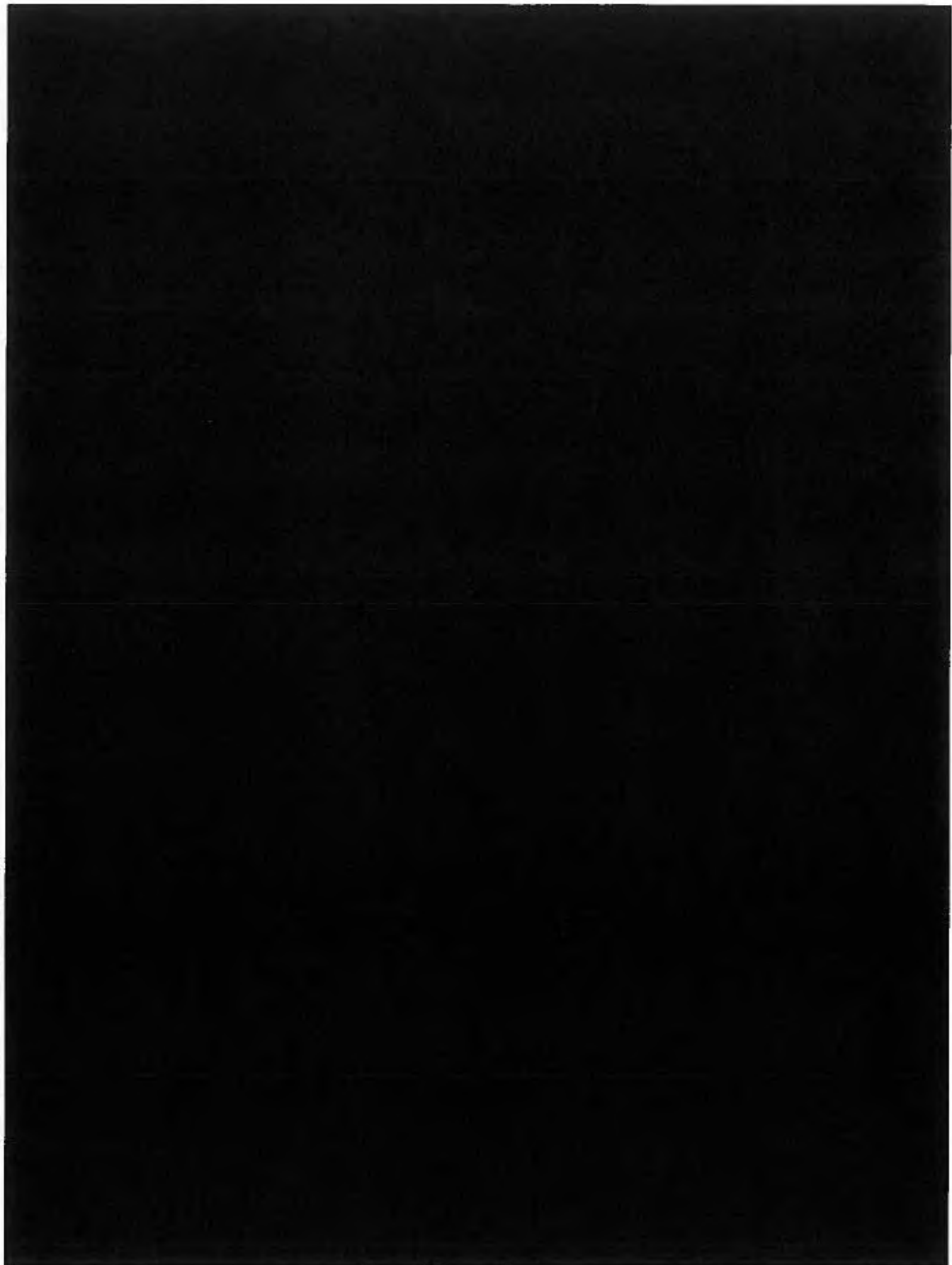


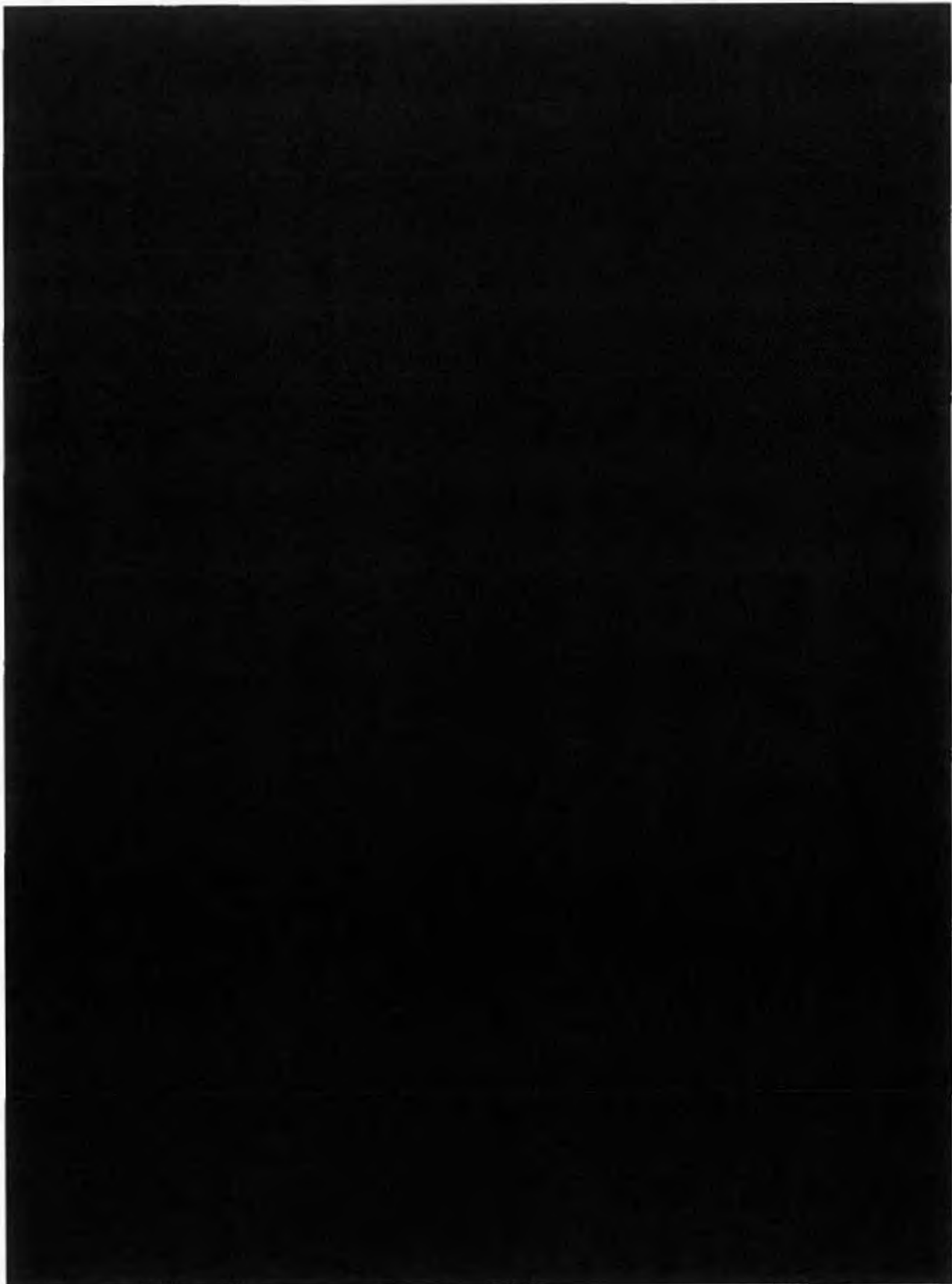


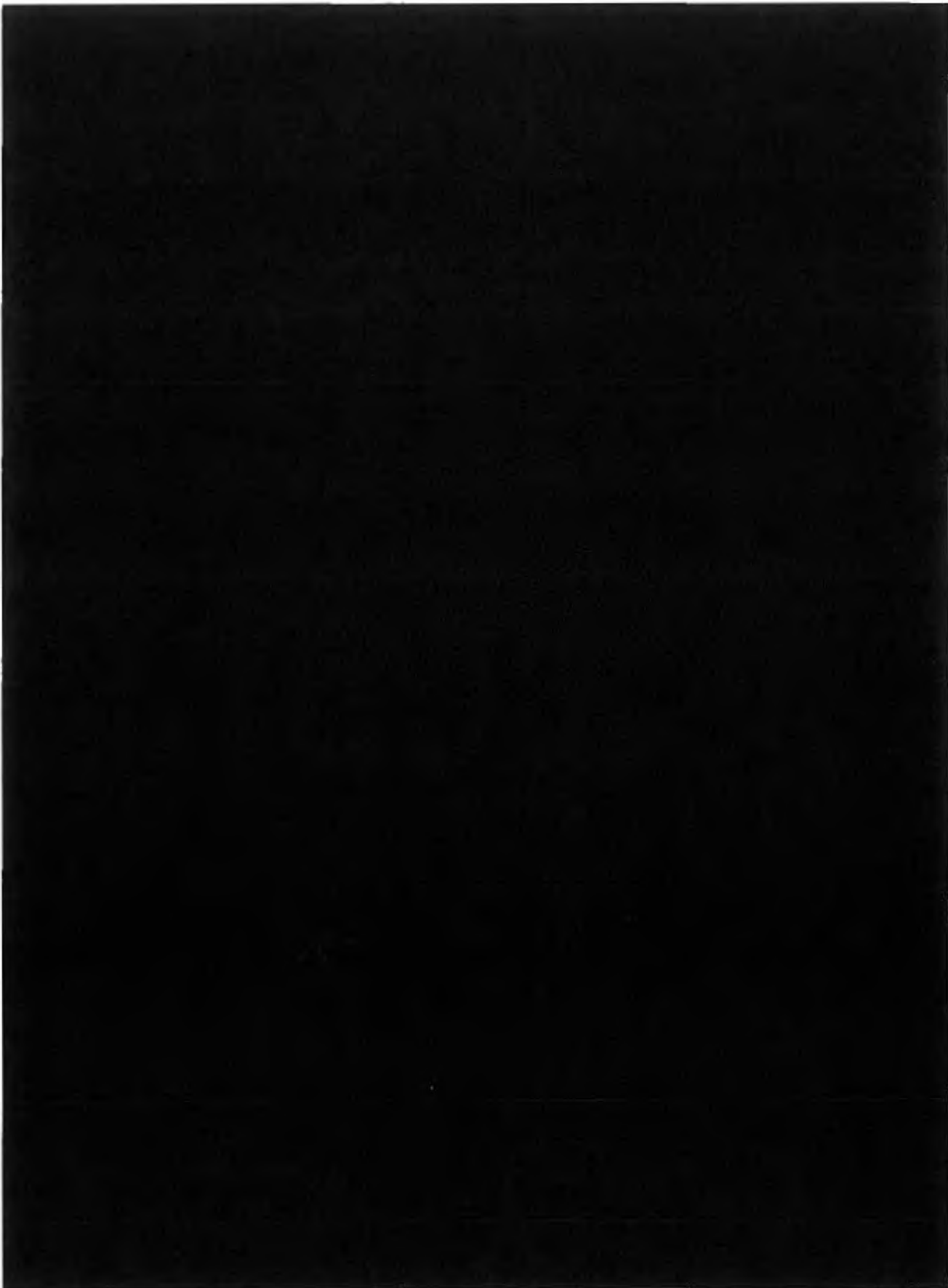


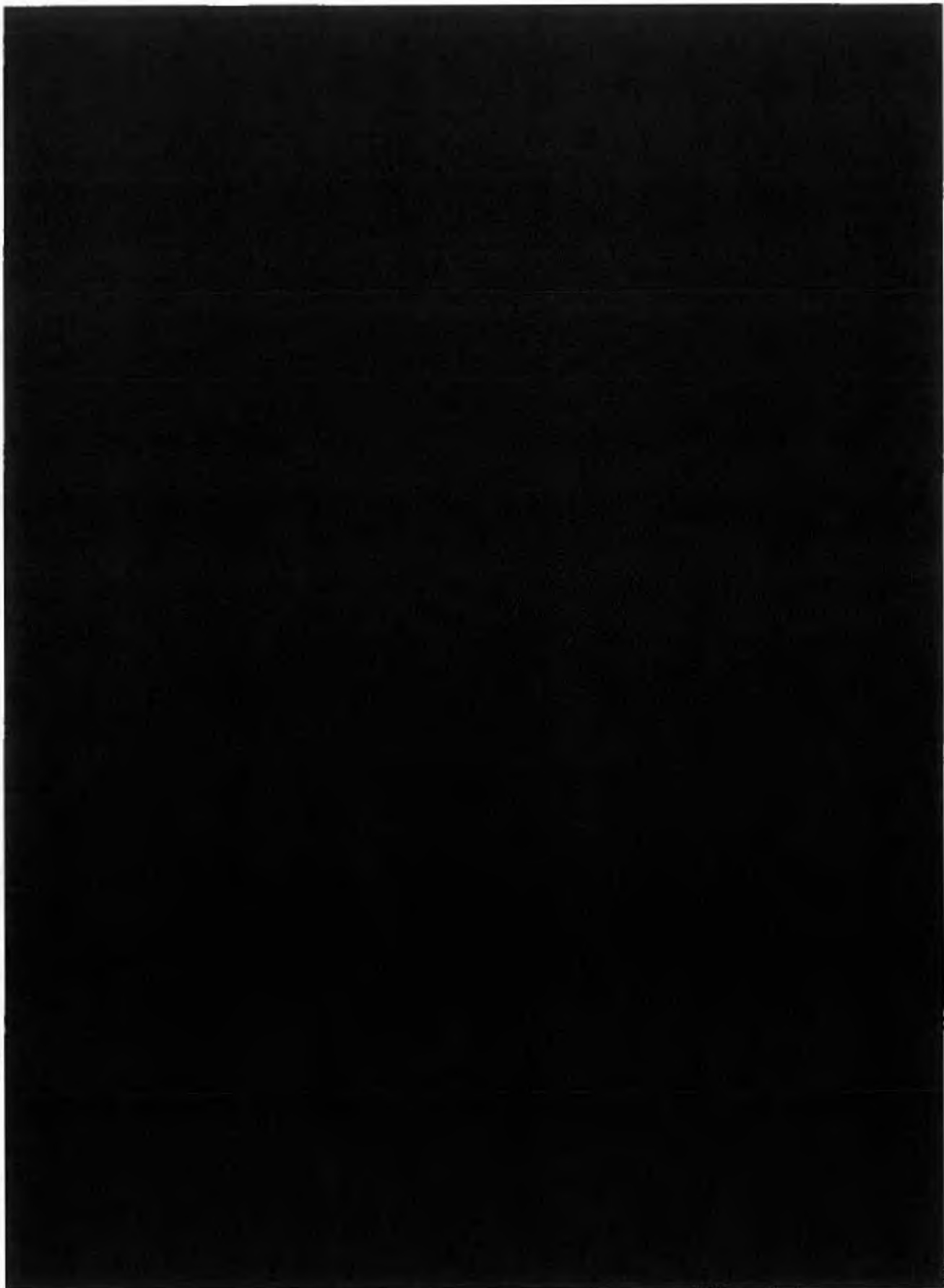


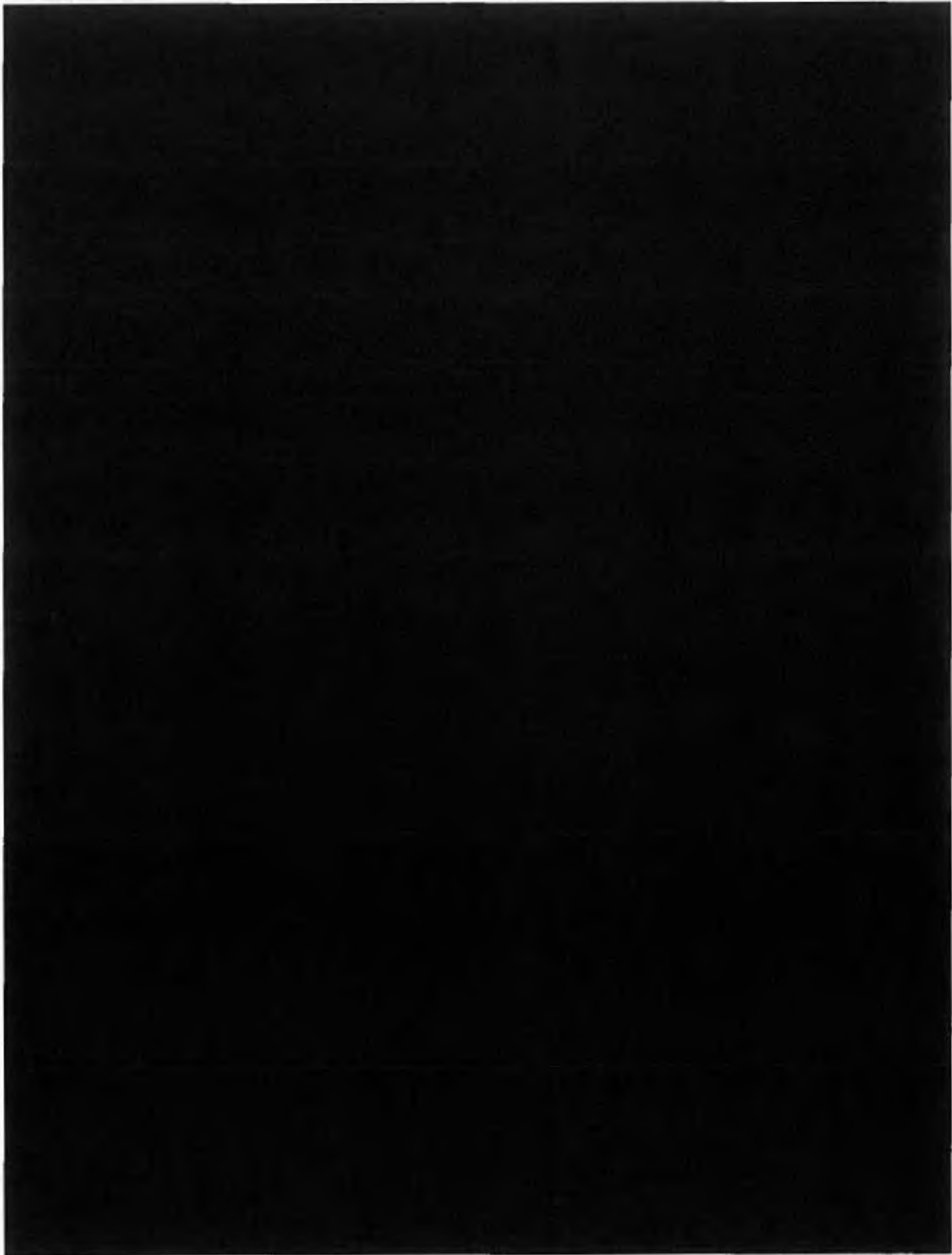


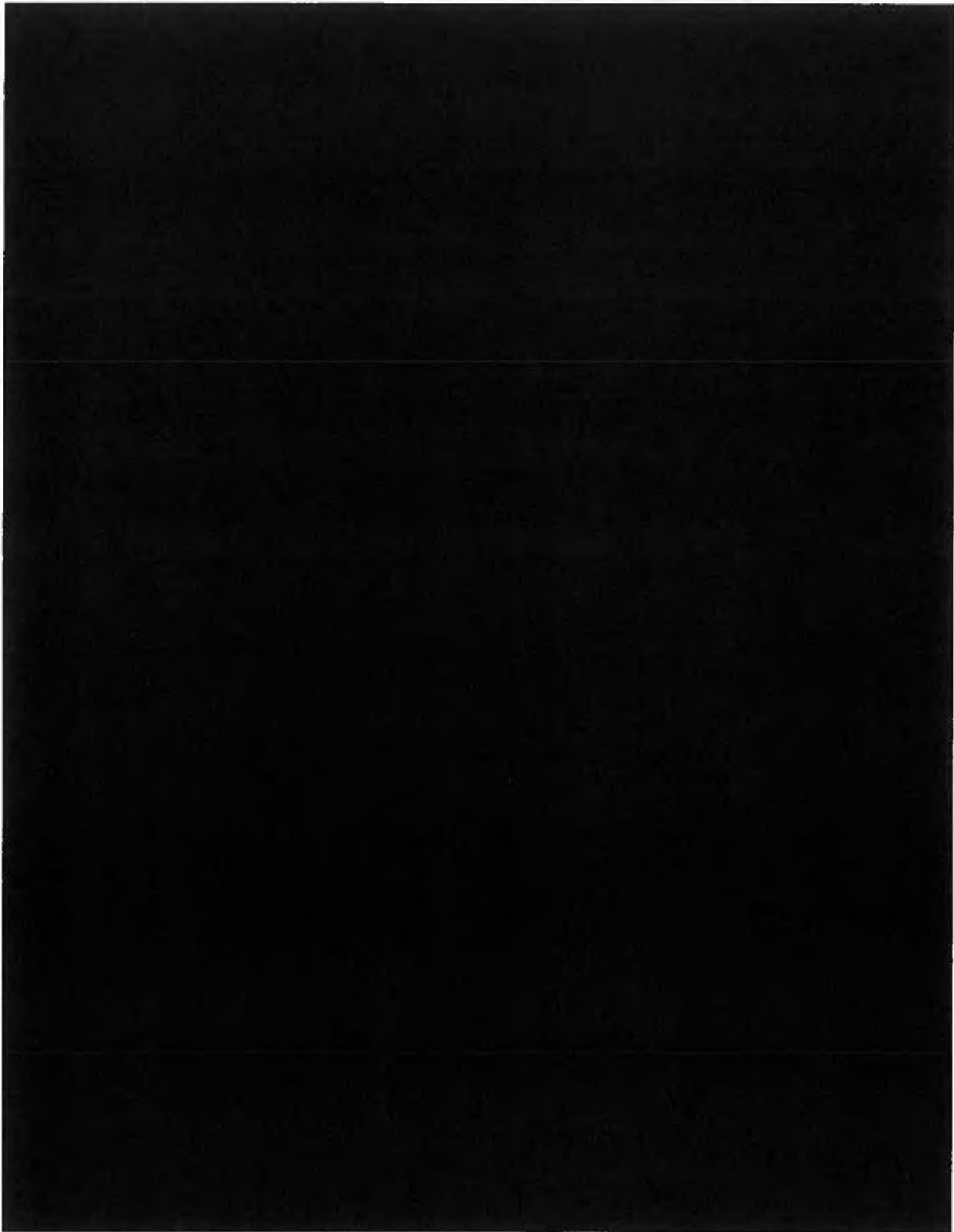


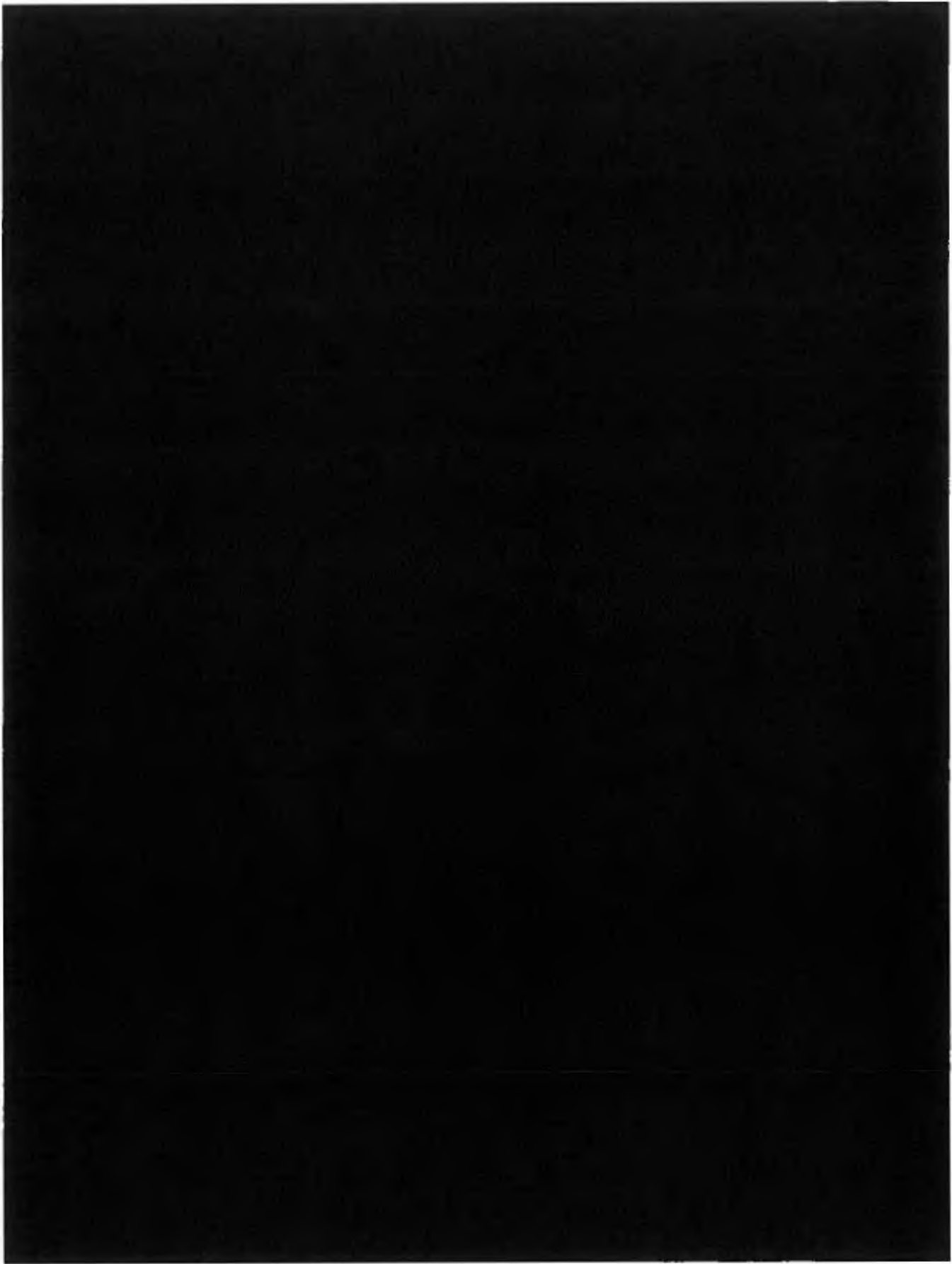


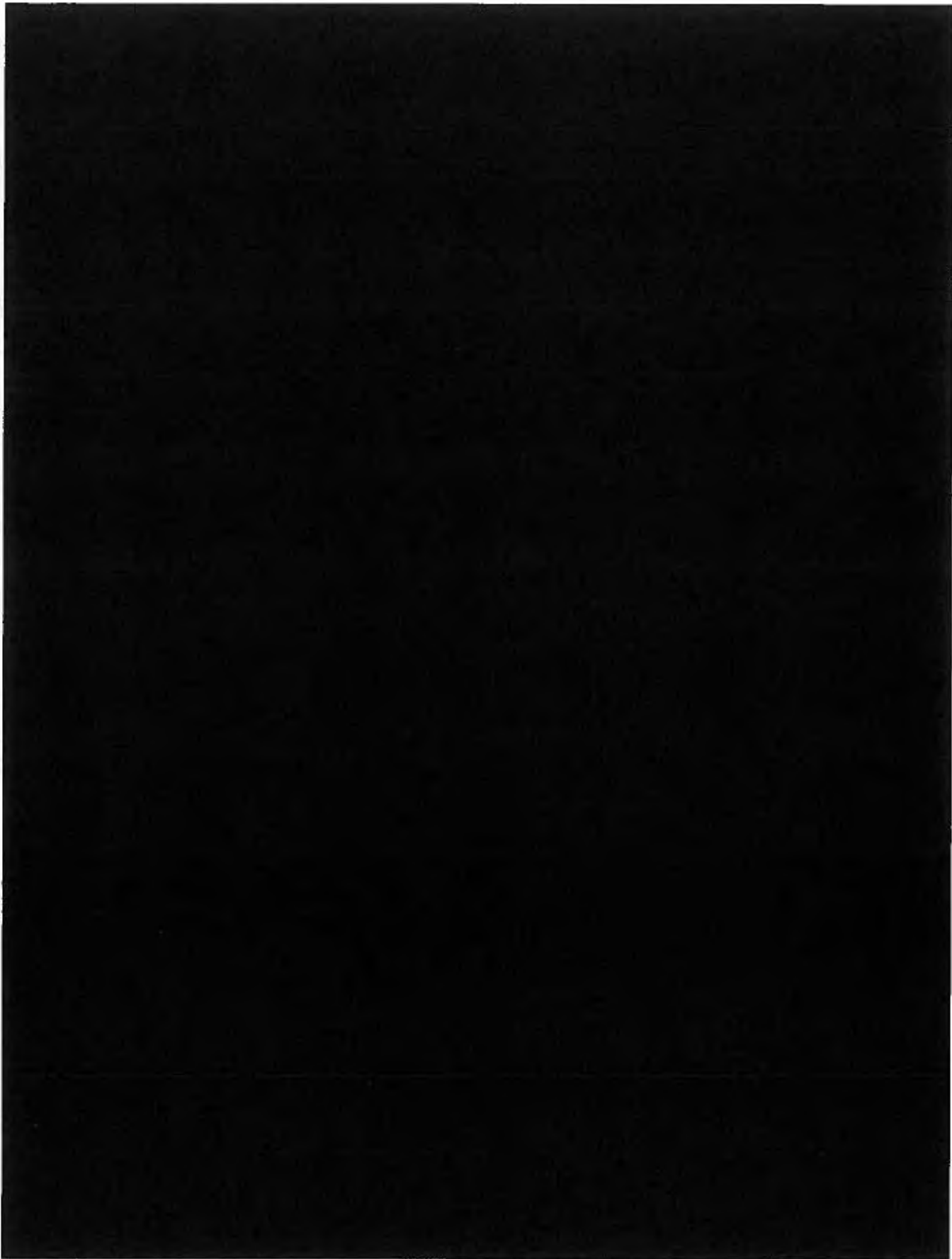


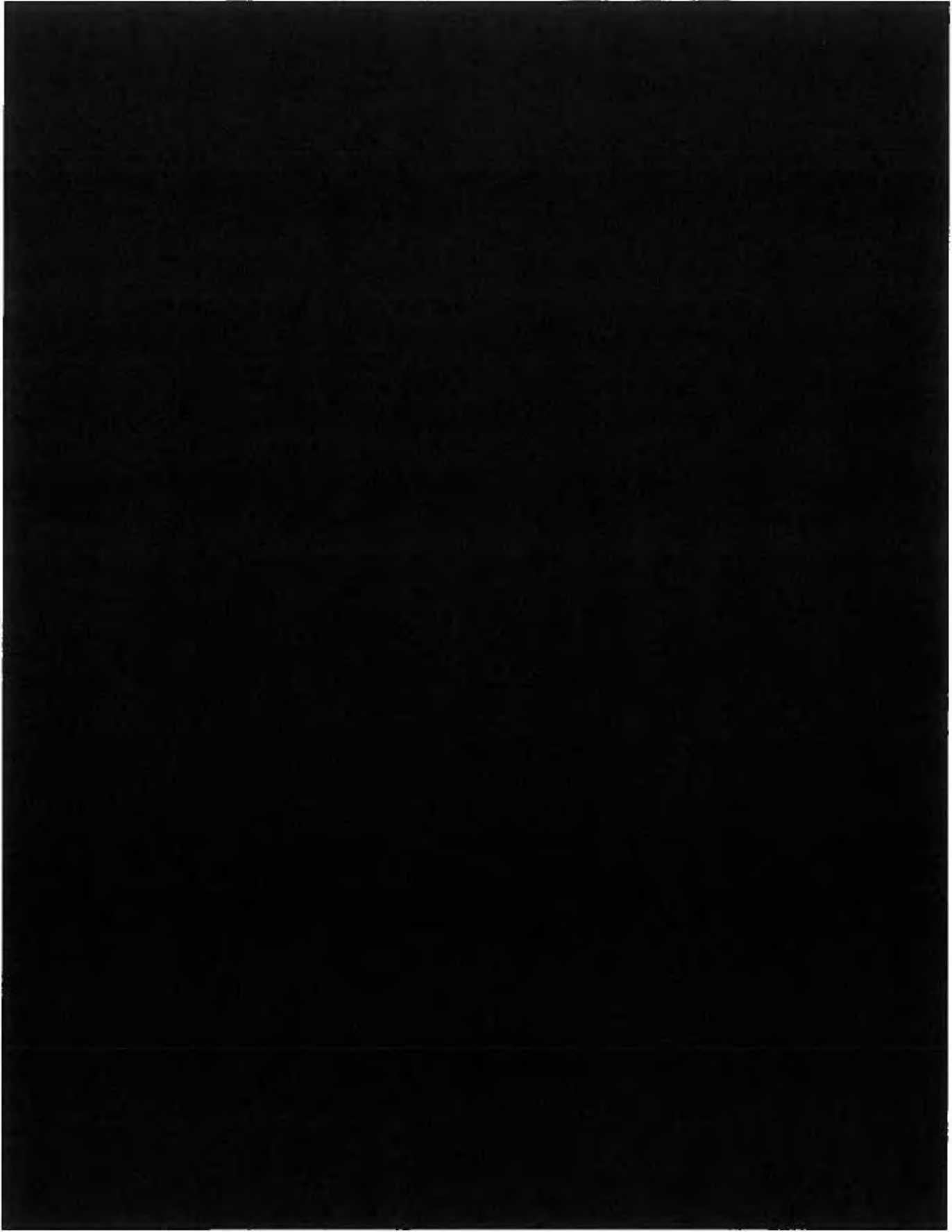


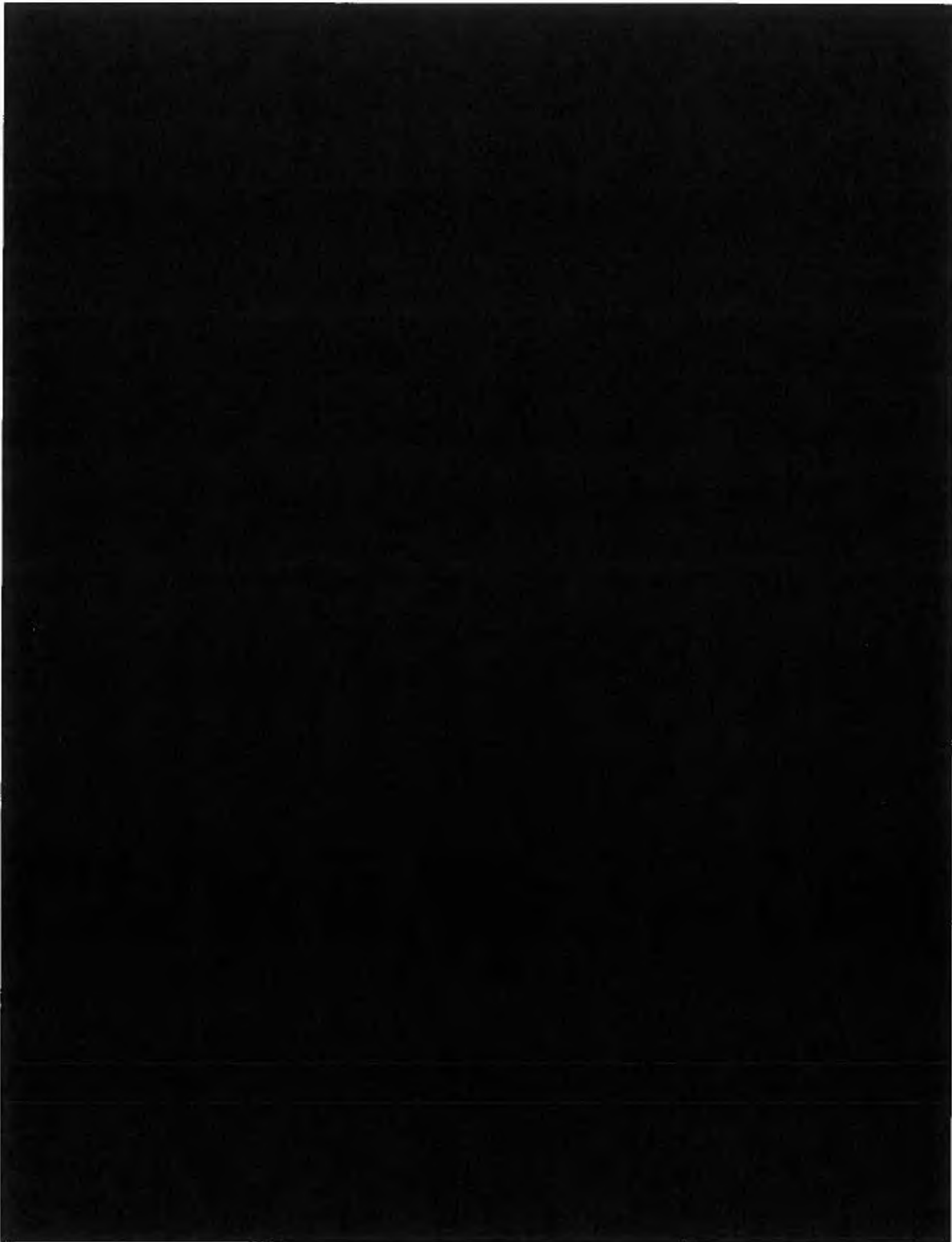


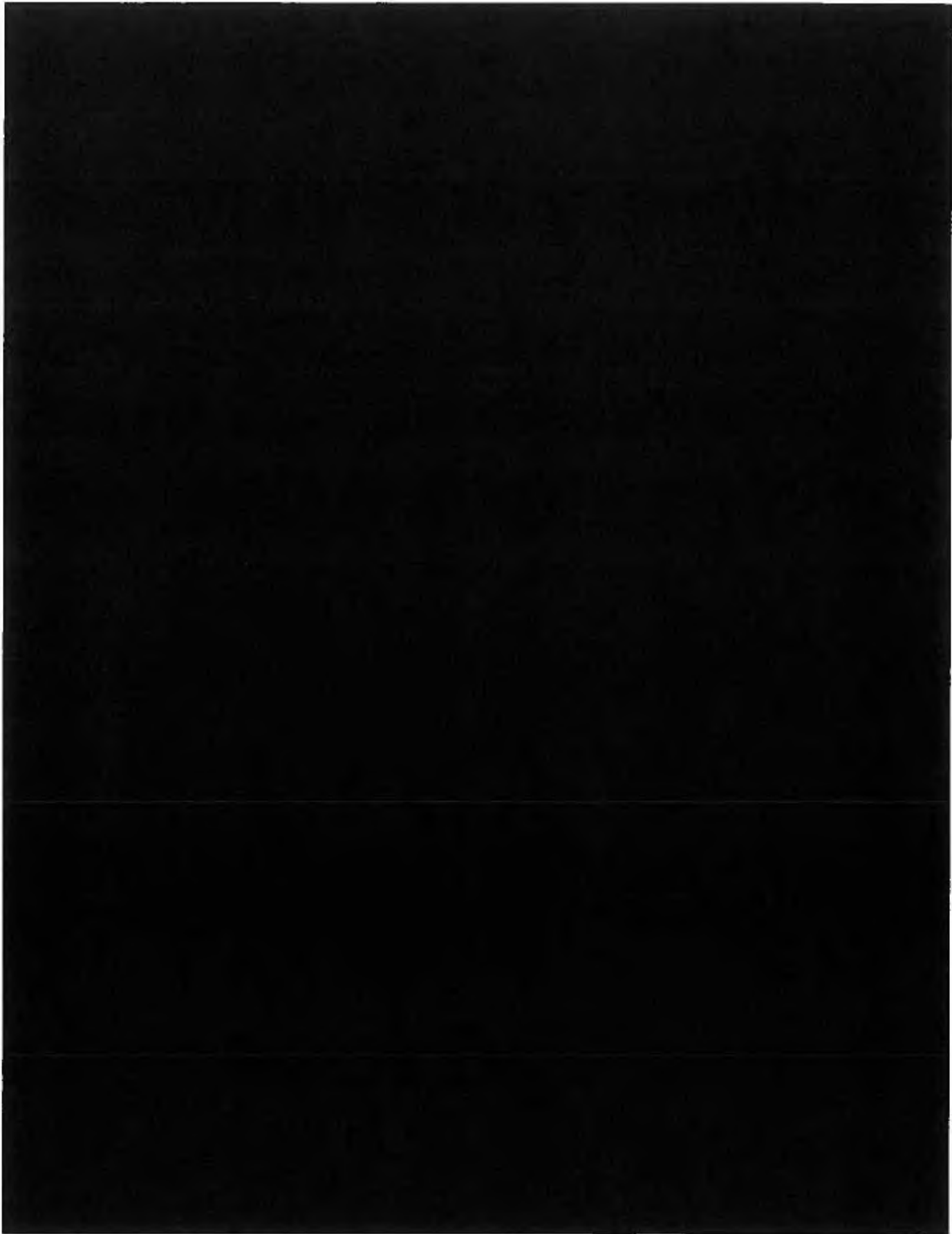


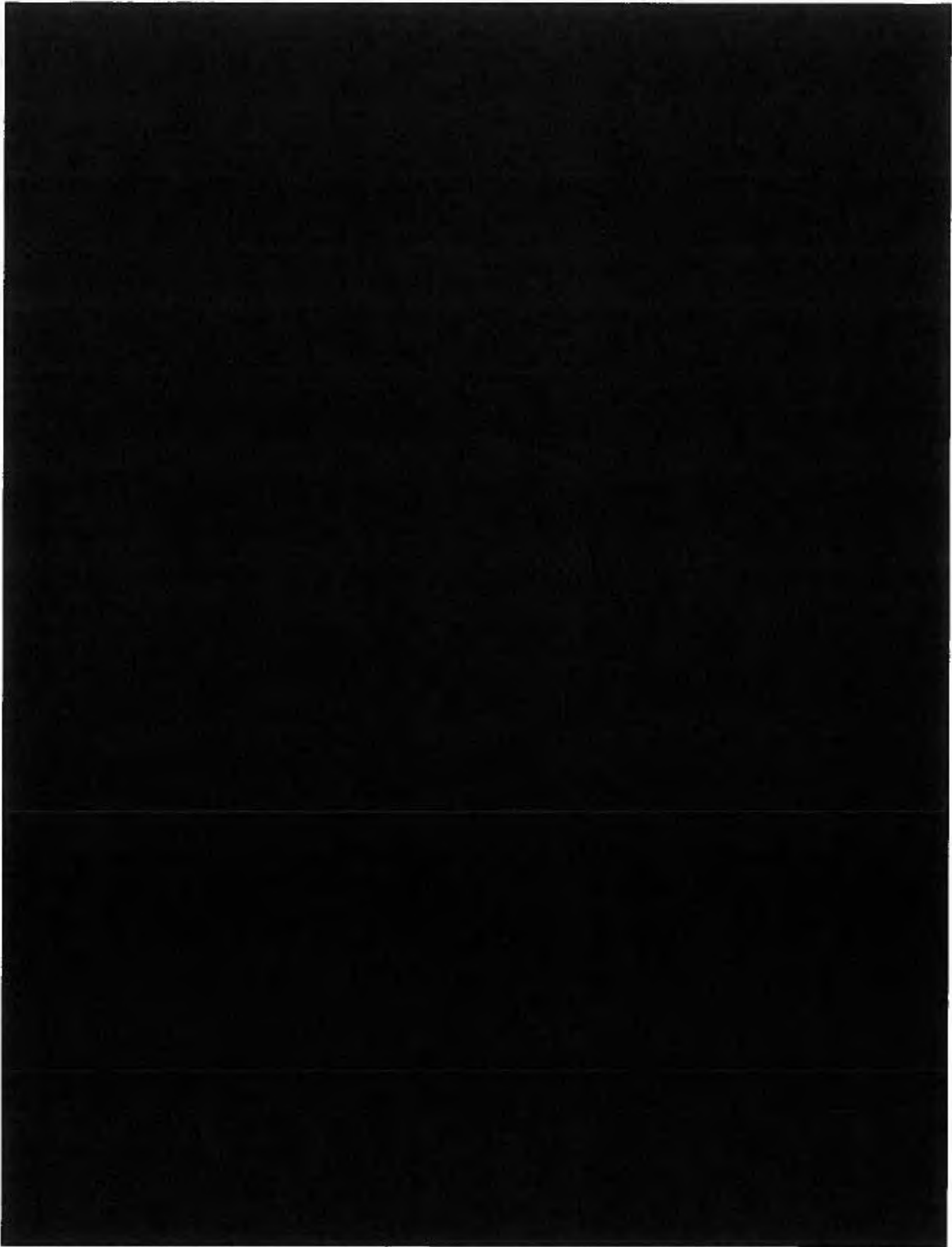


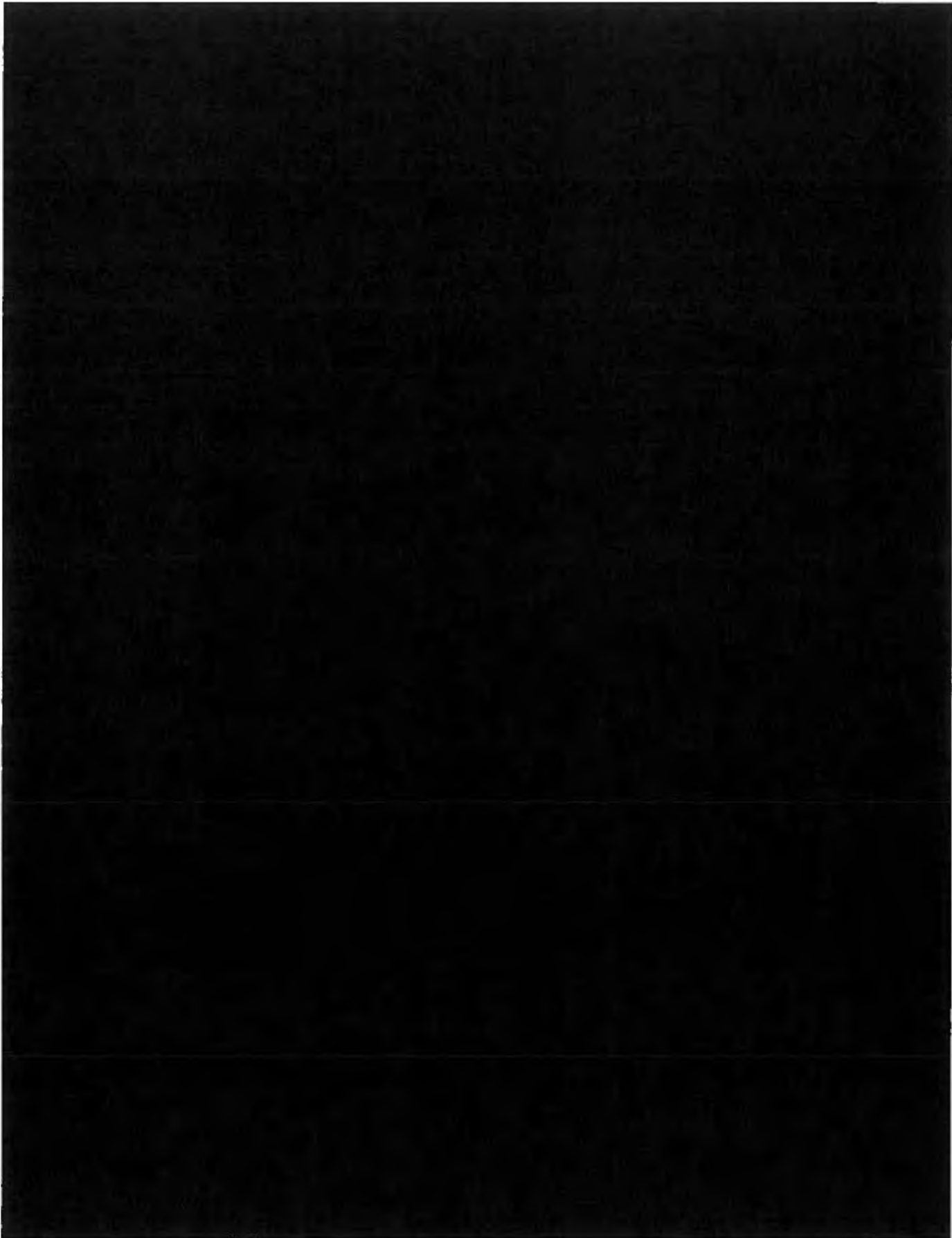


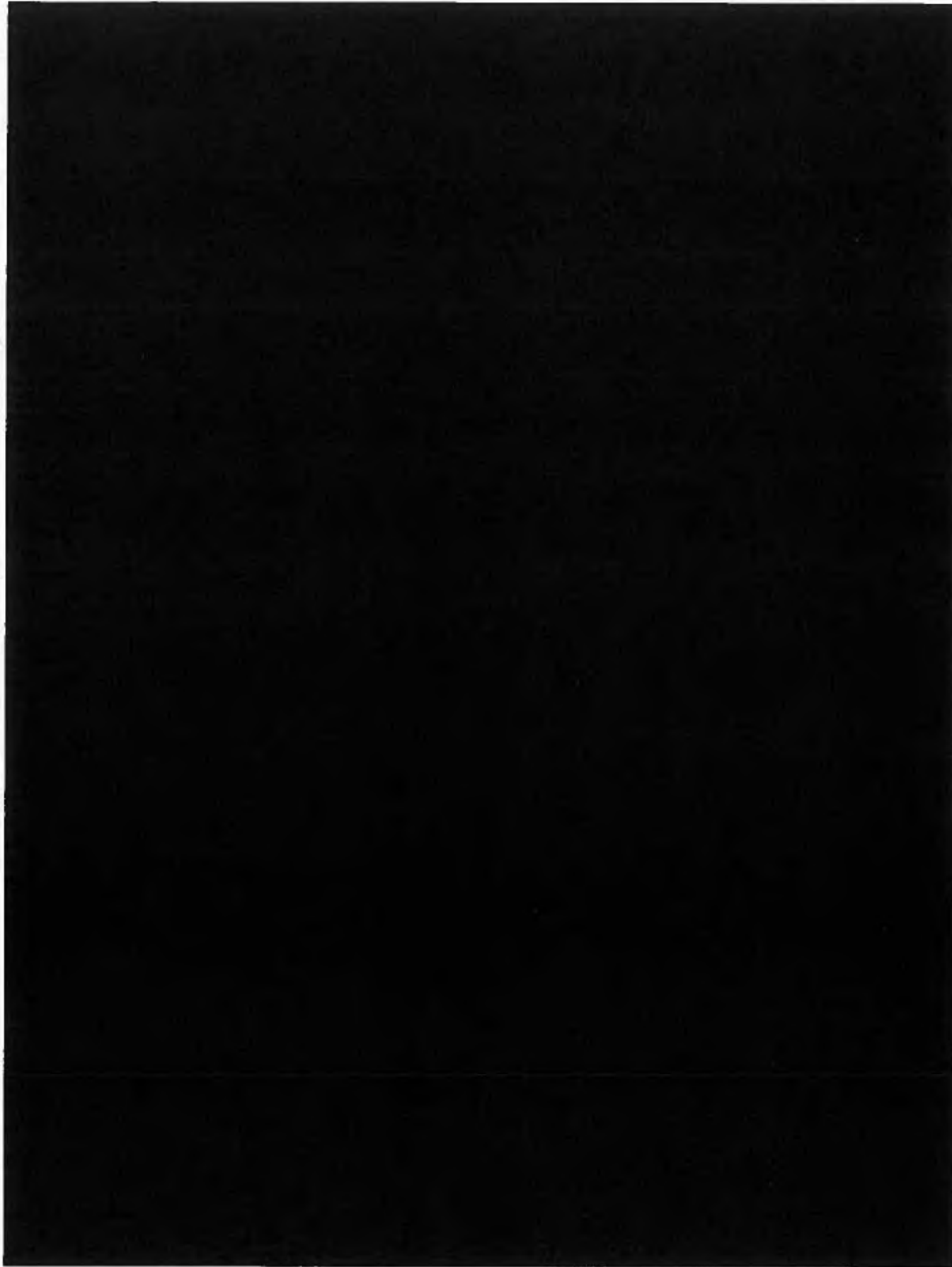


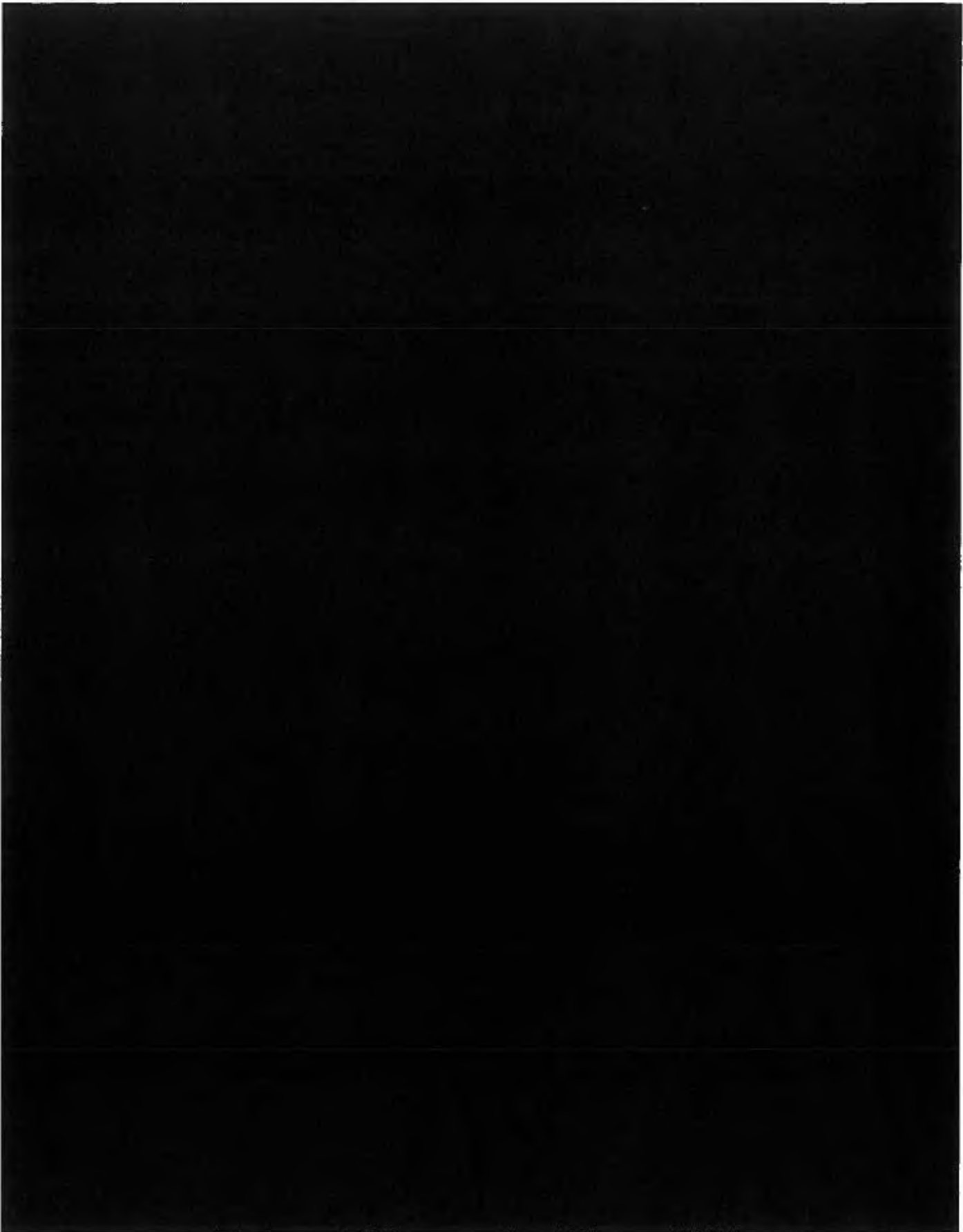


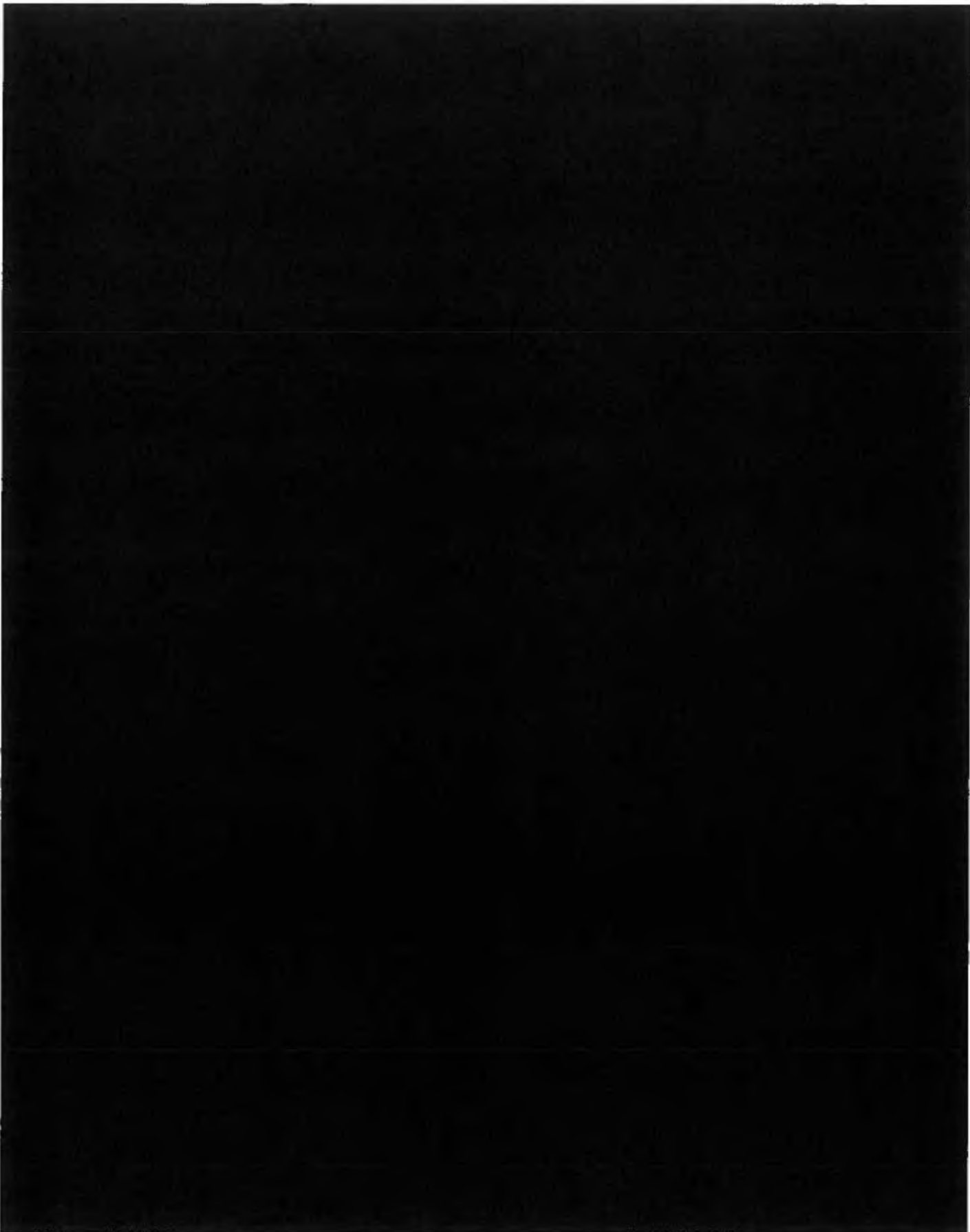


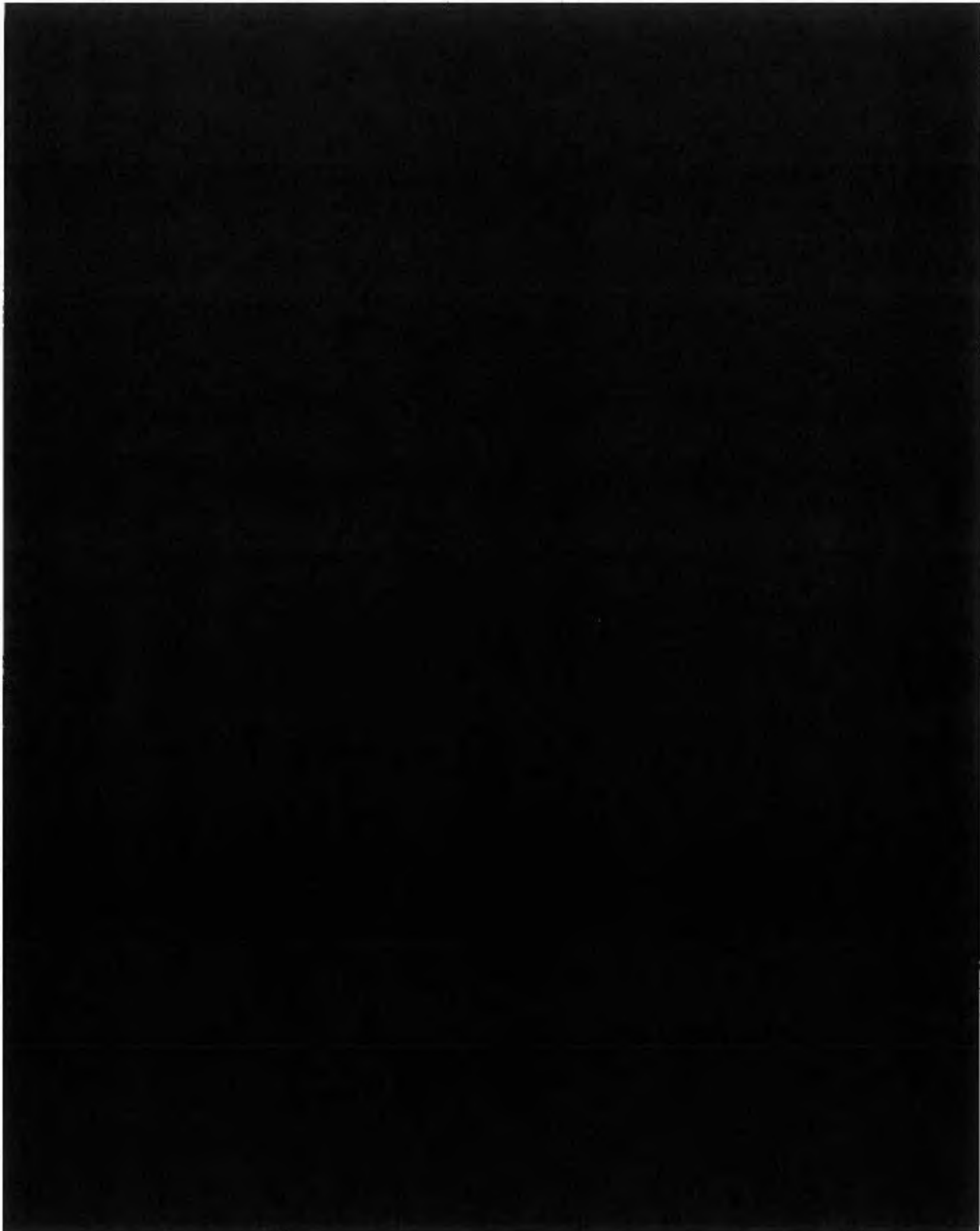


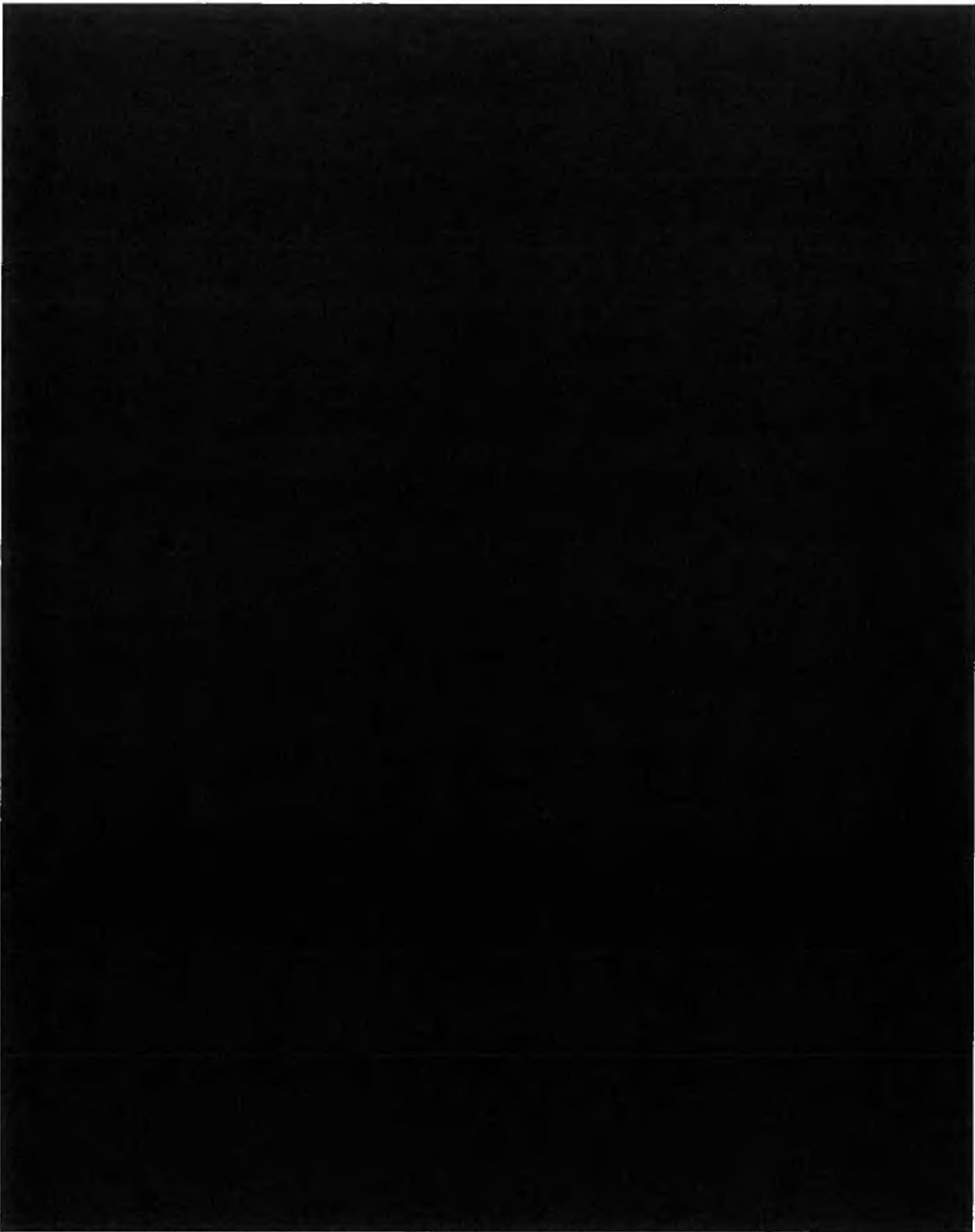


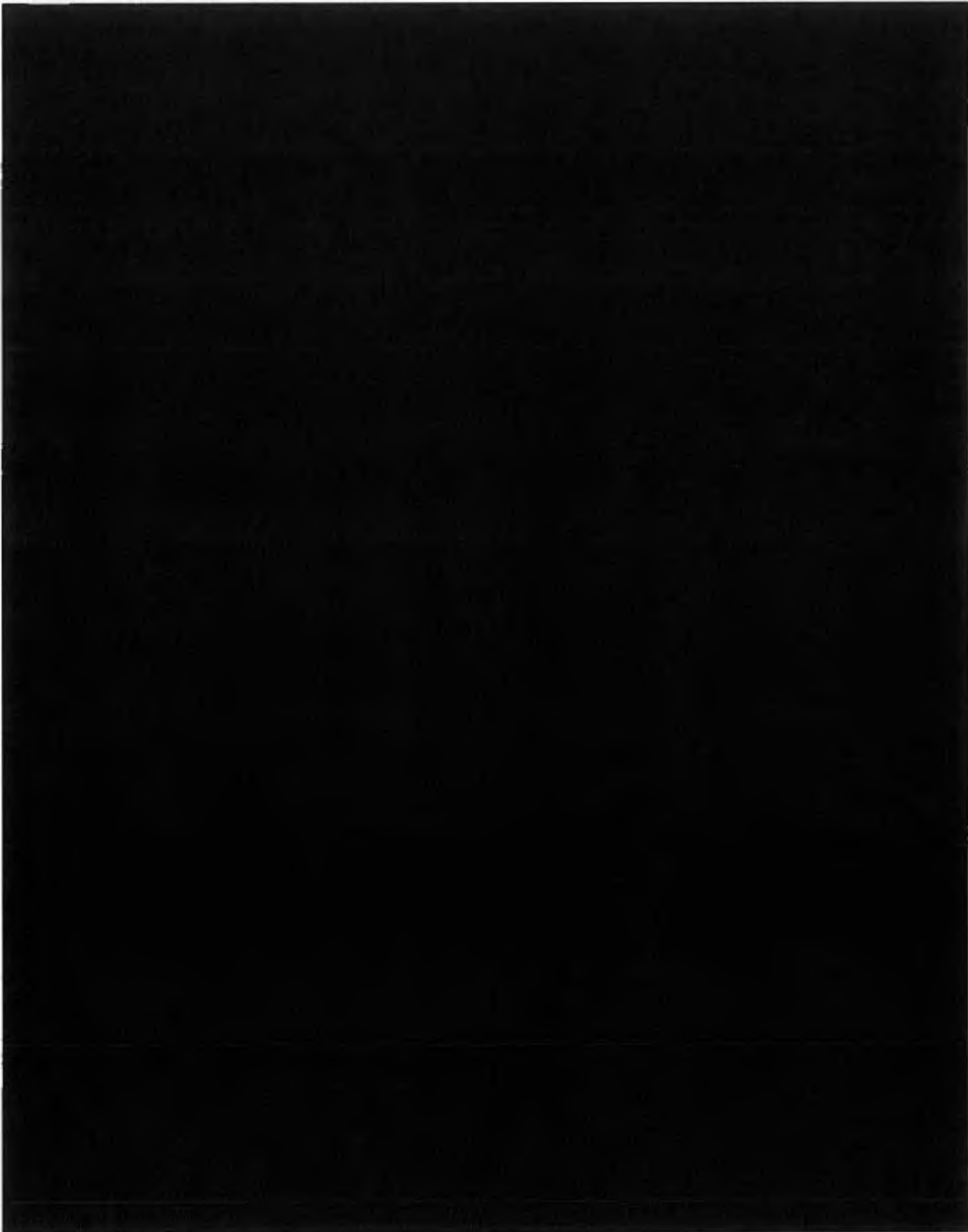


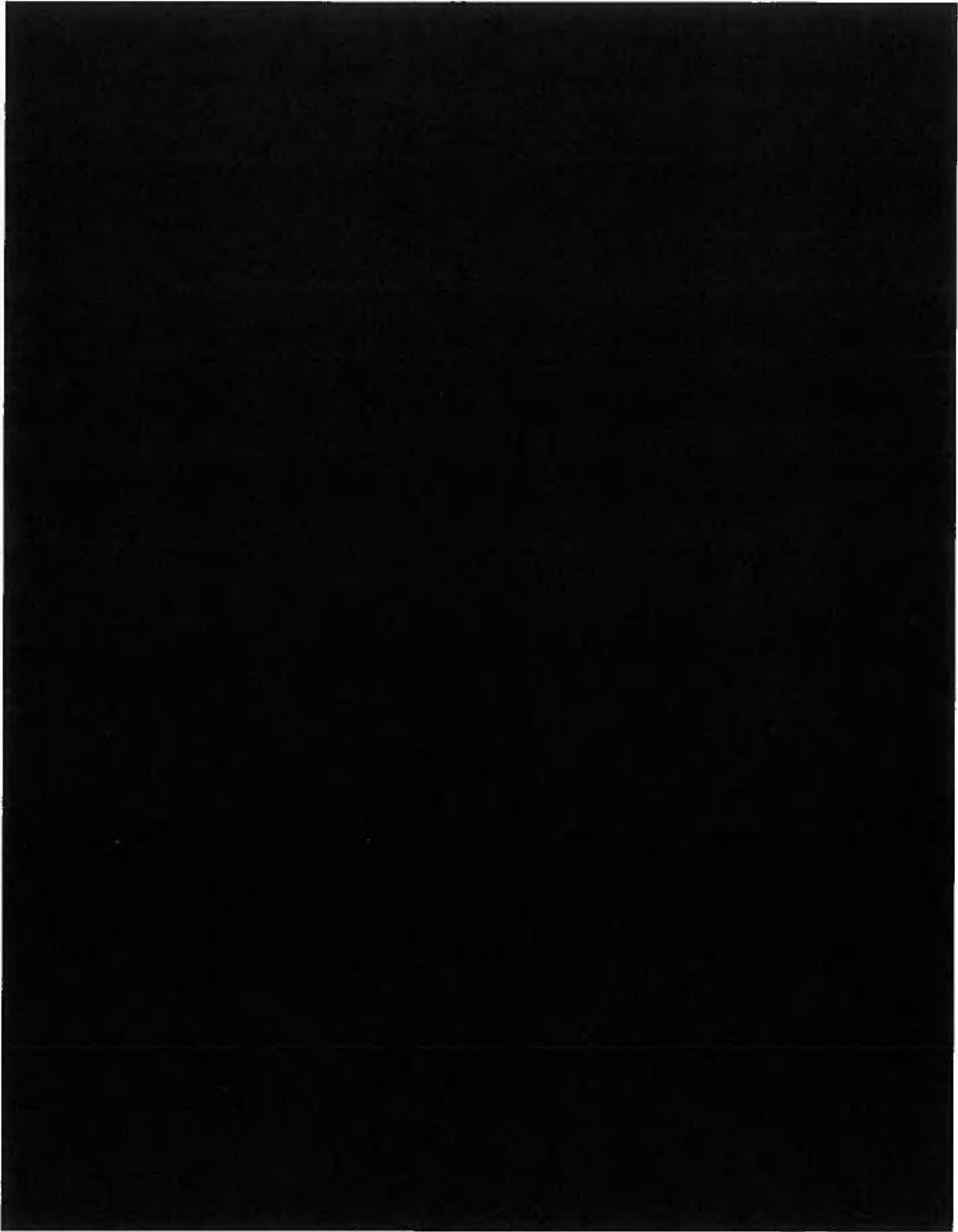


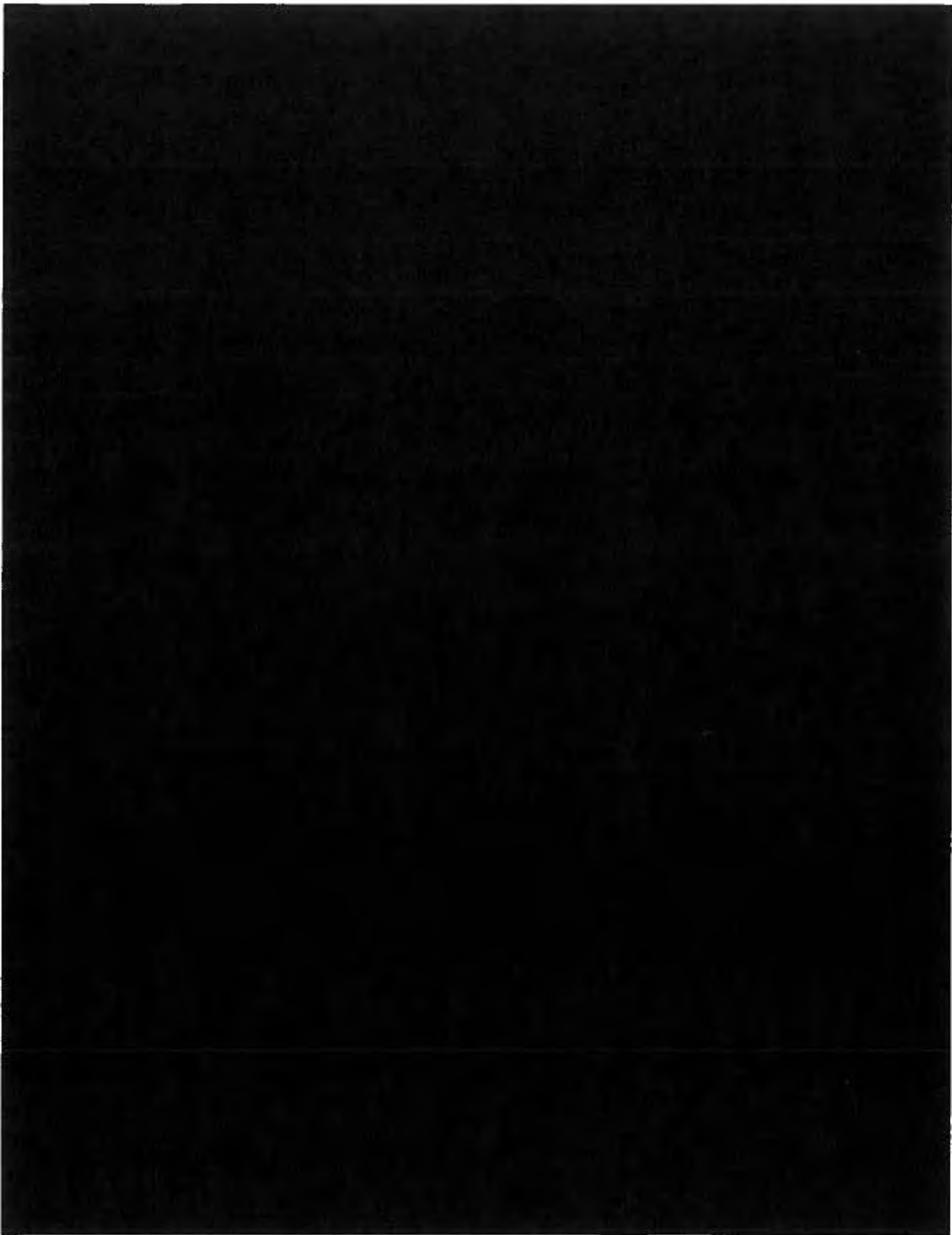


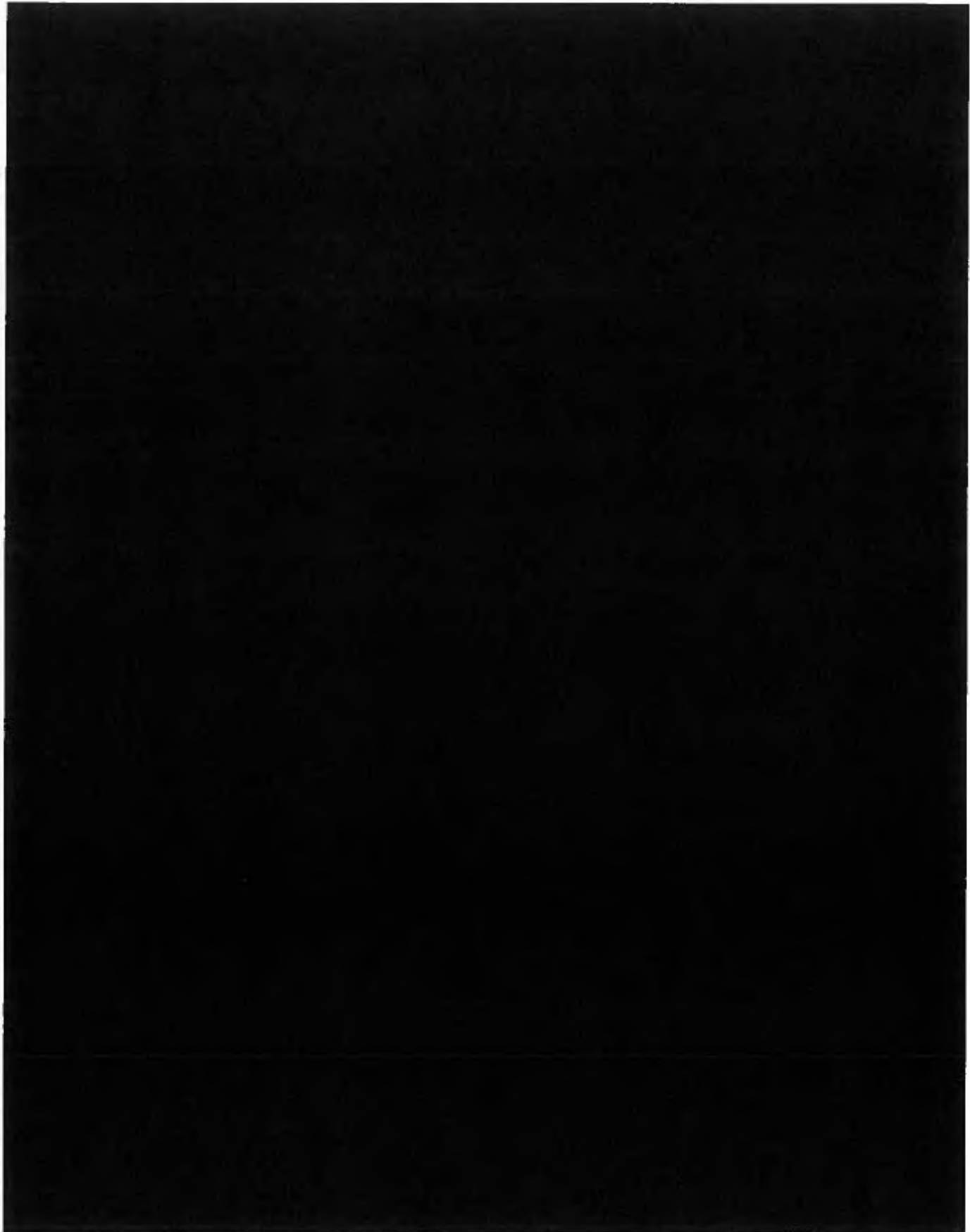


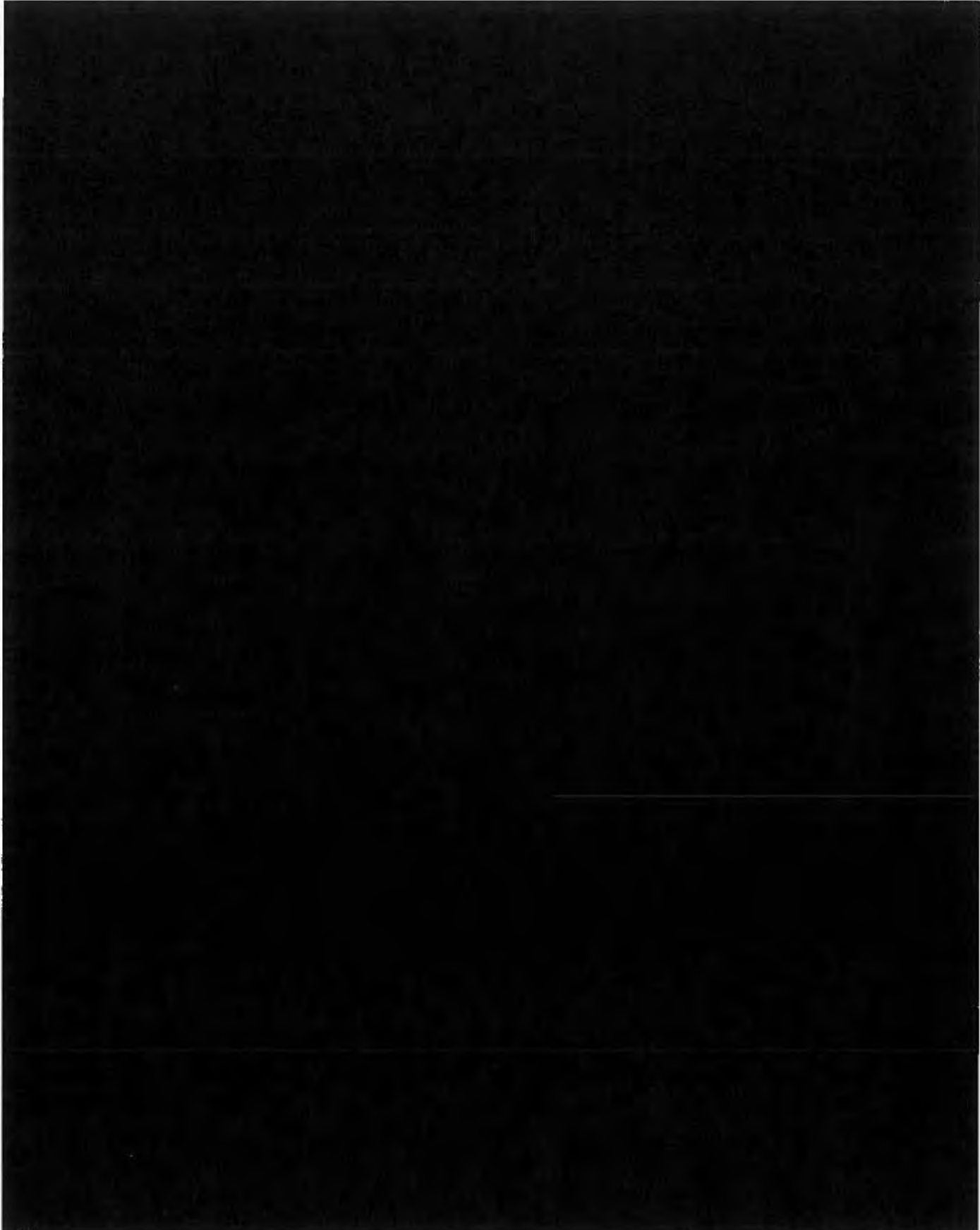


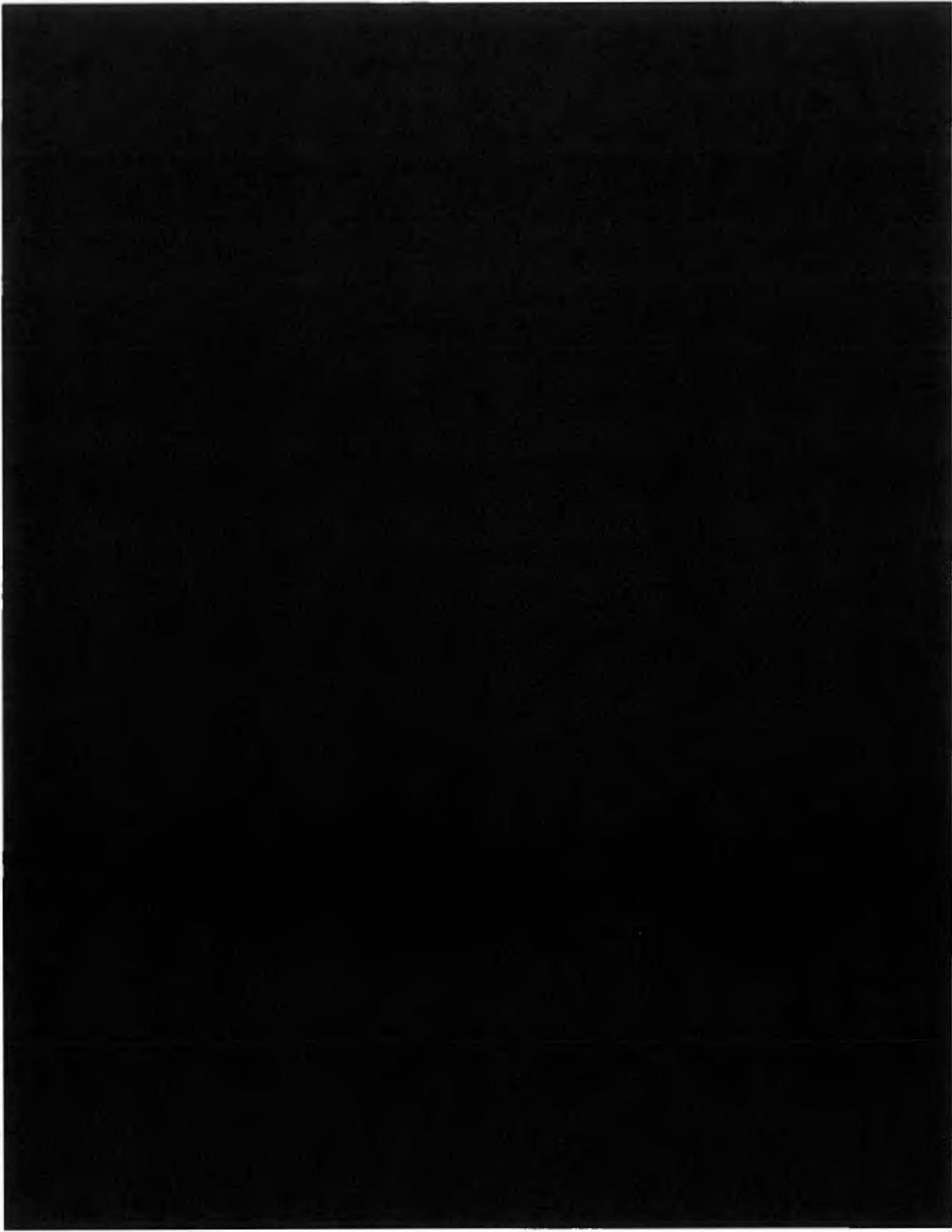


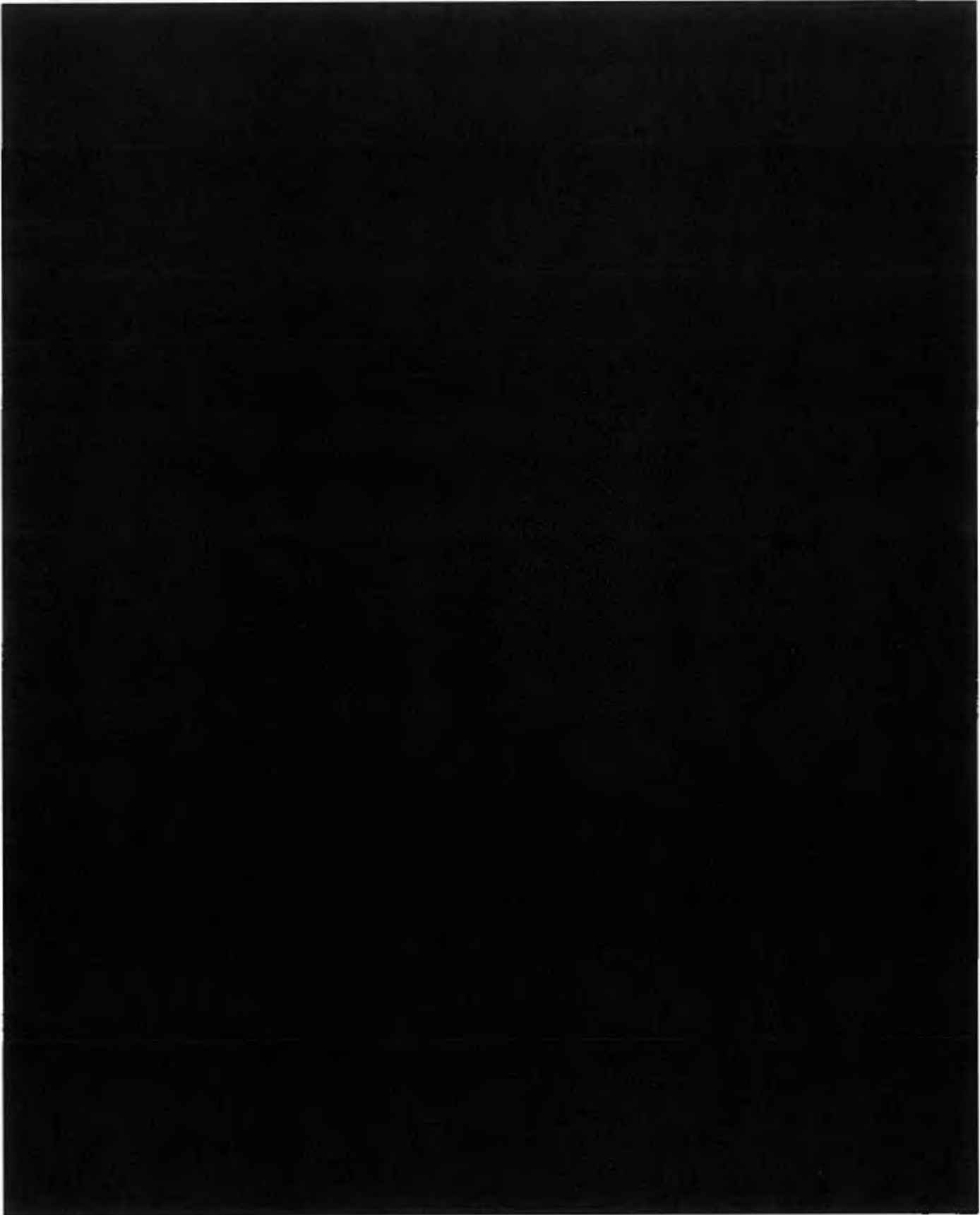


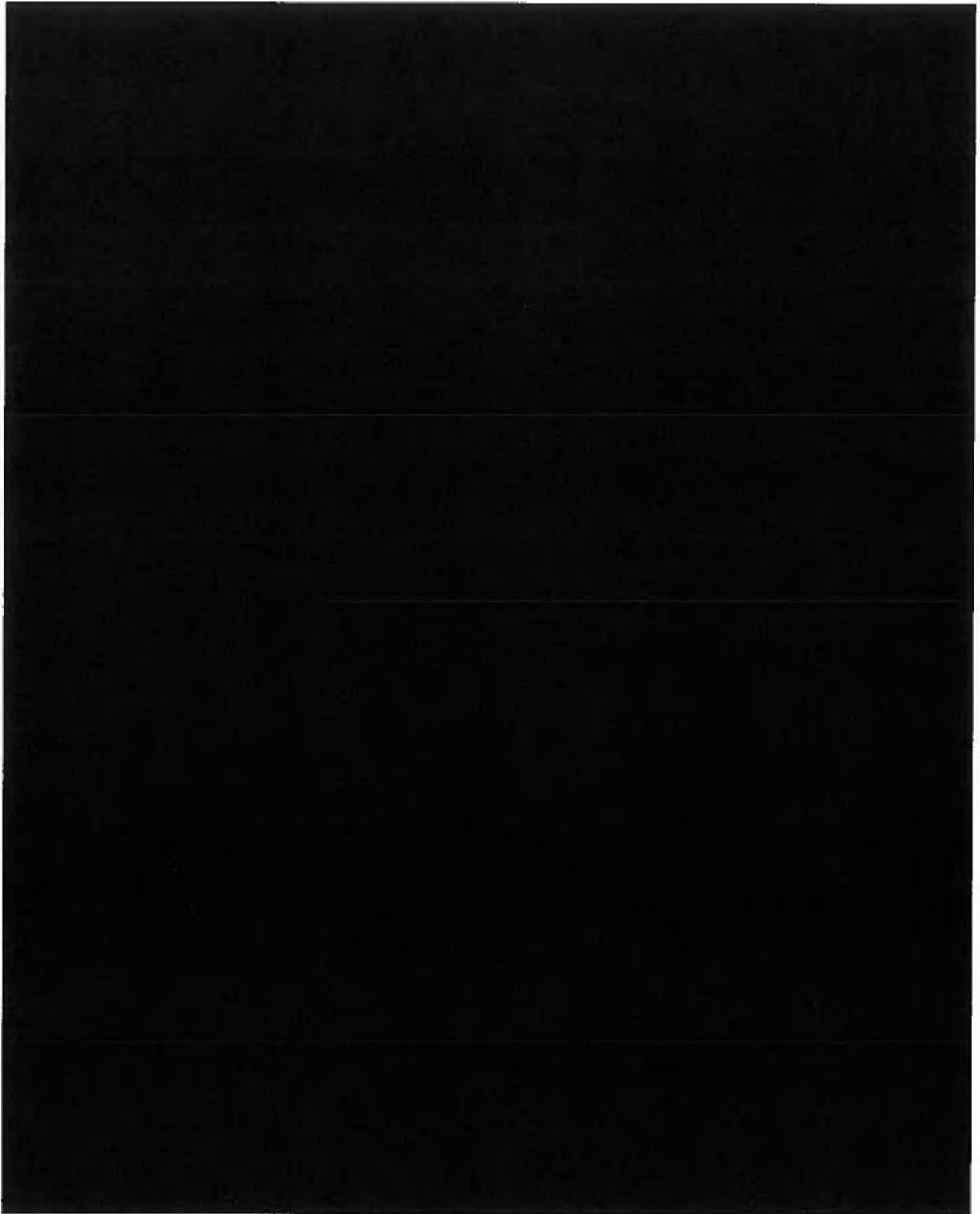


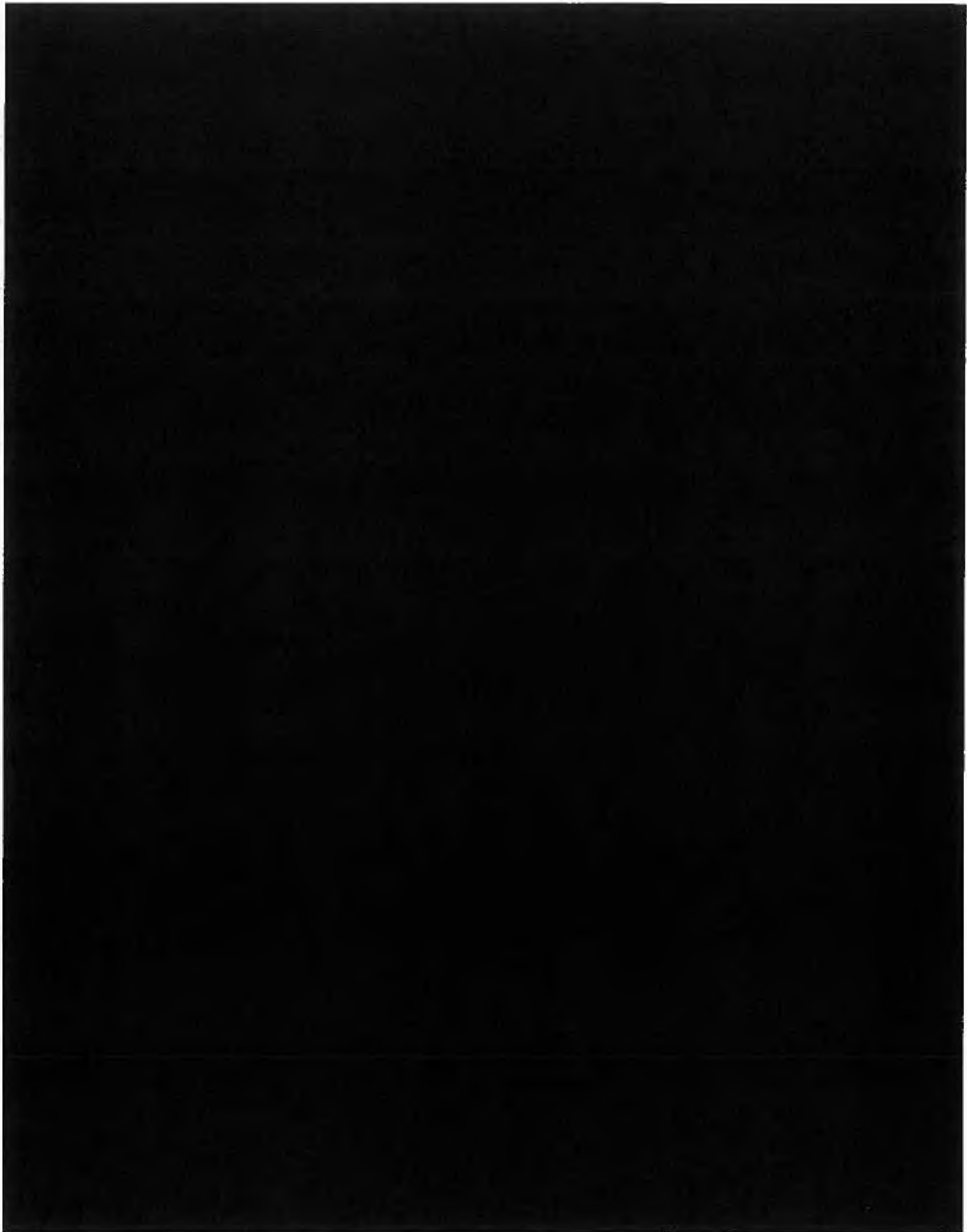


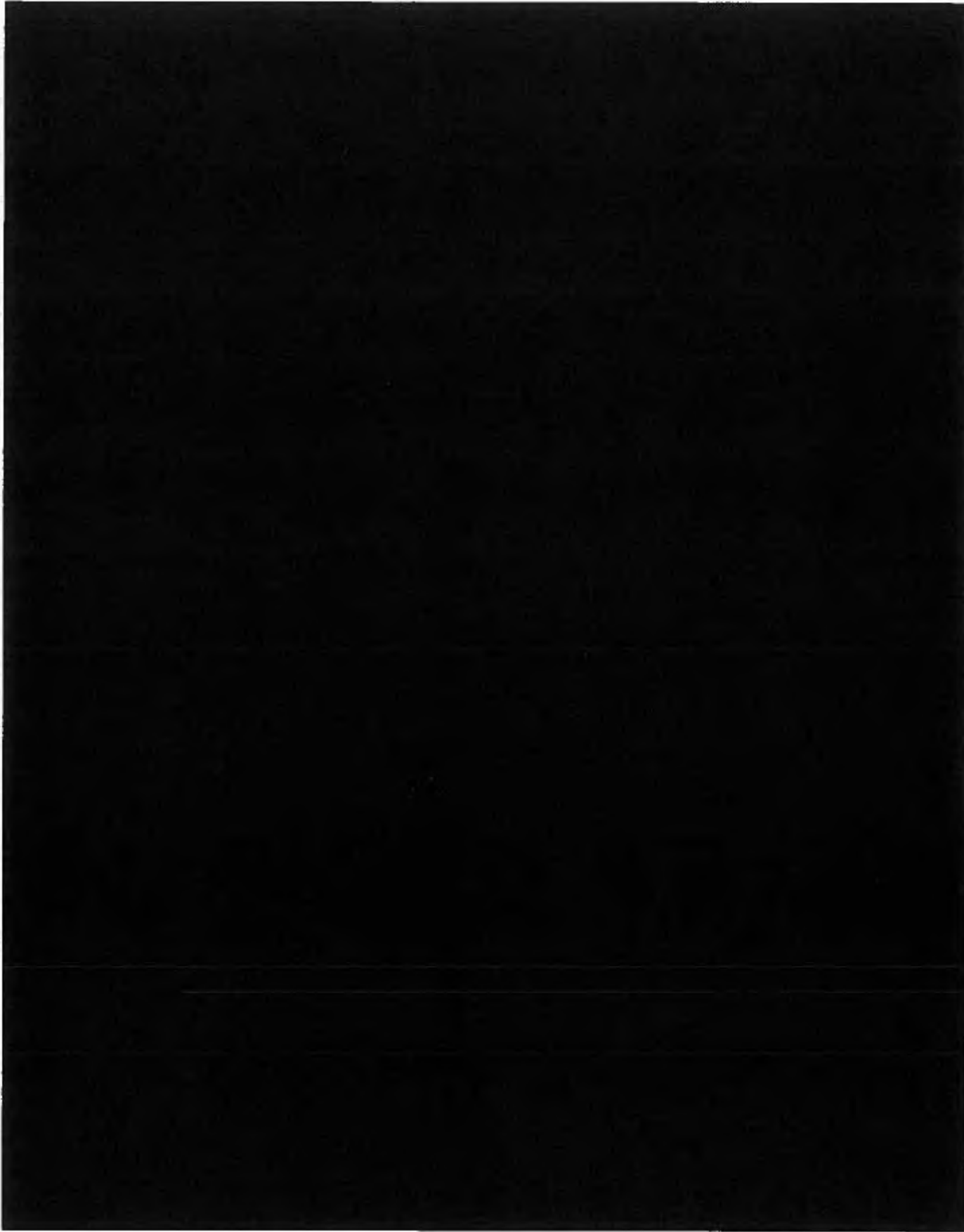




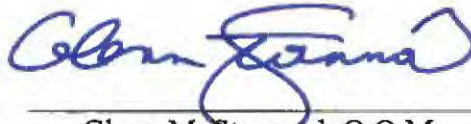








SIGNED at Ottawa, Ontario.



Glenn M. Stannard, O.O.M.
Chairperson

APPENDICES

**GLOSSARY OF TERMS /
ACRONYMS USED
THROUGHOUT THIS REPORT**

Glossary of Terms / Acronyms used throughout this Report

1 CMBG	1 Canadian Mechanized Brigade Group
2iC	Second in Command
2Lt	Second Lieutenant
AA	Alcoholics Anonymous
Adj, Adjt	Adjutant
AHE	Alberta Hospital at Edmonton
AISC	Administrative Investigation Support Centre
AJAG	Assistant Judge Advocate General
AO	Assisting Officer
ASU	Area Support Unit
ATIP, ATI	Access to Information and Privacy, Access to Information
AWOL	Absent without leave
BAC	Base Addictions Counsellor
BGen	Brigadier-General
BOI	Board of Inquiry
Capt	Captain
Cdr	Commander
CDS	Chief of the Defence Staff
CDU	Care Delivery Unit
CEA	Canada Evidence Act
CF	Canadian Forces
CAF	Canadian Armed Forces (as of April 1, 2012)
CFAO	Canadian Forces Administrative Orders
CFB	Canadian Forces Base
CFLA	Canadian Forces Legal Advisor
CFNIS	Canadian Forces National Investigation Service
CFPM	Canadian Forces Provost Marshal
CLS	Chief Land Staff
CO	Commanding Officer
CoC	Chain of Command
CO CFNIS, CO NIS	Commanding Officer of the CF National Investigation Service
Col	Colonel
CPIC	Canadian Police Information Centre
CPKN	Canadian Police Knowledge Network
Cpl	Corporal
CWO	Chief Warrant Officer
DAIP	Director Access to Information and Privacy
DAOD	Defence Administrative Orders and Directives
DCDS	Deputy Chief of the Defence Staff
DAPA	Director of Army Public Affairs
DCO	Deputy Commanding Officer
DComd CF MP Gp	Deputy Commander Canadian Forces Military Police Group

DCCS	Director Defence Counsel Services
Det. Cdr	Detachment Commander
Det. Insp.	Detective Inspector
DMP	Director Military Prosecution
DNA	Deoxyribonucleic acid
DND	Department of National Defence
DOJ	Department of Justice
DPAO	Director Public Affairs Operations
DPM	Deputy Provost Marshal
Dr.	Doctor
DSM	Diagnostic and Statistical Manual of Mental Disorders
EGFS	Edmonton Garrison Fire Service
EPS	Edmonton Police Service
FCC	Federal Court of Canada
GIS	General Investigation Section
GO	General Occurrence
HQ	Headquarters
IAW	In accordance with
ID, Ident	Identification
Insp.	Inspector
IP	Investigation Plan
JAG	Judge Advocate General
LCdr	Lieutenant-Commander
LCol	Lieutenant-Colonel
LDSH, LdSH	Lord Strathcona's Horse
LDSH (RC)	Lord Strathcona's Horse (Royal Canadians)
LEGAD	Legal Advisor
LFPM	Land Force Provost Marshal
LFWA	Land Force Western Area
LGen	Lieutenant-General
Maj	Major
MCM	Major Case Management
MCpl	Master Corporal
ME	Medical Examiner
MEL	Medical employment limitations
MGen	Major-General
MND	Minister of National Defence
MP	Military Police
MPCC	Military Police Complaints Commission
MP HQ	Military Police Headquarters
MPIR	Military Police Investigation Report
MPPCC	Military Police Professional Code of Conduct
MPPTP	Military Police Policies and Technical Procedures
MPRR	Member's Personnel Record Resume
MRL	Media response lines

MS	Master Seaman
MWO	Master Warrant Officer
NCO	Non-commissioned officer
NDA	National Defence Act
NDHQ	National Defence Headquarters
NIS	National Investigation Service
NOK	Next of kin
OC	Officer Commanding
OPP	Ontario Provincial Police
OST	Out of Service Training
PAI	Personality Assessment Inventory
PAO	Public Affairs Officer
PEN	Personal Emergency Notification
PIH	Public Interest Hearing
PLQ	Primary Leadership Qualification
PNOK	Primary next of kin
PO2	Petty Officer, 2 nd Class
PPCLI	Princess Patricia's Canadian Light Infantry
Pte	Private
PTSD	Post-traumatic Stress Disorder
QA	Quality Assurance
QL3/5/6A/6B	Qualifying Level 3/5/6A/6B
QR&O	Queen's Regulations and Orders for the Canadian Forces
RAH	Royal Alexandra Hospital
RCMP	Royal Canadian Mounted Police
Ret'd	Retired
RSM	Regimental Sergeant-Major
SA	Situational awareness
SAMPIS	Security and Military Police Information System
SCC	Supreme Court of Canada
SDB	Supplementary Death Benefits
Sgt	Sergeant
SI	Summary Investigation
SNOK	Secondary Next of Kin
SOP	Standard Operation Procedure
S/Sgt	Staff Sergeant
TCAT	Temporary Category
UMS	Unit Medical Station
VAC	Victims Assistance Coordinator
VCDS	Vice Chief of the Defence Staff
WO	Warrant Officer
WR	Western Region Detachment
WRT	With respect to

**DECISION TO CONDUCT
A PUBLIC INTEREST
INVESTIGATION
– APRIL 29, 2011**



April 29, 2011

Distribution List

Our File: MPCC-2011-004 (Fynes)

In accordance with the provisions of subsection 250.38(3) of the *National Defence Act* (NDA), this letter will serve as notice of my decision to cause the Military Police Complaints Commission to conduct a public interest investigation into the above complaint.

This complaint relates to three investigations conducted by the Canadian Forces National Investigation Service (CFNIS) after the complainants' son, Corporal (Cpl) Stuart Langridge, committed suicide on March 15th, 2008.

The complainants allege that the first CFNIS investigation into their son's death (the Sudden Death investigation) was not conducted in an impartial way, and that it tarnished their son's reputation in an attempt to protect his Canadian Forces Chain of Command. They explain that their son, who had served in Bosnia and Afghanistan, was suffering from Post Traumatic Stress Disorder and depression, and committed suicide shortly after being ordered out of a psychiatric facility, when he had commented that he would rather kill himself than return to his Unit, and when the complainants had been told that he was under a suicide watch at his Unit. They allege that the CFNIS investigator made an incorrect finding about their son's alcohol and drug addiction which was prejudicial to their son's memory. They further allege that the finding in the CFNIS report that the military had made several attempts to help their son in dealing with his problems was incorrect and irrelevant to the investigation, and that it was intended to absolve their son's Chain of Command of any liability. The complainants express concern that CFNIS did not possess the necessary independence to uncover and reveal information prejudicial to the Canadian Forces.

The complainants make other allegations about the conduct of the Sudden Death investigation. In particular, they complain about a failure by CFNIS to disclose the existence of a suicide note from their son and to provide a copy of the note for over a year after their son's death; a failure to return their son's personal property seized as exhibits for over a year after the investigation was concluded; erroneous indications provided to the Alberta Medical Examiner that their son was facing disciplinary issues; and a failure to show respect to their son's body during the initial hours of the investigation. Further, the complainants were dissatisfied with the extent of the information that was redacted out of the copy of the investigation report they were provided, and they raised concerns about the justification for not providing them with more information about the investigation.

The complainants also take issue with two other CFNIS investigations. The first one (the 2009 investigation) was opened in November 2009, when the office of the Canadian Forces Ombudsman raised the possibility that there may have been a neglect of duty on the part of at least one CF member in representing the complainants' son's former common law spouse as his primary next of kin, despite knowledge that the relationship had ended prior to Cpl. Langridge's death. The complainants indicate they have a direct interest in this investigation, since the designation of their son's ex-girlfriend as primary next of kin has prevented them from making funeral arrangements for their son, and has required that they take court action to have records corrected. The second investigation (the 2010 investigation) was opened in April 2010, when the complainants formally requested that CFNIS investigate any criminal negligence committed by members of their son's Regiment in ordering their son to leave the psychiatric facility shortly before his death, in imposing restrictive conditions on him in order to obtain further care, in ignoring his suicide risk which had been assessed as high, and in not conducting or not properly conducting a suicide watch to prevent their son's death.

With respect to the 2009 and 2010 investigations, Mr. and Mrs. Fynes complain that they have not been kept updated on the progress of the investigations, and that a significant time period has elapsed with no apparent result. They raise issues about the CFNIS' ability to conduct these investigations, and about its independence, in light of information they received indicating that updates on the NIS investigations would be incorporated into a CF debriefing on other matters. They further allege that, when they were advised that the investigations had been completed, the CFNIS inappropriately cancelled a briefing its members were supposed to provide on the investigations because the complainants requested that their lawyer be present. A written briefing was to be provided instead, and the complainants have recently been advised that it is currently being sent to them. However, they raise concerns about the delay in providing this briefing.

The conduct that is the subject of the complaint occurred during the period of March 2008 to the present. The complainants have already sought, and been granted, an extension of the time period in which to file their complaint in accordance with section 250.2 of the NDA.

In considering the public interest in conducting an investigation pursuant to subsection 250.38(1) of the NDA, I have noted the seriousness of the allegations made by the complainants, as well as the gravity of the underlying events. One of the primary functions of the Military Police is to ensure that members of the Canadian Forces act in accordance with the law and the military Code of Service Discipline. The allegations in this complaint, if true, raise issues about the MP's ability to investigate and report on any misconduct by CF members with impartiality and independence. The possibility that a bias may exist – leading MPs to favour the CF Chain of Command in the conduct

of their investigations or to feel in any way prevented from exposing information detrimental to the CF – goes to the core of military policing and of the MP's ability to perform its important role. Even a perception that the MP lacks the necessary objectivity or independence to investigate the CF Chain of Command could negatively impact on public confidence in the MP. The possibility that this alleged lack of independence and impartiality could lead to delay in investigations and to an inability to keep complainants and individuals directly affected informed also raises important issues in terms of the MPs' ability to fulfill their duties.

The allegations in this complaint, if true, may raise systemic issues relating to processes, policies or training, and the complainants have specifically requested that any such issues be examined by this Commission.

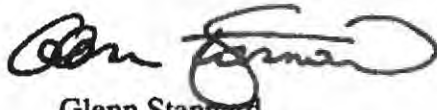
It is also a significant public interest consideration that this Commission's conduct of an immediate, first instance investigation of this complaint will contribute to engender confidence in the process for the complainants. The events which gave rise to this complaint began over three years ago. Since then, Mr. and Mrs. Fynes have complained about the delay and difficulty in obtaining information about the investigations. More importantly, throughout their interaction with Military Police authorities and with the Canadian Forces more generally, and in part as a result of the conduct they complain about in this case, the complainants have indicated that they have lost faith in the Military Police and do not trust them. In their words, they feel that they have been "frustrated by a continuous campaign of obfuscation and ongoing indifference." In terms of their overall interaction with the Canadian Forces, the Ombudsman reported that the complainants felt that they were being ignored and even silenced by the CF. They have indicated that they felt they had been deceived, misled and intentionally marginalized in their dealings with DND and the CF, and as a result had lost faith in the system. Under the circumstances, referring the matter back to the Canadian Forces Provost Marshal for an internal investigation to be conducted prior to affording the complainants an opportunity to request a review by this Commission would risk compounding the complainants' distrust in military and MP authorities, and possibly delaying the resolution of their complaint. The complainants have expressed their wish to have this Commission conduct a public interest investigation, and I have taken those wishes into consideration as well.

For all of these reasons, I consider it advisable in the public interest, pursuant to subsection 250.38(1) of the NDA to cause this Commission to conduct an investigation into this complaint and, if warranted, to hold a hearing.

The complainants have not specifically identified the subjects of their complaint. They raise issues with the conduct of the investigators involved in all three of the investigations at issue, all conducted by CFNIS Western Region. This Commission will proceed with the identification and notification of the subjects once disclosure of

the investigative files has been received and reviewed, and after an initial interview with the complainants has been conducted in order to clarify all of their allegations.

Yours truly,

A handwritten signature in black ink, appearing to read "Glenn Stannard". The signature is fluid and cursive, with a large loop at the end.

Glenn Stannard
Chair

Distribution List:

The Honourable Peter Mackay, P.C., M.P.
Minister of National Defence
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2

General W.J. Natynczyk, CMM, MSC, CD
Chief of the Defence Staff
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2

Brigadier-General Blaise Cathcart, OMM, CD, QC
Judge Advocate General
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, ON
K1A 0K2

Colonel T.D. Grubb
Canadian Forces Provost Marshal
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2

Lieutenant-Colonel Robert Delaney
Commanding Officer, NIS
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

Major Daniel Dandurand
Commanding Officer
NIS Western Region
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5

Mr. Shaun Fynes
Mrs. Sheila Fynes

**DECISION TO HOLD A
PUBLIC INTEREST HEARING
– SEPTEMBER 6, 2011**



September 6, 2011

Distribution List

Our File: MPCC-2011-004 (Fynes)

In accordance with the provisions of subsection 250.4(1)(b) of the *National Defence Act* (NDA), this letter will serve as notice of my decision to cause the Military Police Complaints Commission to hold a public interest hearing into the above complaint.

The complainants' son, Corporal (Cpl) Stuart Langridge, committed suicide at Canadian Forces Base/Area Support Unit (CFB/ASU) Edmonton on March 15, 2008. Mr. and Mrs. Fynes are complaining about the police investigations conducted by the Canadian Forces National Investigation Service (CFNIS) after their son's death and about the conduct of CFNIS members in their interactions with them. Their allegations include:

- CFNIS did not conduct independent investigations into this matter;
- The investigations they did conduct were inadequate and biased;
- The investigations were aimed at exonerating Canadian Forces (CF) members of any responsibility for their failure to prevent Cpl Langridge's death and for the manner in which the complainants were subsequently treated;
- CFNIS failed to investigate important issues;
- CFNIS participated in efforts to explain and justify the conduct of CF members instead of conducting independent investigations into potential criminal or service offences committed by CF members;
- CFNIS members allowed non-Military Police members of the CF and a broader CF concern about potential litigation to influence or dictate their decisions about the type of information to be provided to the complainants and the manner in which that information would be provided; and
- The CFNIS members involved lacked professionalism and competence in their handling of various aspects of the case, and in particular in failing to disclose the existence of a suicide note from their son to the complainants.

On April 29, 2011, I made a decision to conduct a public interest investigation into this complaint. This decision was based on the nature and seriousness of the allegations, as well as on the loss of confidence in internal CF processes by the complainants.

Based on a preliminary review of the investigative files and on an interview with the complainants to clarify their allegations, the Commission has identified the 13 subjects of this complaint and provided them with notification. The enclosed list of allegations was prepared on the basis of the information received from the complainants and was provided to the subjects of the complaint.

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This preliminary review of the documentary materials and interview with the complainants has led me to conclude that the nature of the issues raised in this complaint makes the holding of a public hearing not only warranted in the public interest, but necessary in order properly to dispose of this complaint.

The allegations in this complaint put into question the very ability of the Military Police (MP) to conduct independent investigations into the behaviour of members of the CF, particularly when decisions made by the Chain of Command are involved. If these allegations are substantiated the implications are of profound significance. One of the MP's central functions is to enforce criminal and military law within the CF. For this purpose, the MP investigates and reports on misconduct by CF members, thereby ensuring that members of the CF act in accordance with the law and the military Code of Service Discipline. If, as alleged in this complaint, a bias did exist that prevented CFNIS from uncovering and exposing information detrimental to the Canadian Forces, then the ability of the MP to carry out this important function would be significantly impaired. Similarly, and perhaps even more importantly, if the CFNIS did not possess the required degree of independence to make decisions about what issues to investigate, how to investigate these issues, and what information to provide to complainants without being influenced by the interests of other elements of the CF, or if the CFNIS improperly failed to exercise this independence, then it would be difficult if not impossible for the Military Police to carry out its core functions.

The allegations in this complaint strike at the very core of how the Military Police performs its role. Independent oversight is meant to ensure that the MP can perform its functions with a high degree of professionalism and that public confidence in the police is maintained. Because the allegations here raise the possibility that the Military Police is unable to perform some of its most basic duties in support of the military justice system and the rule of law, they must be examined to the fullest, and this examination must take place in an open, public and transparent setting. Ensuring that independent police investigations are conducted into potential criminal or service offences committed by members of the military is in the interest of the public as a whole.

Openness is particularly important in light of the fact that these allegations themselves raise issues about transparency. Allegations that a failure to provide information was influenced by other CF interests or motivated by litigation concerns, and that MP members participated in efforts to justify CF actions instead of investigating them, by definition raise concerns about a possible lack of transparency in MP processes. As a result, the process used to shed light on this matter and determine whether these allegations are well founded should itself be open and transparent.

The allegations in this complaint have significance and implications beyond the specific facts and the specific parties in this case. They potentially raise complex issues about the policies, practices and organization of the Military Police. These issues will be better addressed in the context of a public hearing where evidence relevant to this complaint can be examined in depth through an open process, and where all parties can be provided with a full opportunity to present their views and to bring or challenge evidence.

The holding of public hearings is the most appropriate process to provide the necessary level of accountability and transparency in this case. The public's interest to be informed of, and to come to an understanding about, these important issues will be supported by the Commission receiving evidence to support or refute these allegations in a public hearing.

For all these reasons, I consider that it is warranted in the public interest to hold a hearing into this complaint. I have not come to this decision lightly, considering the significant investment in time and in resources involved in the holding of a hearing, particularly in this time of necessary fiscal restraint. However, because of the nature of the allegations, holding a public interest hearing is the only appropriate manner to dispose of this complaint.

The Commission will make every effort to proceed as expeditiously as possible in order to minimize the time required to resolve this complaint. The hearing process will commence with a case conference on October 13, 2011. By that time, the Commission will expect the parties to have retained counsel, if they wish, and to be in a position to advise the Commission of any preliminary issues and of their views on scheduling so that a date can be set for the beginning of the hearing of evidence.

Yours truly,

A handwritten signature in black ink, appearing to read "Glenn M. Stannard", written in a cursive style.

Glenn M. Stannard
Chairperson

Enclosures: Decision letter of April 29, 2011
List of allegations

Distribution List:

The Honourable Peter Mackay, P.C., M.P.
Minister of National Defence
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

General W.J. Natynczyk, CMM, MSC, CD
Chief of the Defence Staff
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

Brigadier-General Blaise Cathcart, CD
Judge Advocate General
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

Colonel T.D. Grubb
Canadian Forces Provost Marshal
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

Mr. Shaun Fynes
Mrs. Sheila Fynes

Sergeant Jon Bigelow
Canadian Forces National Investigations Services
National Defence Headquarters
2200 Walkley Road
Ottawa, Ontario K1A 0K2

Warrant Officer Sean Der Bonneteau

Master Warrant Officer Ross Tourout
PO Box 17000, Station Forces
Oromocto, NB E2V 4J5

Lieutenant-Colonel (ret'd) William H. Garrick

Lieutenant-Colonel Gilles Sansterre
Deputy Commander
Canadian Forces Military Police Group / PS
National Defence Headquarters
2200 Walkley Road
Ottawa, Ontario K1A 0K2

Warrant Officer Blair Hart
Canadian Forces National Investigation Service
Atlantic Region Detachment
PO Box 99000, Station Forces
Halifax, NS B3K 5X5

Petty Officer, 2nd Class Eric McLaughlin
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5

Sergeant David Mitchell
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5

Major Brian Frei

Sergeant Matthew Alan Ritco
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5

Major Daniel Dandurand
CFB Borden
PO Box 1000, Station Main
Borden, Ontario L0M 1C0

Sergeant Scott Shannon
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5

Chief Warrant Officer (ret'd) Barry Watson

Military Police
Complaints
Commission

Chairperson



Commission d'examen
des plaintes concernant
la police militaire

Président

April 29, 2011

Distribution List

Our File: MPCC-2011-004 (Fynes)

In accordance with the provisions of subsection 250.38(3) of the *National Defence Act* (NDA), this letter will serve as notice of my decision to cause the Military Police Complaints Commission to conduct a public interest investigation into the above complaint.

This complaint relates to three investigations conducted by the Canadian Forces National Investigation Service (CFNIS) after the complainants' son, Corporal (Cpl) Stuart Langridge, committed suicide on March 15th, 2008.

The complainants allege that the first CFNIS investigation into their son's death (the Sudden Death investigation) was not conducted in an impartial way, and that it tarnished their son's reputation in an attempt to protect his Canadian Forces Chain of Command. They explain that their son, who had served in Bosnia and Afghanistan, was suffering from Post Traumatic Stress Disorder and depression, and committed suicide shortly after being ordered out of a psychiatric facility, when he had commented that he would rather kill himself than return to his Unit, and when the complainants had been told that he was under a suicide watch at his Unit. They allege that the CFNIS investigator made an incorrect finding about their son's alcohol and drug addiction which was prejudicial to their son's memory. They further allege that the finding in the CFNIS report that the military had made several attempts to help their son in dealing with his problems was incorrect and irrelevant to the investigation, and that it was intended to absolve their son's Chain of Command of any liability. The complainants express concern that CFNIS did not possess the necessary independence to uncover and reveal information prejudicial to the Canadian Forces.

The complainants make other allegations about the conduct of the Sudden Death investigation. In particular, they complain about a failure by CFNIS to disclose the existence of a suicide note from their son and to provide a copy of the note for over a year after their son's death; a failure to return their son's personal property seized as exhibits for over a year after the investigation was concluded; erroneous indications provided to the Alberta Medical Examiner that their son was facing disciplinary issues; and a failure to show respect to their son's body during the initial hours of the investigation. Further, the complainants were dissatisfied with the extent of the information that was redacted out of the copy of the investigation report they were provided, and they raised concerns about the justification for not providing them with more information about the investigation.

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The complainants also take issue with two other CFNIS investigations. The first one (the 2009 investigation) was opened in November 2009, when the office of the Canadian Forces Ombudsman raised the possibility that there may have been a neglect of duty on the part of at least one CF member in representing the complainants' son's former common law spouse as his primary next of kin, despite knowledge that the relationship had ended prior to Cpl. Langridge's death. The complainants indicate they have a direct interest in this investigation, since the designation of their son's ex-girlfriend as primary next of kin has prevented them from making funeral arrangements for their son, and has required that they take court action to have records corrected. The second investigation (the 2010 investigation) was opened in April 2010, when the complainants formally requested that CFNIS investigate any criminal negligence committed by members of their son's Regiment in ordering their son to leave the psychiatric facility shortly before his death, in imposing restrictive conditions on him in order to obtain further care, in ignoring his suicide risk which had been assessed as high, and in not conducting or not properly conducting a suicide watch to prevent their son's death.

With respect to the 2009 and 2010 investigations, Mr. and Mrs. Fynes complain that they have not been kept updated on the progress of the investigations, and that a significant time period has elapsed with no apparent result. They raise issues about the CFNIS' ability to conduct these investigations, and about its independence, in light of information they received indicating that updates on the NIS investigations would be incorporated into a CF debriefing on other matters. They further allege that, when they were advised that the investigations had been completed, the CFNIS inappropriately cancelled a briefing its members were supposed to provide on the investigations because the complainants requested that their lawyer be present. A written briefing was to be provided instead, and the complainants have recently been advised that it is currently being sent to them. However, they raise concerns about the delay in providing this briefing.

The conduct that is the subject of the complaint occurred during the period of March 2008 to the present. The complainants have already sought, and been granted, an extension of the time period in which to file their complaint in accordance with section 250.2 of the NDA.

In considering the public interest in conducting an investigation pursuant to subsection 250.38(1) of the NDA, I have noted the seriousness of the allegations made by the complainants, as well as the gravity of the underlying events. One of the primary functions of the Military Police is to ensure that members of the Canadian Forces act in accordance with the law and the military Code of Service Discipline. The allegations in this complaint, if true, raise issues about the MP's ability to investigate and report on any misconduct by CF members with impartiality and independence. The possibility that a bias may exist – leading MPs to favour the CF Chain of Command in the conduct

of their investigations or to feel in any way prevented from exposing information detrimental to the CF – goes to the core of military policing and of the MP's ability to perform its important role. Even a perception that the MP lacks the necessary objectivity or independence to investigate the CF Chain of Command could negatively impact on public confidence in the MP. The possibility that this alleged lack of independence and impartiality could lead to delay in investigations and to an inability to keep complainants and individuals directly affected informed also raises important issues in terms of the MPs' ability to fulfill their duties.

The allegations in this complaint, if true, may raise systemic issues relating to processes, policies or training, and the complainants have specifically requested that any such issues be examined by this Commission.

It is also a significant public interest consideration that this Commission's conduct of an immediate, first instance investigation of this complaint will contribute to engender confidence in the process for the complainants. The events which gave rise to this complaint began over three years ago. Since then, Mr. and Mrs. Fynes have complained about the delay and difficulty in obtaining information about the investigations. More importantly, throughout their interaction with Military Police authorities and with the Canadian Forces more generally, and in part as a result of the conduct they complain about in this case, the complainants have indicated that they have lost faith in the Military Police and do not trust them. In their words, they feel that they have been "frustrated by a continuous campaign of obfuscation and ongoing indifference." In terms of their overall interaction with the Canadian Forces, the Ombudsman reported that the complainants felt that they were being ignored and even silenced by the CF. They have indicated that they felt they had been deceived, misled and intentionally marginalized in their dealings with DND and the CF, and as a result had lost faith in the system. Under the circumstances, referring the matter back to the Canadian Forces Provost Marshal for an internal investigation to be conducted prior to affording the complainants an opportunity to request a review by this Commission would risk compounding the complainants' distrust in military and MP authorities, and possibly delaying the resolution of their complaint. The complainants have expressed their wish to have this Commission conduct a public interest investigation, and I have taken those wishes into consideration as well.

For all of these reasons, I consider it advisable in the public interest, pursuant to subsection 250.38(1) of the NDA to cause this Commission to conduct an investigation into this complaint and, if warranted, to hold a hearing.

The complainants have not specifically identified the subjects of their complaint. They raise issues with the conduct of the investigators involved in all three of the investigations at issue, all conducted by CFNIS Western Region. This Commission will proceed with the identification and notification of the subjects once disclosure of

the investigative files has been received and reviewed, and after an initial interview with the complainants has been conducted in order to clarify all of their allegations.

Yours truly,

A handwritten signature in black ink, appearing to read "Glenn Stanhard". The signature is fluid and cursive, with a large loop at the end.

Glenn Stanhard
Chair

Distribution List:

**The Honourable Peter Mackay, P.C., M.P.
Minister of National Defence
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2**

**General W.J. Natynczyk, CMM, MSC, CD
Chief of the Defence Staff
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2**

**Brigadier-General Blaise Cathcart, OMM, CD, QC
Judge Advocate General
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, ON
K1A 0K2**

**Colonel T.D. Grubb
Canadian Forces Provost Marshal
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario – K1A 0K2**

**Lieutenant-Colonel Robert Delaney
Commanding Officer, NIS
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario K1A 0K2**

**Major Daniel Dandurand
Commanding Officer
NIS Western Region
PO Box 10500, Station Forces
Edmonton, AB T5J 4J5**

**Mr. Shaun Fynes
Mrs. Sheila Fynes**

MPCC 2011-004 (Fynes) – Allegations

This complaint relates to the conduct of CFNIS members in their interactions with the complainants (Mr. Shaun Fynes and Mrs. Sheila Fynes) in response to their concerns following the death of their son, Cpl Stuart Langridge, on March 15, 2008. The complaint also relates to the conduct of the following three investigations by CFNIS:

- The 2008 Sudden Death investigation;
- The 2009 investigation into alleged service offences committed in designating the Primary Next-of-Kin (PNOK); and
- The 2010 Criminal Negligence investigation.

The allegations made by the complainants have been grouped in three categories, based on the type of issues complained about.

ALLEGATIONS RELATING TO INDEPENDENCE AND IMPARTIALITY

1. The NIS investigations were not conducted in an independent and impartial manner. NIS lacks the independence, on a structural level, to conduct such investigations.
2. The 2008, 2009 and 2010 investigations were aimed at exonerating the Lord Strathcona's Horse (Royal Canadians) regiment (LDSH) Chain of Command and the Canadian Forces (CF) more generally of any responsibility for their failure to prevent Cpl Langridge's death and for the manner in which the complainants were subsequently treated.
3. The 2008 Sudden Death investigation report contained findings that were inaccurate, that the investigator was not qualified to make, and that were aimed at attacking Cpl Langridge's character and exonerating CF members of any wrongdoing or liability.
4. The 2008 Sudden Death investigation was overly intrusive in light of its initial aim of determining the cause of death. Obtaining and including in the file Cpl Langridge's medical records was unnecessary for this purpose.
5. When they did start to examine the issue of the underlying causes of Cpl Langridge's suicide in the 2008 investigation, NIS investigators failed to pursue this examination in a complete and unbiased manner. The investigators were selective in the information they obtained and included, and their selection was not objective or impartial. The conclusions drawn by the investigators were based on incomplete facts which contained numerous contradictions and discrepancies.

MPCC 2011-004 (Fynes) – Allegations

6. The NIS investigators in the 2008 Sudden Death Investigation met with CF members from the LDSH regiment prior to attending the scene. They were influenced by these meetings and discussions and this tainted the remainder of their investigation.
7. NIS members involved in the conduct of the 2008 Sudden Death Investigation provided inaccurate information to the Alberta Medical Examiner (ME) about whether Cpl Langridge was the subject of disciplinary action in the CF. This resulted in an inaccurate mention on the ME certificate that Cpl Langridge had “disciplinary issues.” NIS refused to make any attempt to have this inaccuracy corrected.
8. The NIS and its members made inaccurate statements about where Cpl Langridge was residing immediately prior to his death. Those statements were aimed at exonerating the LDSH Chain of command of any responsibility and were examples of NIS participation in broader efforts by the CF to exonerate themselves from any responsibility.
9. NIS members commented, during a meeting with the complainants, that a statement made by their Assisting Officer indicating that the complainants were “deceived, misled and intentionally marginalized in their dealings with DND and the CF” was likely the result of Stockholm syndrome. This demonstrated a previously-held view by NIS members that any views critical of the CF must be wrong. Such views prevented NIS members from conducting independent investigations into the actions of CF members.
10. NIS agreed to participate in an intended briefing that was offered to the complainants by the CF and that was to include information about the CF Board of Inquiry, as well as about the CFNIS investigations. NIS failed to preserve its independence by failing to ensure that its police investigations were kept separate and distinct from other internal CF processes.
11. NIS participated in broader CF efforts to provide explanations and justifications in response to the complainants’ concerns, instead of conducting independent investigations in response to those concerns.
12. Concerns raised by the complainants in discussions with CFNIS members (particularly, concerns about damages to Cpl Langridge’s vehicle while in CF custody) were discussed by NIS members with non-MP members of the CF (in particular, Land Forces Western Area). This was done for the purpose of participating in CF efforts to explain and justify their actions and not for the purpose of conducting an independent investigation.
13. NIS and its members failed to provide adequate and timely information to the complainants. NIS participated in broader Canadian Forces efforts to withhold information from the complainants. NIS members allowed non-MP members of the CF, including CF legal advisers, to influence or dictate their decisions about the type of information provided to the complainants and the manner in which this information would be provided. NIS members allowed a broader

MPCC 2011-004 (Fynes) – Allegations

CF concern over potential litigation between the complainants and the CF to dictate or influence their decisions about the information to be provided to the complainants and the manner in which that information would be provided. In particular:

- a) NIS improperly withheld information from the complainants about its 2008 Sudden Death Investigation by providing a copy of the report which contained numerous redactions having no justification in law or privacy protection. The complainants were provided with an incomplete file with no specific or satisfactory explanation for withholding information.
- b) NIS members failed to provide regular updates to the complainants as promised. Communication was irregular and contained unexplained gaps of many months.
- c) NIS acquiesced and participated in an effort by the CF to prevent the complainants from communicating with CF members. The complainants received a letter advising them that, in light of anticipated litigation, they were not to communicate directly with any member of the CF. No exception was made to allow the complainants to communicate with the NIS members investigating their complaints and NIS members in fact did not contact the complainants during this period.
- d) NIS cancelled a planned verbal briefing on the 2009 and 2010 investigations that was to be provided to the complainants. This decision was made because the complainants requested that their lawyer attend the briefing as an observer. In cancelling a briefing about the police investigations because of potential litigation between the complainants and the CF, the NIS failed to act independently.
- e) The written briefing provided to the complainants by NIS in May 2011 in replacement for the planned verbal briefing did not contain sufficient information to answer the complainants' questions.

ALLEGATIONS RELATING TO INSUFFICIENT INVESTIGATION OR FAILURE TO INVESTIGATE

14. The investigations conducted by CFNIS were inadequate. The investigations failed to properly address the issues to be investigated. NIS members failed to investigate other issues, and failed to provide an appropriate response to the complainants with respect to the concerns they specifically brought to their attention.
15. NIS failed to properly investigate in a timely manner the potential criminal or service offences committed by members of the LDSH Chain of Command and other CF members prior to Cpl Langridge's death. Conduct requiring further investigation, follow-up and analysis was uncovered during the 2008 investigation and was specifically brought to the attention of the NIS by the complainants. This conduct was not adequately investigated.
16. NIS failed to investigate the potential service offences committed by CF members in the application of (or failure to apply) suicide prevention policies in Cpl Langridge's case. NIS failed to investigate what policies were applicable and whether they were followed. In particular, NIS

MPCC 2011-004 (Fynes) – Allegations

failed to investigate whether a requirement existed for the CF to conduct a Summary Investigation for each instance of attempted suicide by a member and whether this was in fact done in Cpl Langridge's case.

17. In the conduct of the 2008 Sudden Death Investigation and the subsequent 2010 Criminal Negligence Investigation, NIS members failed to conduct the necessary follow-up and analysis to resolve conflicts and discrepancies in the information obtained, including in relation to the alleged "suicide watch" (or lack thereof) conducted prior to Cpl Langridge's death.
18. The activity undertaken by the NIS investigators in the 2008 Sudden Death investigation had no clearly defined and understood purpose. NIS investigators failed to produce a report that provided a satisfactory explanation for the issues they undertook to investigate. NIS failed to provide clarity for its own personnel and for the complainants about what those issues were.
19. NIS failed to properly investigate in a timely manner the potential service offences committed by members of the CF in designating Cpl Langridge's former partner as next-of-kin. Facts requiring further investigation, follow-up and analysis were specifically brought to the attention of the NIS by the complainants and were not adequately investigated, including facts relating to CF interactions with the funeral director and with the complainants about the Registration of Death documents and facts relating to Cpl Langridge's missing paperwork located after his death.
20. In the conduct of the 2009 PNOK investigation, NIS members failed to investigate the actual issue that they had been asked to investigate: whether service offences were committed in appointing Cpl Langridge's former common law partner as next-of-kin for purposes of arranging the funeral. By focussing only on whether or not Cpl Langridge's former partner still qualified as his common law spouse under CF policies, NIS members failed to answer the actual question brought to them for investigation.
21. NIS failed to investigate or refer to the police of competent jurisdiction for investigation the potential criminal or service offences committed by Cpl Langridge's former partner and the two CF members who accompanied her during her visit to the funeral director. Conduct which required further investigation, follow-up and analysis (including conduct which may have amounted to fraud in the provision of false information for the purpose of obtaining benefits) was specifically brought to the attention of the NIS by the complainants and was not adequately investigated.
22. NIS failed to investigate, follow up, or provide a response to the complainants with respect to the concerns they raised about how Cpl Langridge's vehicle was damaged while in CF custody.

MPCC 2011-004 (Fynes) – Allegations

23. NIS failed to investigate, follow up or provide a response to the complainants with respect to the concerns they raised about damage done to Cpl Langridge's blackberry and computer while in NIS and CF custody.
24. NIS failed to investigate, follow up or provide a response to the complainants with respect to the concerns they raised about the information they obtained from Rogers telephone indicating that someone was accessing the internet from Cpl Langridge's blackberry after his death.

ALLEGATIONS RELATING TO PROFESSIONALISM AND COMPETENCE

25. The CFNIS members involved in the investigations lacked the necessary skills, professionalism and competence to conduct these investigations and to resolve the issues brought to their attention by the complainants.
26. NIS failed to advise the complainants of the existence of a suicide note left for them by Cpl Langridge and failed to provide the note until many months after Cpl Langridge's death and after the investigation was concluded. NIS never came forward to reveal the existence of the note, which was learned by the complainants through other means. Once the complainants were advised, NIS failed to send the original note until the complainants made a specific request.
27. NIS members failed to promptly cut down Cpl Langridge and show respect for his body once they arrived at the scene.
28. NIS failed to dispose of the seized exhibits when closing the Sudden Death investigation in July 2008 and failed to have the items returned to the complainants in a timely manner.
29. NIS members failed to complete the 2009 PNOK and the 2010 Criminal Negligence investigations within a reasonable time.
30. NIS members failed to provide their written briefing within a reasonable time after the verbal briefing on the 2009 and 2010 investigations was cancelled in February 2011.
31. The NIS members involved in the investigations lacked the experience and training necessary to perform these investigations. They did not appear to have knowledge of the appropriate steps to take and appeared paralysed in any ability to take initiative.
32. NIS reports contained inaccurate factual statements. In particular:
 - a) The 2008 investigation report contained incorrect facts, including an account of a suicide attempt and hospitalization of Cpl Langridge, whereas hospital records show he was not hospitalized during this period and the MP making the statement took no notes

MPCC 2011-004 (Fynes) – Allegations

about the incident. The inaccurate factual statements were not re-examined by NIS members when the complainants brought new facts to their attention.

- b) The written briefing for the 2009 and 2010 investigations incorrectly stated that both of the investigations had been opened at the request of the complainants.
- c) The statement in the 2009 investigation written briefing that the NDA trumps all provincial law was inaccurate.

33. Inaccurate rationales were provided by NIS members to explain or justify the actions taken by NIS. In particular:

- a) NIS members, during a meeting with the complainants, justified the NIS decision not to provide the suicide note sooner on the basis that it had to be kept in case of appeals.
- b) NIS members inaccurately stated that the responsibility for failing to promptly cut down Cpl Langridge's body rested with the Alberta Medical Examiner.
- c) NIS members took the position that it was not their responsibility if the ME overheard things during the processing of the scene and made his inaccurate comment about the disciplinary issues on that basis.
- d) NIS members advised the complainants that, under MP policies, they were allowed to retain the exhibits for a period of one year to provide for an appeal period.

**DECISION TO RECOMMEND
FUNDING FOR
LEGAL REPRESENTATION
FOR THE COMPLAINANTS
– OCTOBER 26, 2011**



MILITARY POLICE COMPLAINTS COMMISSION

IN THE MATTER of a conduct complaint under section 250.18 of the *National Defence Act* by Mr. Shaun Fynes and Mrs. Sheila Fynes.

DECISION TO RECOMMEND FUNDING FOR LEGAL REPRESENTATION FOR THE COMPLAINANTS, MR SHAUN FYNES AND MRS SHEILA FYNES

MPCC 2011-004 (Fynes) Public Interest Hearing pursuant to Section 250.38(1) of the *National Defence Act*

INTRODUCTION

On September 26, 2011, the complainants, Shaun and Sheila Fynes, filed a Motion requesting that this Commission recommend that public funding be provided for their legal representation during the Public Interest Hearing to be held into their complaint. Affidavits from the complainants were filed in support of the Motion, and an additional affidavit was filed on October 17, 2011, providing details about the complainants' financial situation.

On October 5, 2011, Department of Justice counsel Mr. Alain Prefontaine filed written Submissions in response to the Motion on behalf of the Government of Canada.

At the Case Conference held on October 19, 2011, the complainants' counsel, Col (ret'd) Michel Drapeau, presented oral submissions in support of the Motion. Counsel for the subjects of the complaint, Department of Justice counsel Ms. Elizabeth Richards, took no position on the Motion. Counsel for the Government of Canada, Mr. Prefontaine, advised the Commission in advance that he would not be presenting oral submissions to supplement his written submissions, and he did not attend the Case Conference. His written Submissions were read into the record.

Canada

DECISION

Having considered the oral and written submissions presented by the Parties and by the Government of Canada, as well as the written evidence filed in support of the Motion, I have made a decision to recommend that the Government of Canada provide funding for the legal representation of the complainants, in order to enable them to participate fully in this Hearing.

1) Authority to Issue a Funding Recommendation

For the reasons set out by the Federal Court in *Jones v. Canada (Royal Canadian Mounted Police Public Complaints Commission)*¹ and by this Commission in its decision to recommend funding in the Afghanistan Public Interest Hearings,² it has been established that this Commission has a discretion to recommend funding for legal representation for a Party to its Hearings. As stated by Justice Reed in *Jones*, a decision to recommend funding is a matter within the Commission's "complete discretion," and the factors relevant to this decision are for the Commission to determine.³

The governing principle is that where the factors to be considered in reaching a discretionary decision are not set out in the legislation, the decision-maker can determine the appropriate factors, in light of the purpose and object of the applicable statute:

In *Electric Power & Telephone Act (P.E.I.), Re*⁴ the Prince Edward Island Court of Appeal held that where legislation is silent as to the factors which an administrative decision-maker must take into consideration, the decision-maker has the discretion to determine the appropriate factors. Those factors, however, must be related to the purpose and object of the statute conferring the discretion.⁵

2) Relevant Factors And Their Application In This Case

Justice Reed's reasons in the *Jones* case provide useful guidance as to the factors relevant to the exercise of the Commission's discretion regarding a funding recommendation.

¹ 1998 CanLII 8157 (F.C.); (1998), 162 D.L.R. (4th) 750.

² *Decision to Recommend Funding for Legal Counsel for the B.C. Civil Liberties Association*, 05 Feb 2009, MPCC 2007-006, 2008-24 & 2008-42.

³ *Jones*, *supra*, at para. 27.

⁴ (1994), 116 Nfld. & P.E.I.R. 181; 363 A.P.R. 181 (PEI CA). See, in particular, para. 14-16.

⁵ Macaulay & Sprague, *Hearings Before Administrative Tribunals*, Fourth Ed., 2010, Thomson Reuters (Carswell), at p. 5B-31.

a) The Quality of the Hearing Process

One of the factors that Justice Reed suggested would be “crucial for the Commission” was “whether legal representation of the complainants would improve the quality of the proceedings before it.”⁶ I agree that ensuring the proper conduct of the Hearing is a crucial factor. Like the hearings at issue in the *Jones* case, this Hearing is expected to last for many weeks, to involve a large amount of evidence, both documentary and oral, and to address complex issues.⁷ For these reasons, and as was the case in *Jones*, it would be difficult if not impossible for unrepresented complainants to deal with these proceedings. Providing legal representation for the complainants will contribute to the proper conduct of the Hearing and will improve its quality.

b) Statutory Right of Participation

Pursuant to s. 250.44 of the *National Defence Act*,⁸ the complainants are entitled to be afforded a “full and ample opportunity, in person or by counsel, to present evidence, to cross-examine witnesses and to make representations at the hearing.”

In the *Jones* case, a section of the *RCMP Act*⁹ on which s. 250.44 was modeled and which is, in all respects relevant here, identical to s. 250.44, was considered. Justice Reed wrote:

The Commission has an obligation under subsection 45.45(5) to ensure that “the parties [which includes a complainant] and any other person” are afforded “a full and ample opportunity” to present evidence, to cross-examine witnesses and to make representations. If the Commission considers that for the purposes of the present inquiry, “a full and ample opportunity” can best be achieved by the complainants having counsel, then it is open to the Commission to recommend that the state fund counsel.¹⁰ [emphasis added]

In the present case, I am convinced that the “full and ample opportunity” to participate to which the complainants are entitled pursuant to the *National Defence Act* can only be achieved through legal representation. In light of the complexity of the issues, the anticipated volume of the documentary disclosure, and the anticipated number of witnesses, the complainants would simply not be able to exercise their statutory right to cross-examine, to present relevant evidence and to make meaningful representations to the Commission without the assistance of counsel.

⁶ *Jones, supra*, at para. 25

⁷ See *Jones, supra*, at para. 18.

⁸ R.S.C. 1985, c. N-5.

⁹ R.S.C. 1985, c. R-10.

¹⁰ *Jones, supra*, at para. 19.

The affidavit evidence before me, which was not challenged by any of the Parties or by counsel for the Government of Canada, convinces me that Mr. and Mrs. Fynes would not be able to pay for their legal representation without funding from the Government. Their income is moderate; they have no significant assets or investments; and they have children, including one son who is autistic and whom they help financially. The overall cost for their legal representation at the Hearing, even at the reduced rates which their counsel propose to charge, would range somewhere between \$125,000 and \$200,000. I am satisfied that, without public funding, the Fynes would not be able to afford this expense and could not be represented. Because of the anticipated length of the proceedings, it is not realistic to expect that the complainants will be able to find counsel who would be willing or able to represent them *pro bono*.

On the other hand, and even in these times of necessary fiscal restraint, the scale of this expense from a governmental perspective is not excessive. Indeed, it would in fact appear to be a relatively small price to pay to ensure that this Public Interest Hearing can proceed properly; that the statutory rights of the complainants can be exercised and that fairness and its appearance can be preserved.¹¹

In his Submissions, Mr. Prefontaine cautions against the adoption of a “circuitous logic” that would lead to a conclusion that, because of the participatory rights enacted in s. 250.44 of the *National Defence Act*, recommendations for public funding would always have to be issued for all Parties and “everyone else enjoying the same participatory right.”¹²

I am of the view that s. 250.44 does not determine how the discretion to recommend public funding ought to be exercised. Rather, as found by Justice Reed in the *Jones* decision, a statutory right to participate as set out in s. 250.44 is a factor relevant to the exercise of the discretion to make a funding recommendation.¹³ This does not mean that taking into account the statutory right to participate will lead to an automatic funding recommendation for all individuals with participatory rights. On the contrary, in order for a recommendation to be warranted, there must be a demonstration that, in the context of a particular hearing, the participatory right cannot be exercised properly without legal representation, and that the individuals requesting the recommendation for public funding cannot otherwise afford the cost of their own legal representation. As set out above, all these matters have been demonstrated in the present case.

¹¹ On the issue of fairness, see *infra* “c) Fairness and Equality of Representation”

¹² *Government of Canada Submissions, supra*, at para. 5.

¹³ *Jones, supra*, at para. 19.

c) Fairness and Equality of Representation

An additional factor that needs to be considered in the context of a decision as to whether to recommend funding is fairness.

In order for a hearing to be able to fulfill its purpose to further the public interest, fairness at the hearing is paramount. In the context of Hearings such as the present one, fairness may require equality of representation. In *Jones*, Justice Reed observed, “[t]here is considerable support for the proposition, however, that without state-funded legal representation the complainants/applicants will be at a great disadvantage – there will not be a level playing field.”¹⁴ [emphasis added]

She went on to remark:

My observation is that when decision-makers have before them one party who is represented by conscientious, experienced and highly competent counsel, a description that we all know from experience applies to Mr. Whitehall, they prefer that the opposite party be on a similar footing. They prefer that one party not be unrepresented. An equality in representation usually makes for easier and better decision-making.¹⁵ [emphasis added]

The same considerations apply in the present case. Ms. Richards, Department of Justice counsel who at the Case Conference was able to confirm that she now acts for all the subjects of the complaint, previously advised the Commission in her request for an adjournment of the Case Conference, that, as present or former members of the Canadian Forces, all the subjects were entitled to seek legal representation at public expense in accordance with the applicable Treasury Board policy, which may entitle them to representation by the Department of Justice or by outside counsel.

Justice Reed’s comment about “conscientious, experienced and highly competent counsel” applies fully to Ms. Richards, who has appeared before this Commission in the past and who will be representing the subjects here. Without public funding, the complainants will have no choice but to appear unrepresented. The apparent unfairness that would result from a situation where one party is represented by highly qualified counsel at public expense and the other party, despite having expressed the desire to be represented, is left without legal representation because of lack of public funding, would negatively impact on the hearing process and on public confidence in this Commission’s independent oversight role.

¹⁴ *Jones, supra*, at para. 7.

¹⁵ *Jones, supra*, at para. 25.

Mr. Prefontaine has argued that equality in representation is already achieved in this case. He cites the role of Commission counsel and the fact that “the representational model at play in an adversary proceeding, like a trial, does not apply to the inquisitorial hearing conducted by the Commission to investigate a conduct complaint.”¹⁶

I agree that this Commission’s proceedings are investigative rather than adjudicative. However, for the purposes of the present Motion, this is not a reason to refrain from recommending funding for counsel.

In *Jones*, Justice Reed was also dealing with an investigative or “inquisitorial” rather than an adjudicative or “adversarial” proceeding. She found that such categorizations do not diminish the importance to the proceedings of legal representation for the Parties:

[20] Another argument made by counsel for the R.C.M.P., as support for the proposition that the Commission lacks authority to make a recommendation of the type in question, is based on the nature of the inquiry proceedings. It is argued that: the proceedings are not adversarial in nature; the complainants initiate the process but then have no direct interest that is affected thereby; the named R.C.M.P. members are the ones who are at risk; the Commission counsel presents the evidence to the Commission, essentially acting as a prosecutor.

[21] I do not find that description to be complete. [...] While the proceedings are theoretically not adversarial, there is much about them that engenders all the trappings of such a process, e.g., the right of all to cross-examine, the definition of complainants as “parties”, the fact that the Commission cannot ban all lawyers from the room (one of the applicants’ suggestions) or prevent cross-examination of the witnesses (another of the applicants’ suggestions). [...]

[22] The inquiry is public; it has many of the trappings of an adversarial proceeding; the Commission cannot turn it into a purely investigative type of proceeding; the Commission cannot prevent the presence of counsel acting on behalf of individuals who appear before the Commission; it cannot prevent the cross-examination of witnesses. I am not persuaded that the nature of the proceeding leads to a conclusion that independent legal representation of the complainants is a matter about which the Commission should not be concerned.¹⁷
[emphasis added]

Even taking into account the nature of the proceedings, which are dictated by the statute itself, Parliament has seen fit to provide for a statutory right of participation for the Parties in s. 250.44. The complainant and the subject of the complaint are the only two parties specifically designated as Parties by the statute.¹⁸ From this legislative scheme, it

¹⁶ *Government of Canada Submissions, supra*, at para. 7-8. See also para. 14-21.

¹⁷ *Jones, supra*, at para. 20-22.

¹⁸ *National Defence Act*, ss. 250.44 (a).

is clear that they are both equally deemed to have a substantial and direct interest in a hearing.

In this context, to appear to equate the interests of the complainants with those of the Commission and to argue that the role of Commission counsel is to further their right to participate, is as misguided as it would be to propose to equate the interests of the subjects of the complaint with those of the Commission and to suggest that their participatory rights can be furthered by Commission counsel. As the title makes clear, Commission counsel is counsel for the Commission. As my counsel, Commission counsel's role is to present as much information as possible to the Commission and to test its accuracy in order to ensure that findings and recommendations can be made on the basis of information that is complete and accurate. The complainants and the subjects each have their own distinct interests in the proceedings and Parliament has recognized these interests as requiring specific and equal rights of participation.

Further, as pointed out by Col Drapeau in his oral submissions at the Case Conference, the legislation and applicable regulations assign an important role for all the Parties in the hearing process and provide for "full, complete and meaningful participation."¹⁹ Pursuant to the *National Defence Act*, Parties can present evidence, both documentary and viva voce, cross-examine witnesses, and make representations.²⁰ The *Rules of Procedure for Hearings before the Military Police Complaints Commission*²¹ further provide that Parties can file documents, present motions, participate in pre-hearing conferences, and request the issuance of summons.

For all these reasons, I agree with Justice Reed that the Commission has a legitimate interest in the issue of the complainants' legal representation

3) The *Caron* Case

Mr. Prefontaine also argues that the factors to be considered in determining whether to issue a recommendation for public funding in proceedings like this Hearing are those set out in the Supreme Court of Canada decision in *R. v. Caron*.²² He goes on to submit that the factors enumerated in *Caron* suggest that the Commission ought not to recommend funding for counsel for the complainants.

¹⁹ Military Police Complaints Commission, *Transcript of Case Management Conference*, MPCC 2011-004, at p. 33-34.

²⁰ See s. 250.44 of the *National Defence Act*.

²¹ SOR/2002-241. See Rules 12, 17, 29, 30, 33 and 39.

²² 2011 SCC 5.

In the first place, and as argued by Col Drapeau in his oral submissions,²³ I find that the *Caron* case has no direct application to the present situation. *Caron* dealt with the limited circumstances of litigation in which the interests of justice require a court to issue an *order to compel* Government to provide funding, as opposed to the situation here where the Commission is being asked to make a *recommendation* for funding. Unlike in *Caron*, this is not a situation where an intrusion into matters generally determined by the legislative or executive branches of Government is being contemplated.²⁴ This Commission can only recommend that funding be granted. The Government will then have to assess this recommendation and come to its own determination.

Further, however, it is my view that even if the test set out by the Supreme Court of Canada in *Caron* were applicable, a recommendation for funding would still be warranted here. Indeed, to the extent that the factors adopted in *Caron* could serve as a guide to this Commission in the exercise of its discretion, I find that they support issuing a funding recommendation in this case.

On the first factor listed in *Caron*,²⁵ of a genuine inability to fund their own counsel and a lack of other realistic options for bringing the issues to trial, I find that the complainants “genuinely cannot afford” to cover the cost of their representation. Further, I am of the view that no other realistic options exist for bringing the complainants’ issues and perspective to a hearing. As indicated above, the Parties’ interests are not represented by Commission counsel; their participation is essential to the process; and the extent of their participation is not as limited as Mr. Prefontaine suggests.

On the second *Caron* factor – that the “claim” be *prima facie* meritorious and “at least of sufficient merit that it is contrary to the interests of justice for the opportunity to pursue the case to be forfeited just because the litigant lacks financial means”²⁶ – I find that the complainants’ interests here fulfill this requirement. It is not known at this time what findings or recommendations may ultimately be made about the allegations in the complaint. That is a determination that will be made on the basis of the evidence presented at the Hearing. However, it has already been determined that the issues raised in the complaint are sufficiently serious to warrant calling a Hearing in the public interest.²⁷ The complainants clearly have a direct interest in the issues raised, as the investigations in question related to the death of their son and to the manner in which the complainants themselves were treated by the Canadian Forces. *The National Defence*

²³ Military Police Complaints Commission, *Transcript of Case Management Conference*, MPCC 2011-004, at p. 32.

²⁴ See *Caron*, *supra*, at para. 6 & *Government of Canada Submissions*, *supra*, at para. 1.

²⁵ See *Caron*, *supra*, at para. 39.

²⁶ *Caron*, *supra*, at para. 39.

²⁷ See September 6, 2011 Decision to call a Public Interest Hearing, MPCC 2011-004.

Act recognizes their right to participate in the process. It would, in the circumstances, be contrary to the interests of justice if they were unable to participate simply because they lack the financial means to retain counsel.

The third *Caron* factor is that the issues transcend individual interests, be of public importance, and have not been resolved in previous cases.²⁸ In this connection, I find that the issues here are of public interest beyond the complainants' individual interests.²⁹ I find further that the complainants' full participation is also in itself in the public interest so as to ensure that the Public Interest Hearing proceeds properly and that all issues are fully brought to light before the Commission. I also find that many of the issues raised by this complaint, in particular with respect to the independence and impartiality of the Military Police, have not been examined in previous cases.

Finally, the *Caron* decision suggests that public funding should only be granted where its absence "would work a serious injustice to the *public* interest."³⁰ [emphasis in original] That is the case here. The independent oversight regime put in place by Part IV of the *National Defence Act* is meant to foster public confidence in the Military Police and as such this regime furthers the public interest. By definition, Public Interest Hearings are called because it is in the public interest to address the issues raised through this process.³¹ Public confidence in the process, and thus the ability of the process to fulfill its purpose, will in turn be dependent on the Parties' ability to act on their statutory right to participate in the proceedings. If the process cannot function properly because one of the Parties is unable to exercise this right to participate because of lack of access to legal representation that would otherwise be necessary, the public interest that warranted calling the Hearing in the first place is affected.

The words of Justice Reed find application here:

While the complainant may initiate the proceeding, he or she, in a case such as the present, acts as a representative of the public interest - the public interest in ensuring that the police do not overstep the bounds of what is proper conduct. The public interest is as important as the R.C.M.P. members' private interests in their jobs and reputations.³²

²⁸ *Caron, supra*, at para. 39.

²⁹ See September 6, 2011 Decision to call a Public Interest Hearing, MPCC 2011-004.

³⁰ *Caron, supra*, at para. 5.

³¹ See *National Defence Act*, s. 250.38.

³² *Jones, supra*, at para. 21.

I find accordingly that the general *Caron* requirement that the absence of funding work “a serious injustice to the *public interest*” is also met and that providing funding for legal representation for the complainants in this matter is in the public interest.

RECOMMENDATION

For all these reasons, I have decided to issue a recommendation to the Government of Canada to grant funding for the complainants’ legal representation. I recommend that this funding be granted at the reduced hourly rates suggested in the Motion: \$175 for Col Drapeau and \$100 for Mr. Juneau. I recommend that funding be granted for each counsel for the requested 40 hours of preparation, as well as for the time spent attending the Hearing, with two additional hours of preparation for each day of Hearing. Considering the volume of materials involved, I consider that the amount of hours requested is reasonable, and that providing funding at this level is necessary to allow the complainants to participate in this Public Interest Hearing into the investigations related to their son’s death.

In correspondence addressed to the Commission, Mr. Prefontaine, as counsel for the Government of Canada, indicated that the Government “will consider the recommendation of the Commission, if the Commission decides to make one.” I accept at face value Mr. Prefontaine’s assurance that this Commission’s recommendation will be considered, notwithstanding the position he took in his Submissions.

IT IS HEREBY RECOMMENDED that the Government of Canada provide funding to the complainants for their legal representation at this Hearing, in accordance with the rates and for the number of hours outlined in these reasons.

DATED at Ottawa, Ontario this 26th day of October, 2011.



Glenn M. Stannard, O.O.M.
Chair

PUBLICATION BAN ORDER
– MAY 17, 2012

Military Police
Complaints
Commission



Commission d'examen
des plaintes concernant
la police militaire

Chairperson

Président

MILITARY POLICE COMPLAINTS COMMISSION

IN THE MATTER of a conduct complaint under section 250.18 of the *National Defence Act* by Mr. Shaun Fynes and Mrs. Sheila Fynes.

PUBLICATION BAN ORDER

MPCC 2011-004 (Fynes) Public Interest Hearings pursuant to
Section 250.38(1) of the *National Defence Act*

On April 17, 2012, Col (ret'd) Michel Drapeau, counsel for the complainants, requested that excerpts of the video recording made of the scene of Cpl Stuart Langridge's suicide on March 15, 2008, be exhibited at the Hearing on April 19, 2012. The request was made in order to provide information about the scene of the suicide and the conduct of the investigators. Elizabeth Richards, counsel for the subjects of the complaint, submitted that it was not in the public interest to view such a private and graphic video recording publicly but added that, if it was deemed necessary to view the video recording publicly, then she would request that the Commission exhibit the entire video recording, up to the point where the body is removed from the room and the inventory of the deceased's personal effects commences, in order to ensure that all relevant details were presented in their full and fair context. Ms. Richards further added that if a decision was made to play the video it would be most appropriate to do so when the Military Police investigator who prepared the videotape testifies. Commission Counsel took no position as to the request to exhibit the video publicly.

I determined that I would make an order regarding the request to view the video recording publicly after hearing submissions concerning the publication ban.

On April 19, 2012, Commission Counsel applied for a permanent order restricting the publication or broadcast of the images or audio contained in the video recording made of Cpl Stuart Langridge's body by CFNIS investigators at the scene of his suicide March 15, 2008, owing to the sensitive and graphic nature of these records. The application preceded the testimony of Mr. Dennis Caufield, Investigator for the Chief Medical Examiner of Alberta. He attended the scene of the suicide on March 15, 2008, and the video was viewed at the Hearing in part to refresh his recollection of the scene that day.

Prior to the viewing, Col (ret'd) Drapeau advised that his clients supported the application for the publication ban and that they have a significant privacy interest that would be severely injured should the graphic recordings enter into the public domain for unrestricted broadcast. Ms. Richards also advised that she did not oppose a publication

Canada

ban on the video recording in question.

Significantly, there were also no objections to the requested publication ban from any members of the media.

Having heard and considered the submissions of counsel, I ordered that the video would be viewed publicly at the Hearing on April 19, 2012, and that the video would be played continuously up to the point at which the body is removed from the room and the investigators begin to inventory the personal effects in the room.

I then made an order granting the publication ban on the morning of April 19, 2012, with written reasons being reserved. These reasons are as follows.

First, section 250.15 of the *National Defence Act*¹ authorizes me to make rules respecting the conduct of matters and business before the Commission, including the conduct of Commission investigations and hearings. Similarly, rule 6 of the *Rules of Procedure for Hearings before the Military Police Complaints Commission*² authorizes me to take the steps deemed necessary to deal with a question that is not provided in those Rules. The courts have also repeatedly affirmed that statutory bodies, such as this Commission, are deemed to have such implied powers as are necessary for the achievement of their purposes, including the power to control their own proceedings.

With specific regard to the power of statutory bodies to order publication bans, I note that in *Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*,³ Cory J. (writing a separate concurring judgment for himself and two other justices) concluded that the implied powers of such statutory bodies must be interpreted broadly in order that they might protect the rights and interests of individuals implicated in their proceedings and, specifically, that such implied powers would include the power to order a publication ban. The majority did not consider this question.

The imposition of a publication ban requires a careful balancing of interests. In *Dagenais v. Canadian Broadcasting Corporation*,⁴ and *R. v. Mentuck*,⁵ it was determined that a publication ban shall only be ordered where such an order is necessary in order to prevent a serious risk to the proper administration of justice because reasonably alternative measures will not prevent the risk, and the salutary effects of the publication ban outweigh the deleterious effects on the rights and interests of the parties and the public, including the effects on the right to free expression.

¹ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.15.

² SOR/2002-241.

³ [1995] 2 S.C.R. 97.

⁴ [1994] 3 S.C.R. 835.

⁵ [2001] 3 S.C.R. 442.

This brings us to the specific interests at stake. It has been recognized, in cases such as *Canadian Broadcasting Corporation v. New Brunswick (Attorney General)*,⁶ that the privacy interests of witnesses and victims can be the basis of reasonable limitations on certain rights, including freedom of expression and freedom of the press as guaranteed in section 2(b) of the *Canadian Charter of Rights and Freedoms*. Additionally, it has been held in cases such as *R. v. Dagenais*,⁷ *R. v. Glowatski*,⁸ and *R. v. Bernardo*⁹ that, in certain circumstances, the privacy interests of the family of a deceased person will take precedence over the right to freedom of expression and freedom of the press as guaranteed in section 2(b) of the *Canadian Charter of Rights and Freedoms*.¹⁰ As noted above, the complainants assert a significant privacy interest that would be severely injured by the publication of the video recording.

Section 250.42 of the *National Defence Act* has mandated that a public interest hearing is to be held in public, although the Complaints Commission is expressly authorized by paragraph 250.42(c) of the *National Defence Act* to exclude the public from any hearing under section 250.38 of that Act where information affecting individual privacy or personal security is expected to be disclosed and where the affected privacy or security interest outweighs the public's interest in the information. In order to ensure that this Hearing be as open as possible, members of the public and the media were permitted to attend the viewing of the video recording in question, notwithstanding its sensitive nature and the complainants' privacy interest.

In light of the above, I have concluded that a ban on the publication of these recordings and images is necessary to protect the affected privacy interests. I am satisfied that the privacy interests of the late Cpl Langridge's family outweighs the media's interest in publishing or broadcasting images of the circumstances of his suicide so as to inform the public, specifically the graphic contents of the video recordings made on March 15, 2008.

Finally, I have also concluded that such a publication ban constitutes the least possible restriction on the freedom of expression and of the press as guaranteed by section 2(b) of the *Canadian Charter of Rights and Freedoms*, consistent with the protection of the aforementioned privacy interests, particularly because members of the media were present during the public viewing of the video and thus are able to describe and report on its contents.

⁶ [1996] 3 S.C.R. 480.

⁷ 2009 SKQB 104, 243 C.C.C. (3d) 554.

⁸ [1999] B.C.J. No. 3210 (B.C. S.C.).

⁹ [1995] O.J. No. 1472 (Ont. Gen. Div.).

¹⁰ *Canadian Charter of Rights and Freedoms*, s. 2(b), Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, (U.K.) 1982, c. 11.

IT IS HEREBY ORDERED that any recorded sounds or images captured at the scene of Cpl Langridge's suicide shall not be published or broadcast in any way. As directed in my verbal reasons of April 19, 2012, the exhibit shall be sealed now that the video recording has been publicly viewed in these proceedings.

For clarity, this order will remain in effect until such time as it is overturned by this Commission or a reviewing court.

DATED at Ottawa, Ontario on this 17th day of May, 2012.



Glenn M. Stannard, O.O.M.
Chairperson

**RULING ON
MOTION BY COMPLAINANTS
TO ISSUE SUMMONS TO
APPEAR – JUNE 14, 2012**



MILITARY POLICE COMPLAINTS COMMISSION

IN THE MATTER of a conduct complaint under section 250.18 of the *National Defence Act* by Mr. Shaun Fynes and Mrs. Sheila Fynes.

RULING ON MOTION BY COMPLAINANTS TO SUMMON PATRICK MARTEL TO ATTEND AND GIVE EVIDENCE

MPCC 2011-004 (Fynes) Public Interest Hearings pursuant to Section 250.38(1) of the *National Defence Act*

Background

On May 25, 2012, counsel for the complainants wrote to Commission counsel to convey a request, pursuant to subsection 33(1) of the *Rules of Procedure for Hearings Before the Military Police Complaints Commission*, that the Commission call Mr. Patrick Martel, an investigator with the Department of National Defence and Canadian Forces Ombudsman (hereinafter, the Ombudsman), to testify in this proceeding. In this letter, Col (ret'd) Drapeau described the need for Mr. Martel, who had already executed an affidavit for Commission counsel on March 22, 2012, to appear as a witness in the following terms:

Mr. Martel was assigned to investigate the complaint made by Mr. and Mrs. Fynes to the DND/CF Ombudsman. His Affidavit dated March 22, 2012 addresses his communications with the NIS with regards to matters outside the mandate of the DND/CF Ombudsman. This Affidavit is silent on matters within the said mandate and which were investigated by the Office of the DND/CF Ombudsman. This Affidavit is also silent on why the said DND/CF Ombudsman investigation was inexplicably ceased.

After having been advised that the Ombudsman intended to oppose his motion to call Mr. Martel, on May 31, 2012, Col (ret'd) Drapeau again wrote to the Commission regarding this matter. Having been advised that counsel for the Ombudsman would be arguing that Mr. Martel's evidence would be covered by a privilege under the law of evidence, Col (ret'd) Drapeau provided some legal reasons as to why Mr. Martel should be considered to be a compellable witness in this proceeding.

Arguments

In his May 31, 2012 letter, Col (ret'd) Drapeau noted that the previous Ombudsman had publicly recommended in a 1999 Special Report that the Ombudsman and his staff be given statutory immunity from criminal or civil responsibility for their good faith actions in performing their duties, and that they should also generally be exempt from being compelled to testify or to produce documents in judicial, quasi-judicial or administrative proceedings. However, as Col (ret'd) Drapeau pointed out, these recommendations were never acted upon by the Minister of National Defence or Parliament.

In his letter, Col (ret'd) Drapeau also dismissed the idea that there could be an applicable public interest privilege under section 37 of the *Canada Evidence Act*. He pointed out that, as these hearings have been called in the public interest, it is difficult to maintain that there is a public interest in non-disclosure of information within the knowledge of the proposed witness.

Col (ret'd) Drapeau concluded his letter by listing additional reasons why Mr. Martel should be compelled to testify, which included: the fact that the Ombudsman investigated matters related to this complaint on behalf of the Fynes; the Ombudsman investigators became privy to extensive personal information disclosed by the Fynes relative to their complaint; Ombudsman investigators established contact with the CFNIS; the Fynes have never made any claim of privilege or privacy to information under the control of the Ombudsman pertaining to their complaint; it is in the public interest that the Commission have access to all available information; and it would be a "denial of justice" to deny the Commission access to relevant information under the control of the Ombudsman.

On the evening of June 5, 2012, the evening before the argument of this motion, Mr. Paul Déry-Goldberg, counsel for the Ombudsman sent a letter to the Commission outlining his legal arguments for opposing the complainants' motion to call Mr. Martel.

In this letter, counsel for the Ombudsman drew the Commission's attention to certain provisions of the August 29, 2001 *Ministerial Directive Respecting the Ombudsman for the Department of National Defence and the Canadian Forces*, promulgated as Annex A to *Defence Administrative Order and Directive (DAOD) 5047-1*. The provisions in question include those which describe the mandate of the Ombudsman and also others which emphasize the importance of confidentiality to the work of the Ombudsman.

On the basis of the Ombudsman's mandate and the various terms of the Ministerial Directive dealing with confidentiality, the Ombudsman takes that position that information provided by "constituents" of the Ombudsman – a term which refers to

relevant personnel within the Department and the CF chain of command and, at least in some instances, their families – should be considered confidential and exempt from disclosure in a public hearing such as this.

The Ombudsman went on to argue that the confidentiality of communications with the Ombudsman is further protected as an evidentiary privilege at common law. The Ombudsman argued that communications with the Ombudsman meet the common law test for privilege, known as the “Wigmore test”, and recognized by the Supreme Court of Canada in *Slavutych v. Baker et al.*, [1976] 1 S.C.R. 254. There are four elements to this test for communications to be legally privileged:

- (1) The communications must originate in confidence that they will not be disclosed.
- (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
- (3) The relation must be one which in the opinion of the community ought to be sedulously fostered.
- (4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

The Ombudsman’s position was that communications with the Ombudsman by members of its ‘constituency’ in the discharge of that office’s mandate meet all four elements of this test and are therefore legally privileged from disclosure under the law of evidence. While the Commission is subject to more relaxed rules of evidence than the courts (per NDA paragraph 250.41(1)(c)), its enabling legislation does, in NDA paragraph 250.41(2)(a), preclude the receipt or acceptance of “any evidence or other information that would be inadmissible in a court of law by reason of any privilege under the law of evidence”.

On June 6, 2012, the complainants’ motion was argued before me in open session of this public interest hearing.

Col (ret’d) Drapeau, for the complainants, in argument on his motion, read into the record his letter of May 31, 2012. He also made the further point that, while this Commission, its mandate, and in particular, its power to compel witness testimony under oath, are set in statute, all matters pertaining to the role and mandate of the Ombudsman are found only in the Ministerial Directive or the relevant DAOD. On the question of relevance, Col (ret’d) Drapeau added that “the Ombudsman has played a large role in initiating

some of the very police investigations which are currently being examined by this Commission,” and, “[i]n so doing, their actions are intrinsically linked with the very purpose of this Commission.”

Mr. Déry-Goldberg, for the Ombudsman, placed considerable emphasis on his assessment that there was very little relevant evidence which Mr. Martel could provide that was not already contained in his affidavit. In counsel’s view, Mr. Martel’s testimony could only be relevant to the issue of the timeliness of the CFNIS investigation into next of kin designation in respect of Cpl Langridge. Mr. Déry-Goldberg also emphasized what he termed the “unprecedented” nature of an Ombudsman investigator providing evidence by way of affidavit – evidence which counsel claims has not been contradicted by other witnesses – let alone actually being called upon to testify in a proceeding. He also noted that, at the time Mr. Martel’s affidavit for the Commission was executed, Commission counsel signed a document recognizing the swearing of the affidavit did not constitute a waiver of any privilege not to testify.

Mr. Déry-Goldberg also drew attention to the fact that the testimony of Mr. Martel, beyond what has been provided in his affidavit, has not been sought by Commission counsel, but rather, counsel to the complainants.

Counsel for the Ombudsman then went on to note Col (ret’d) Drapeau was representing someone in a grievance against the Ombudsman and that, in that connection and in that capacity, Col (ret’d) Drapeau had very recently written to the Ombudsman. Counsel for the Ombudsman went on to argue that, in the circumstances, Col (ret’d) Drapeau has “competing interests” which he ought to have divulged to the Commission in seeking what the Ombudsman considers to be an exceptional order to compel the testimony of an employee of the Ombudsman. Mr. Déry-Goldberg added:

I hope in this particular case the reason why Mr. Martel is asked to come and testify before this Commission isn’t because someone wants to embark on a fishing expedition to gain points before another particular case that he hasn’t disclosed to this Commission.

Ms. McLaine, for the respondents, tended to agree with the Ombudsman as to the limited relevance of Mr. Martel’s testimony, but disagreed the Office of the Ombudsman was in a privileged position vis-à-vis the Commission’s authority to compel testimony.

With reference to the Ombudsman’s 1999 Special Report recommendations regarding immunity and privilege for Ombudsmen personnel, Ms. McLaine noted that they are no more than recommendations and have never been implemented.

Ms. McLaine also differed from Mr. Déry-Goldberg's assessment that Mr. Martel's affidavit evidence has not been contradicted by other witnesses, and in this connection, she cited the evidence of LCol King. Ultimately, Ms. McLaine took the position Mr. Martel could and should be called to testify on the "narrow scope" of the communications and interactions between Mr. Martel and the CFNIS members.

Ms. Coutlée, for the Commission, took no position on the complainants' motion to call Mr. Martel or on the merits of the Ombudsman's claim of privilege. Commission counsel disagreed with the Ombudsman's assessment as to the limited range of relevant matters to which Mr. Martel could potentially speak in testimony. She also disagreed with Mr. Déry-Goldberg's assertion that Mr. Martel's affidavit evidence was uncontradicted.

In conclusion, Ms. Coutlée noted the only issue raised by the complainants' motion was whether a summons should issue for Mr. Martel to attend to testify in these proceedings. As such, she argued, should the motion be granted, any potential objections to evidence being sought from the witness, would best be addressed at the time of questioning and not determined at this preliminary stage, in the abstract.

In reply, Col (ret'd) Drapeau argued that he did not share the Ombudsman's assessment of the limited relevance of Mr. Martel's evidence, but indicated the only way to know for sure will be to have him testify. He also took the view any privilege attaching to communications with the Ombudsman in this case would belong to the Fynes and not to the Ombudsman, and that the Fynes have waived any privilege. Col (ret'd) Drapeau also vehemently disputed the suggestion he had any competing interest in calling Mr. Martel to testify in this matter.

In response to questioning from the Chair, Mr. Déry-Goldberg for the Ombudsman disagreed with the notion that the attitude of the complainants regarding the confidentiality of their dealings with the Ombudsman would affect the privileged nature of the Ombudsman's information. He stated: "[t]he privilege we are talking about is the privilege of the Office, not just the privilege of the Fynes."

Analysis & Decision

Col (ret'd) Drapeau, for the complainants, has made a motion in accordance with subsection 33(1) of the *Rules of Procedure for Hearings Before the Military Police Complaints Commission* to call Mr. Patrick Martel, an investigator with the Office of the Department of National Defence and Canadian Forces Ombudsman, to testify in this public interest hearing.

I shall deal first with the question of the potential relevance of the witness.

Contrary to the suggestion of counsel for the Ombudsman, I find it of no consequence, for the purposes of this motion, that this request comes from a party other than Commission counsel. The relevant rule of our Rules of Procedure expressly contemplate witnesses may be called by any party with full standing before the Commission at the hearing, as well as by Commission counsel. Moreover, NDA section 250.44 requires the Commission “afford a full and ample opportunity...to present evidence... at the hearing” to complainants, respondents and anyone else who satisfies the Commission of a “substantial and direct interest in the hearing”.

As such, the failure of Commission counsel to call a witness, in and of itself, cannot fairly be used to infer a lack of relevance to the proposed testimony.

At the present stage, that is the stage of considering the mere compellability of a witness, the requisite degree and likelihood of relevance must necessarily be set at a very low threshold. The fact counsel for the Commission and the for the respondents, as well as counsel for the complainants, disagree with counsel for the Ombudsman’s assessment of the limited relevance of the witness is sufficient, in my view, to dispose of the objections to compellability of the witness on grounds of relevance.

It remains then to address the claim of privilege raised by the Ombudsman to the calling of this witness.

It would be open to the Ombudsman to raise objections, on a case-by-case basis, to specific questions posed to this witness during his examination by counsel. But in arguing against the motion to call Mr. Martel as a witness, the Ombudsman must be taken to be asserting the existence of a class privilege in respect of communications between the Ombudsman and his constituents.

I see no basis for the recognition of such a privilege in respect of ombudsman communications at common law. As the Supreme Court of Canada has recently emphasized, there is only a very limited category of class privileges and that category is unlikely to grow (*National Post v. Canada (Attorney General)* (2010), 254 C.C.C. (3d) 469, 318 D.L.R. (4th) 1.).

Nor is there any legislative basis for class privilege treatment of communications with this Ombudsman. By the very terms of the Ministerial Directive establishing the Office of the DND and CF Ombudsman, the Ombudsman’s confidentiality obligations yield to the legal authorities and mandate of bodies such as this Commission. I extract below the

subsection 27(2) of the Ministerial Directive, cited by the Ombudsman in its argument (the text of relevance to my point has been italicized):

27(2) Except as otherwise authorized by law,

a) no communication to the Ombudsman or information provided to the Ombudsman in any form shall be disclosed by the Ombudsman, except where it is, subject to these directives, necessary for an investigation, report or other authorized purpose; and

b) communications between the Ombudsman and any person in relation to the duties and functions of the Ombudsman are private and confidential.

As the Ministerial Directive has been incorporated into a DAOD and its terms are made an enforceable order to CF members, and a binding directive to departmental employees, it is in my view, equivalent to a regulation. As such, while the duty of confidentiality imposed on the Ombudsman may have legislative, if not statutory, form, so too do its limitations and exceptions.

In my view, the Ministerial Directives, as incorporated in DAOD 5047-1, by their own terms, preclude the possibility of the Ombudsman's obligations of confidentiality achieving the status of an evidentiary class privilege.

Second, even if I am wrong in the foregoing analysis, the Wigmore test is not met in this particular case. According to the submissions of complainants' counsel, which were uncontradicted on this point by the Ombudsman, the Fynes did not have an expectation of, or desire for, the confidential treatment of what they were communicating to the Ombudsman. This being the case, it is difficult to see how the first, fourth, and possibly also the second, prongs of the Wigmore test could be met in this case.

Third, even if I am wrong in this assessment, and the test for privilege could be satisfied in this case, it would have been waived through various statements and actions of complainants' counsel, not least of which being the very presentation of this motion.

While I do not hear Mr. Déry-Goldberg to suggest that the Fynes are not holders of the privilege in question, he disputes that they are the only holders of the privilege in respect of their case with the Ombudsman. In counsel for the Ombudsman's view, the other privilege-holder is the Ombudsman himself. In his view, the Ombudsman must seek to protect the confidentiality of communications with his office by his constituents, even where the constituent in question seeks disclosure of the information.

With respect, such a conception of confidentiality privilege makes no sense. By this argument, clients and patients could not consent to the release of confidential information

without the independent consent of, respectively, their lawyers or physicians. Yet, this of course is not the case. Confidentiality privileges (with the notable exception of police informer privilege) always operate for the sole benefit of the person confiding in the relevant professional or institution, and not for the professional or institution being confided in.

Finally, I will touch upon counsel for the Ombudsman's submission regarding an alleged competing interest on the part of counsel for the complainants and the possibility that he might thereby be tempted to use the appearance of Mr. Martel to advance another matter in which Col (ret'd) Drapeau is acting, but which is unrelated to the present matter.

In my view, this submission is entirely without merit. No conflict-of-interest was demonstrated and, indeed, counsel for the Ombudsman expressly refrained from alleging any conflict-of-interest. He instead spoke of a "competing interest". But I am unaware of any such legal or ethical limitations on counsel, or of any legal or ethical duty to disclose the fact that counsel is acting, in another case, against the employer of a witness, in the present case.


Absent evidence to the contrary, I would assume that any officer of the court appearing before me is acting in the interests of their clients and in keeping with their ethical obligations, including those to the tribunal. Such duties would naturally include refraining from abusing one's rights and privileges in this proceeding to advance the interests of another client in an unrelated matter.

No such contrary evidence was presented. Counsel for the Ombudsman did not even suggest that Mr. Martel, as opposed to any other employee of the Ombudsman, had some particular significance to this other matter. Moreover, counsel for the Ombudsman conceded he had "no evidence" as to any ulterior purpose on Col (ret'd) Drapeau's part in calling for Mr. Martel to testify.

In short, I can see no basis in law or in fact for Mr. Déry-Goldberg's submissions on this point and, indeed, they strike me as improper.

IT IS HEREBY ORDERED that the motion for a summons to be issued to Mr. Patrick Martel, requiring him to appear before this Commission to give evidence in his matter, is granted.

DATED at Ottawa, Ontario this 14th day of June, 2012.



Glenn M. Stannard, O.O.M.
Chairperson

**DECISION TO
RECOMMEND FUNDING FOR
LEGAL COUNSEL
FOR THE COMPLAINANTS
TO PREPARE
CLOSING SUBMISSIONS
– OCTOBER 30, 2012**



MILITARY POLICE COMPLAINTS COMMISSION

IN THE MATTER of a conduct complaint under section 250.18 of the *National Defence Act* by Mr. Shaun Fynes and Mrs. Sheila Fynes.

DECISION TO RECOMMEND FUNDING FOR LEGAL COUNSEL TO PREPARE CLOSING SUBMISSIONS FOR THE COMPLAINANTS, MR SHAUN FYNES AND MRS SHEILA FYNES

MPCC 2011-004 (Fynes) Public Interest Hearing pursuant to Section 250.38(1) of the *National Defence Act*

On September 26, 2011, the complainants, Shaun and Sheila Fynes, filed a Motion requesting that this Commission recommend that public funding be provided for their legal representation during the Public Interest Hearing to be held into their complaint. A Case Conference was held on October 19, 2011, where the complainants' counsel, Col (ret'd) Michel Drapeau, presented oral submissions in support of the Motion. Counsel for the subjects of the complaint, Department of Justice counsel Ms. Elizabeth Richards, took no position on the Motion. Counsel for the Government of Canada, Mr. Alain Préfontaine, provided written submissions that were read into the record.

On October 26, 2011, I issued a recommendation that the Government of Canada provide public funding for legal representation for the complainants. On March 16, 2012, the Honourable Peter MacKay, Minister of National Defence, informed the Commission that the Government of Canada would implement the Commission's recommendation and provide funding for legal representation for the complainants on compassionate grounds.

The public funding provided for legal representation for the complainants was capped at 424 hours for Col (ret'd) Drapeau, at a reduced rate of \$175.00 per hour, and 424 hours for Mr. Joshua Juneau, at a reduced rate of \$100.00 per hour. This was intended to provide each lawyer with 40 hours of preparation time prior to the commencement of the hearings and, during the anticipated 12 weeks of testimony, six hours per day of attendance at the hearings, and two hours per day for preparation. An additional amount was allocated for reasonable disbursements and costs for additional days of hearings.

Canada

On October 19, 2012, Col (ret'd) Drapeau filed a Motion seeking this Commission's recommendation that additional public funding be provided by the Government of Canada for the preparation of closing submissions on behalf of the complainants.

In the Motion, Col (ret'd) Drapeau noted that closing arguments for the Commission's benefit and consideration could extend to 100 pages of written submissions from each of the Parties, with three hours allocated to each Party for oral submissions, and the opportunity to make written reply submissions of up to 30 pages. Col (ret'd) Drapeau expected that preparing these submissions would require a considerable investment of time. He emphasized that Mr. and Mrs. Fynes were not in a financial position to pay for the legal representation required, as was previously established by affidavit evidence received during the initial request for public funding for legal representation.

Col (ret'd) Drapeau estimated that \$3500.00 remained from the public funding previously granted by the Government of Canada. He requested that this Commission recommend that additional public funding be allotted to provide for 100 hours of preparation each for himself and Mr. Juneau, at the reduced hourly rates of \$175.00 per hour and \$100.00 per hour respectively.

On October 24, 2012, Department of Justice counsel Mr. Alain Préfontaine provided a brief response to the Motion on behalf of the Government of Canada. He stated that the Government of Canada relied on the submissions that were provided in response to the complainants' original funding request. Mr. Préfontaine advised that, should this Commission decide to recommend supplemental funding, the Government of Canada would consider that recommendation.

In essence, Mr. Préfontaine's submissions continue to be as follows. First, that the decision of the Federal Court in *Jones v. Canada (Royal Canadian Mounted Police Public Complaints Commission)*¹ spoke to the existence of the Commission's discretion to recommend public funding, but that there was no mechanism to address how the discretion ought to be *exercised*. He emphasized that section 250.44 of the *National Defence Act*, which provides that parties to a Hearing are entitled to be afforded a "full and ample opportunity, in person or by counsel, to present evidence, to cross-examine witnesses and to make representations at the hearing"² does not *guarantee* the right to legal representation, but merely *permits* it.

¹ 1998 CanLII 8157 (F.C.); (1998), 162 D.L.R. (4th) 750.

² R.S.C. 1985, c. N-5.

Mr. Préfontaine's submissions also stated that, while the Federal Court observed in *Jones v Canada* that decision-makers prefer to achieve equality of legal representation for parties, this equality of representation could be accomplished through the efforts of Commission counsel.

Relying on the criteria as to when and why to recommend public interest funding articulated in the decision of the Supreme Court of Canada in *R. v. Caron*,³ Mr. Préfontaine also argued that this case did not warrant a recommendation for public funding. He submitted that other realistic options existed for bringing the issues to a hearing. However, Mr. Préfontaine also stated, as he did in his response to the present Motion, that the Government of Canada would consider the recommendation of the Commission, should the Commission decide to make one.

No submissions were received from Ms. Richards on behalf of the subjects of the complaint. As noted above, she took no position on the original funding motion, and I take the lack of further submissions to mean that this remains the case.

DECISION

Having considered the written submissions presented by Col (ret'd) Drapeau for the complainants, and by Mr. Préfontaine for the Government of Canada, I have made the decision to recommend that the Government of Canada provide supplementary funding for the legal representation of the complainants, in order to enable them to continue to participate fully in this Hearing.

For the reasons set out in my October 26, 2012 decision to recommend funding for the complainants' legal representation, I remain convinced that the "full and ample opportunity" to participate to which the complainants are entitled pursuant to the *National Defence Act*⁴ can only be achieved through continued legal representation, including during the closing submissions phase.

The enormous collection of documents spanning many thousands of pages amassed and entered into evidence, along with the testimony of 91 witnesses over the course of six months, amply illustrates the depth and complexity of this matter. At the conclusion of the hearing phase of a Public Interest Hearing that has amassed such extensive evidence on such a large and complex array of issues, it would be difficult if not impossible for the complainants to articulate, draft, and deliver closing submissions that fully and meaningfully represented their concerns and interests.

³ *R. v. Caron*, 2011 SCC 5.

⁴ R.S.C. 1985, c. N-5, s. 250.44.

It would be equally unrealistic to expect an unrepresented party to face the daunting task of drafting reply submissions after receiving and reviewing closing submissions prepared by the team of able counsel representing the subjects of the complaint.

Col (ret'd) Drapeau grounded the October 19, 2012 Motion on the fact that that Mr. and Mrs. Fynes' financial circumstances remain as indicated in the oral submissions and affidavit evidence provided in support of the original funding motion. I remain satisfied that, without public funding, the Fynes would not be able to afford the expense of legal representation for the purpose of preparing and delivering closing and reply submissions. As I previously noted, even in these times of necessary fiscal restraint, the scale of this expense from a governmental perspective was, and continues to be, a relatively small price to pay to ensure that the statutory rights of the complainants can continue to be exercised and that fairness and its appearance continue to be preserved.

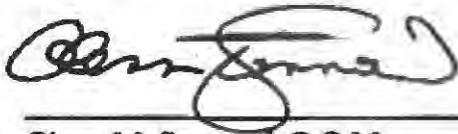
While it is unfortunate that this request for funding for the preparation of closing submissions was not made within the initial funding motion or at an earlier time in the course of the Public Interest Hearing, I have concluded that it is necessary to grant the request and to issue the recommendation, in order to ensure that the integrity and fairness of these proceedings are preserved.

RECOMMENDATION

For all these reasons, I have decided to issue a recommendation to the Government of Canada to grant additional funding for the complainants' legal representation. I recommend that this funding be granted at the reduced hourly rates suggested in the Motion: \$175 for Col (ret'd) Drapeau and \$100 for Mr. Juneau, and that any amount remaining from the funding previously granted be applied towards the additional hours necessary. I recommend that funding be granted for each counsel for the requested 100 hours each to prepare written closing submissions, prepare for and deliver oral submissions, and prepare written reply submissions. Considering the volume of evidence heard in the course of the Public Interest Hearing, and the length and complexity of the submissions anticipated, I consider that the amount of hours requested is reasonable, and that providing funding at this level is necessary to allow the complainants to continue to participate meaningfully in this Public Interest Hearing.

IT IS HEREBY RECOMMENDED that the Government of Canada provide supplementary funding to the complainants for the preparation of closing submissions and reply submissions and legal representation at this Hearing, in accordance with the rates and for the number of hours outlined in these reasons.

DATED at Ottawa, Ontario this 30th day of October, 2012.

A handwritten signature in black ink, appearing to read "Glenn Stannard", written over a horizontal line.

Glenn M. Stannard, O.O.M.
Chair

**RULING ON
REQUEST TO COMMENT ON
THE INTERIM REPORT
– NOVEMBER 29, 2012**



MILITARY POLICE COMPLAINTS COMMISSION

IN THE MATTER of a conduct complaint under section 250.18 of the *National Defence Act* by Mr. Shaun Fynes and Mrs. Sheila Fynes.

RULING ON REQUEST TO COMMENT ON THE INTERIM REPORT

**MPCC 2011-004 (Fynes) Public Interest Hearings pursuant to
Section 250.38(1) of the *National Defence Act***

On November 5, 2012, the Commission received a request from Col (ret'd) Michel Drapeau, counsel for the complainants, asking that the Commission provide a copy of its Interim Report to the complainants "in the same time and manner" that it will be provided to the Minister, the Chief of the Defence Staff or the Deputy Minister and the JAG and the Canadian Forces Provost Marshal pursuant to section 250.48 of the *National Defence Act*.¹ Col (ret'd) Drapeau also requested that the complainants be provided with a copy of the Notice of Action that must be issued to the Commission by the Canadian Forces Provost Marshal, the Chief of the Defence Staff or the Deputy Minister of National Defence after receipt and review of the Interim Report pursuant to section 250.51 of the *NDA*. In addition, he requested that the complainants be permitted to provide comments on the Interim Report and the Notice of Action, and that these comments be taken into consideration by the Commission in the drafting of the Final Report.

In his request, Col (ret'd) Drapeau discussed the legislative framework governing the Interim Report, the Notice of Action, and the Final Report. He characterized the Notice of Action as an "exclusive right to make representations on the MPCC Interim Report," and argued that this legislative framework violates and disregards the common law principles of both procedural fairness and natural justice. He added that the procedure set out by the *NDA* amounted to a "unilateral and *ex parte* privilege granted to DND/CF" that would result in the Parties being accorded unequal procedural rights.

¹ *National Defence Act*, R.S.C., 1985, c. N-5, s. 250.48 ["*NDA*"].

Col (ret'd) Drapeau argued that procedural fairness is a principle of fundamental justice entrenched within s. 7 of the *Canadian Charter of Rights and Freedoms*² as well as section 2(e) of the *Canadian Bill of Rights*.³ He added that procedural fairness in "this constitutional dimension has primacy over all legislation, including the *National Defence Act*, which is the enabling legislation mandating the MPCC to investigate conduct complaints against the military police." For that reason, he submitted that the Commission "is vested with the duty to treat any unconstitutional provision as having no force or effect, negating its effect to the extent of the inconsistency." In the event that it was determined that the Commission's mandate did not extend to rulings on the constitutional validity of the provisions of the *NDA*, Col (ret'd) Drapeau requested that the Commission read s. 250.48 of the *NDA* as giving both Parties equal participation concerning the Interim Report and Final Report.

On November 16, 2012, Department of Justice counsel Mr. Alain Préfontaine provided a written response expressing his opposition to the complainants' request. It is not clear whether these submissions were provided on behalf of the subjects of the complaint, the Canadian Forces Provost Marshal, the Department of National Defence, the Government of Canada, or all or some of them. In the past, Mr. Préfontaine has presented submissions in these proceedings on behalf of the Government of Canada, and has also appeared on behalf of the subjects of the complaint during the testimony of one witness before the Commission.⁴ No submissions were received specifically on behalf of the subjects of the complaint.

In his submissions, Mr. Préfontaine argued that the Commission's mandate does not extend to adjudicating claims or disputes between parties; instead, the Commission was created to investigate complaints concerning the conduct of members of the Military Police and to make findings and recommendations concerning the complaints. As a consequence, he submitted, the Commission lacks the jurisdiction required to review the constitutional validity of s. 250.48 of the *NDA*.

Mr. Préfontaine argued that Parliament intended that the Parties and the institutional representatives (the Department of National Defence, the Canadian Forces, and the military police) be treated differently, and that their rights and obligations therefore be different. During the Hearing stage, he noted, parties possess participatory rights by the operation of s. 250.44 of the *NDA*. Conversely, the institutional representatives do not have such participatory rights. At the end of the Hearing, however, the roles change and the institutional representatives are charged with responding to the findings and

² *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (U.K.)*, 1982, c. 11, s. 7 ["Charter"]."

³ *Canadian Bill of Rights*, S.C. 1960, c. 44, s. 2(e).

⁴ See Transcripts of Proceedings, vol. 33, 12 June 2012 & vol. 34, June 13, 2012.

recommendations presented in the Interim Report, pursuant to s. 250.48 of the *NDA*. In addition, Mr. Préfontaine asserted, the fact that the Parties are designated as recipients only of the Final Report pursuant to s. 250.53(2) of the *NDA* – and not of the Interim Report pursuant to s. 250.48 – makes it clear that Parliament consciously excluded them from the Interim Report phase. By necessary implication, Mr. Préfontaine argued, this exclusion means that any participatory rights of the Parties during the Interim Report phase were purposively overridden by statute. For these reasons, he submitted that there is "no legal basis to grant the request [the complainants] now make."

DECISION

I note first that this decision is confined to the request to comment on the Interim Report and to receive and comment on the Notice of Action.

I have considered the submissions made by Col (ret'd) Drapeau on behalf of the complainants in support of the request, and those of Mr. Préfontaine in opposition. I have concluded that there is no right, constitutional or otherwise, for a Party to comment on an Interim Report or a Notice of Action under the *NDA*.

Col (ret'd) Drapeau cited the decision of the Newfoundland Supreme Court, Trial Division, in *Woolworth Canada v. Newfoundland (Human Rights Commission)*⁵ in support of his argument that both parties must have the same right to see and comment upon the Interim Report. Central to the complaint of bias in that case was the fact that the Human Rights Commission had given one party the investigator's report and the opportunity to make submissions as to whether or not that commission should appoint a board of inquiry in the matter. In other words, the Human Rights Commission made a decision to invoke the adjudication of a board to hear the complaint, a decision affecting the rights of all parties, while having invited **only one of those parties** to make submissions in advance of that decision.

That decision was found, in the circumstances, to give rise to a reasonable apprehension of bias. It should be noted, however, that the procedure respecting the Interim Report is markedly different in purpose, substance and effect.

The Commission does not provide the Interim Report to any of the Parties to the Hearing in order to solicit comments and submissions about the substance of the findings and recommendations. Instead, the Commission is required by statute to provide its findings and recommendations to certain Military Police and Department of National Defence

⁵ *Woolworth Canada Inc. v. Newfoundland (Human Rights Commission)* (1994), 114 Nfld. & P.E.I.R. 315, 1994 CarswellNfld 54 (Nfld. S.C. (T.D.)).

officials in order for them to consider the actions to be taken in response to those findings and recommendations. The Notice of Action is not a means of providing editorial comment that could modify or influence the Commission's decisions. Rather, it is a means of providing information to the Commission about the actions that will or will not be taken in response to the Commission's findings and recommendations, and the reasons for any decision not to take action. The Commission can then comment on the intended actions or inaction in its Final Report.

Neither the complainants nor the subjects of the complaint have a statutory or constitutional right of comment on the Interim Report or on the Notice of Action. It is therefore not the case, as argued in support of this request, that one side possesses a right that the other does not. As argued by Department of Justice counsel, the Interim Report and the Notice of Action engage the "institutional representatives" rather than the Parties. The broader institutions must determine what actions to take, if any, in response to the findings and recommendations that I will make – and if no action is to be taken, those institutions must explain why not. There is no statutory provision for any other parties to be involved at this stage.

In this case, the subjects of the complaint, the Canadian Forces Provost Marshal and the Department of National Defence have all been represented by the same team of Department of Justice and other Government counsel before this Hearing. This may be a cause of some concern for the complainants, and it may create an unfortunate appearance that the Interim Report is being provided to one Party and not to the other. It should therefore be noted that the multiple representation by the Department of Justice must not give rise to a situation where the subjects of the complaint have access to this Commission's report before the complainants do. The multiple representation is also not to be used to provide any opportunity for the subjects of the complaint to have input as to the contents of the Notice of Action. Department of Justice counsel involved in this matter must take all necessary measures to ensure that no such improprieties occur. That having been said, however, the multiple representation alone does not constitute sufficient grounds to conclude that the complainants must be granted a right to comment on the Interim Report and Notice of Action.

With respect to the constitutional arguments raised by the complainants, it was argued that procedural fairness and equal treatment are principles of fundamental justice protected by the *Charter*. On that basis, Col (ret'd) Drapeau invited me to find that the impugned provisions of the *NDA* were of no force or effect to the extent of the inconsistency with those principles. This submission was strongly opposed by Mr. Préfontaine, who denied that the Commission had any jurisdiction to make such determinations.

Section 7 of the *Charter* reads:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.⁶

As stated by Lamer C.J. (as he then was) in *Re B.C. Motor Vehicle Act*, "[t]he principles of fundamental justice [...] are not a protected interest, but rather a qualifier of the right not to be deprived of life, liberty and security of the person."⁷ The principles of fundamental justice, informed in part by natural justice and procedural fairness, are not themselves constitutional rights. The constitutional right guaranteed by section 7 only arises in circumstances where there has been or is threatened to be, a deprivation of life, liberty or security of the person. In this case, it is difficult to see how the interests of Parties before a Public Interest Hearing can be thought to involve such an actual or threatened deprivation, so as to allow them to invoke that *Charter* guarantee.

Section 2(e) of the *Canadian Bill of Rights* is also inapplicable in this situation. The guarantee to a fair hearing in this section applies where the hearing in question involves a determination of the individual's rights and obligations.⁸ This Commission has no mandate to find criminal or civil liability and cannot make any order affecting the legal rights and obligations of the Parties. The Commission's only mandate is to make recommendations, and therefore, as with section 7 of the *Charter*, the threshold to trigger the right protected by section 2(e) of the *Canadian Bill of Rights* is not met.

As for procedural rights themselves, including the right to fairness, principles of fairness have been applied throughout the proceedings to ensure that the Parties' statutory right to participate could be fully exercised. Each Party was granted the opportunity to bring evidence, cross-examine witnesses and make representations. The Commission's findings and recommendations will be based on the evidence heard in the Public Interest Hearing where both Parties participated fully. The process by which governmental authorities advise the Commission of their intended response to the findings and recommendations through the Notice of Action is a different process that does not engage the same participatory rights for the Parties.

⁶ *Charter*, *supra* note 2, s. 7.

⁷ *Re B.C. Motor Vehicle Act*, [1985] 2 SCR 486 at para. 24 [emphasis added].

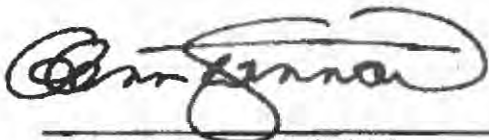
⁸ *Authorson v. Canada (Attorney General)*, [2003] 2 S.C.R. 40 at para. 59; *McBain v. Canada (Canadian Human Rights Commission)*, 1985 CarswellNat 161 (FCA).

I find that no violation of the requirements of natural justice or procedural fairness results from allowing only the institutional recipients of the Interim Report to comment on the findings and recommendations through the Notice of Action. Similarly, no violation occurs by not permitting the Parties before the Hearing to receive or comment on the Notice of Action. This process does not unfairly deprive anyone of a fundamental right guaranteed by the *Charter*, by the *Canadian Bill of Rights* or by the general principles of administrative law. It is therefore unnecessary to discuss in further detail the constitutional and jurisdictional arguments made by Col (ret'd) Drapeau and Mr. Préfontaine.

For all of these reasons, I have concluded that neither the law nor the constitution provide for the requested right to comment on the Interim Report and to receive and comment on the Notice of Action.

IT IS HEREBY ORDERED that the complainants' request to be given the right to comment on the Commission's Interim Report, and to receive and comment upon the Notice of Action, is denied.

DATED at Ottawa, Ontario this 29th day of November, 2012.



Glenn M. Stannard, O.O.M.
Chair

**NOTICE OF ACTION
AND RELATED
CORRESPONDENCE**



National Defence

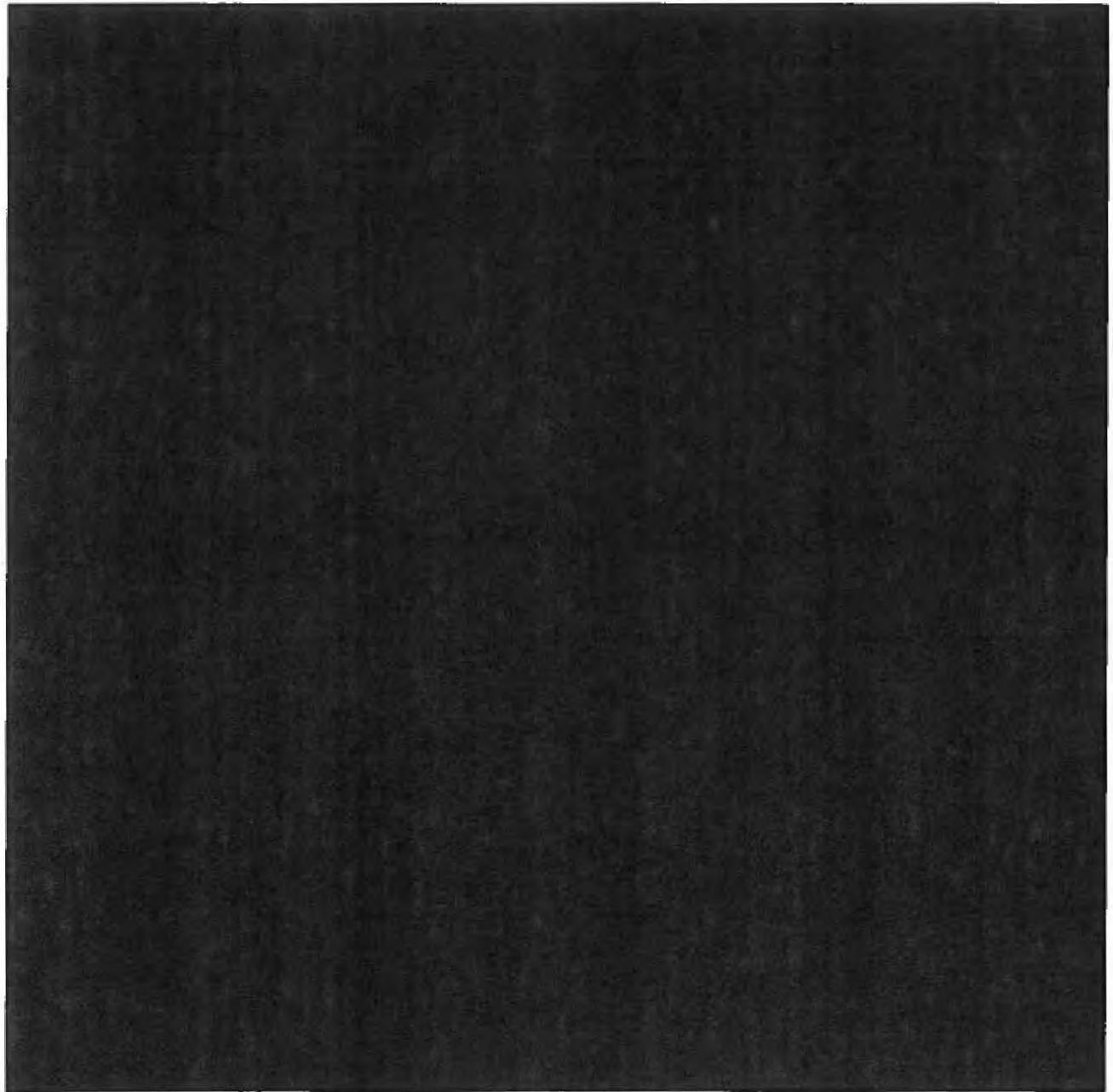
CANADIAN
MP

Canadian Forces Provost Marshal and
Commander Canadian Forces MP Gp
2200 Walkley Road
Ottawa ON K1A 0K2

Défense nationale

PM
CANADIENNE

Grand Prévôt des Forces canadiennes et
Commandant du Gp de la PM des Forces canadiennes
2200, chemin Walkley
Ottawa (Ontario) K1A 0K2

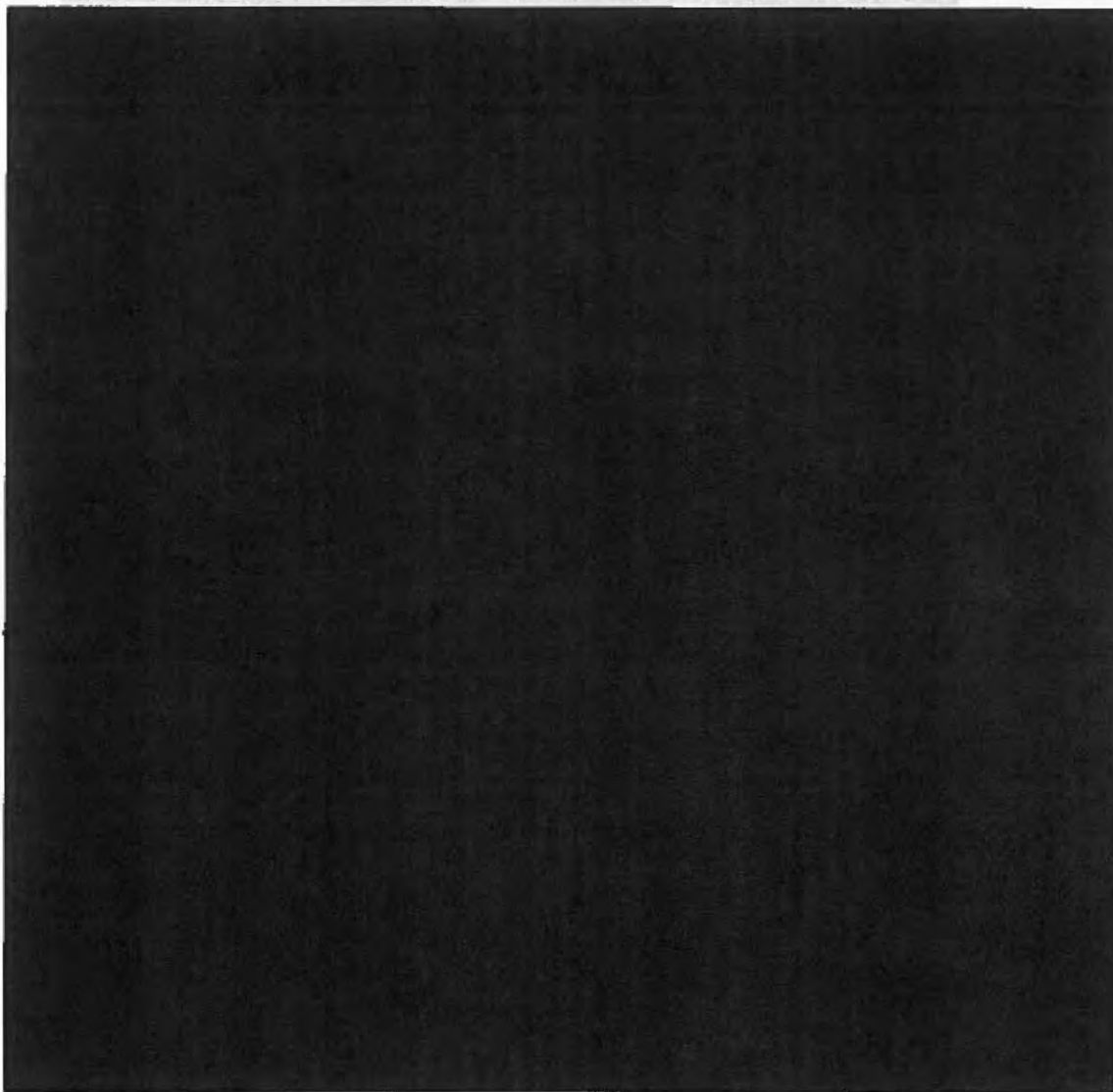


Canada

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DEC 16 2014
4110
Military Police Complaints Commission
Commission d'examen des plaintes
concernant la police militaire

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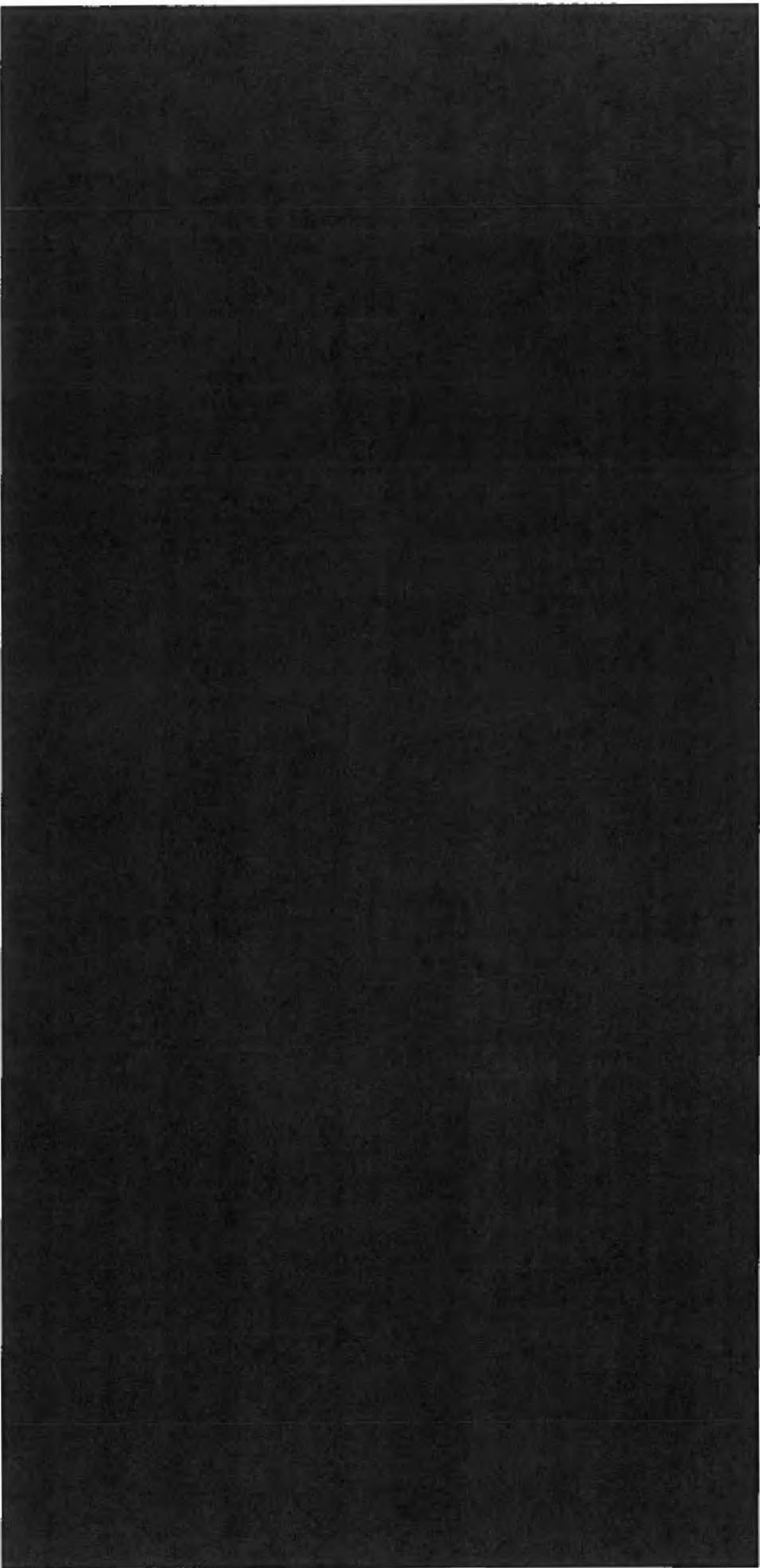
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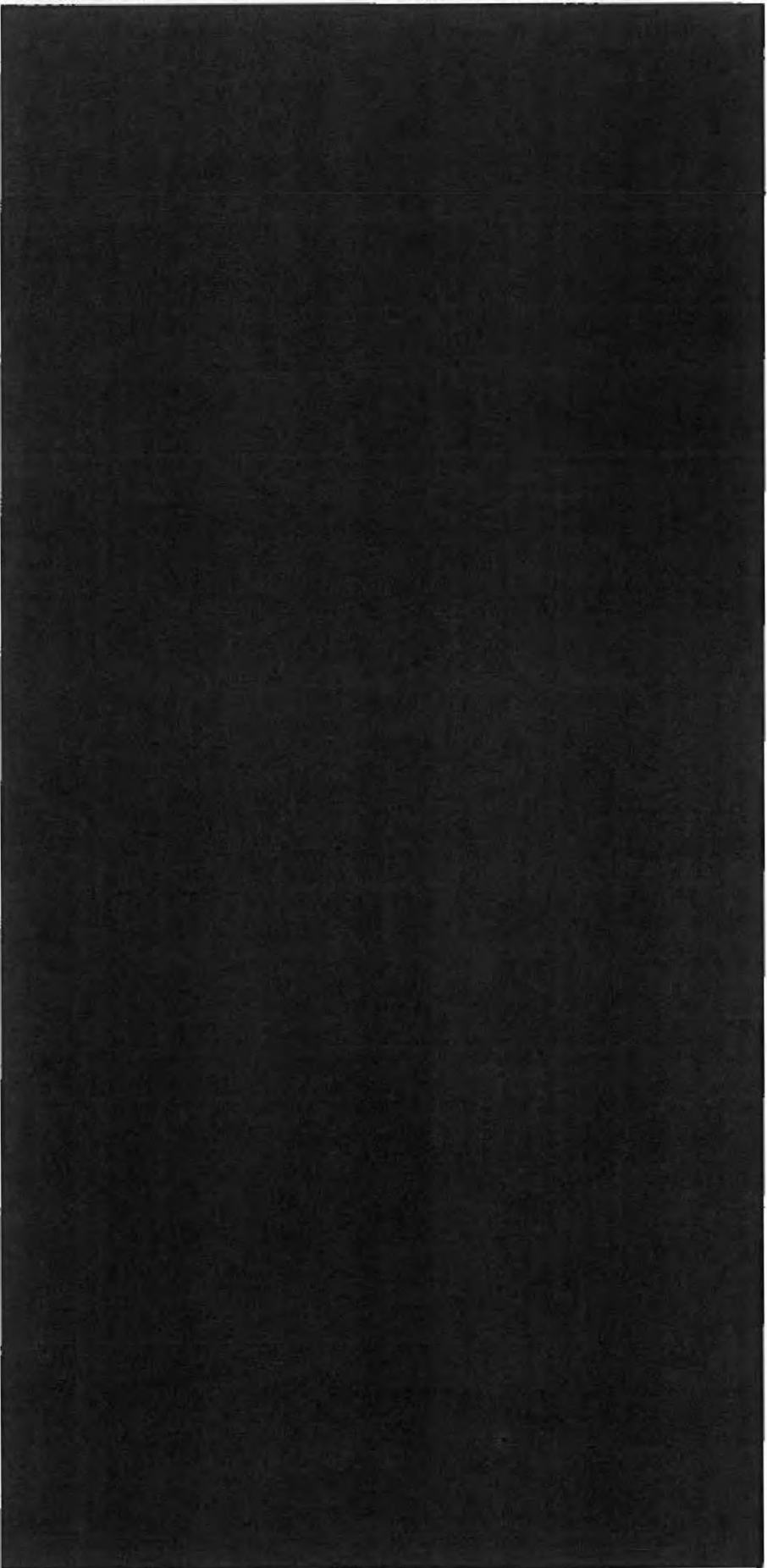


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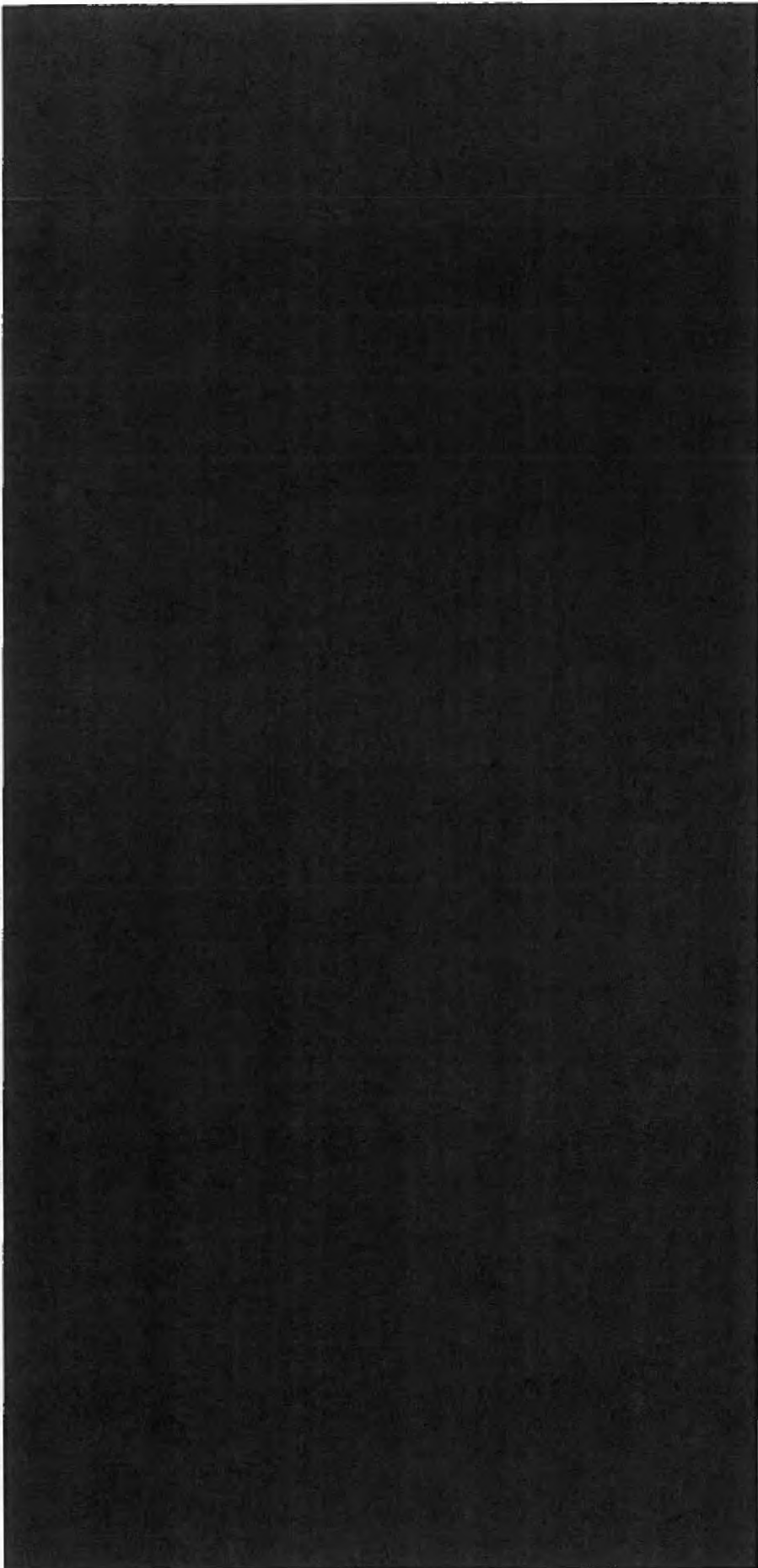


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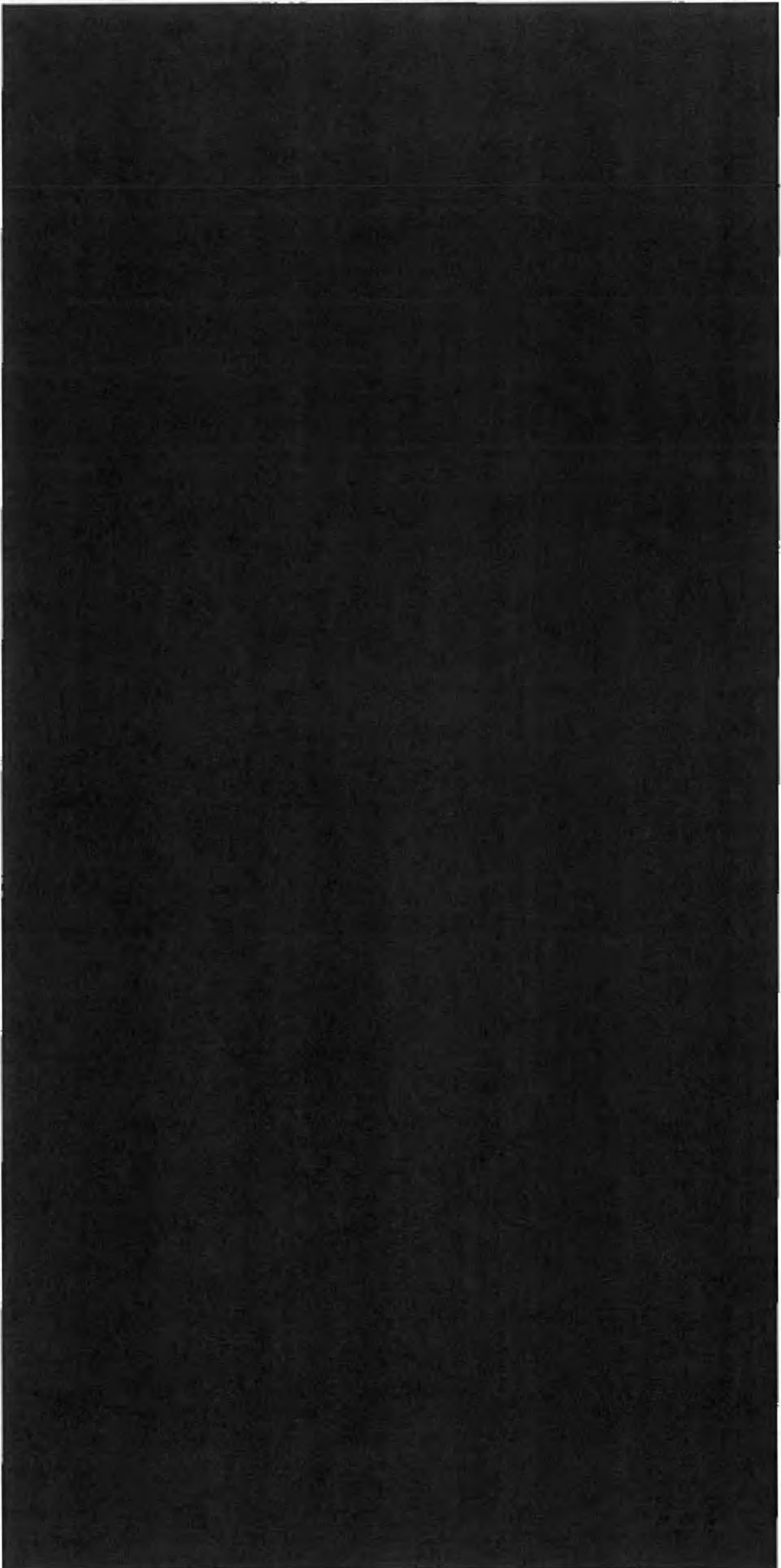


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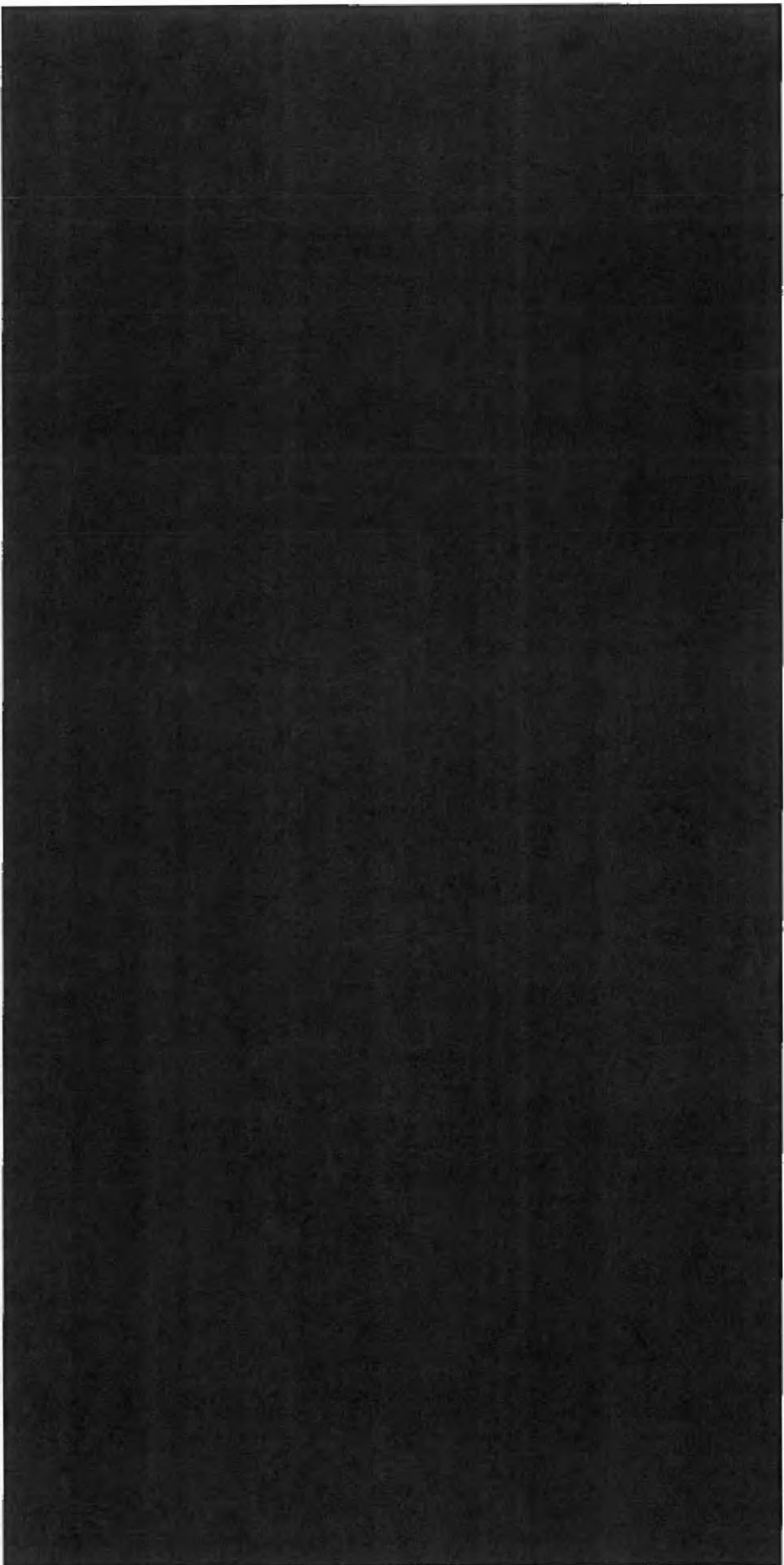


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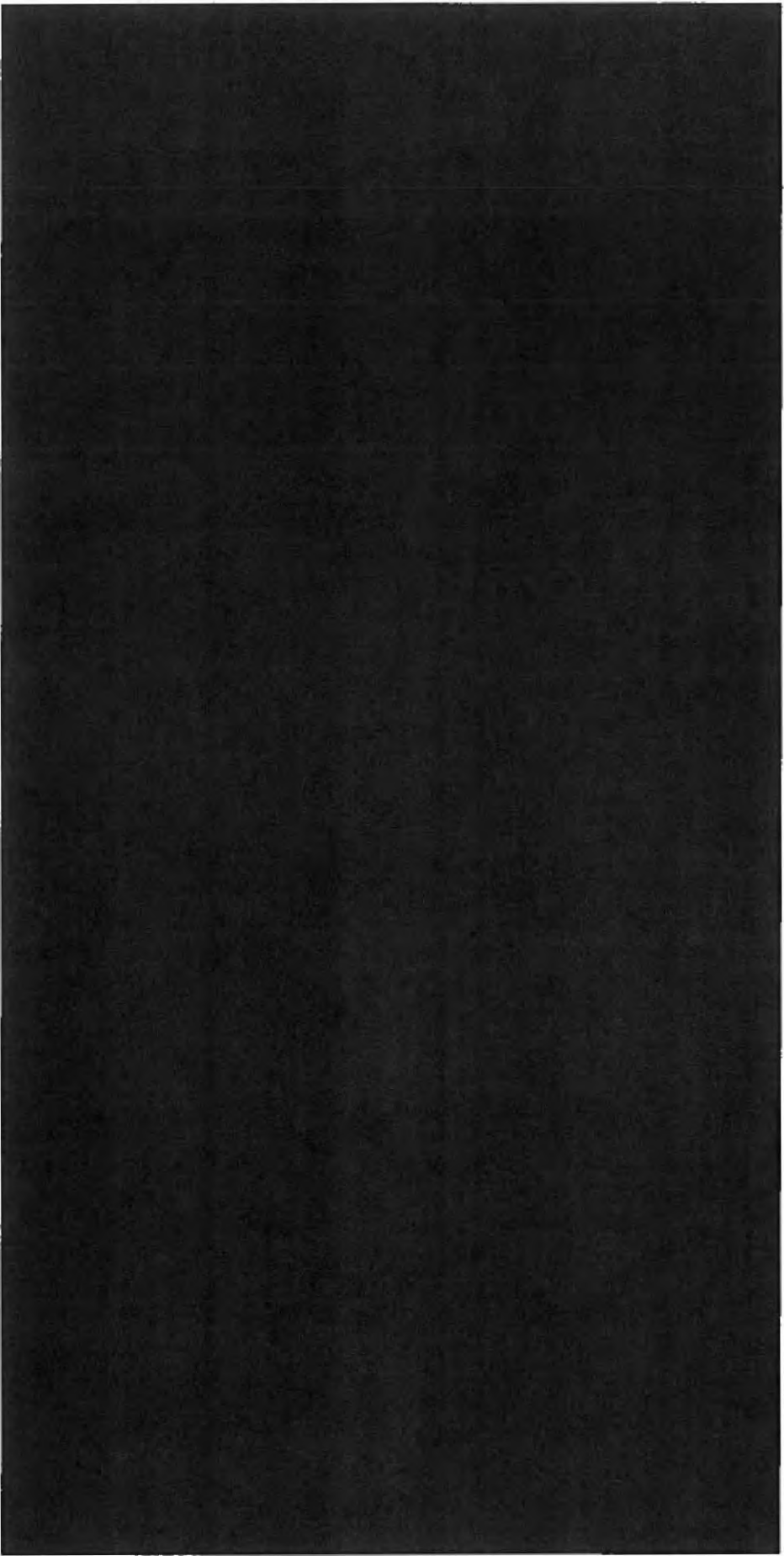


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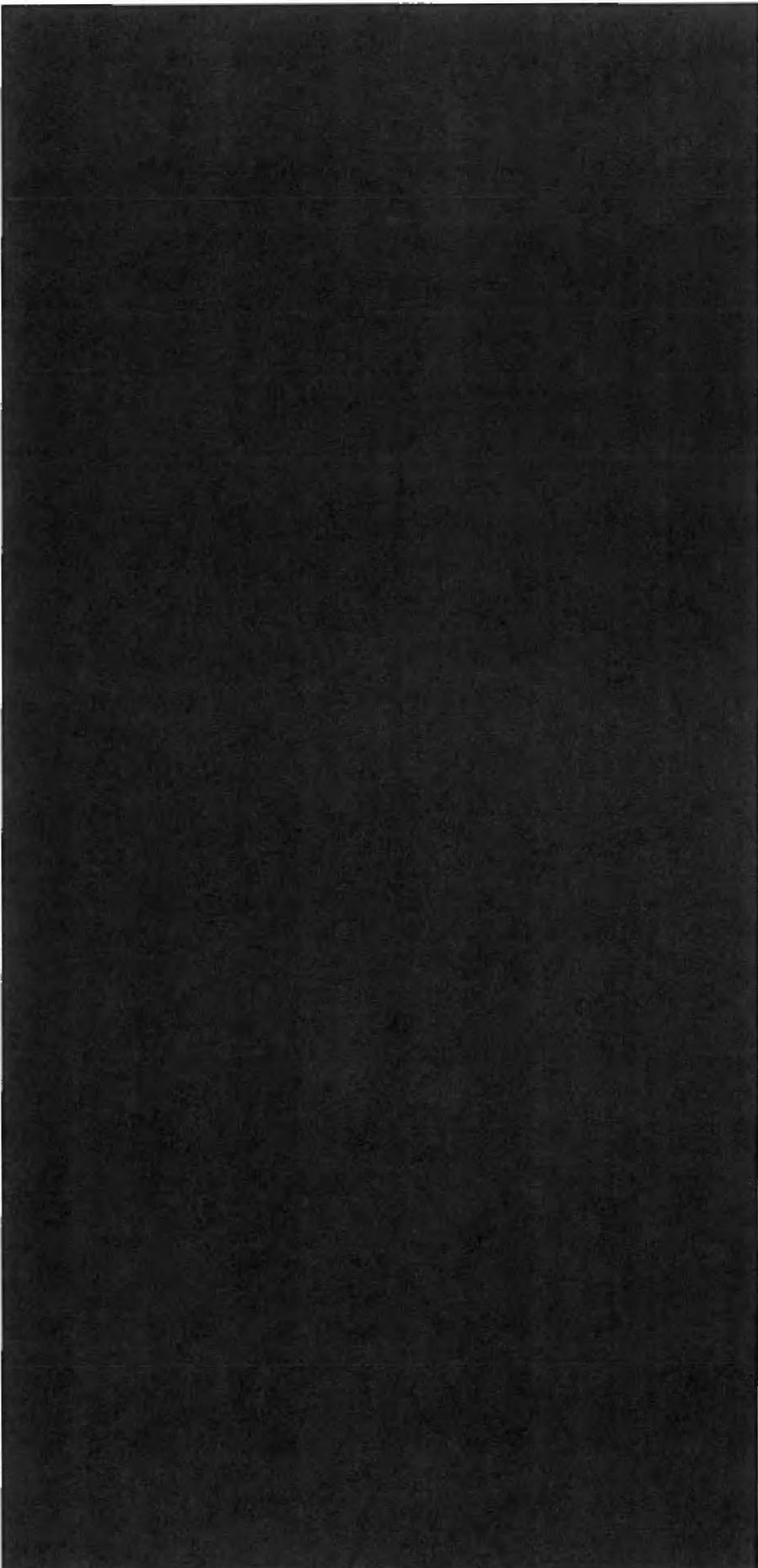


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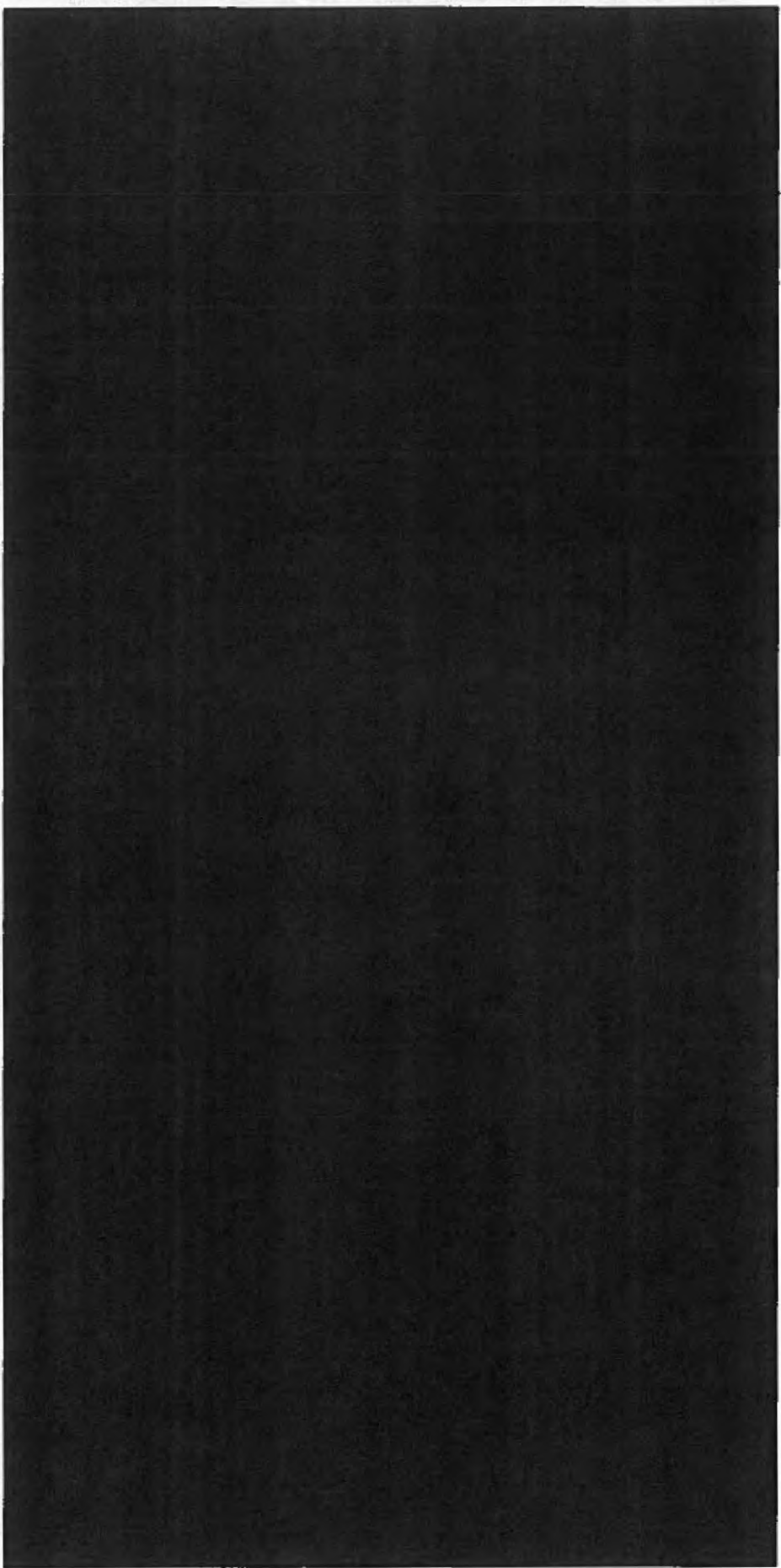


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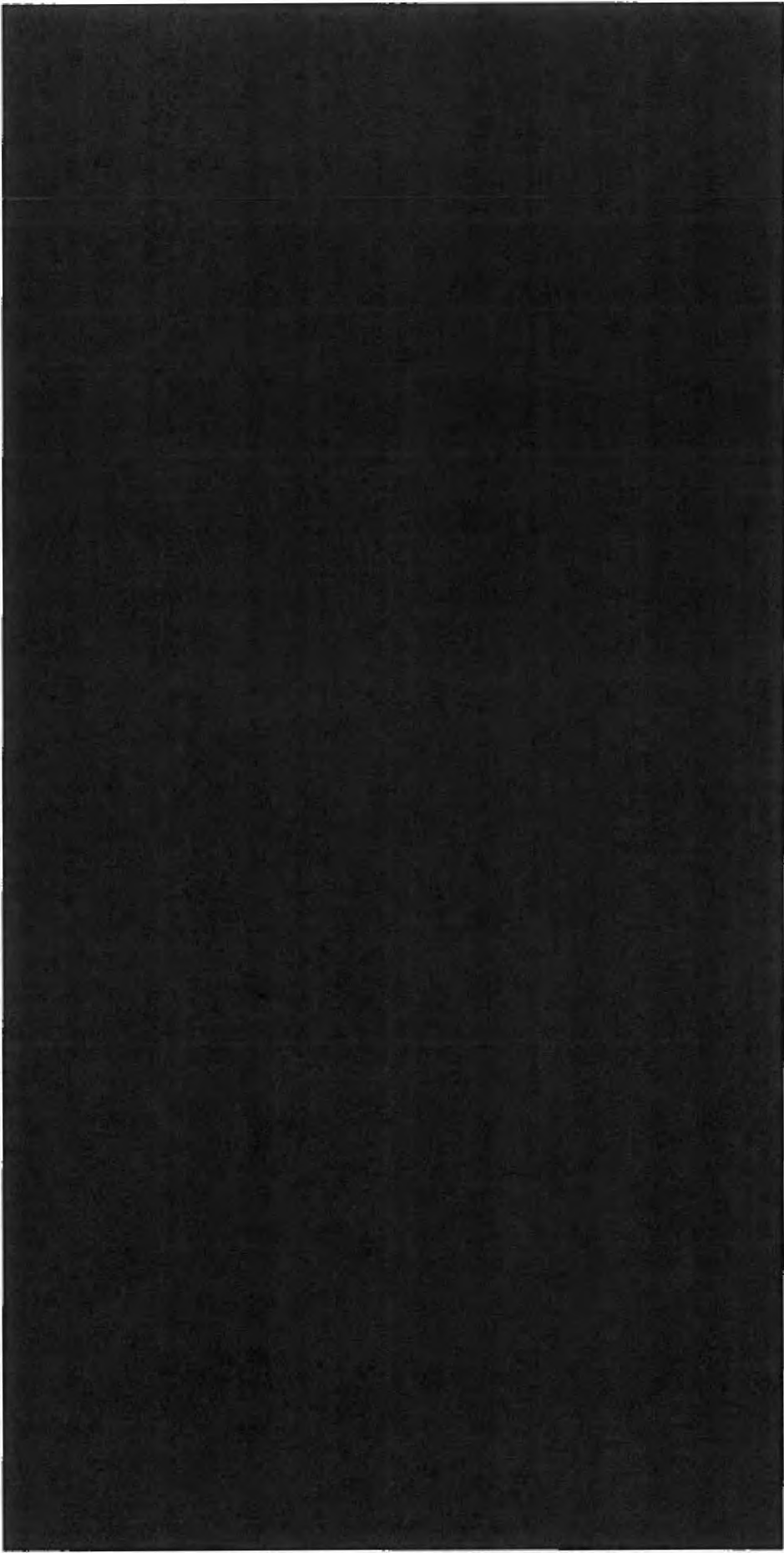


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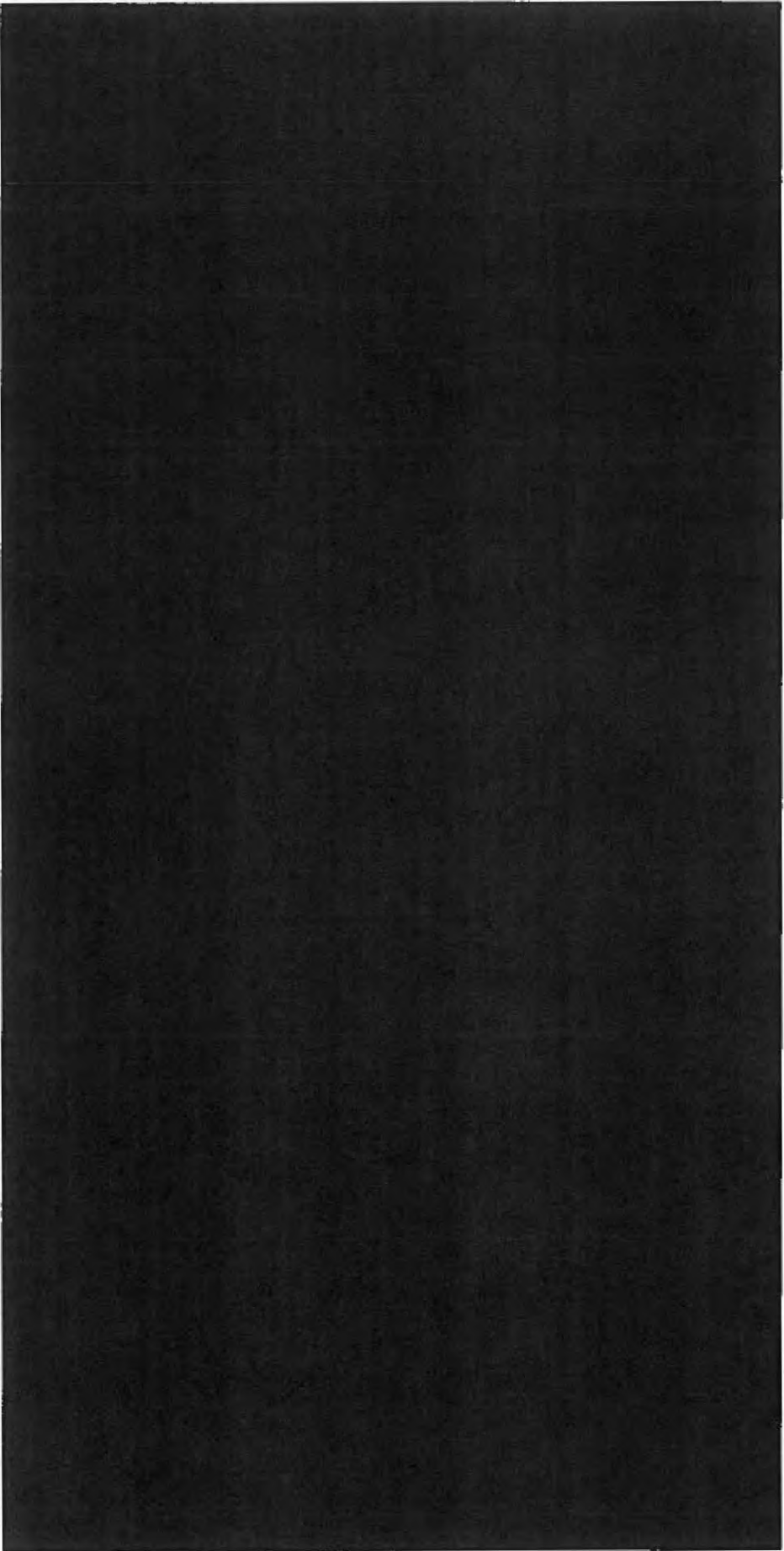


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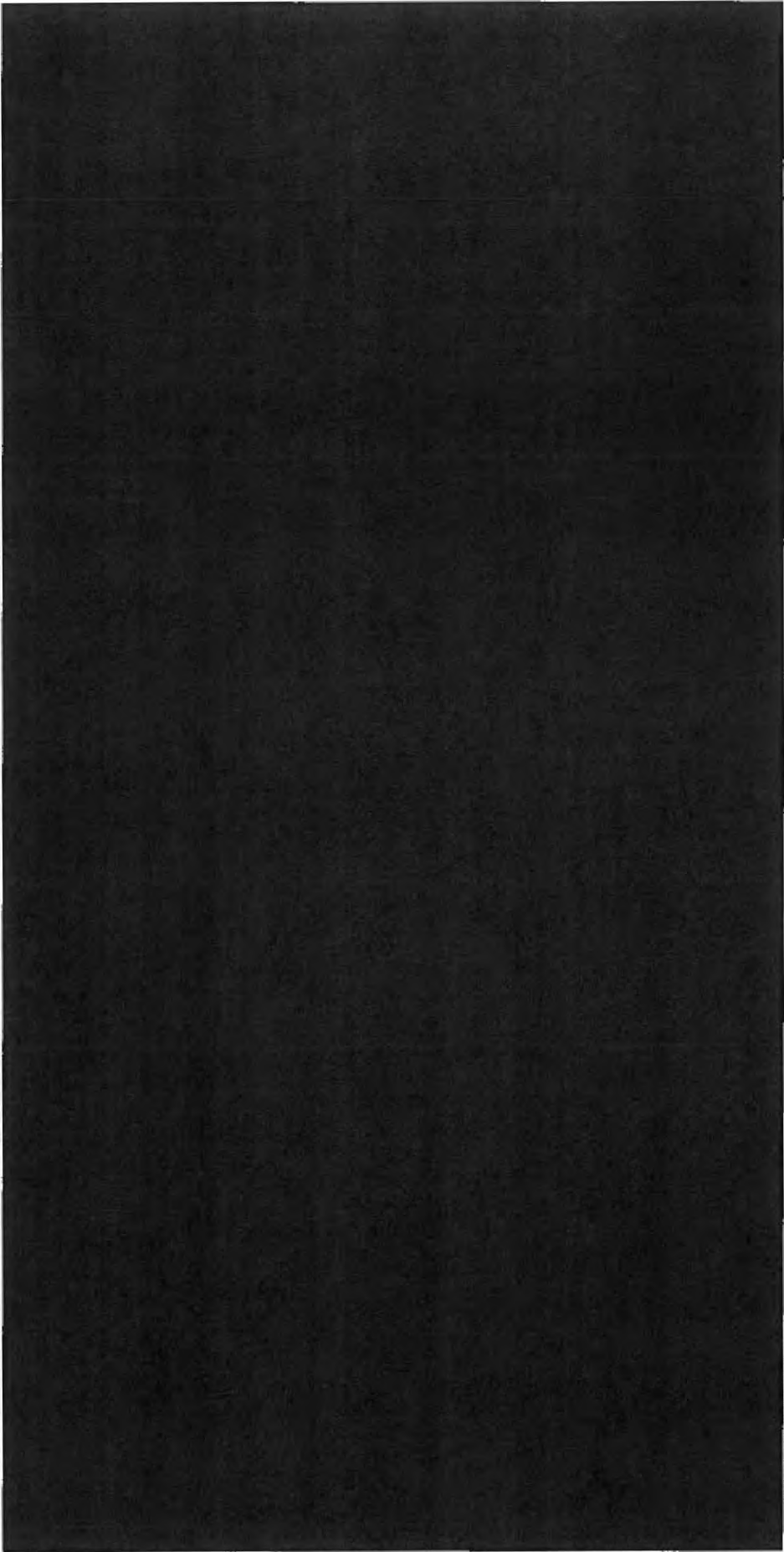


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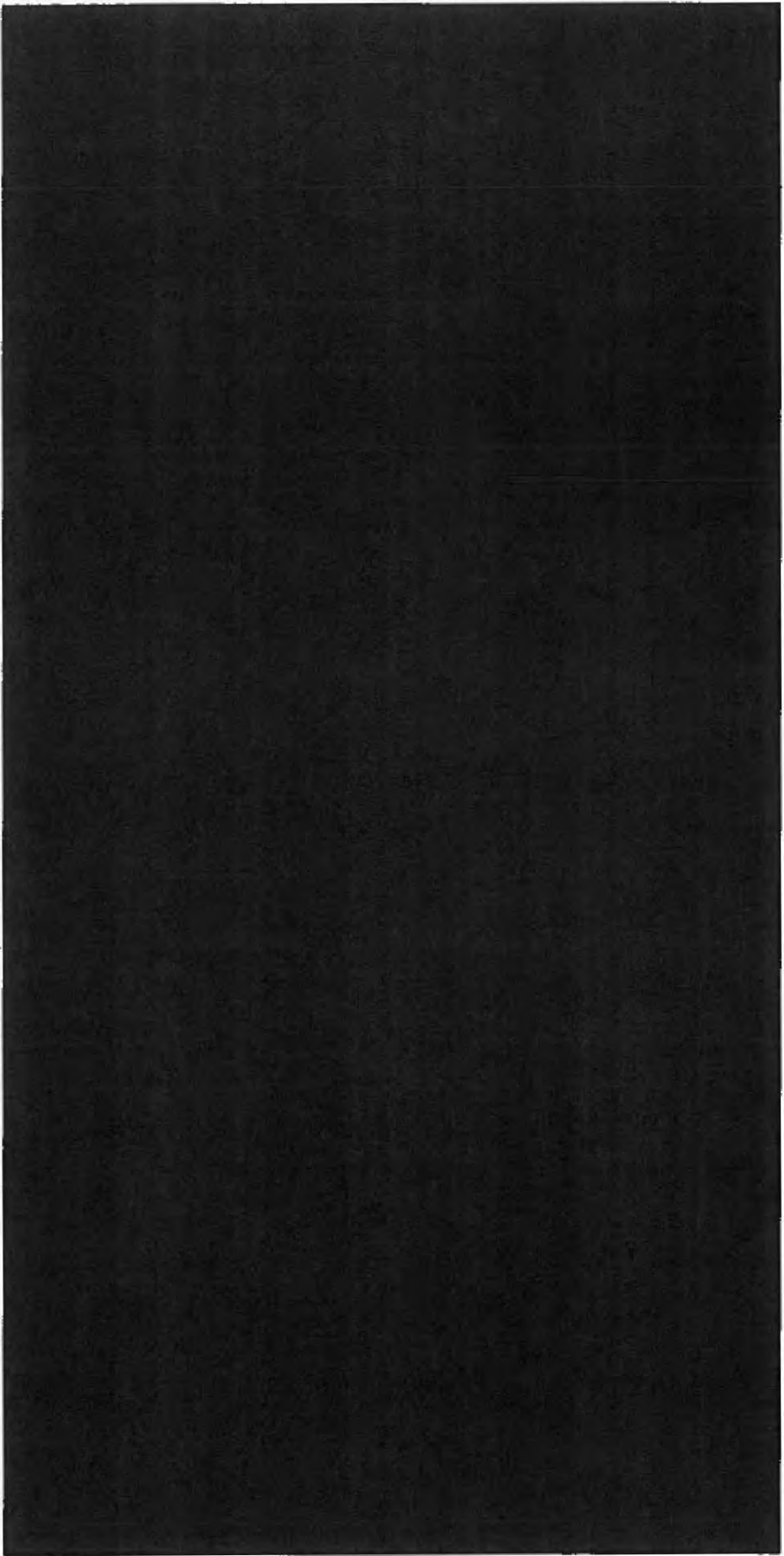


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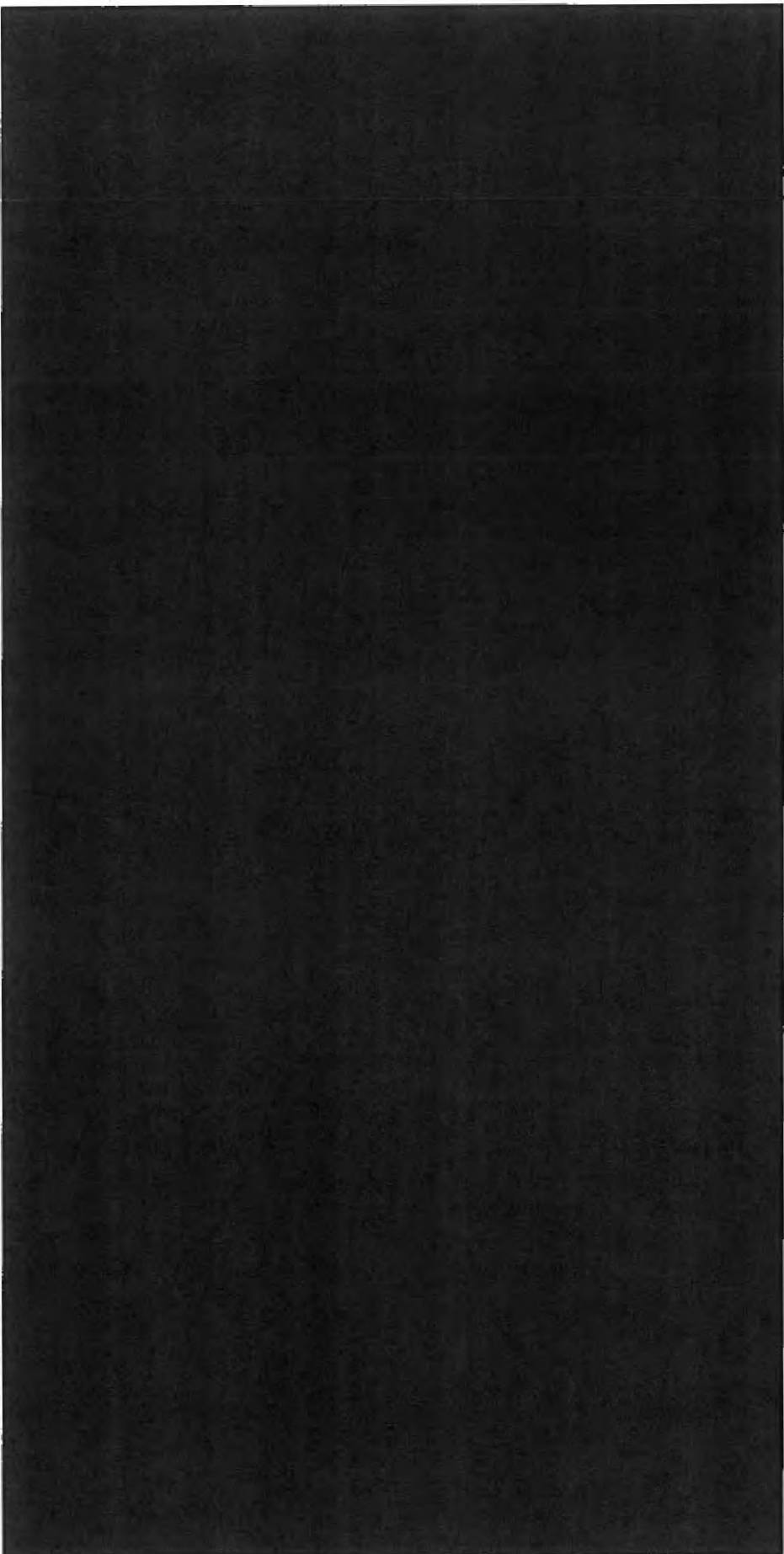


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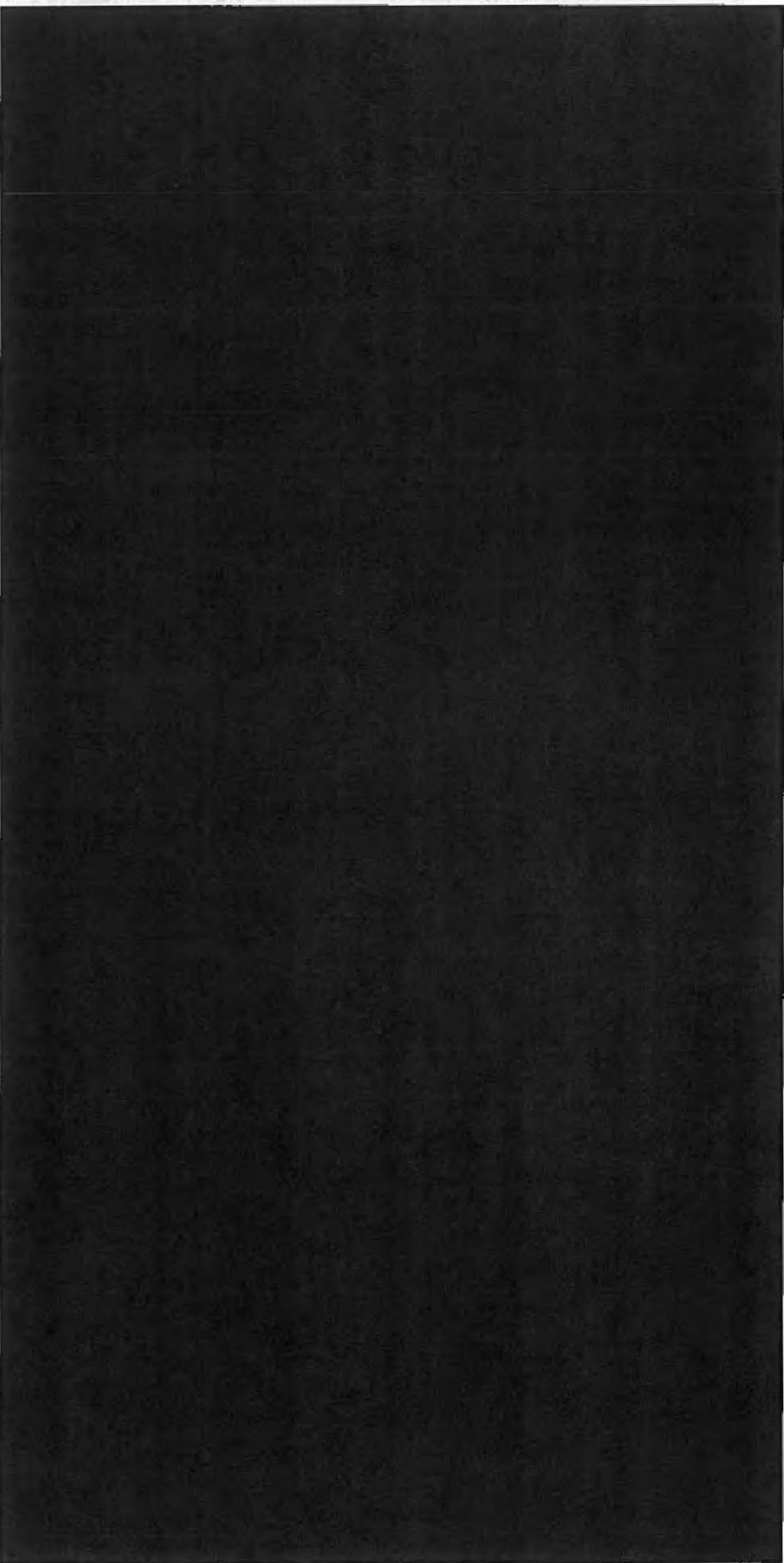


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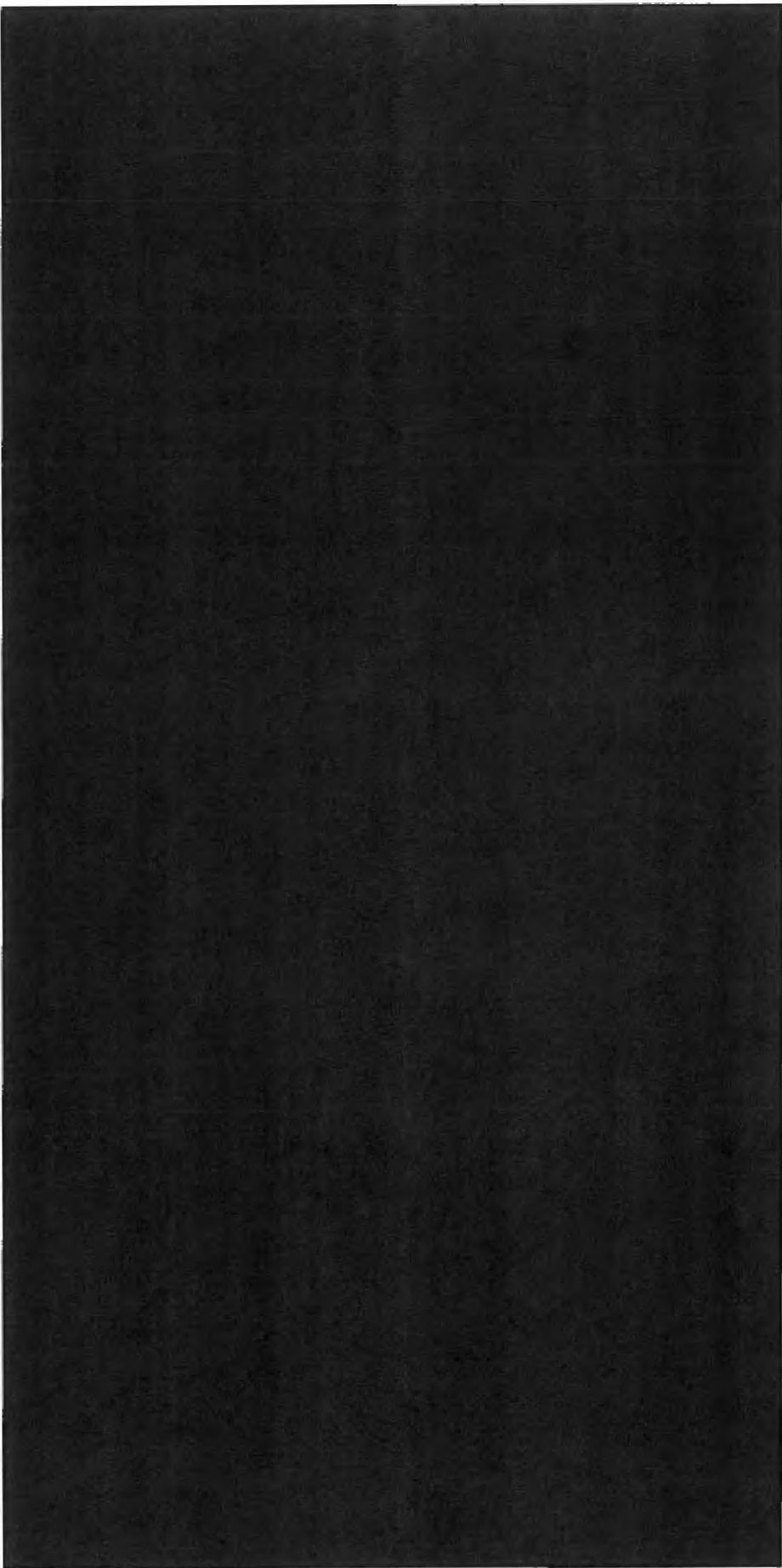


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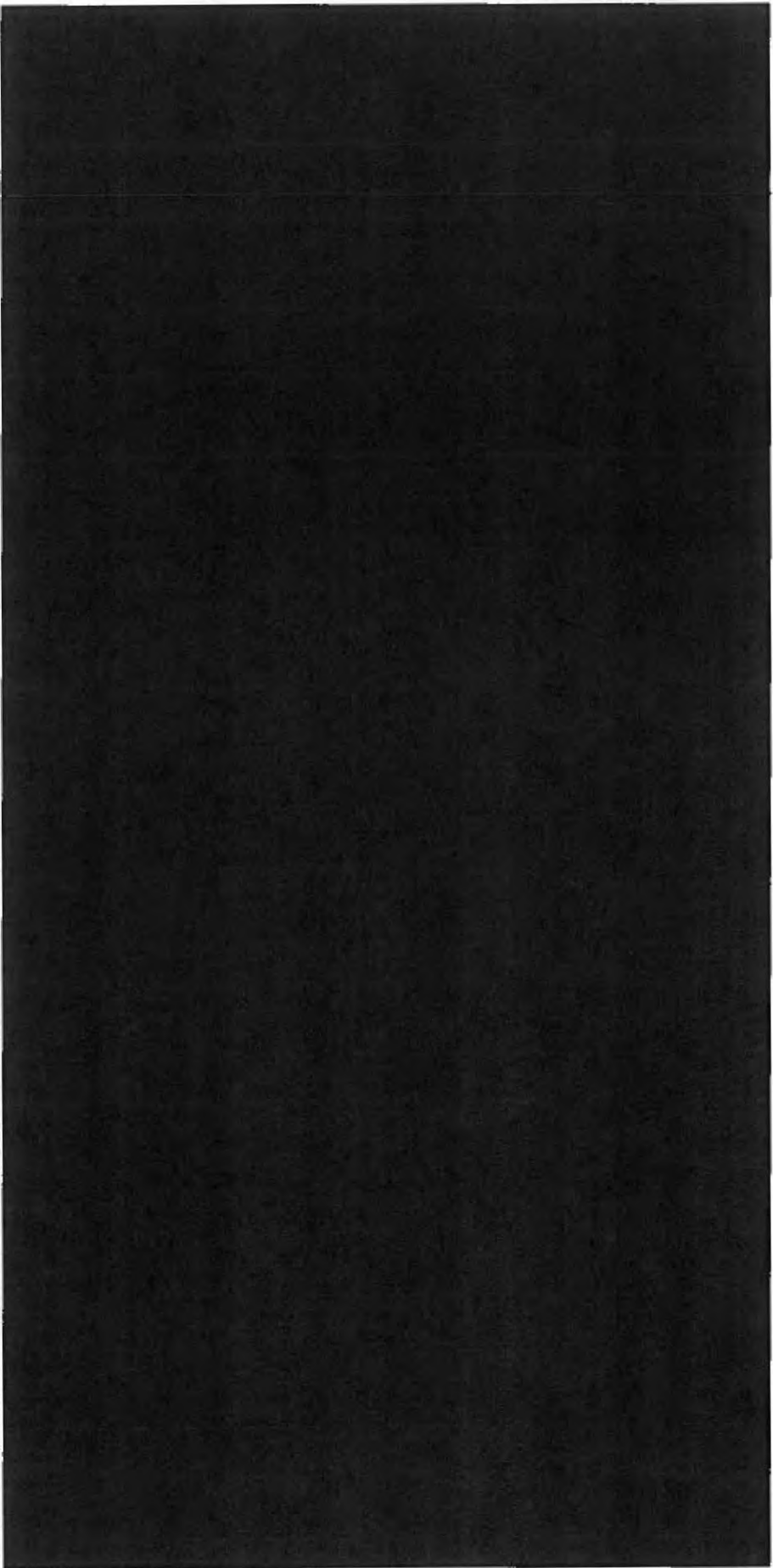


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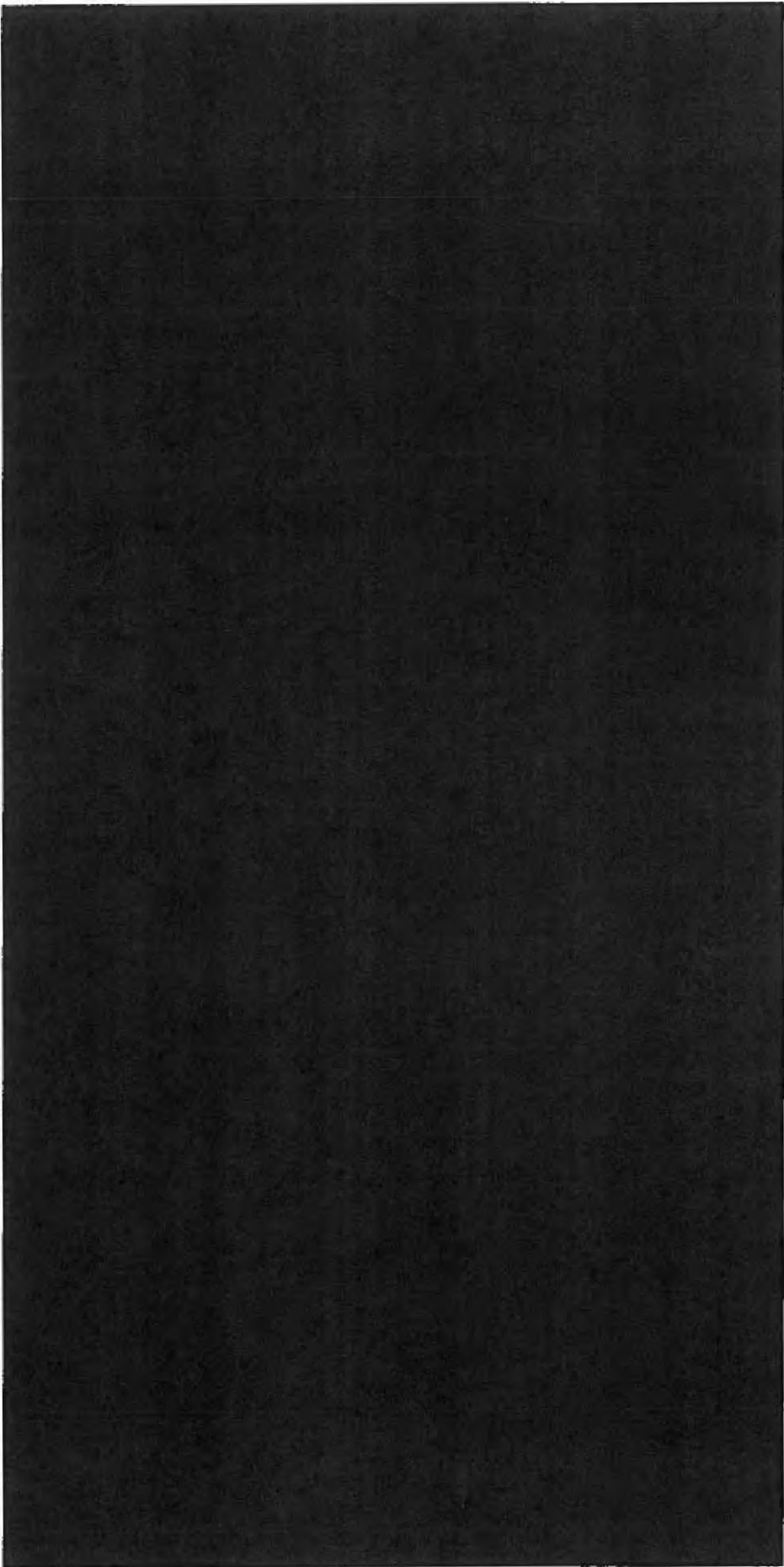


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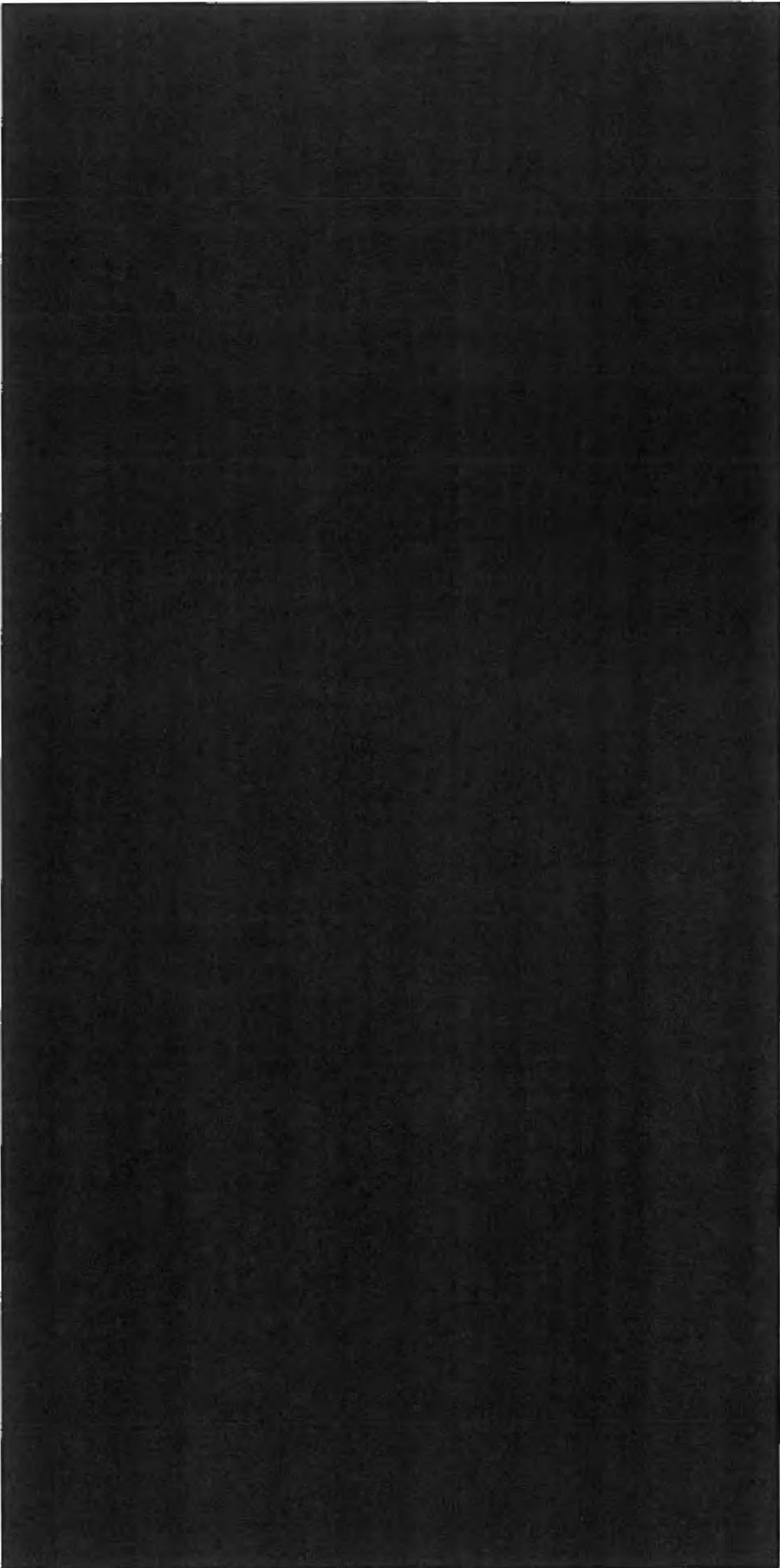


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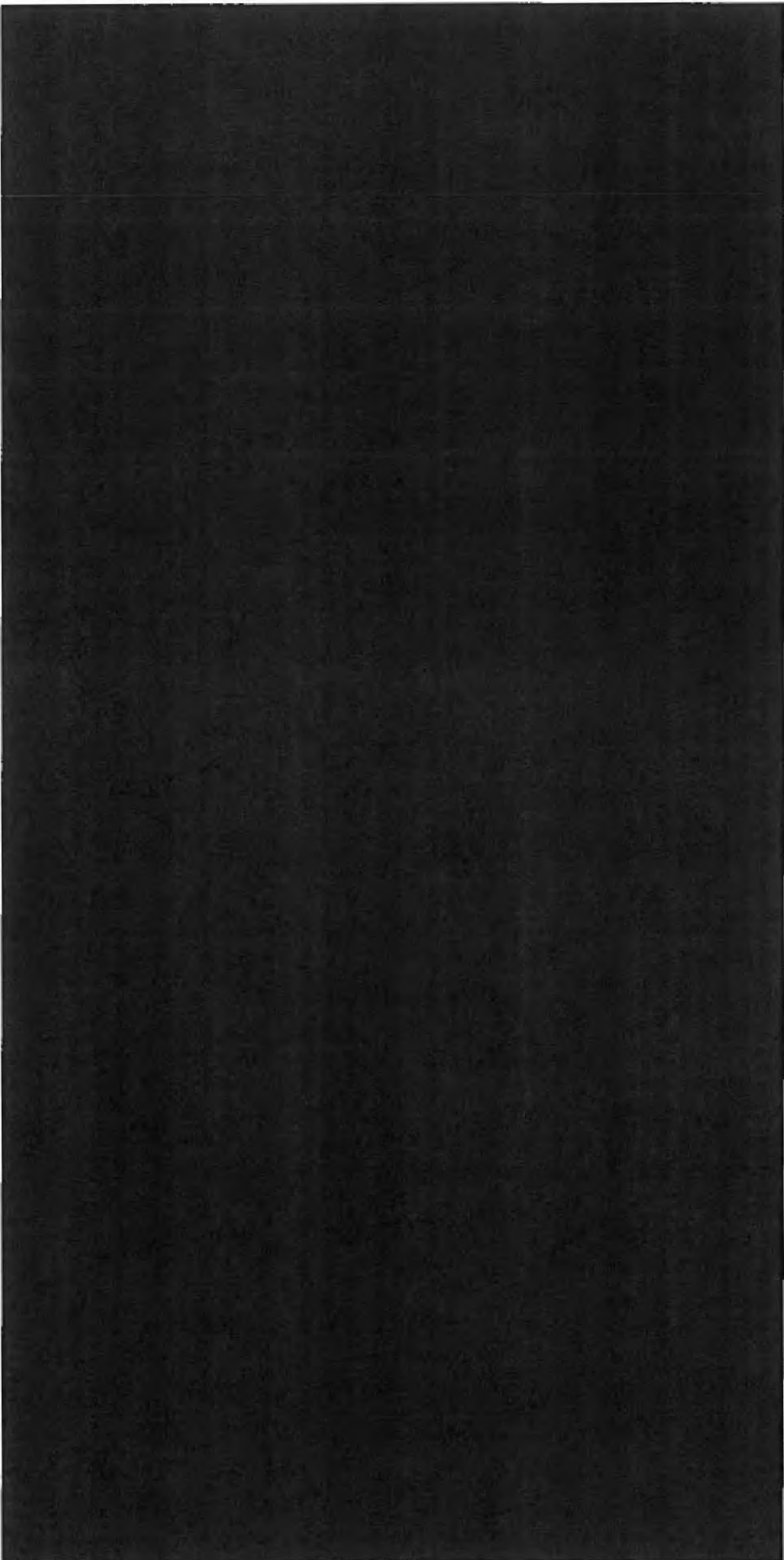


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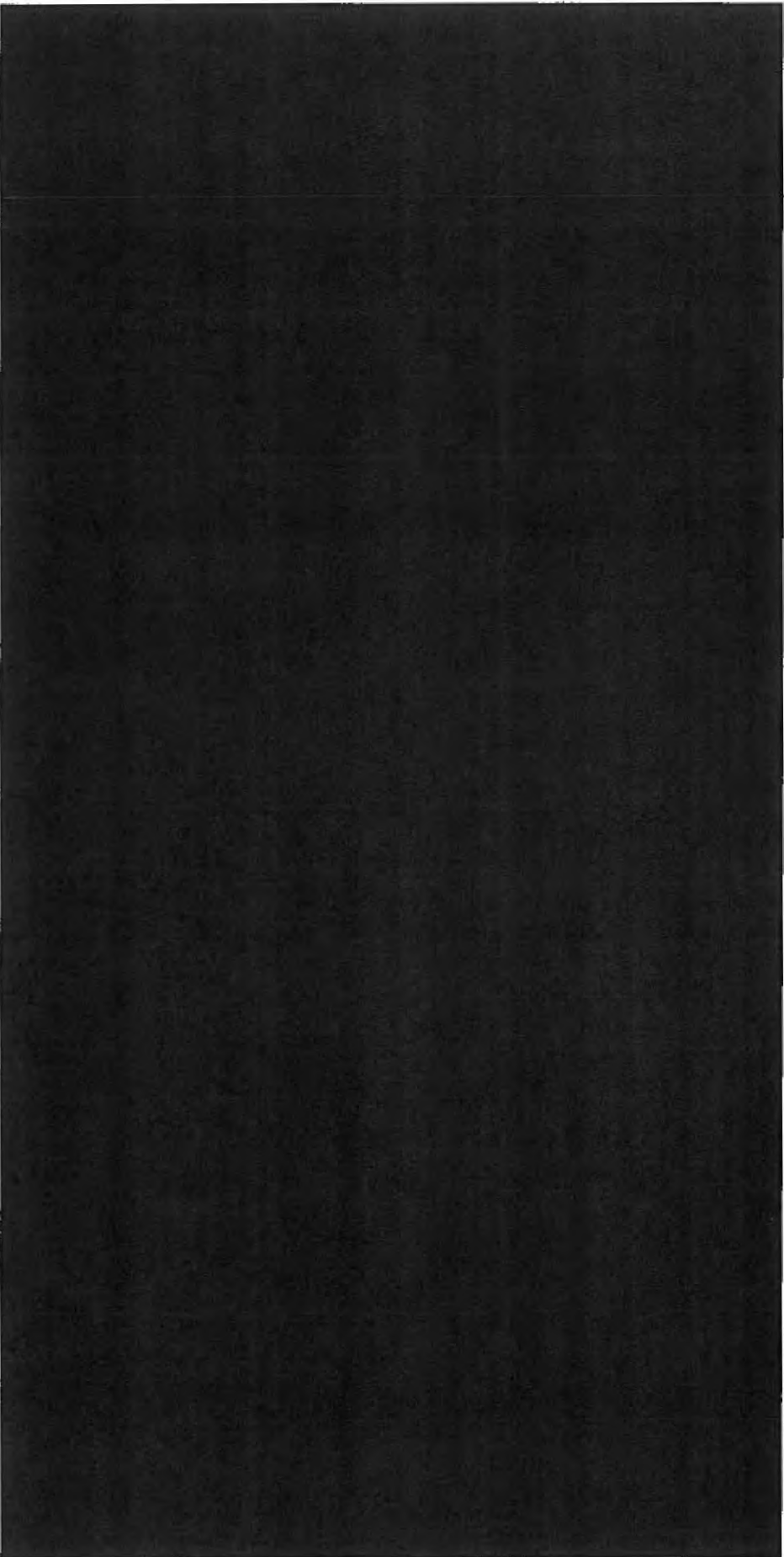


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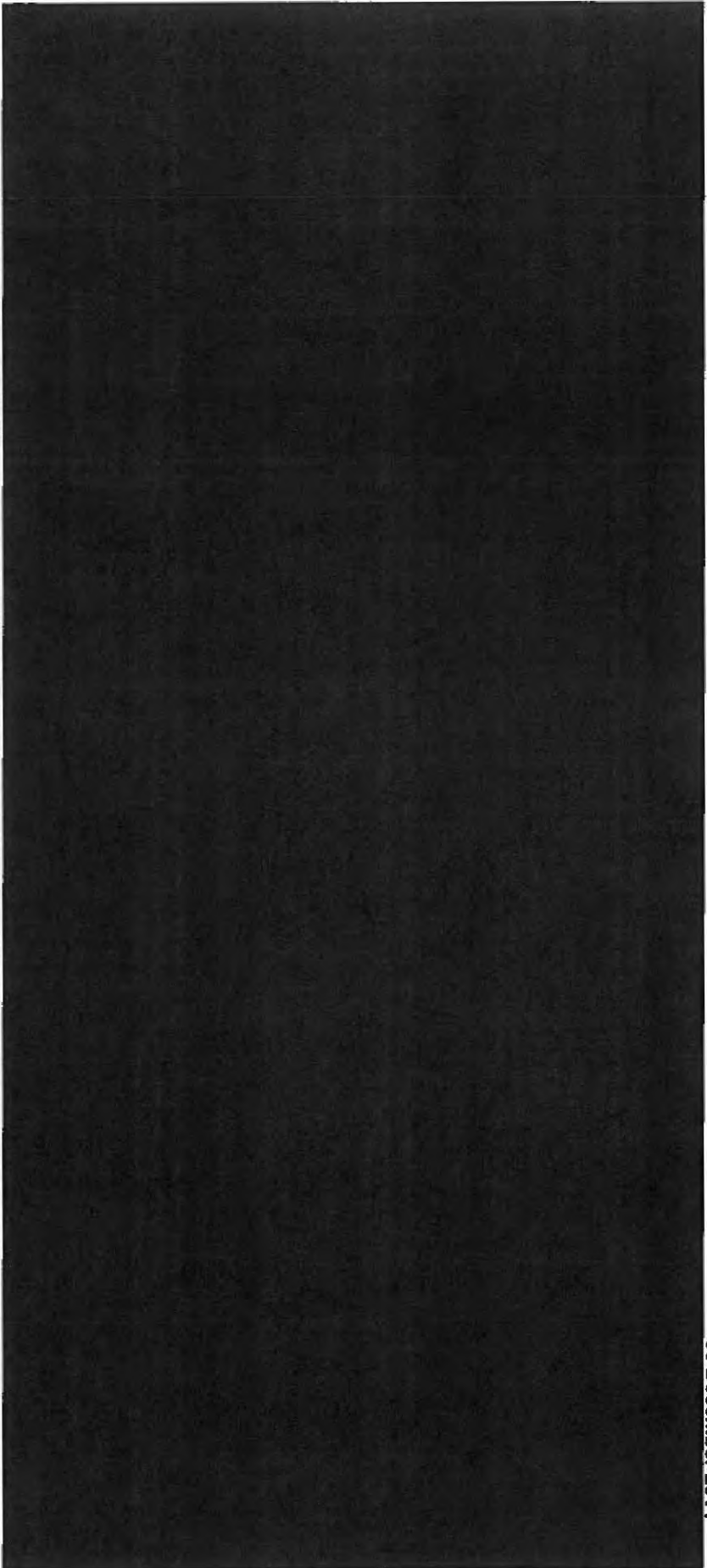


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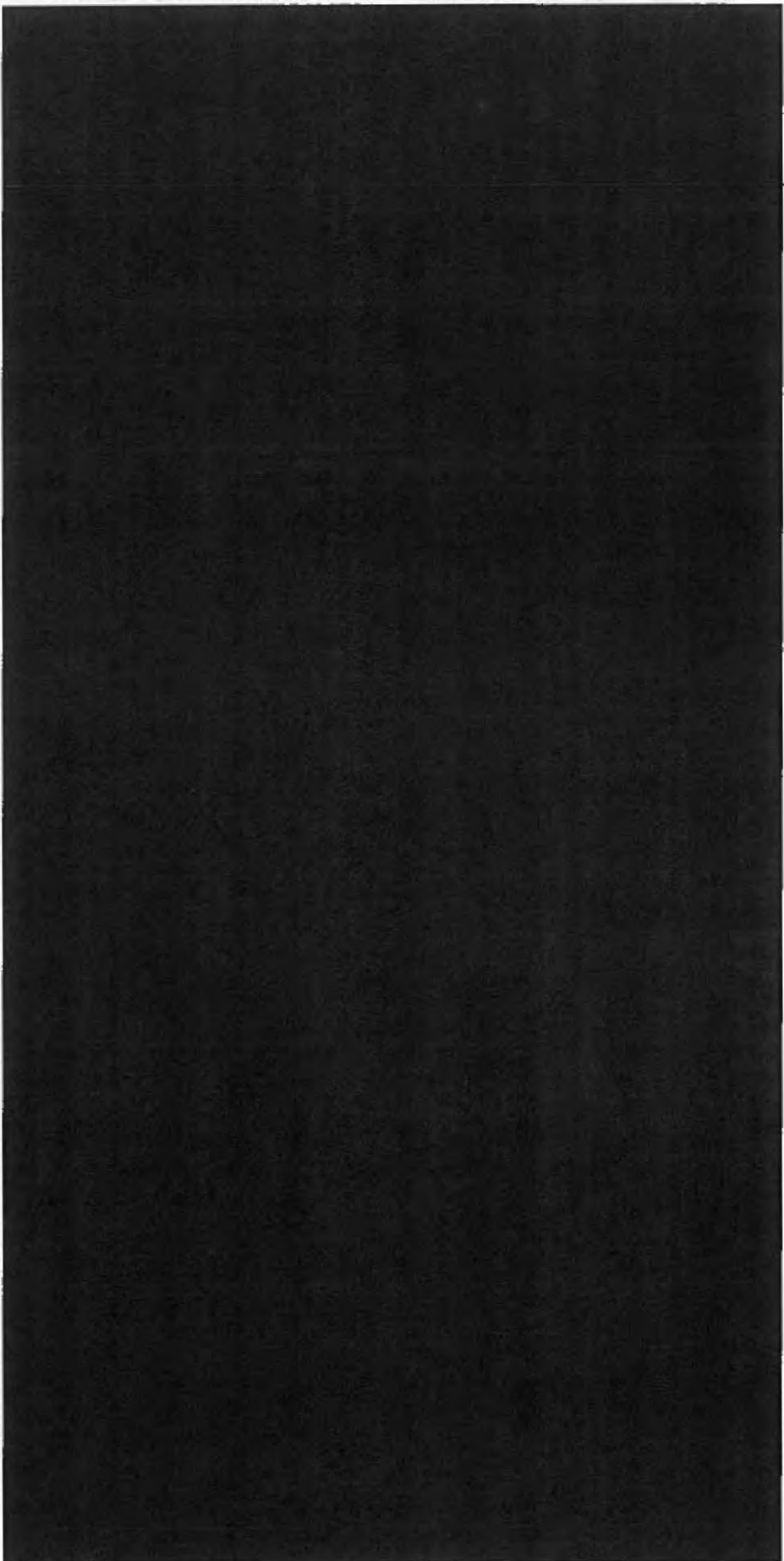


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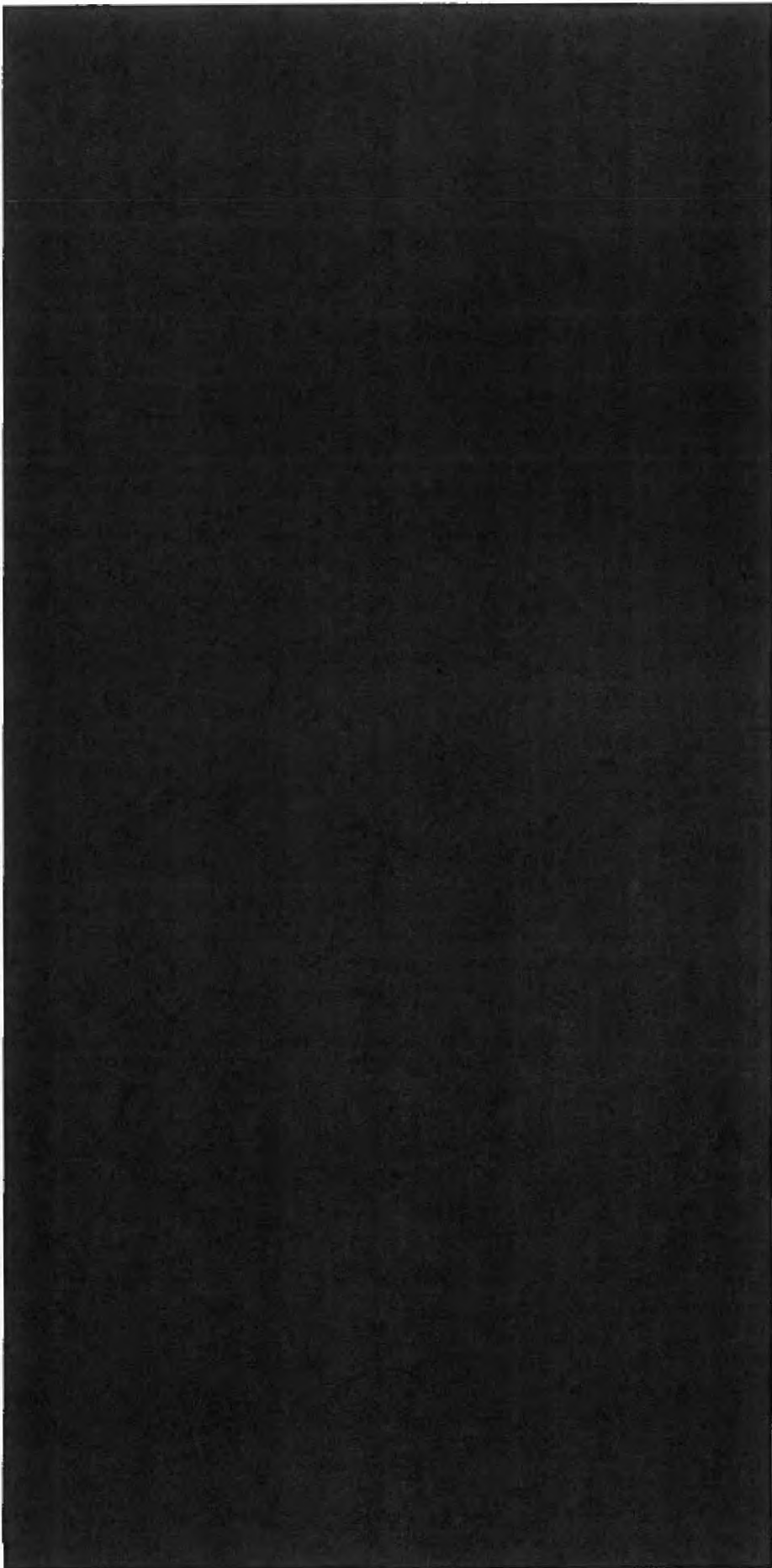


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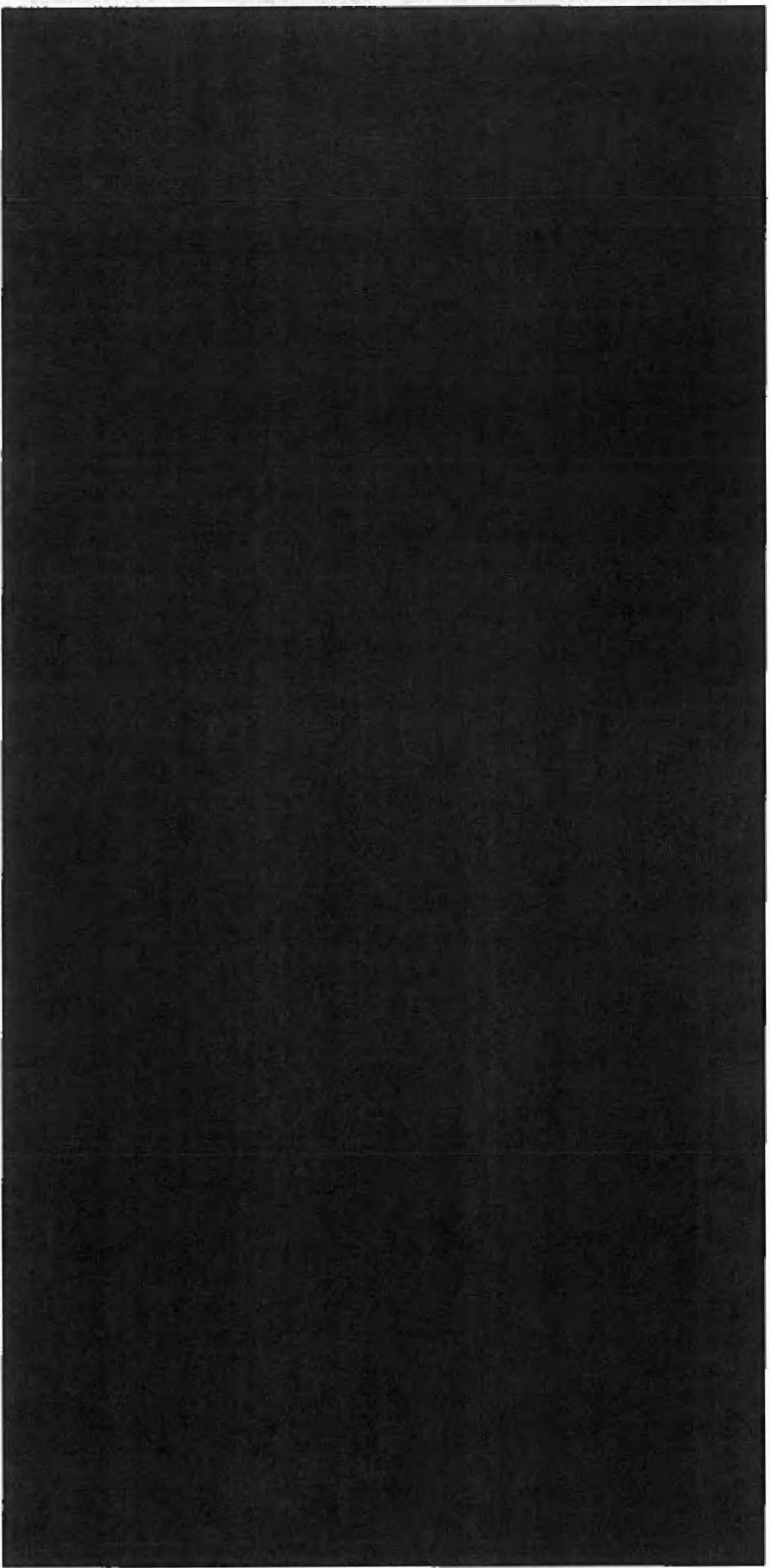


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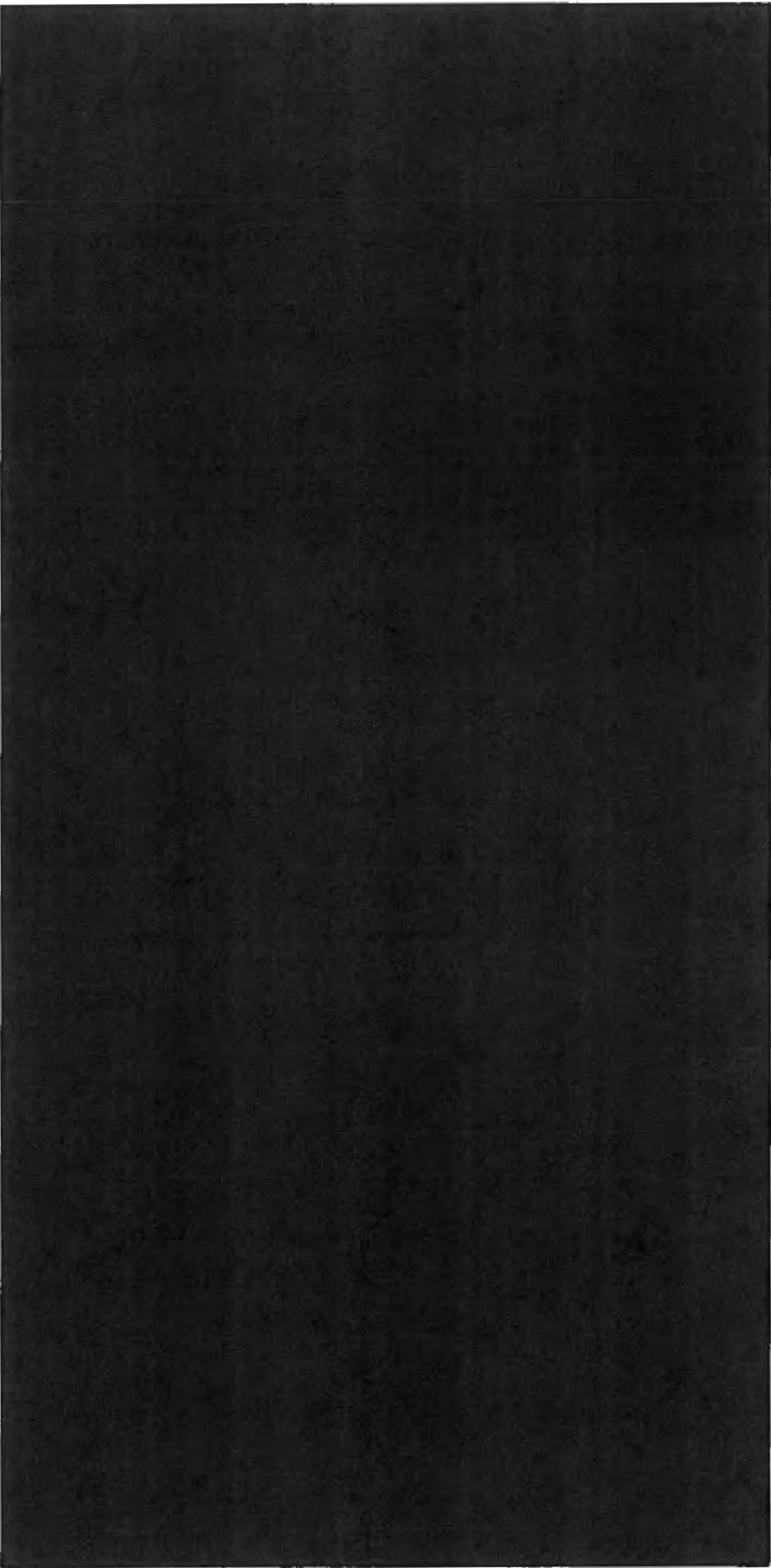


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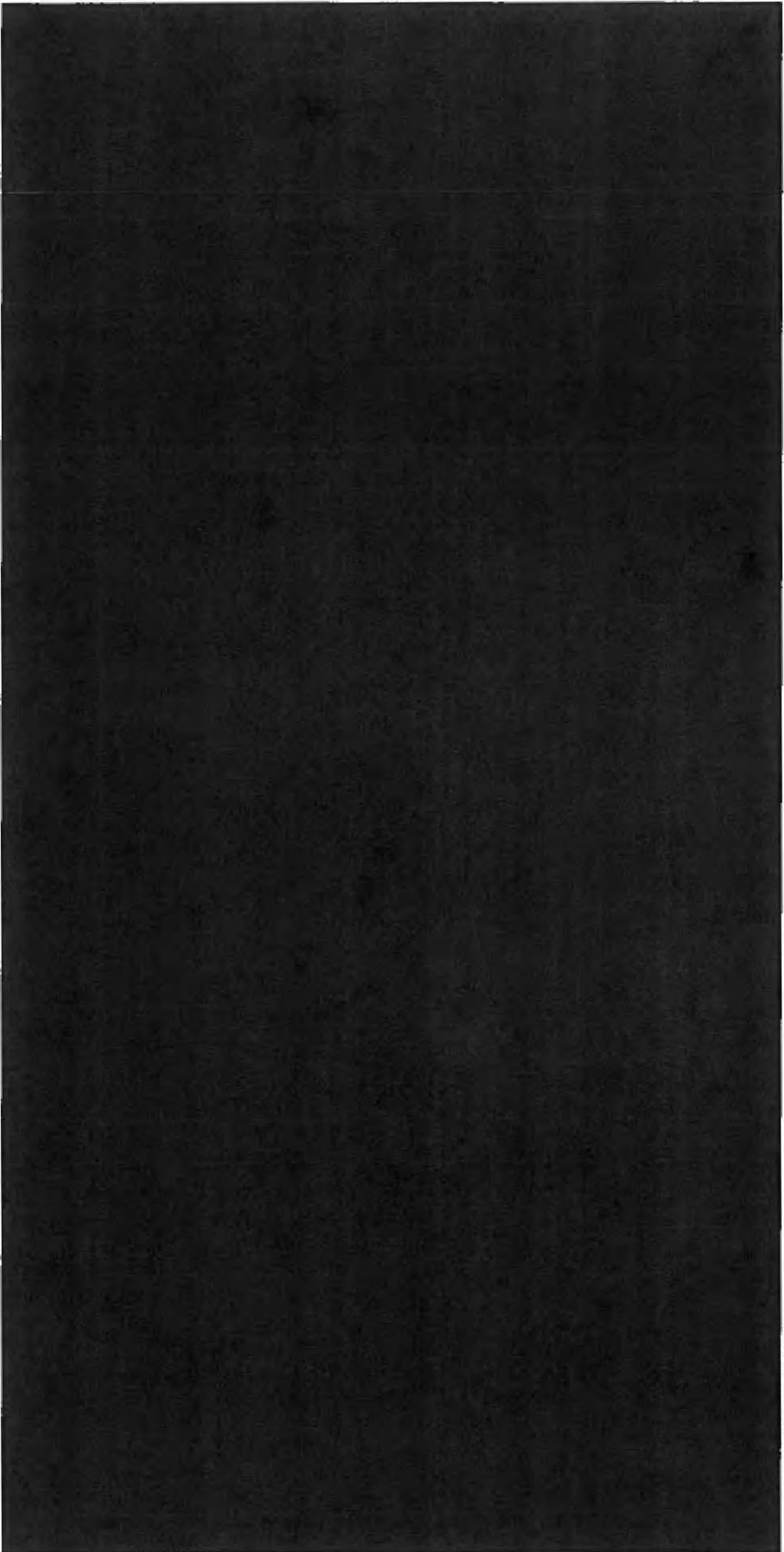


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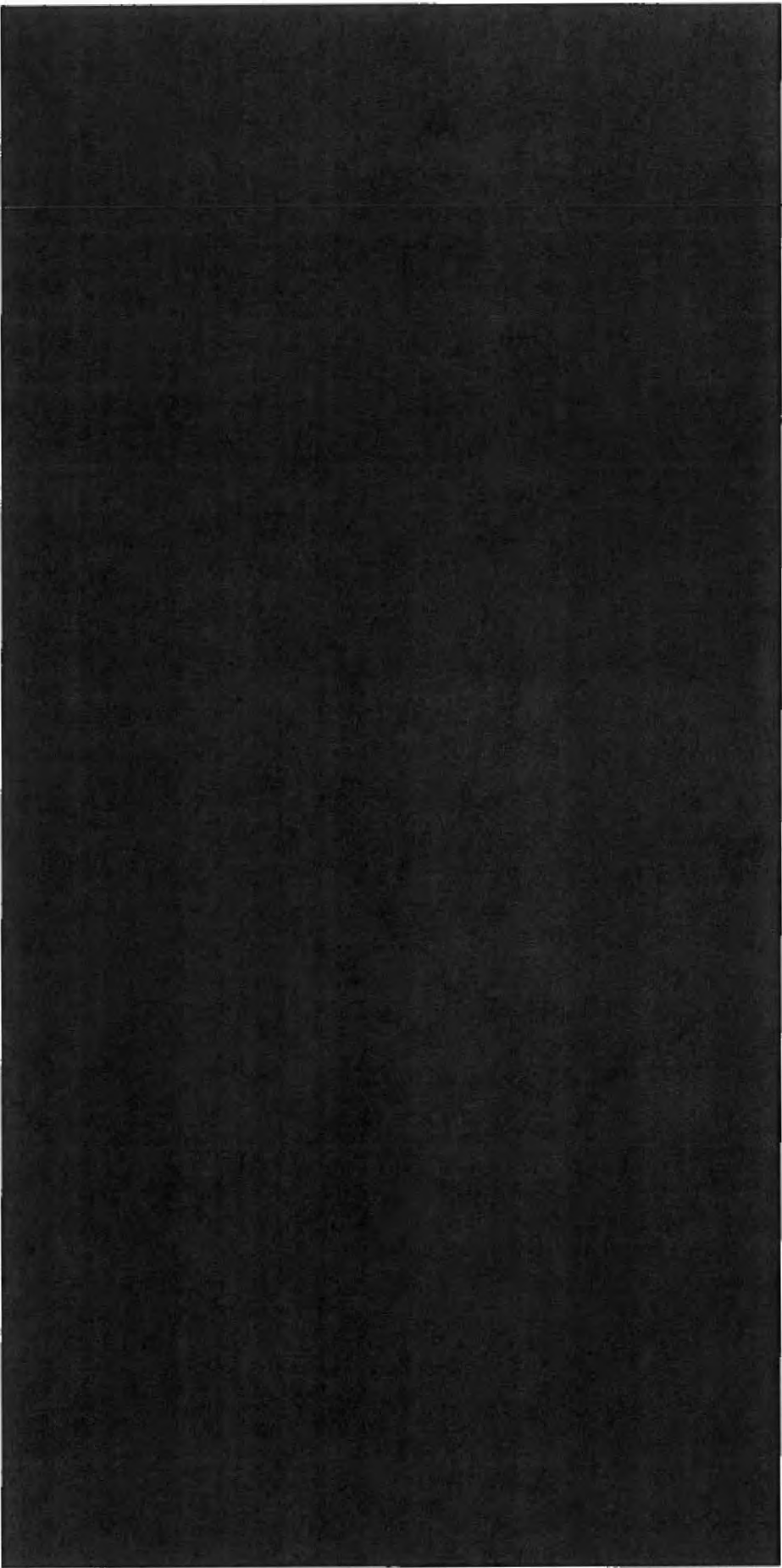


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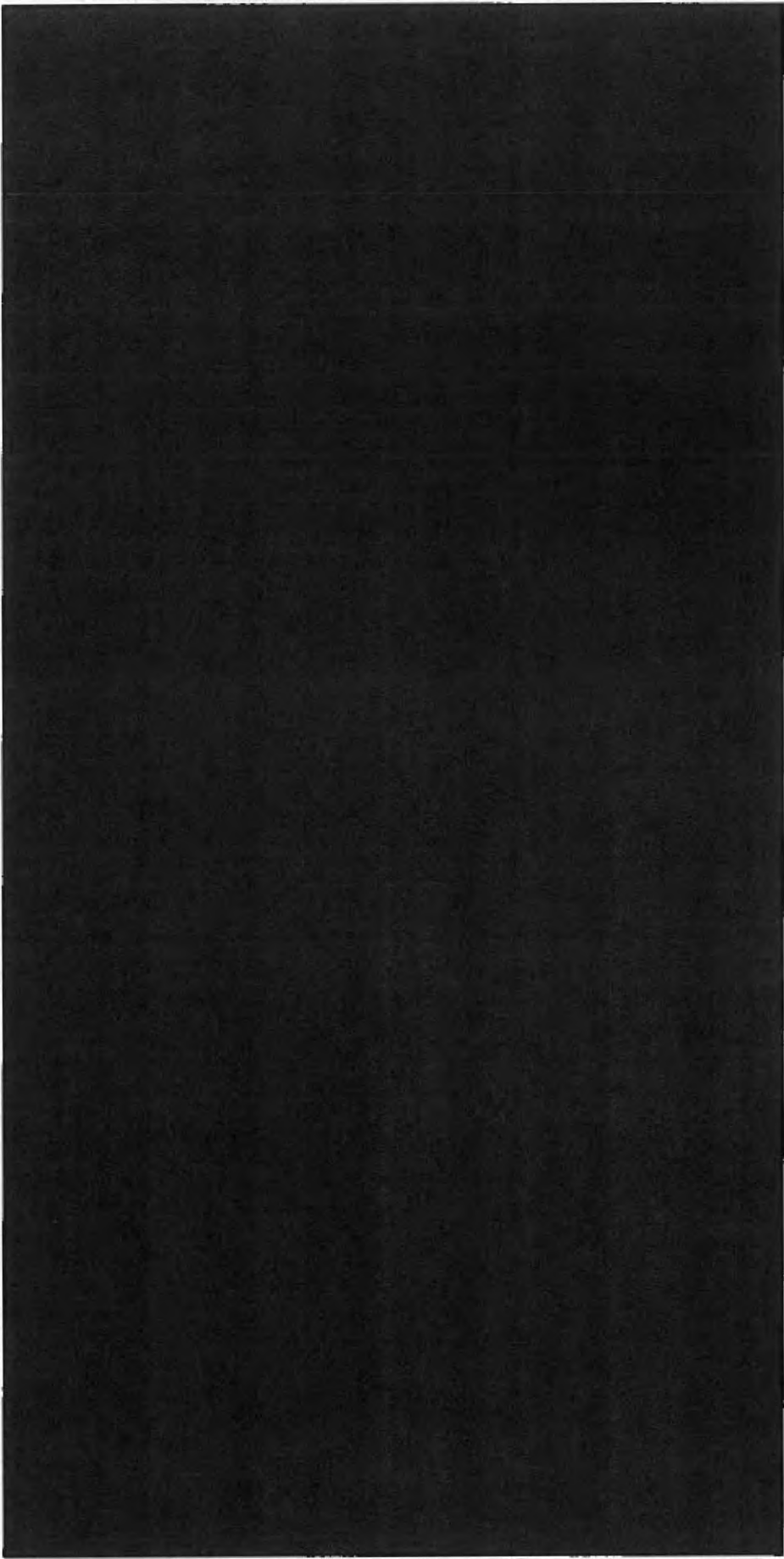


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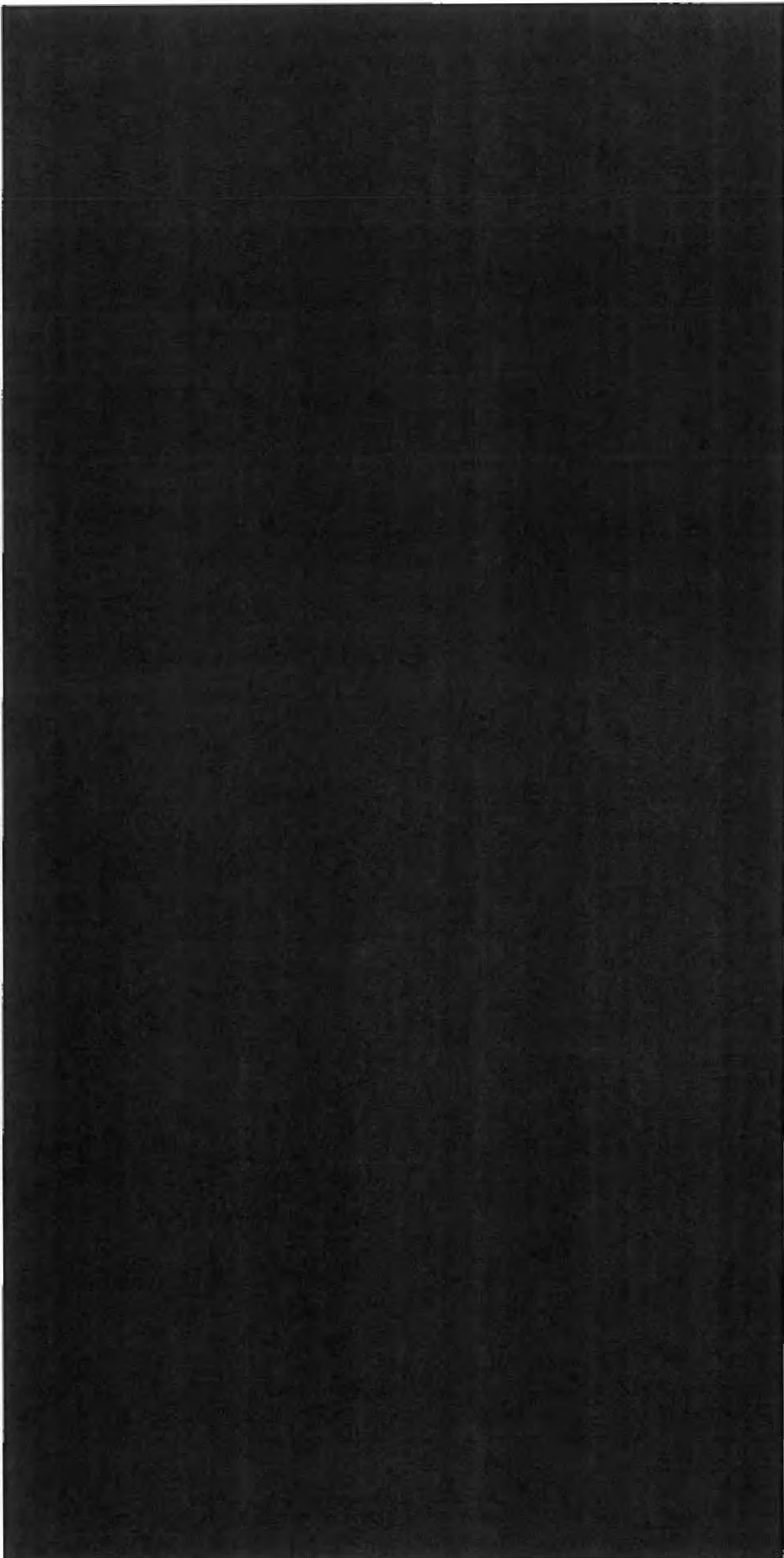


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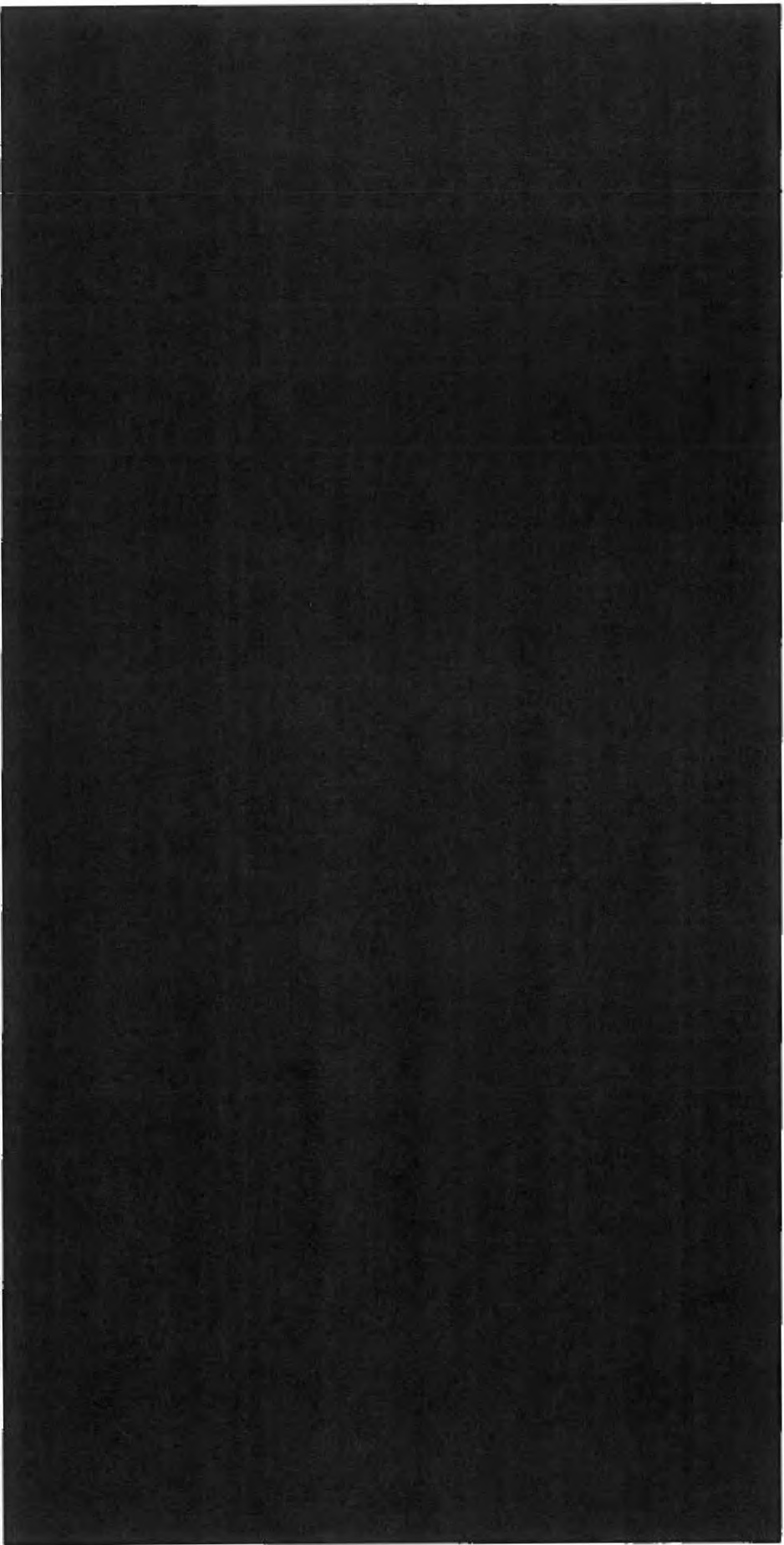


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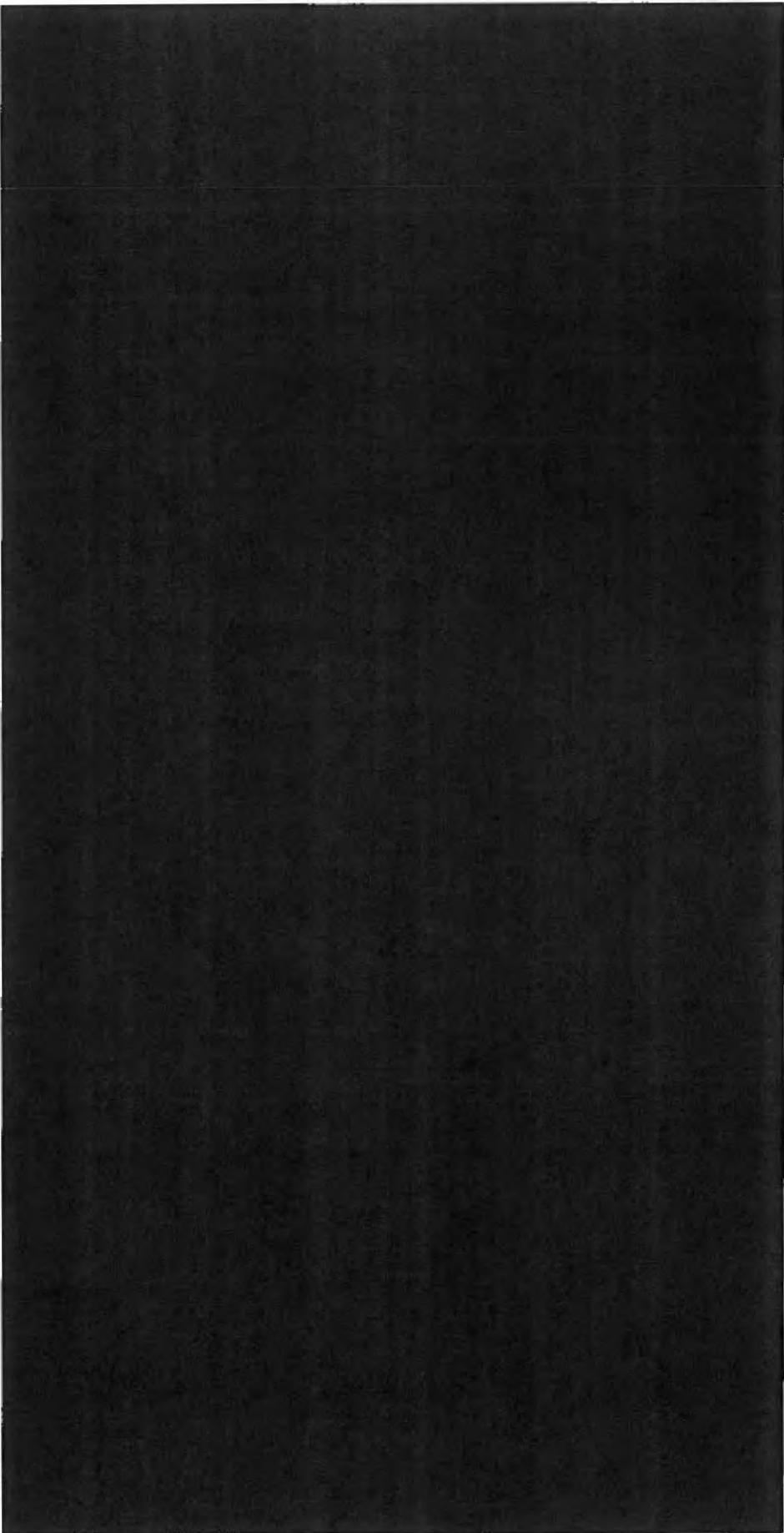


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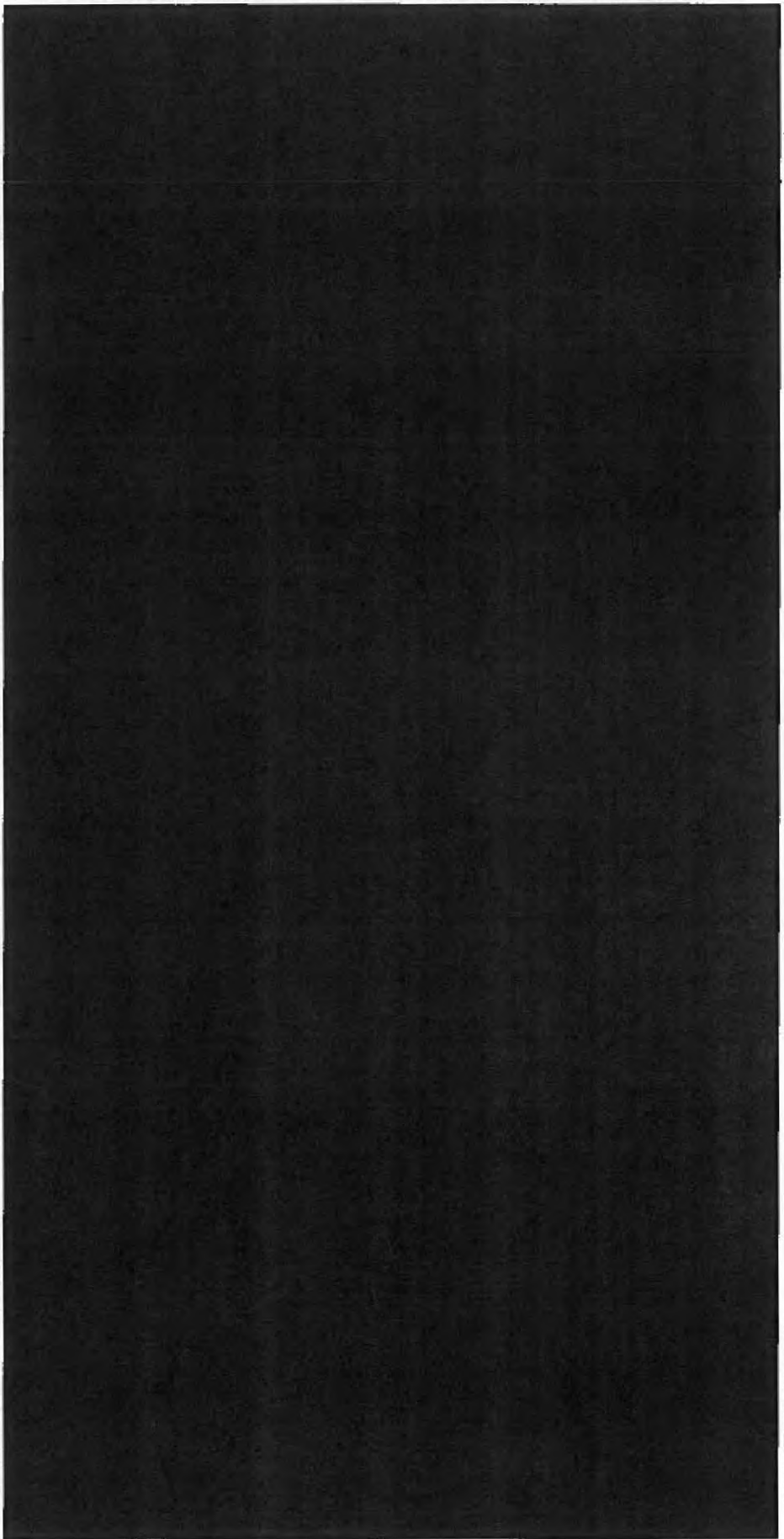


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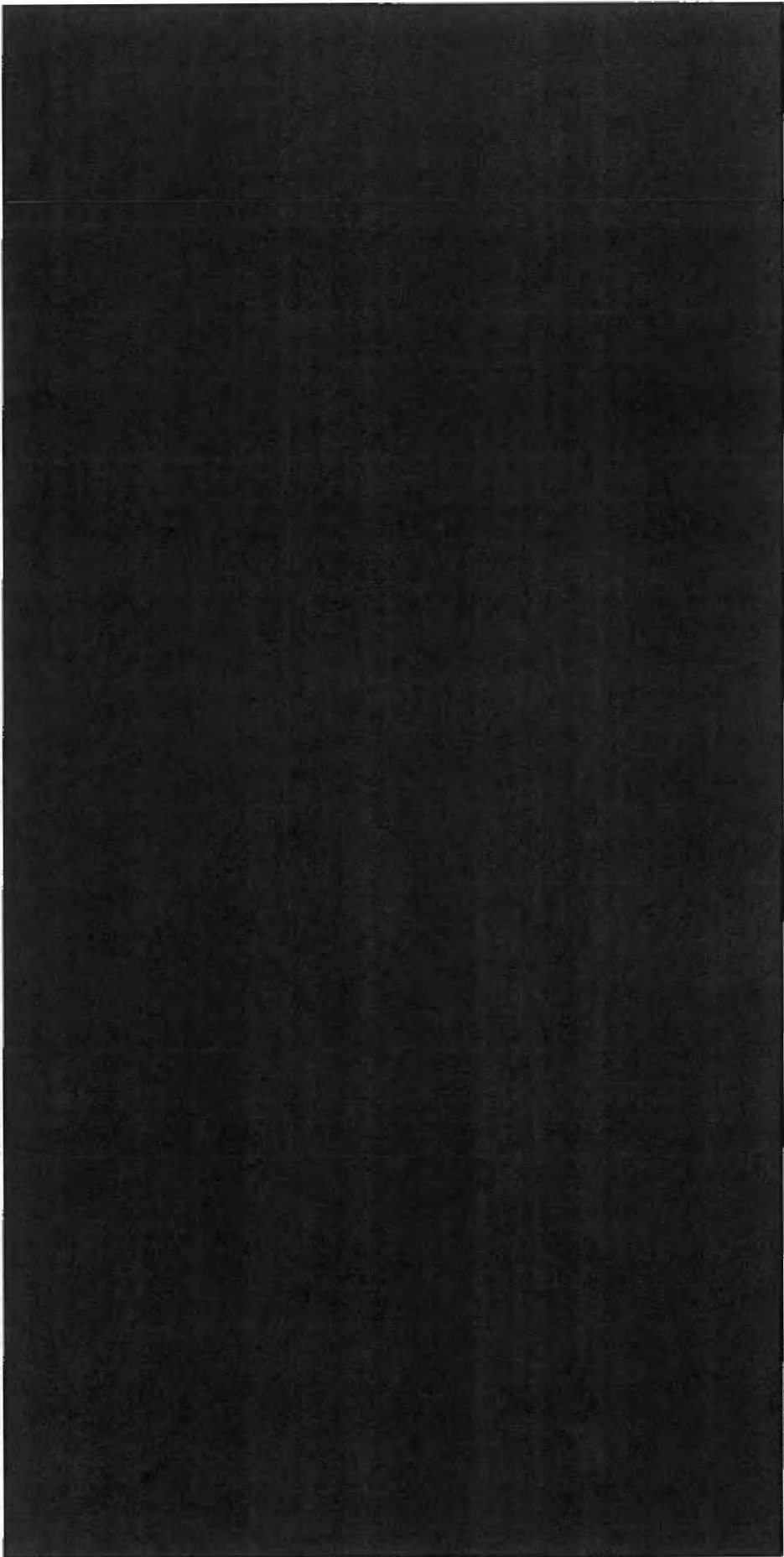


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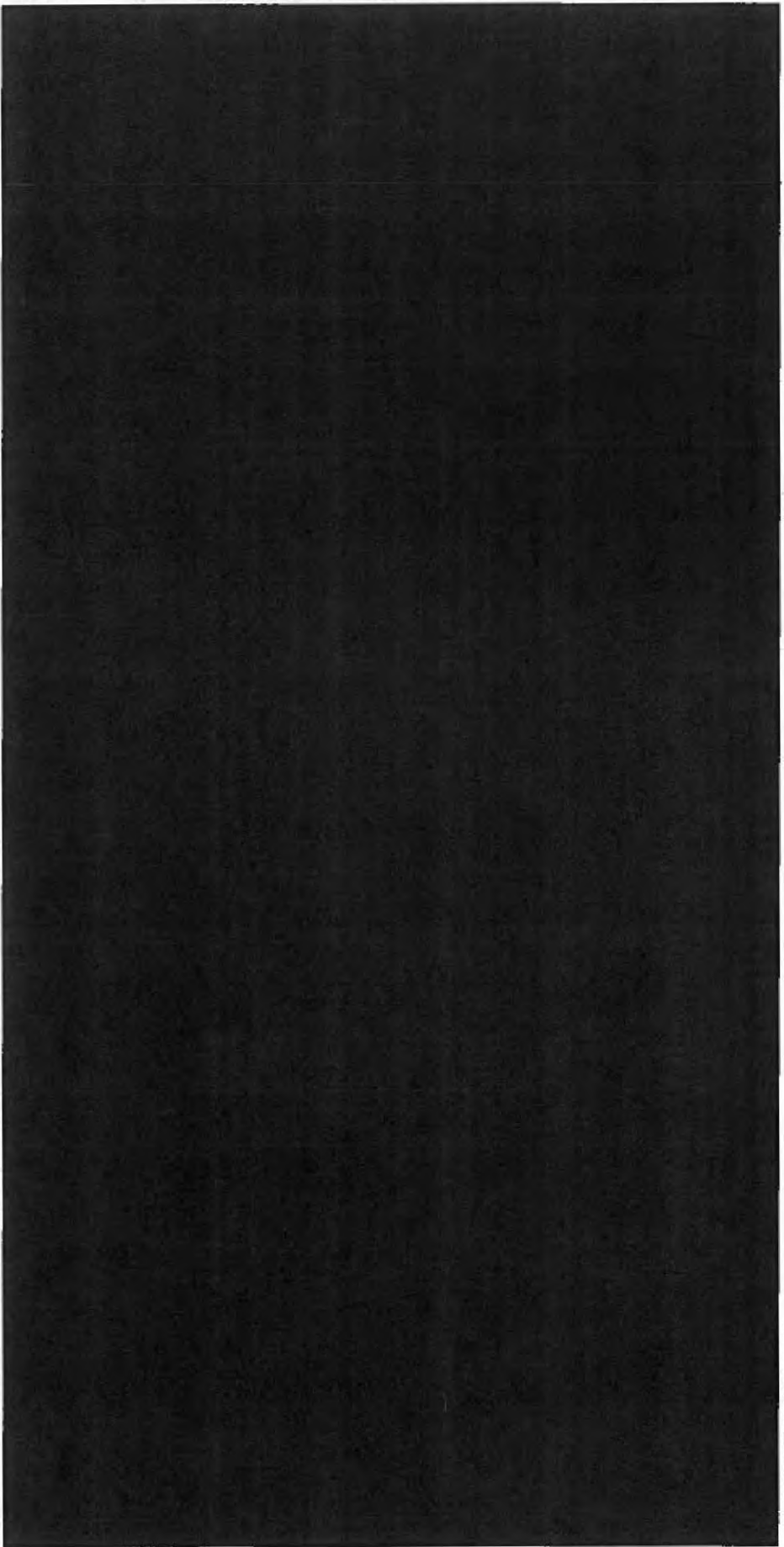


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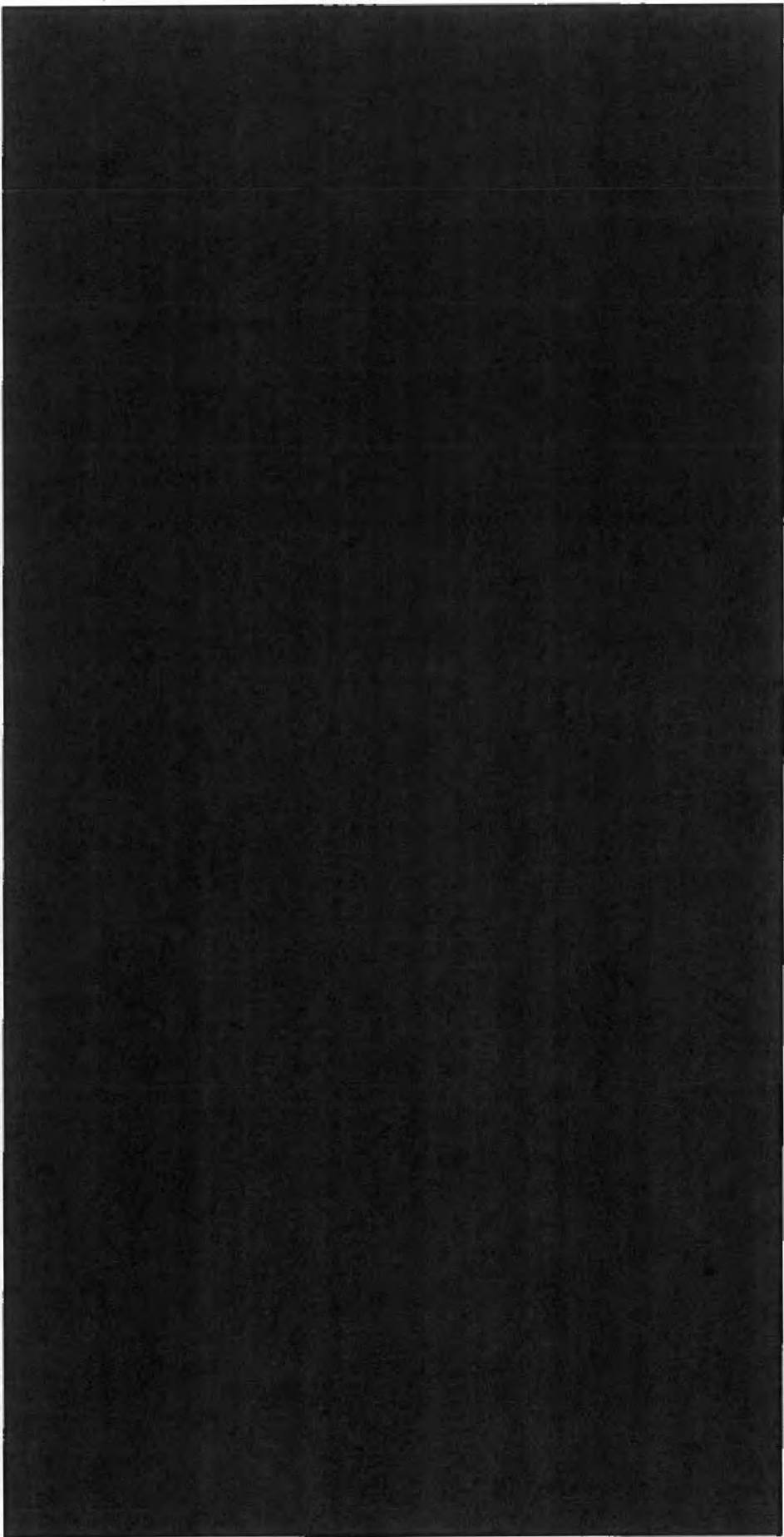


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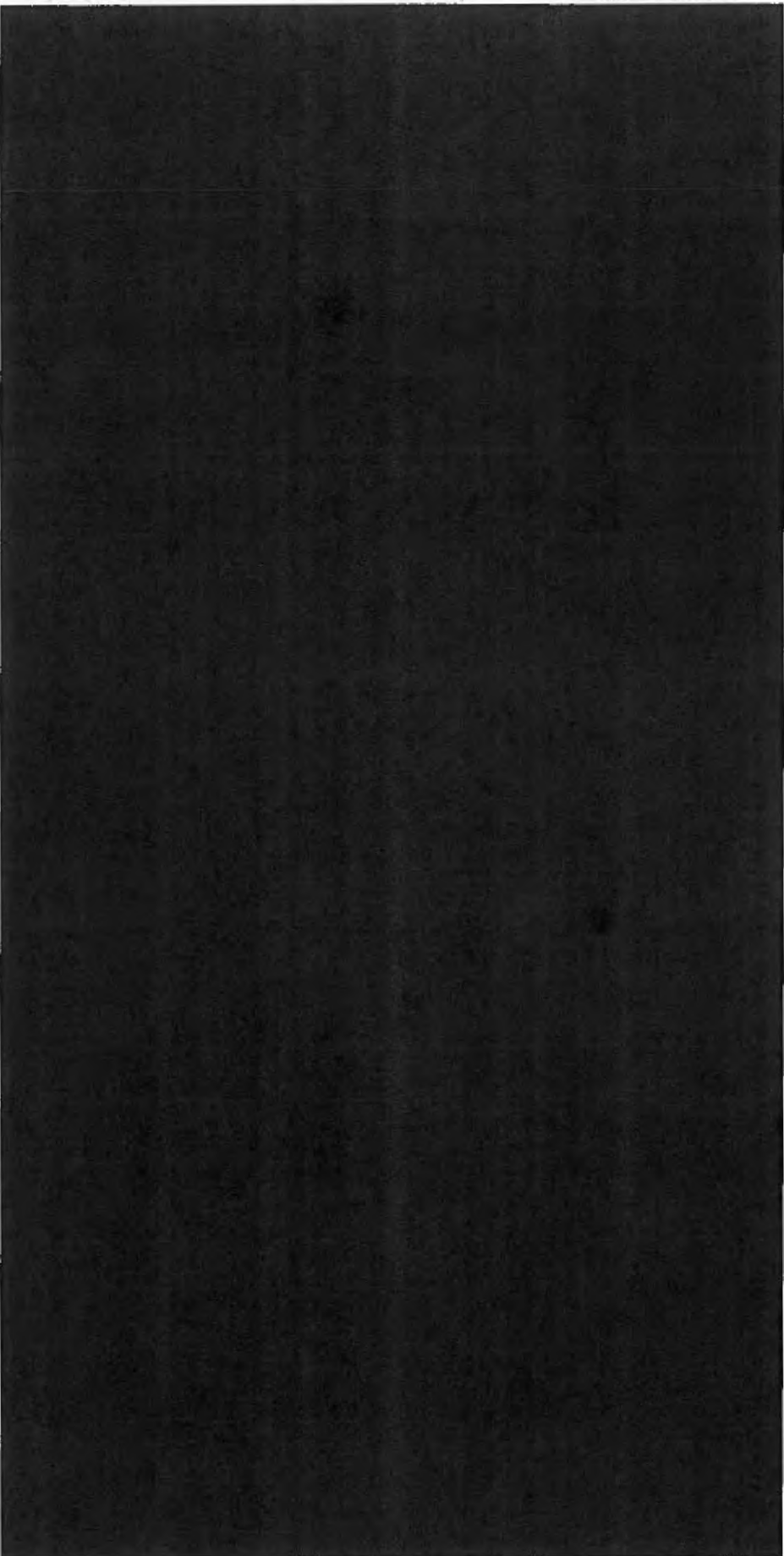


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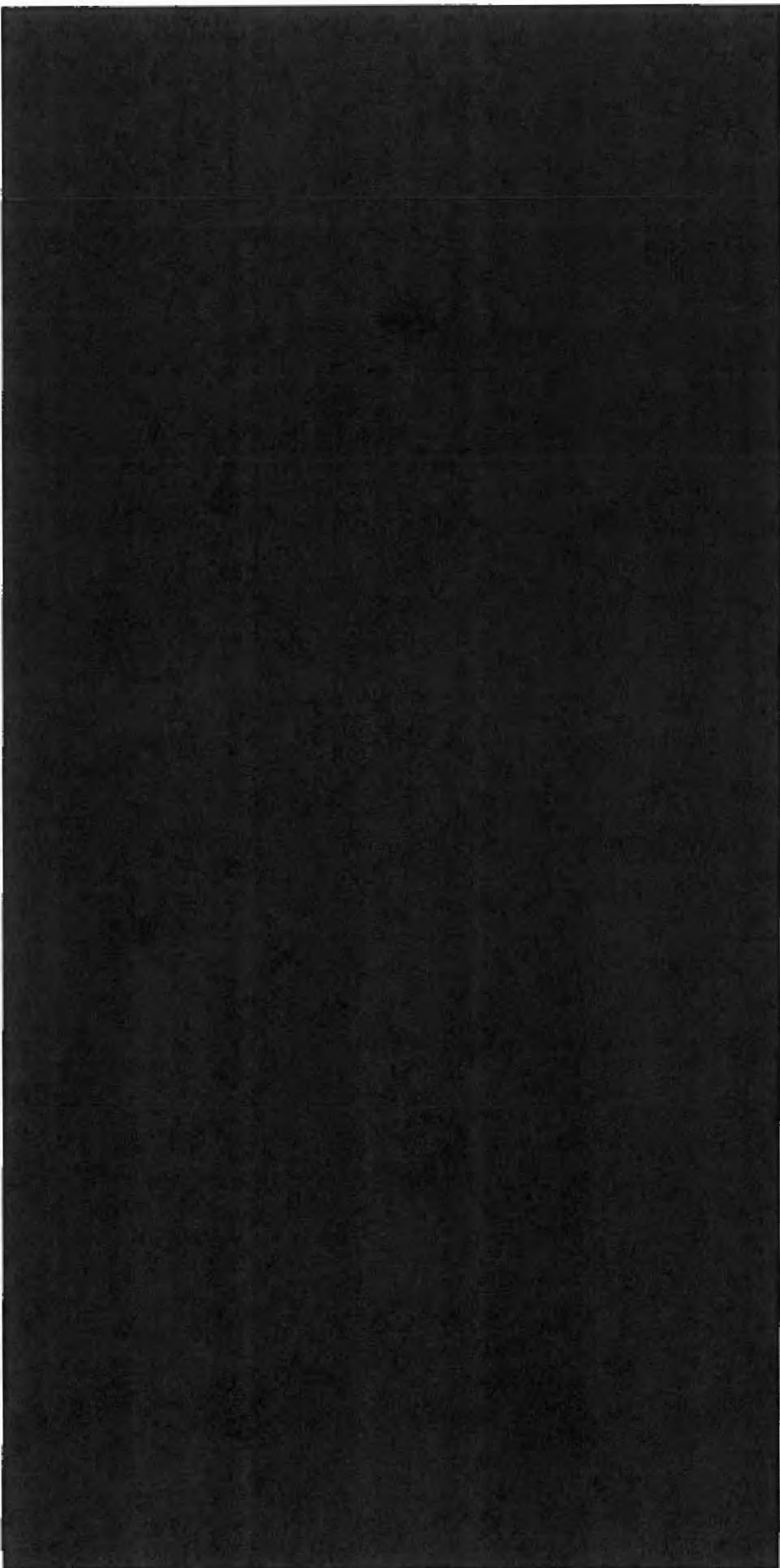


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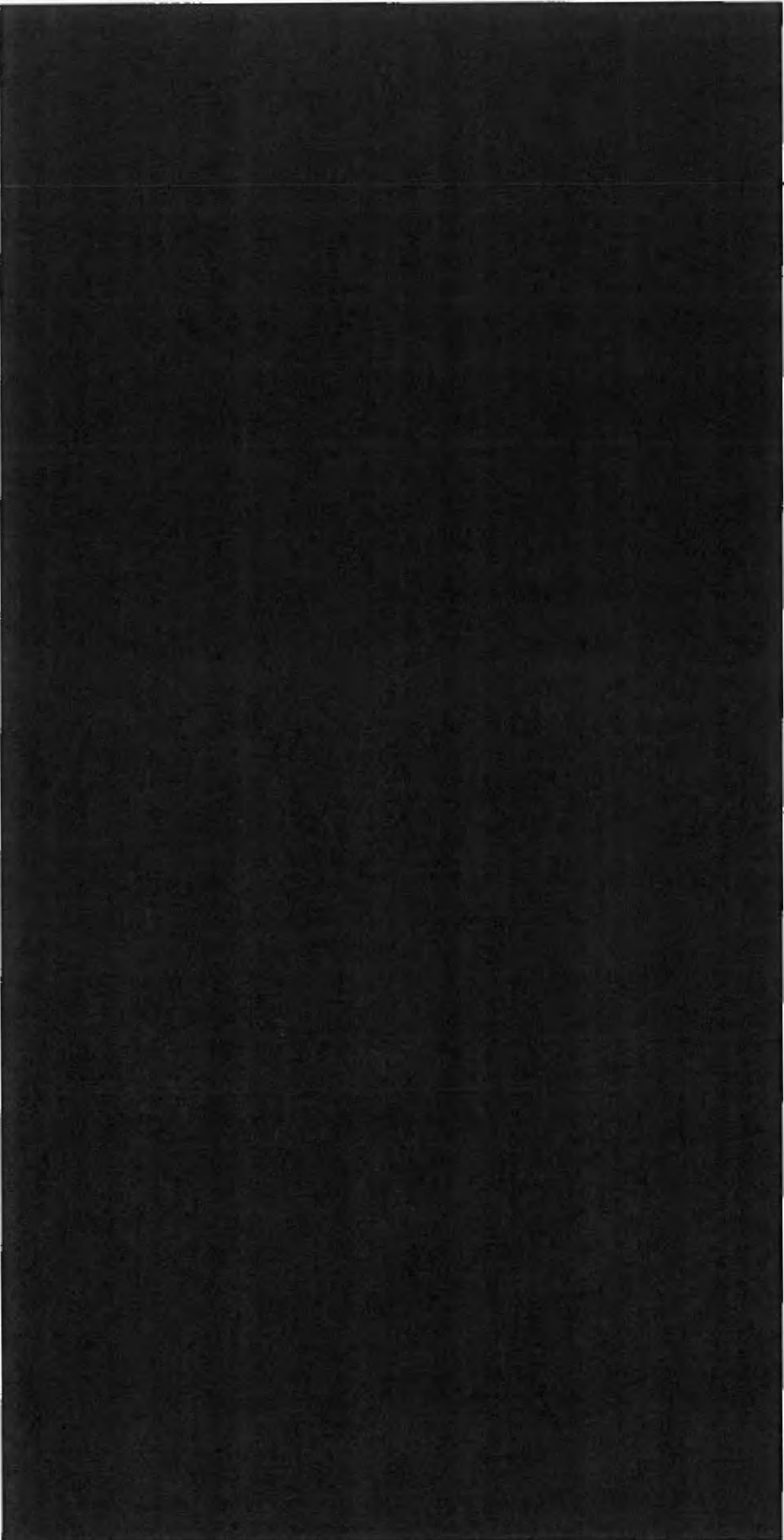


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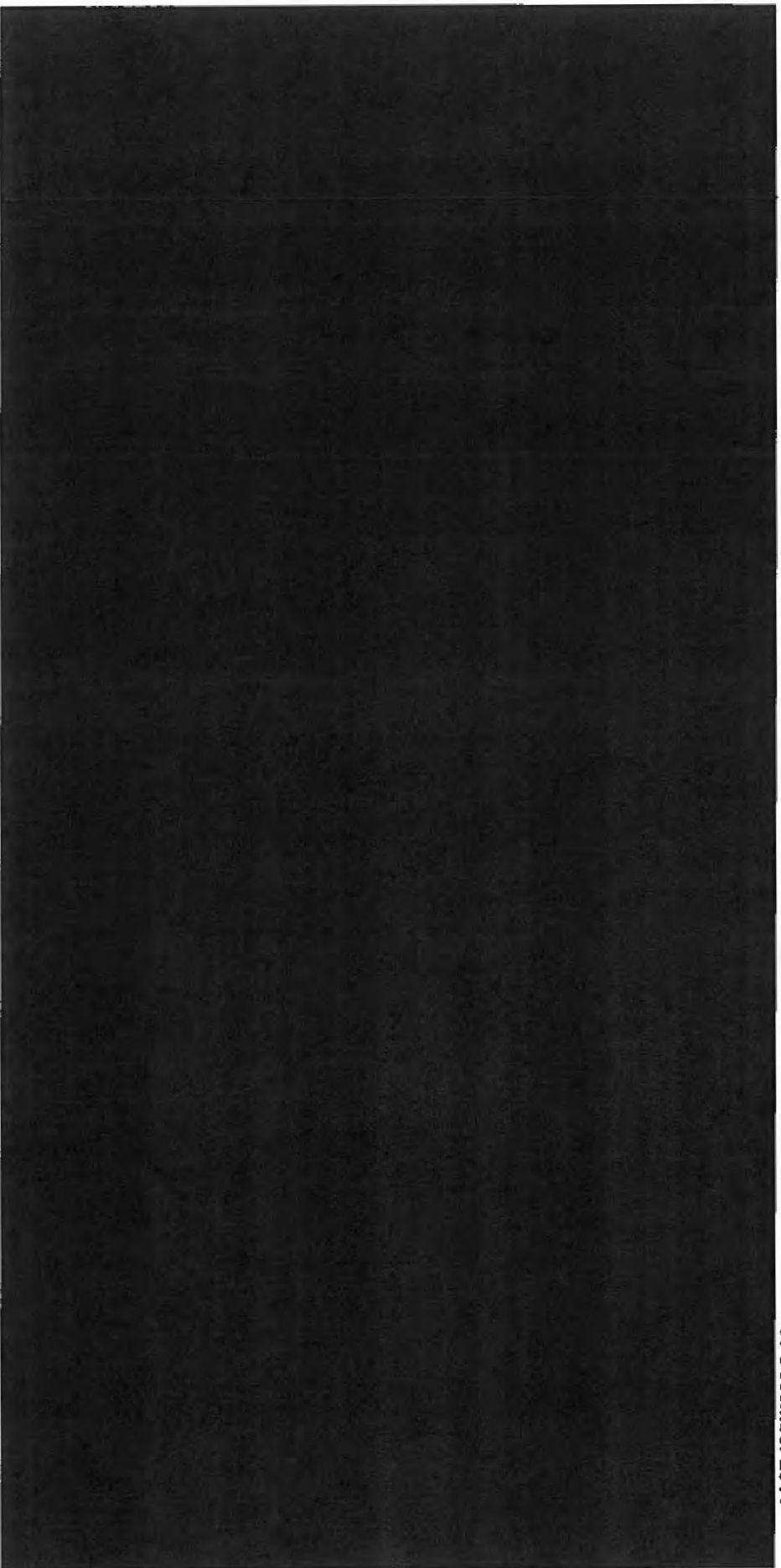


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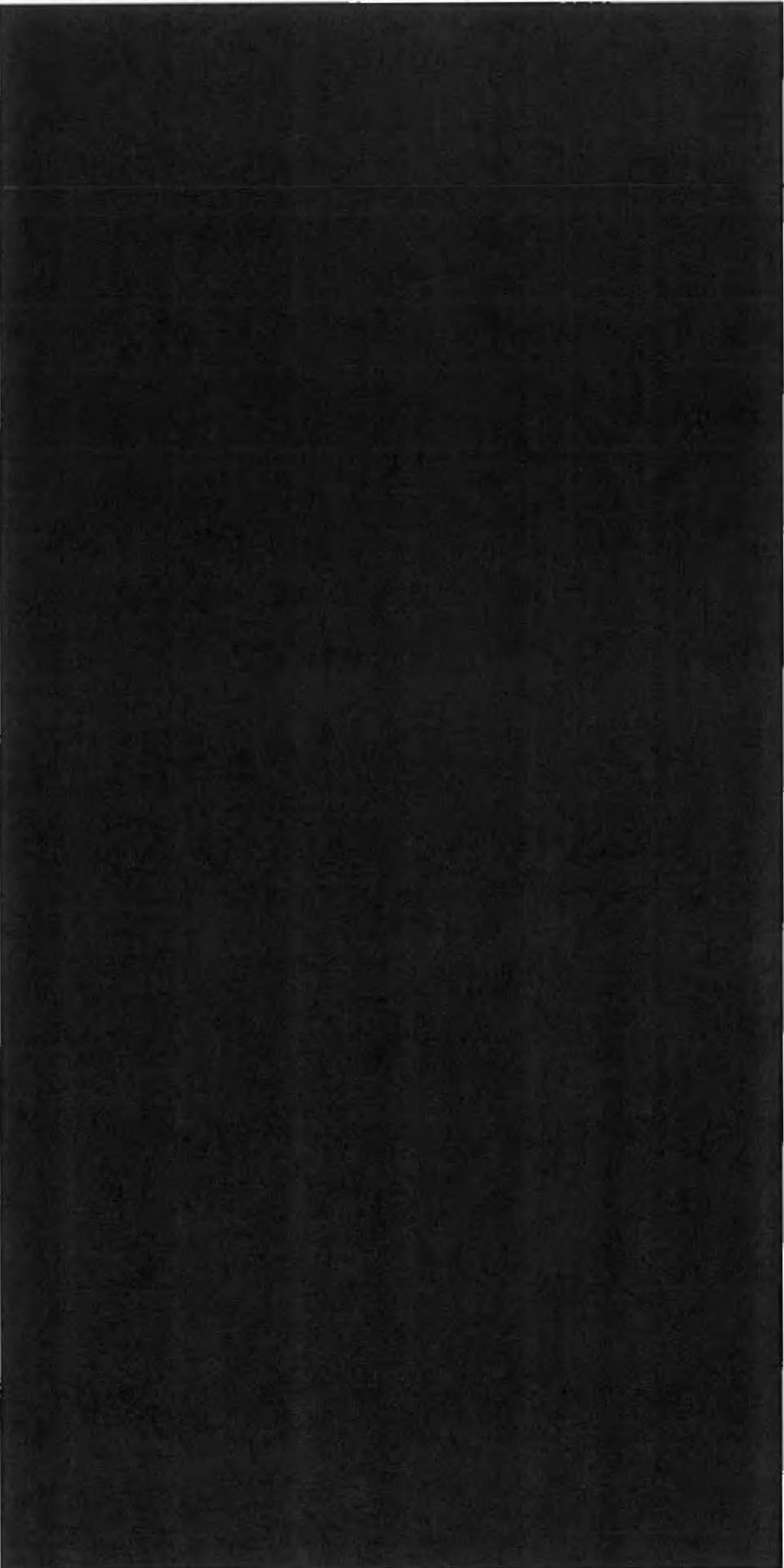


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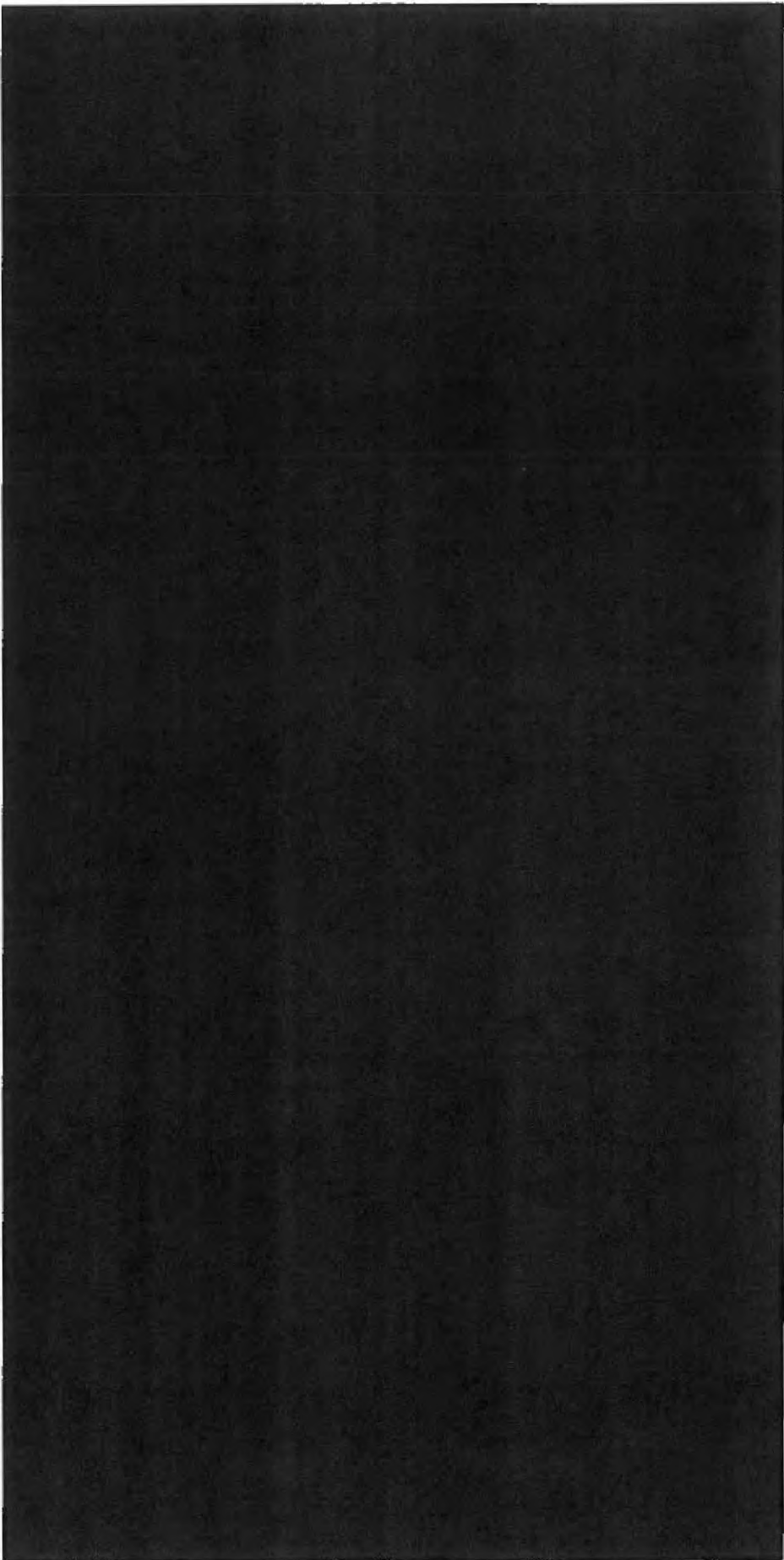


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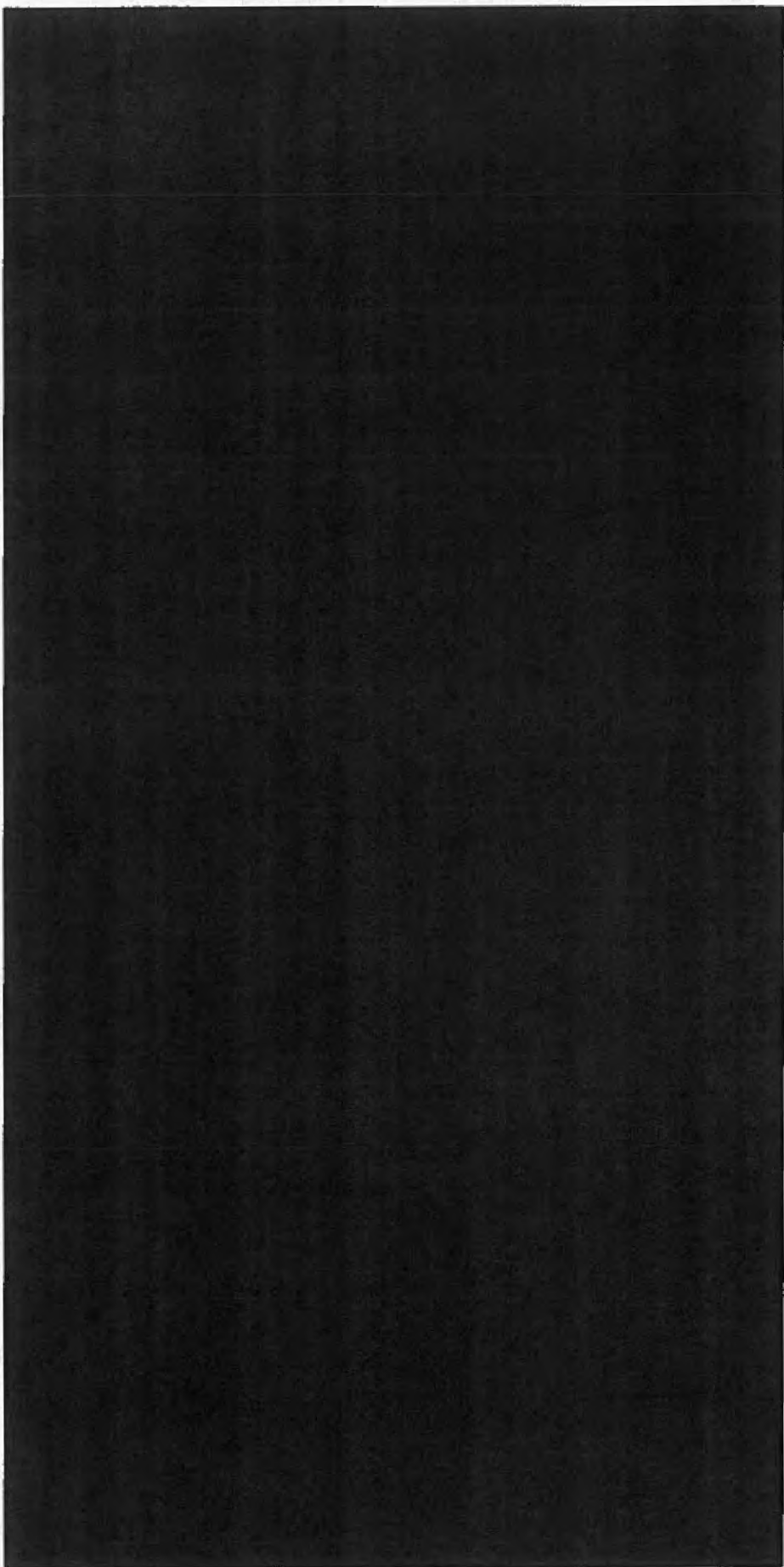


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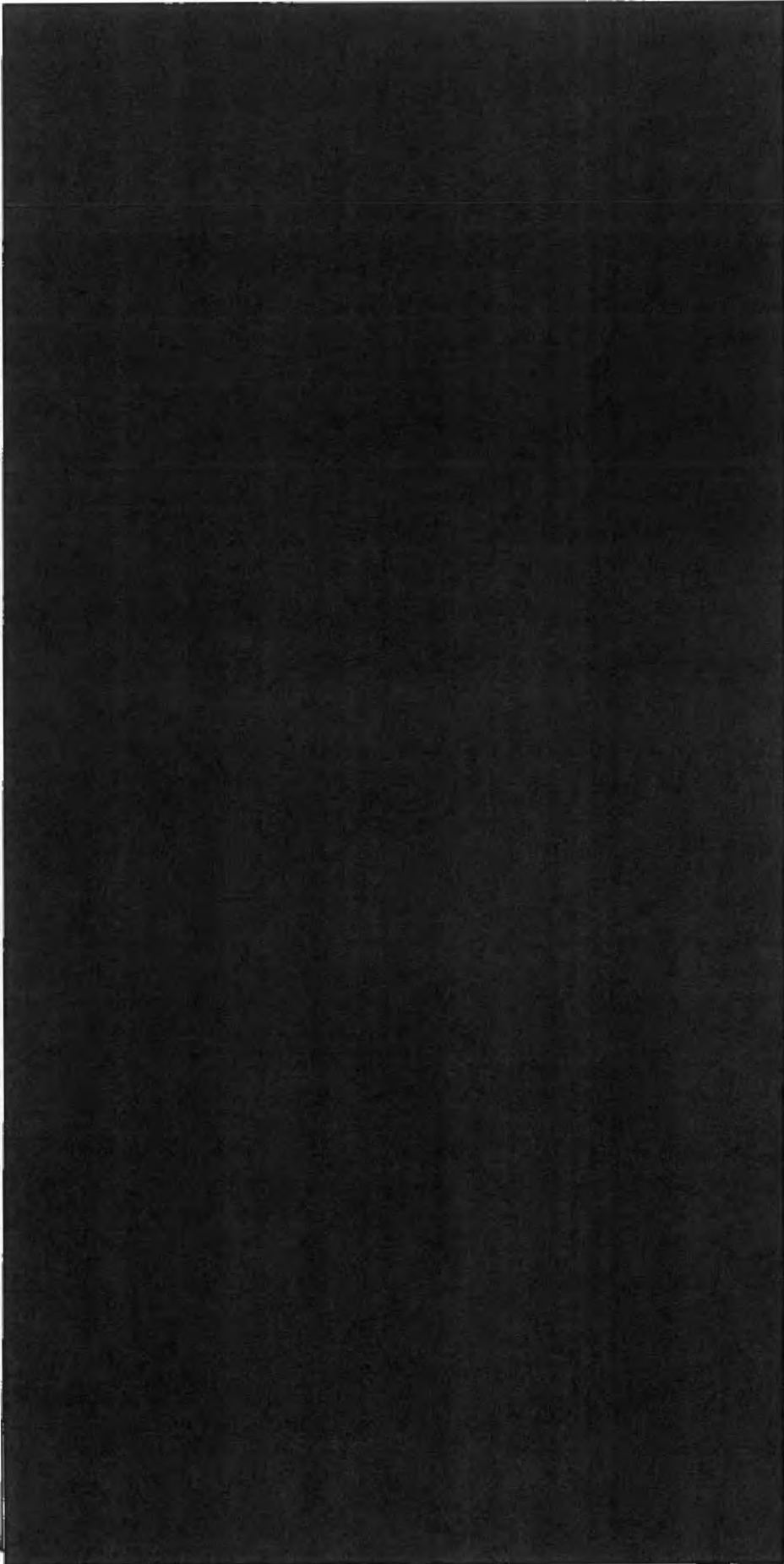


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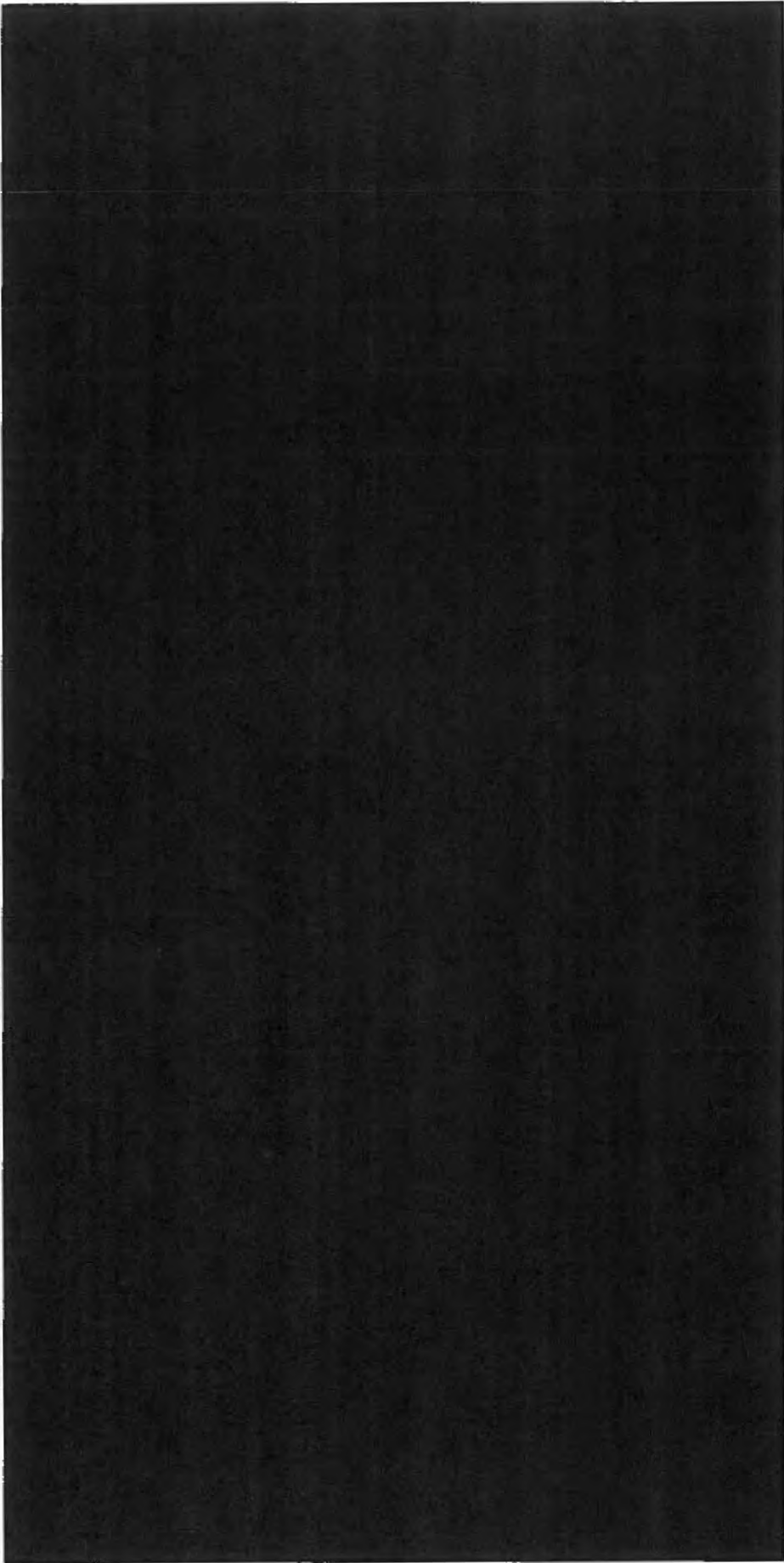


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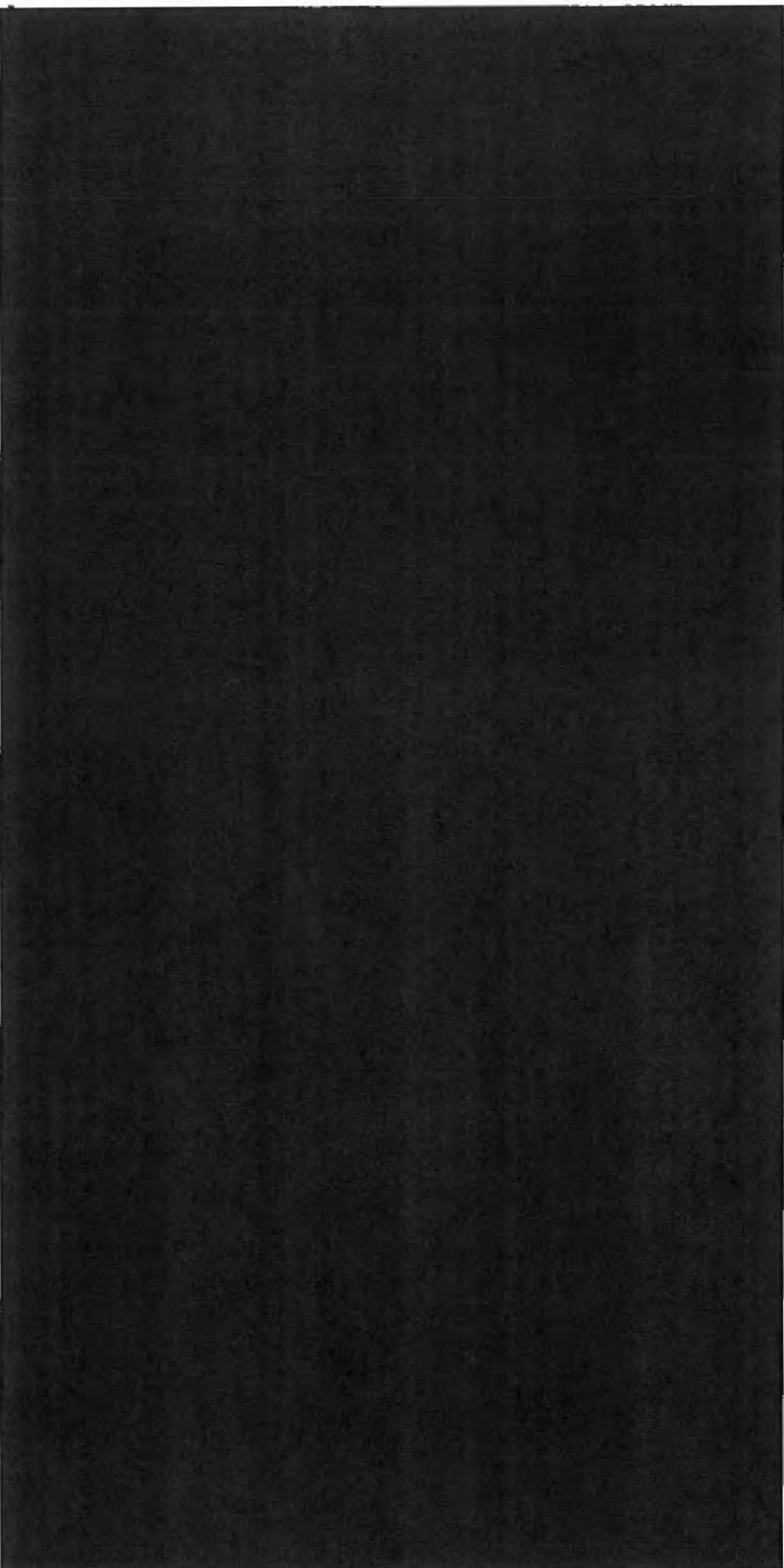


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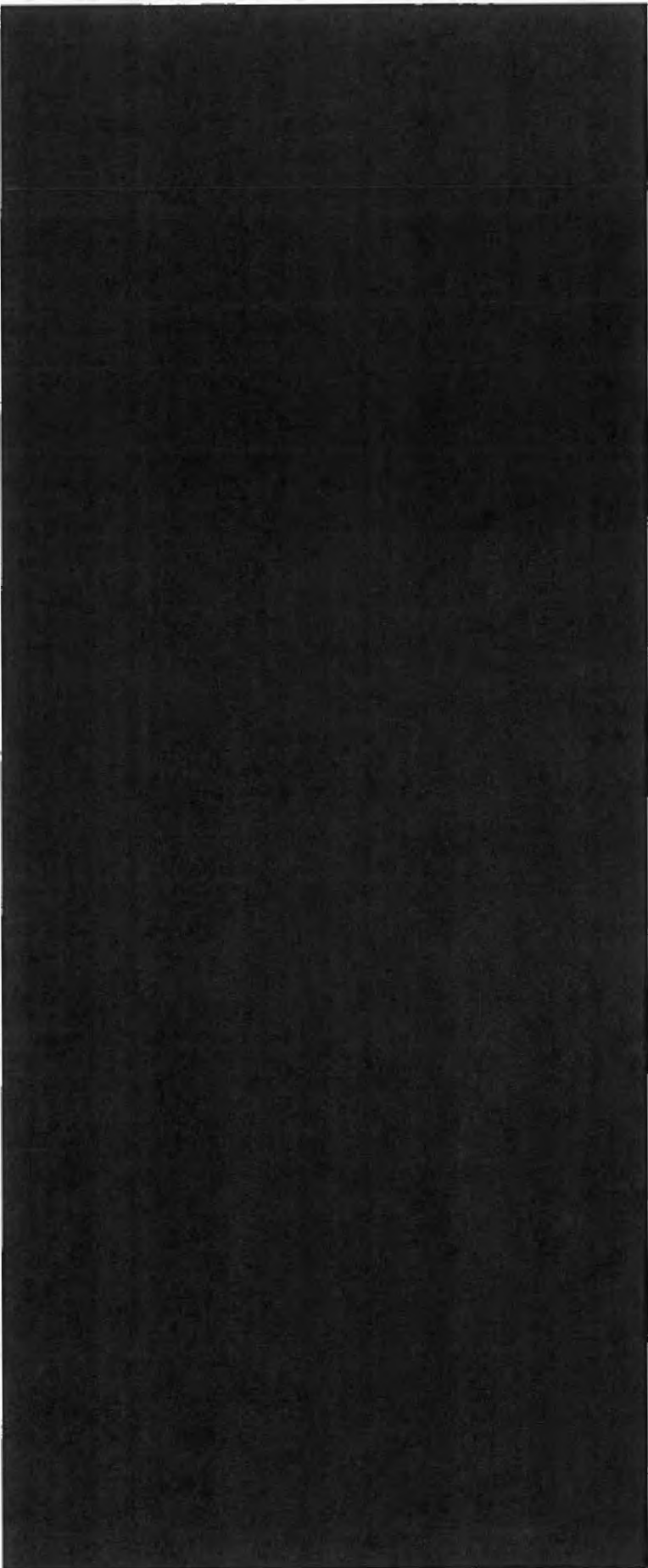


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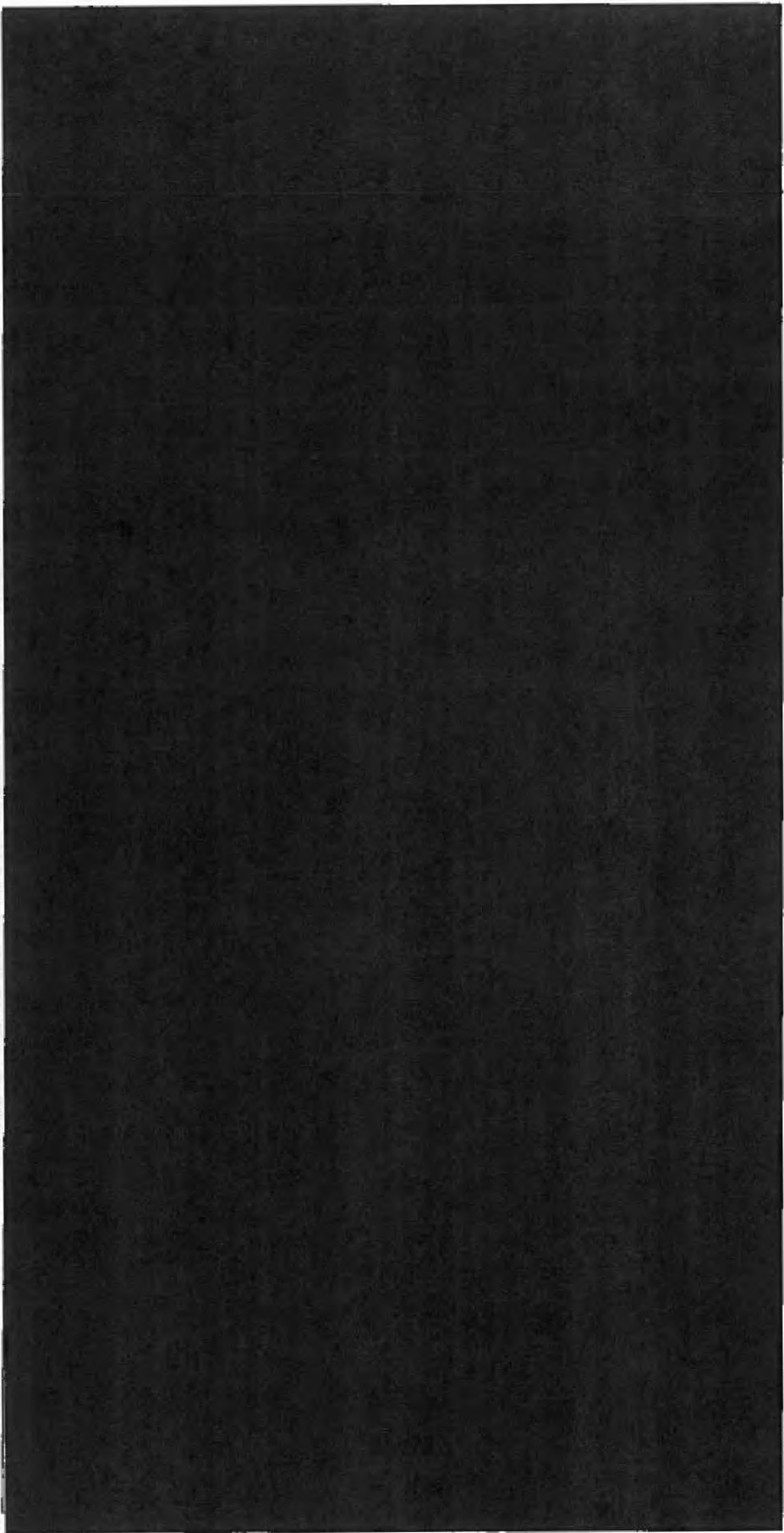


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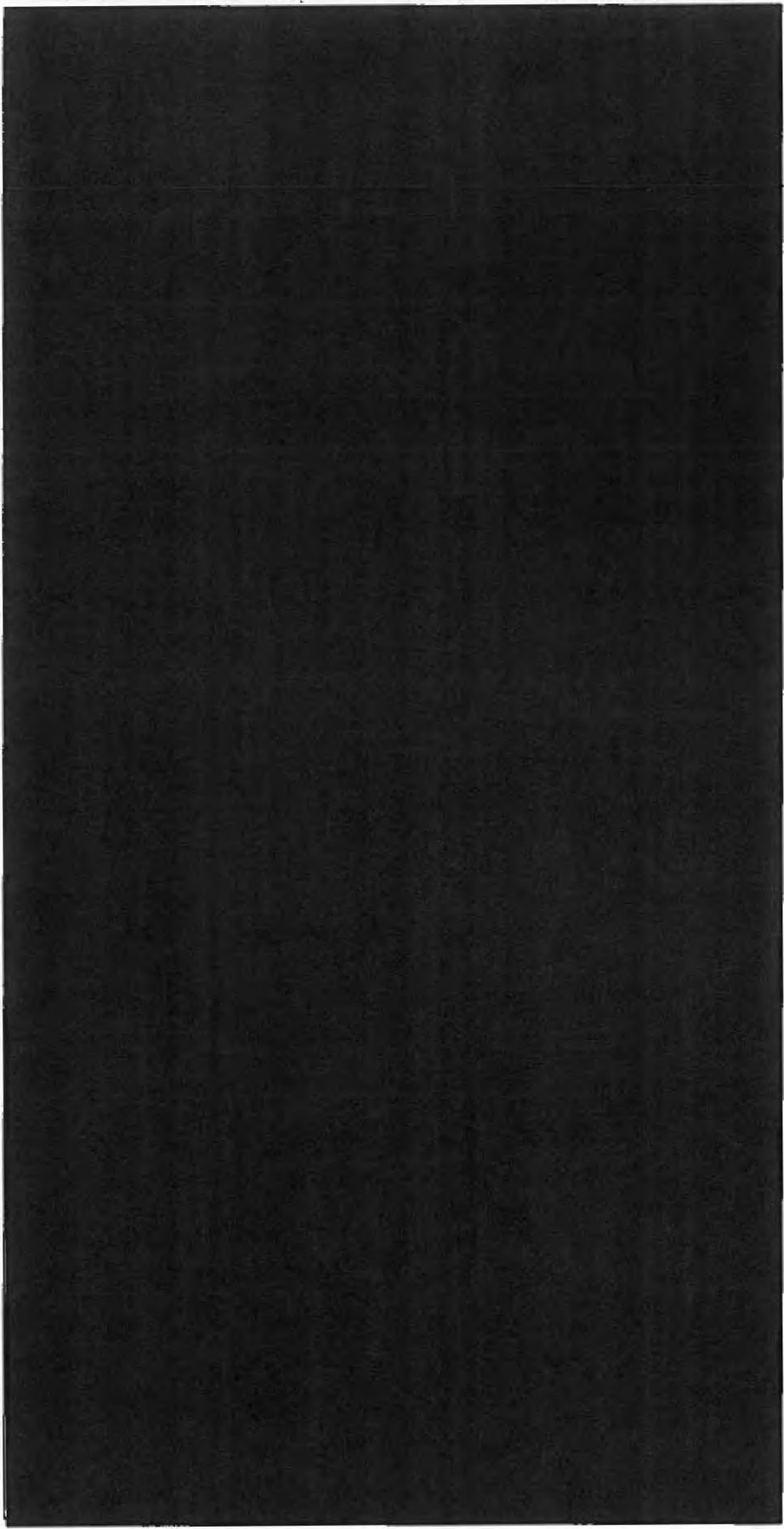


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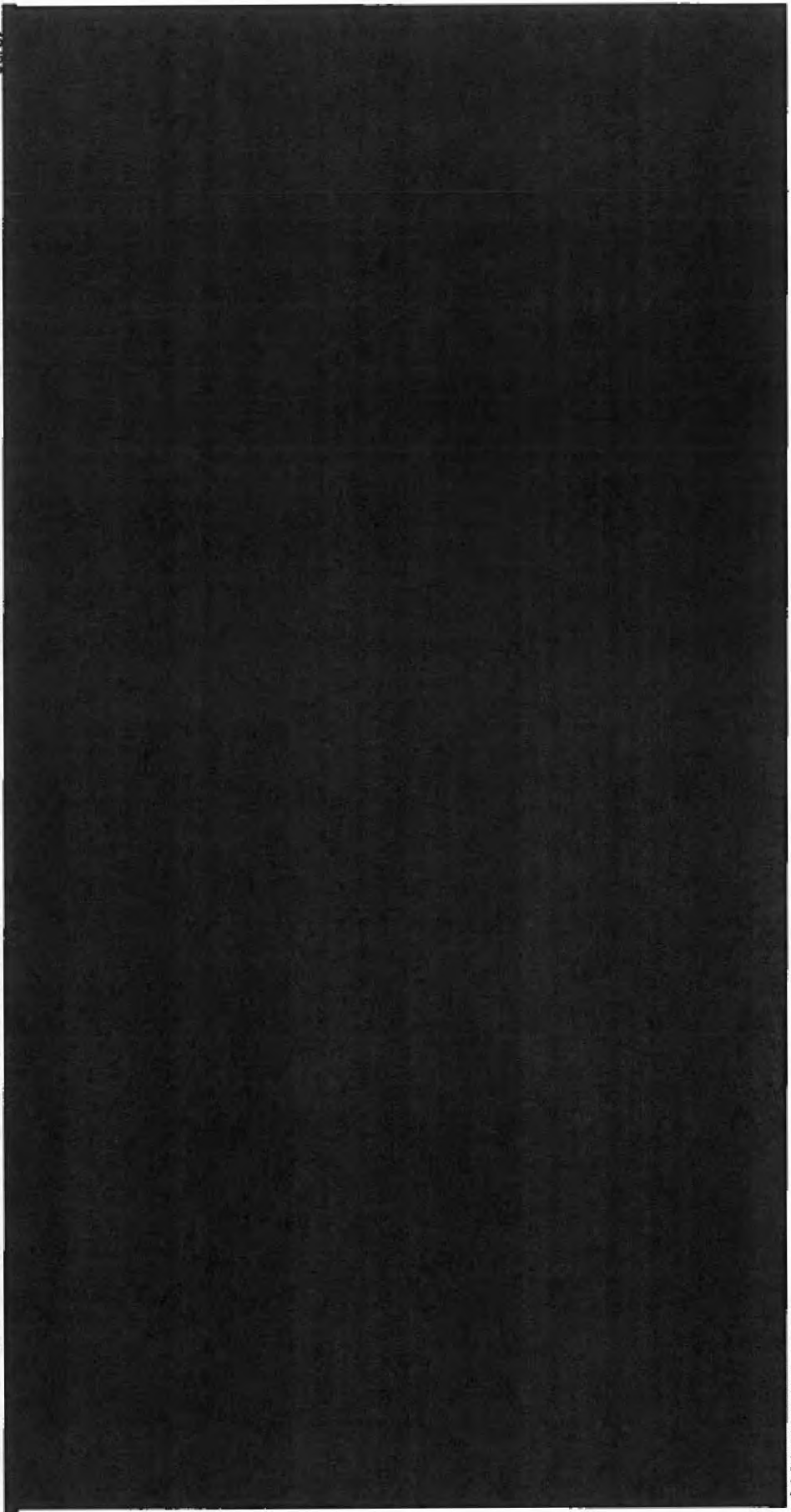


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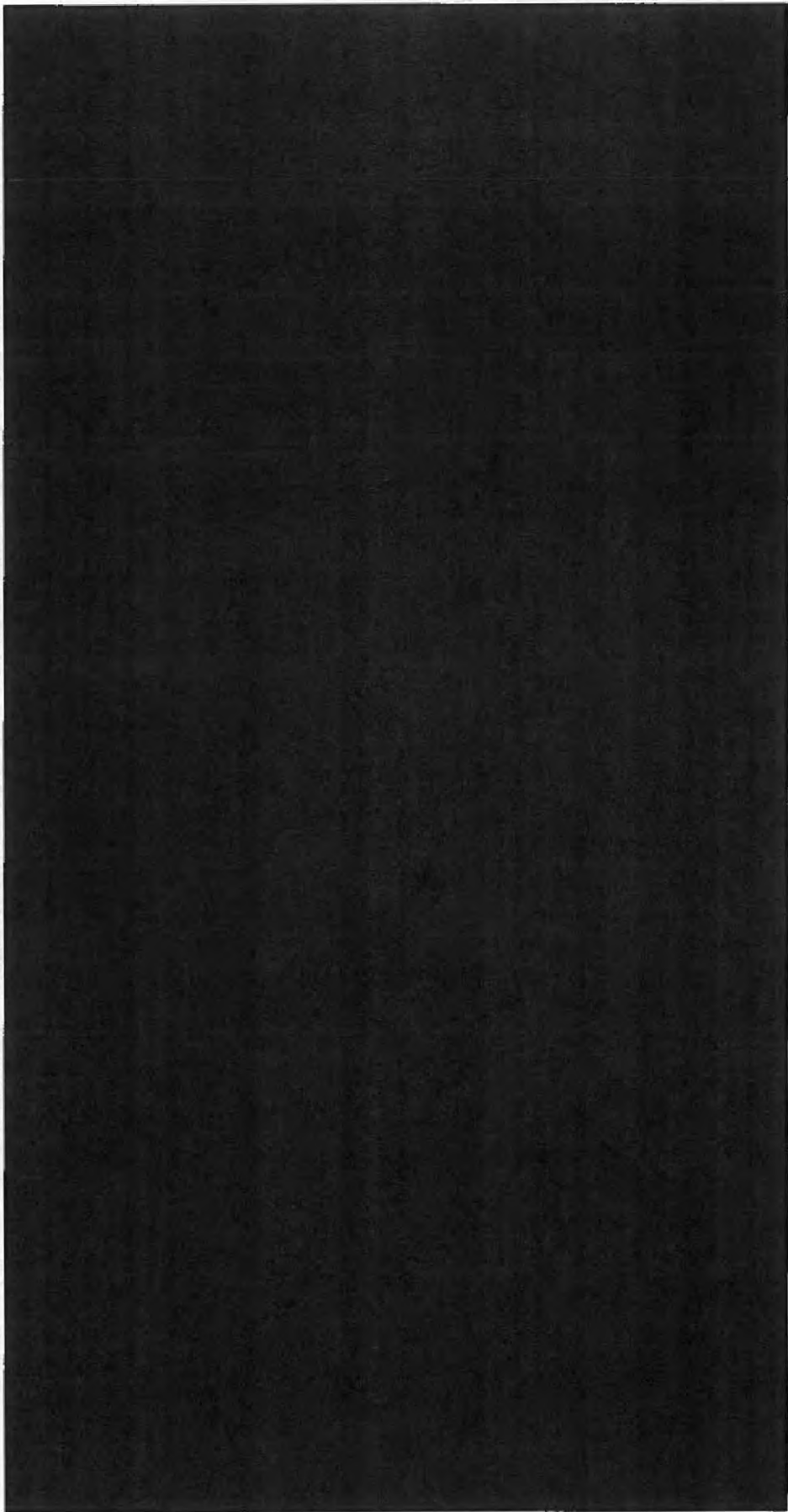


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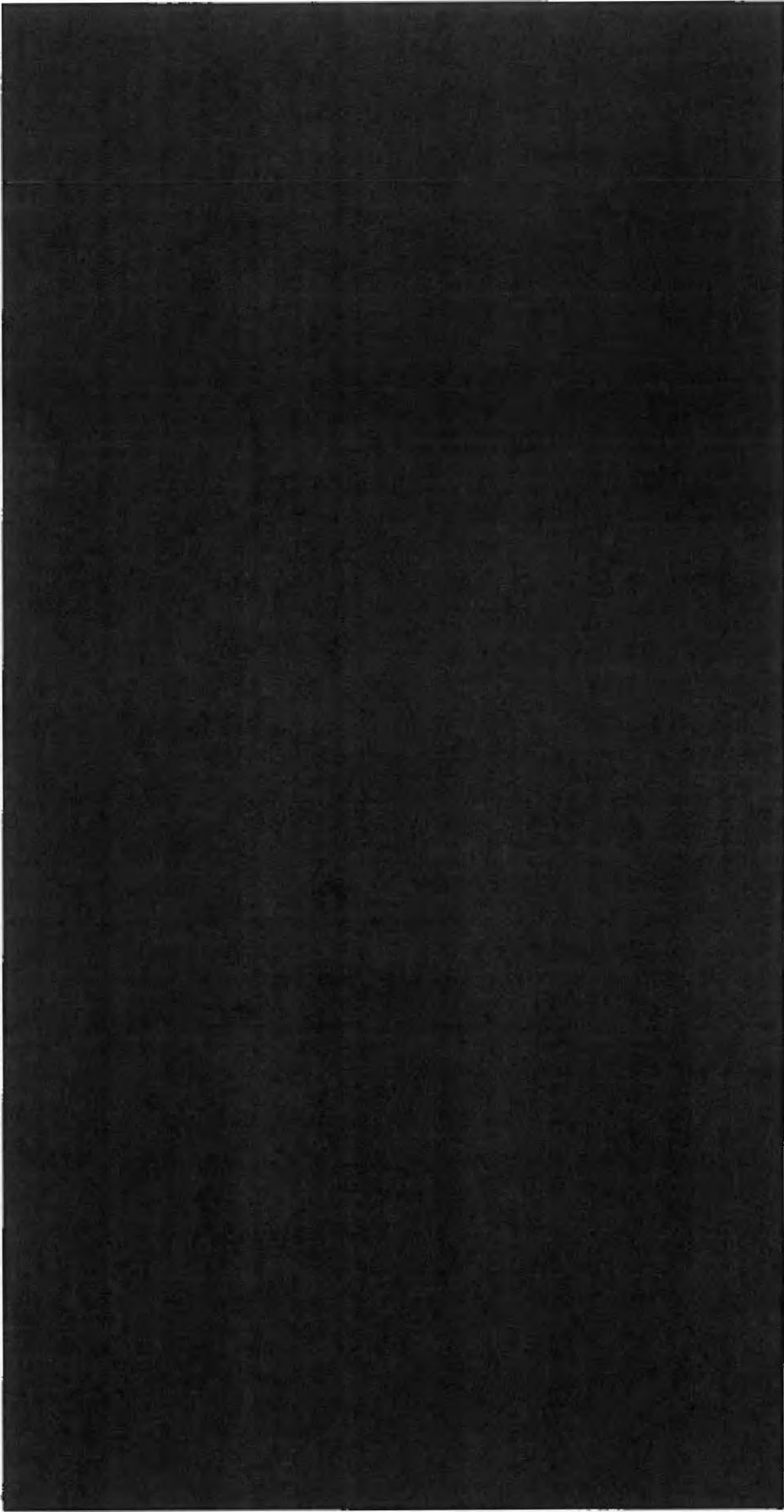


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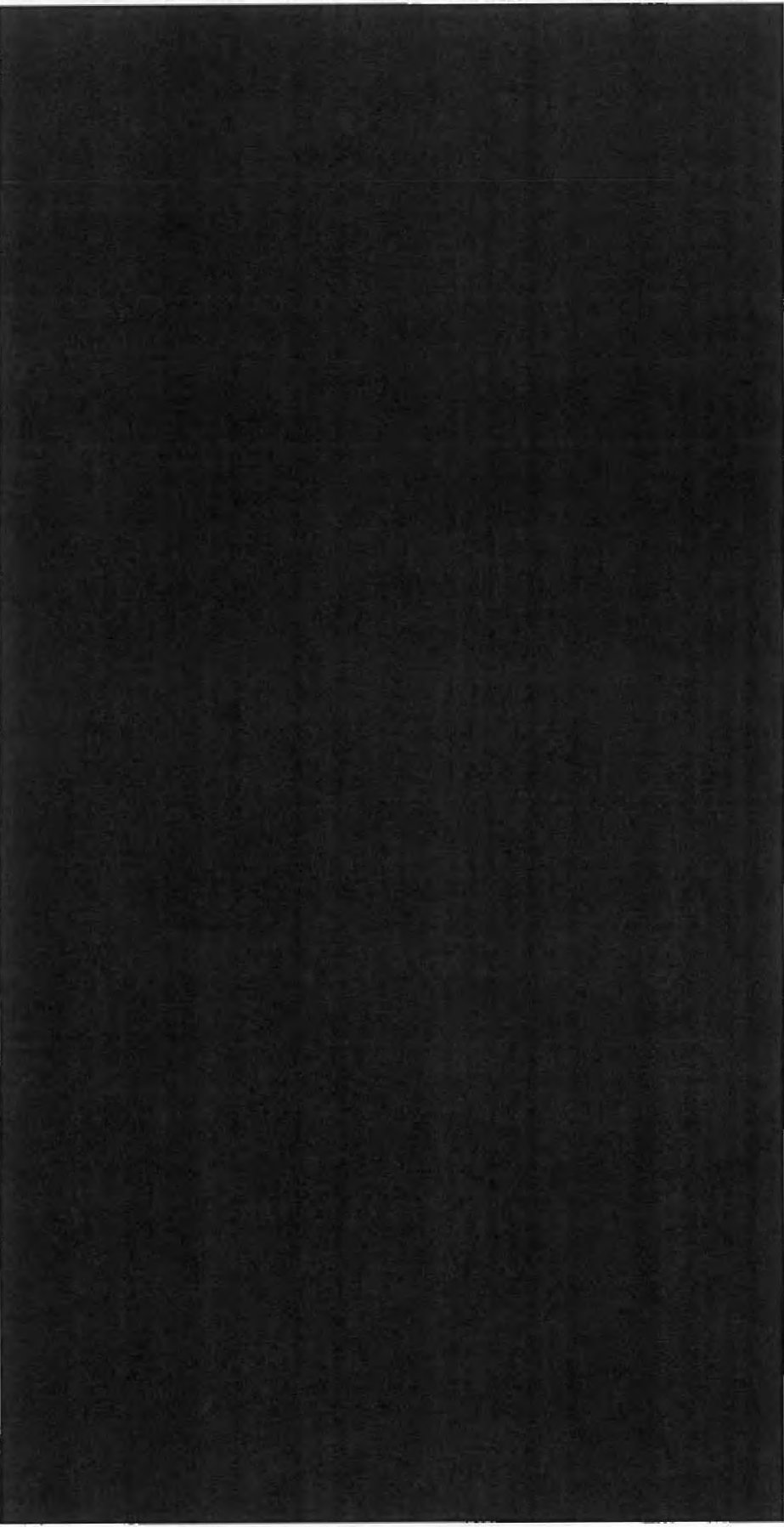


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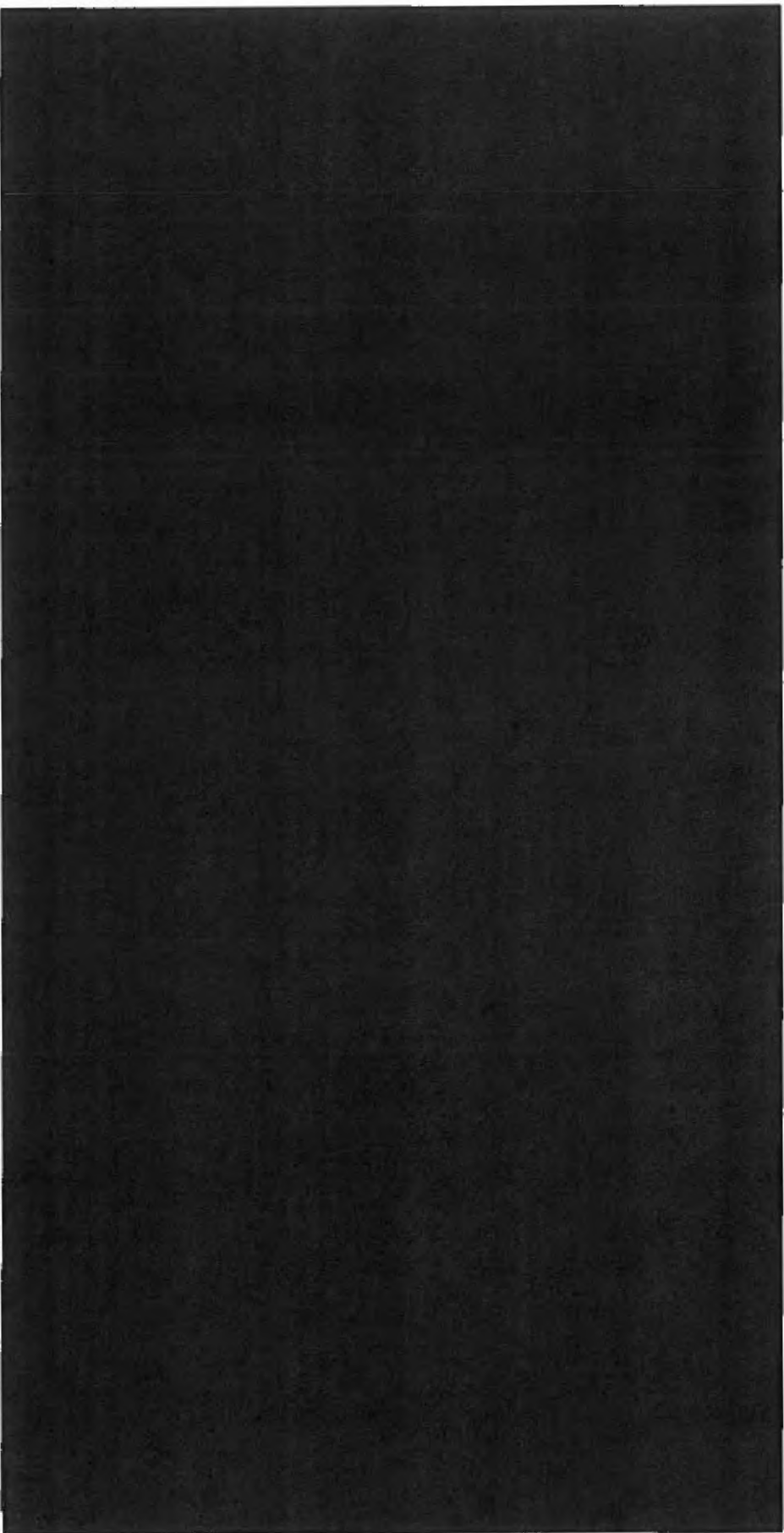


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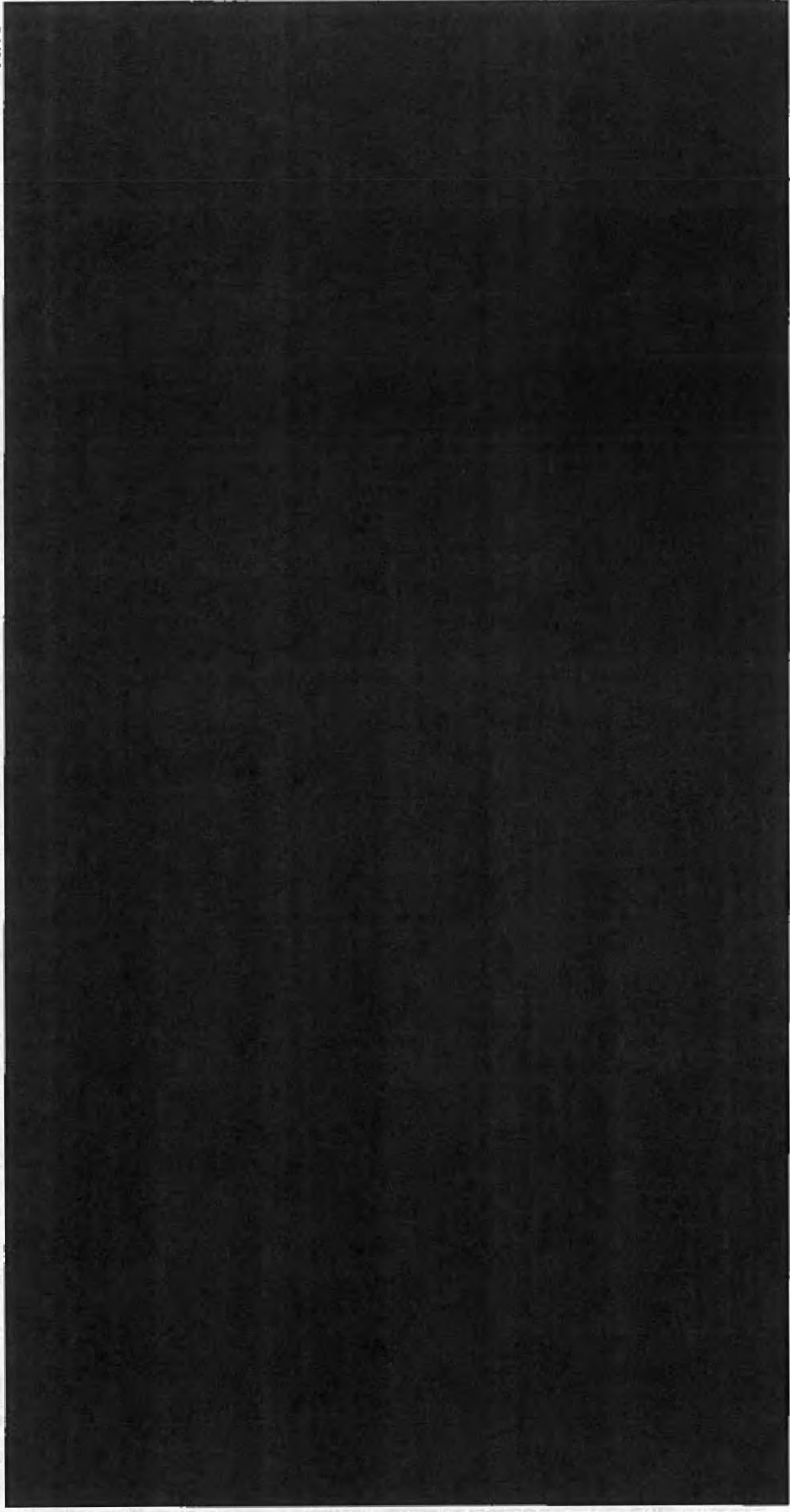


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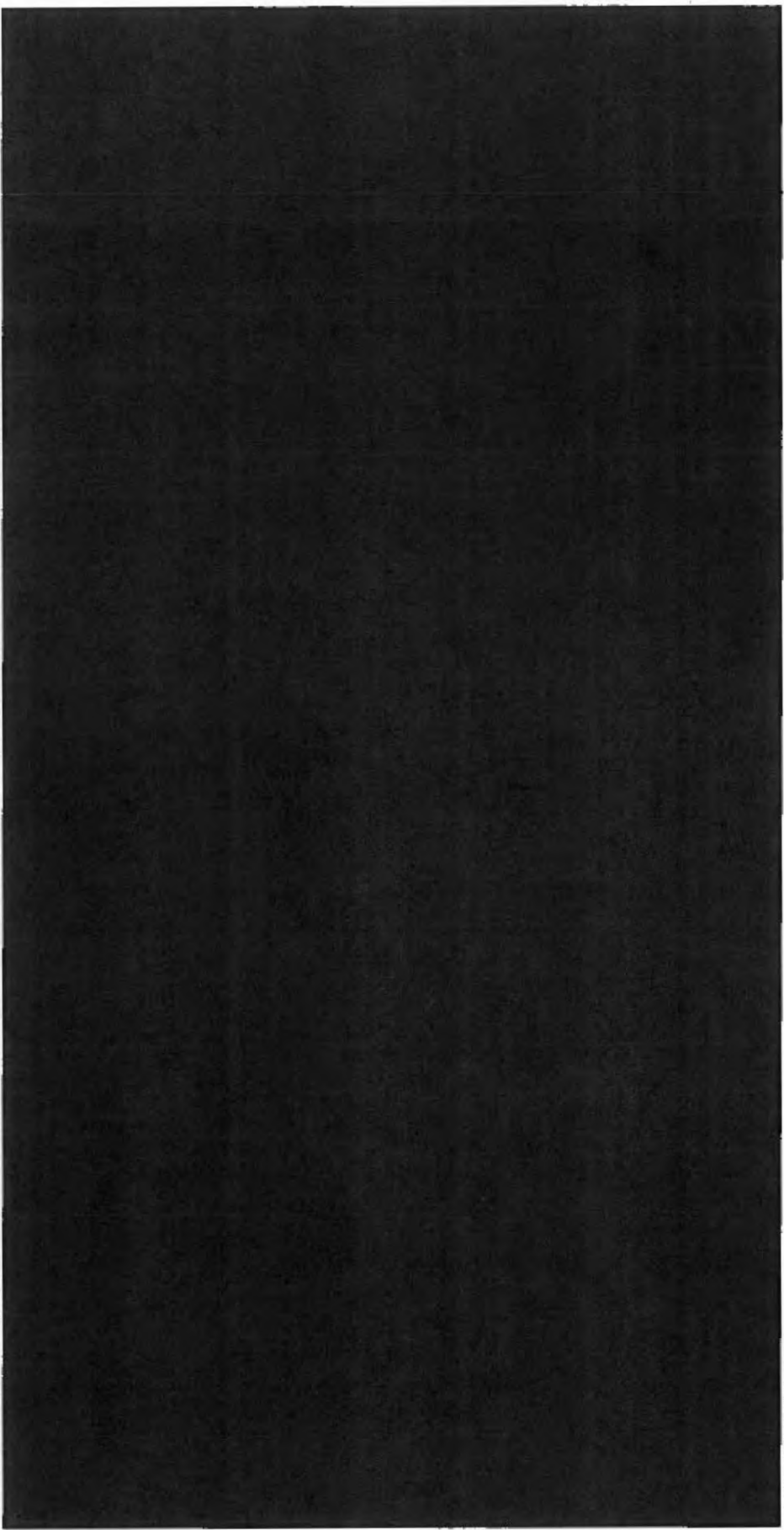


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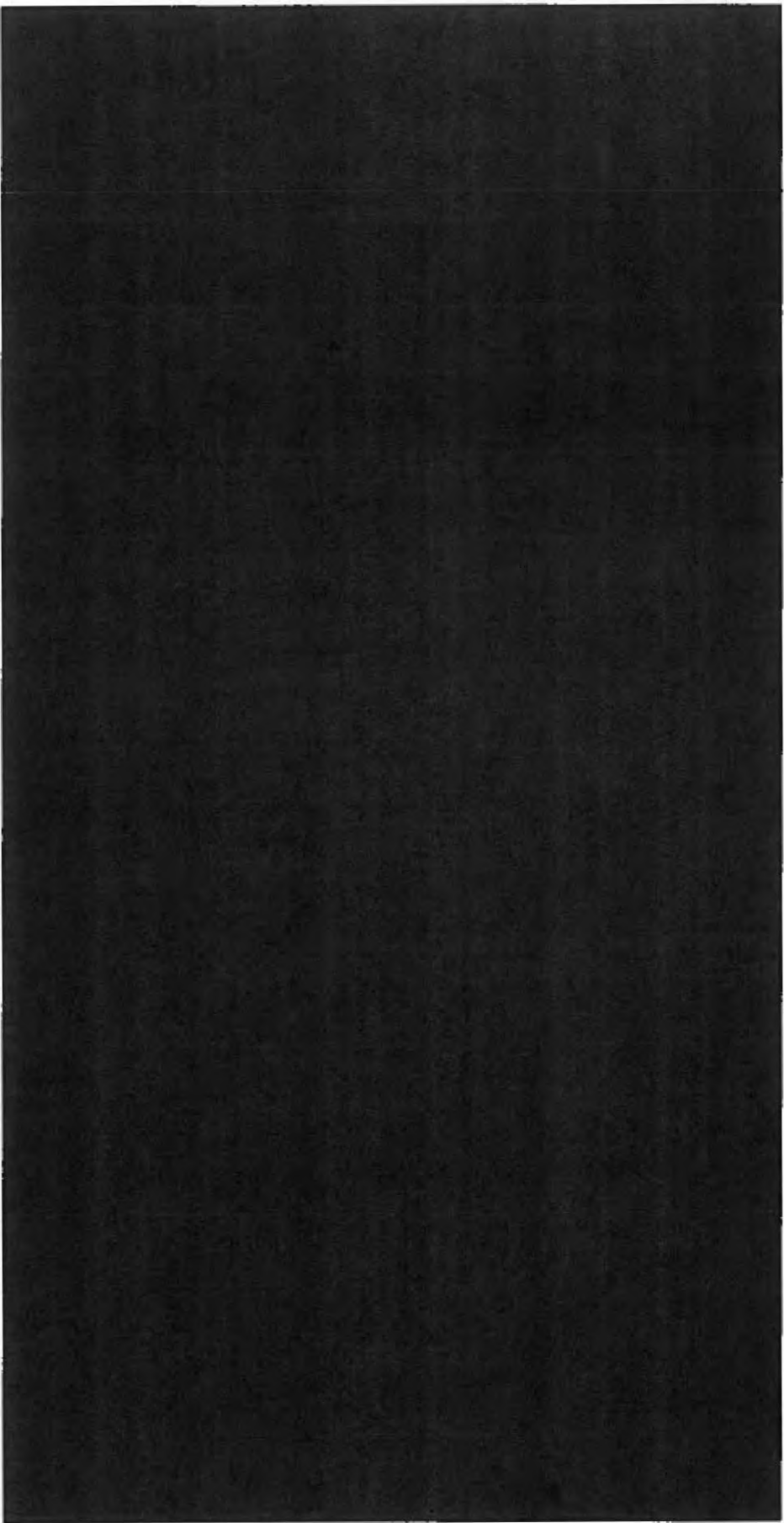


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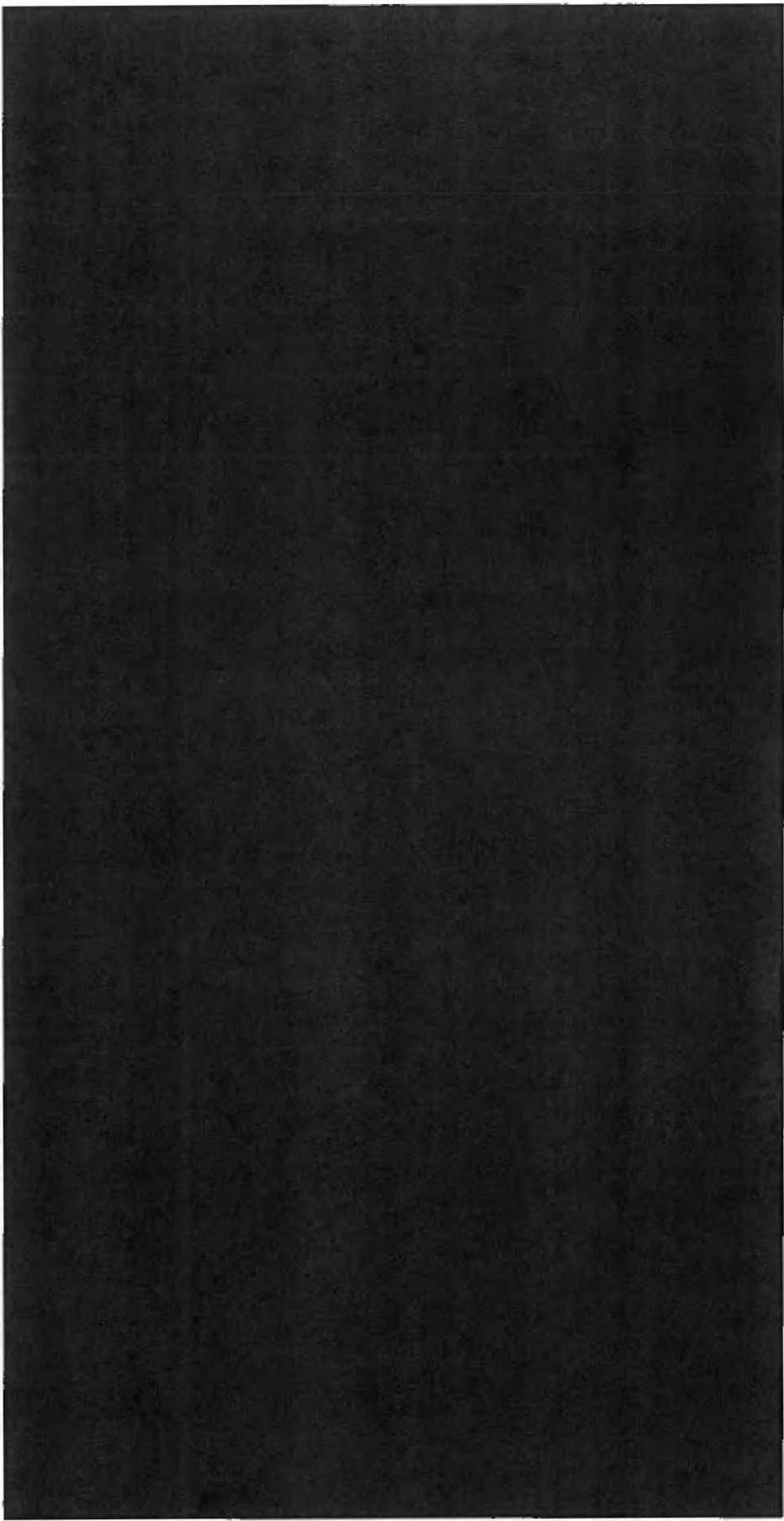


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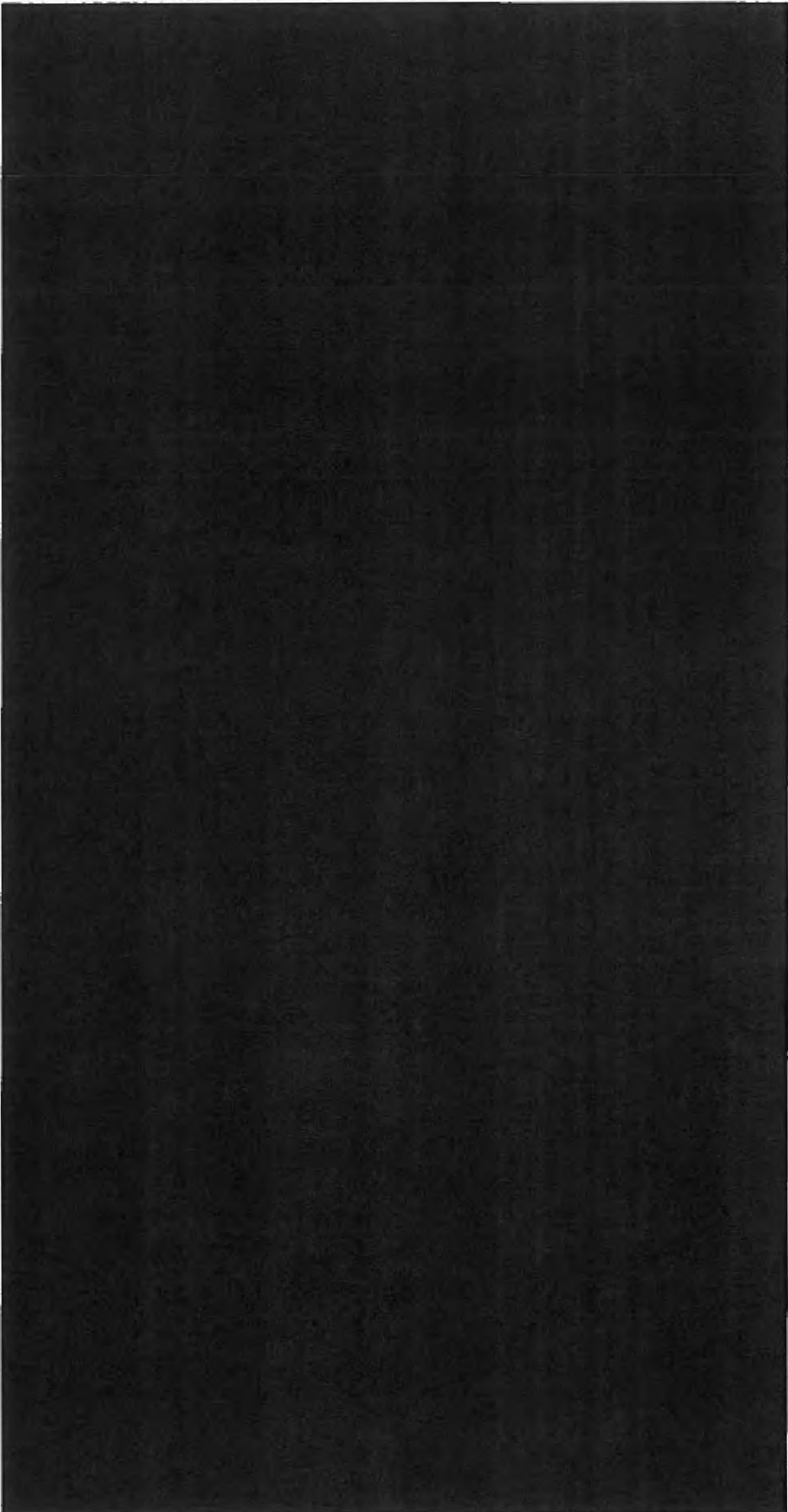


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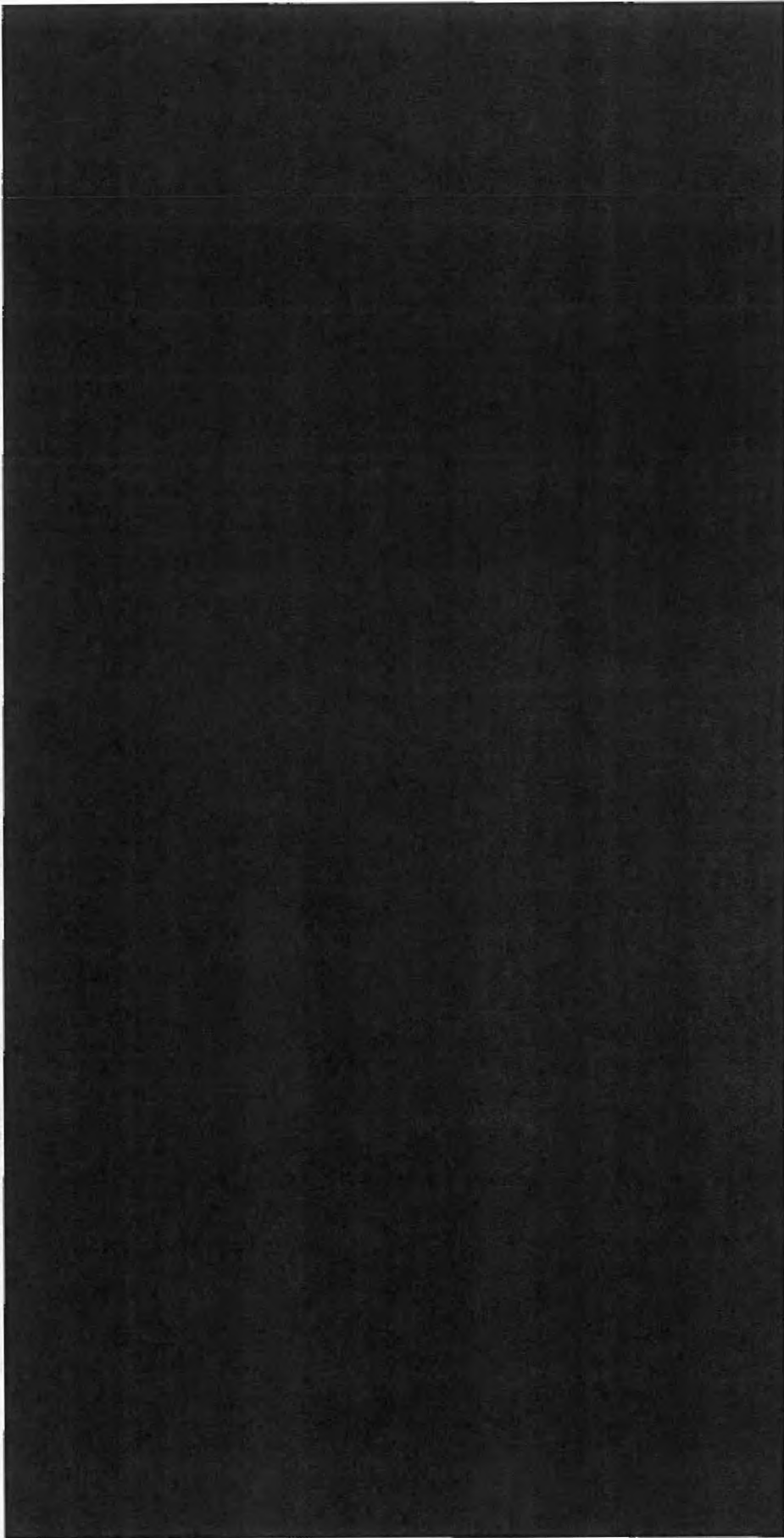


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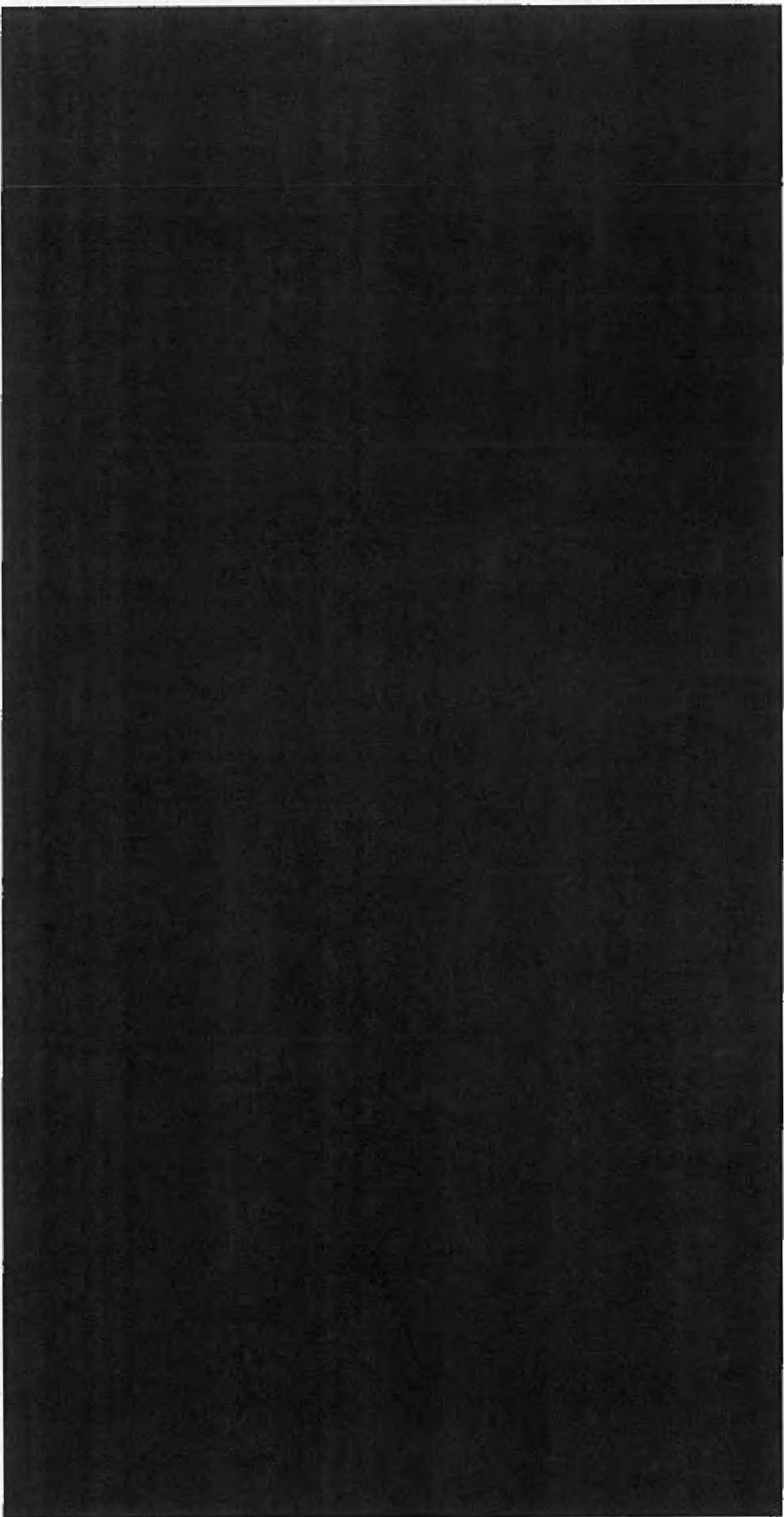


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03 December 2014**



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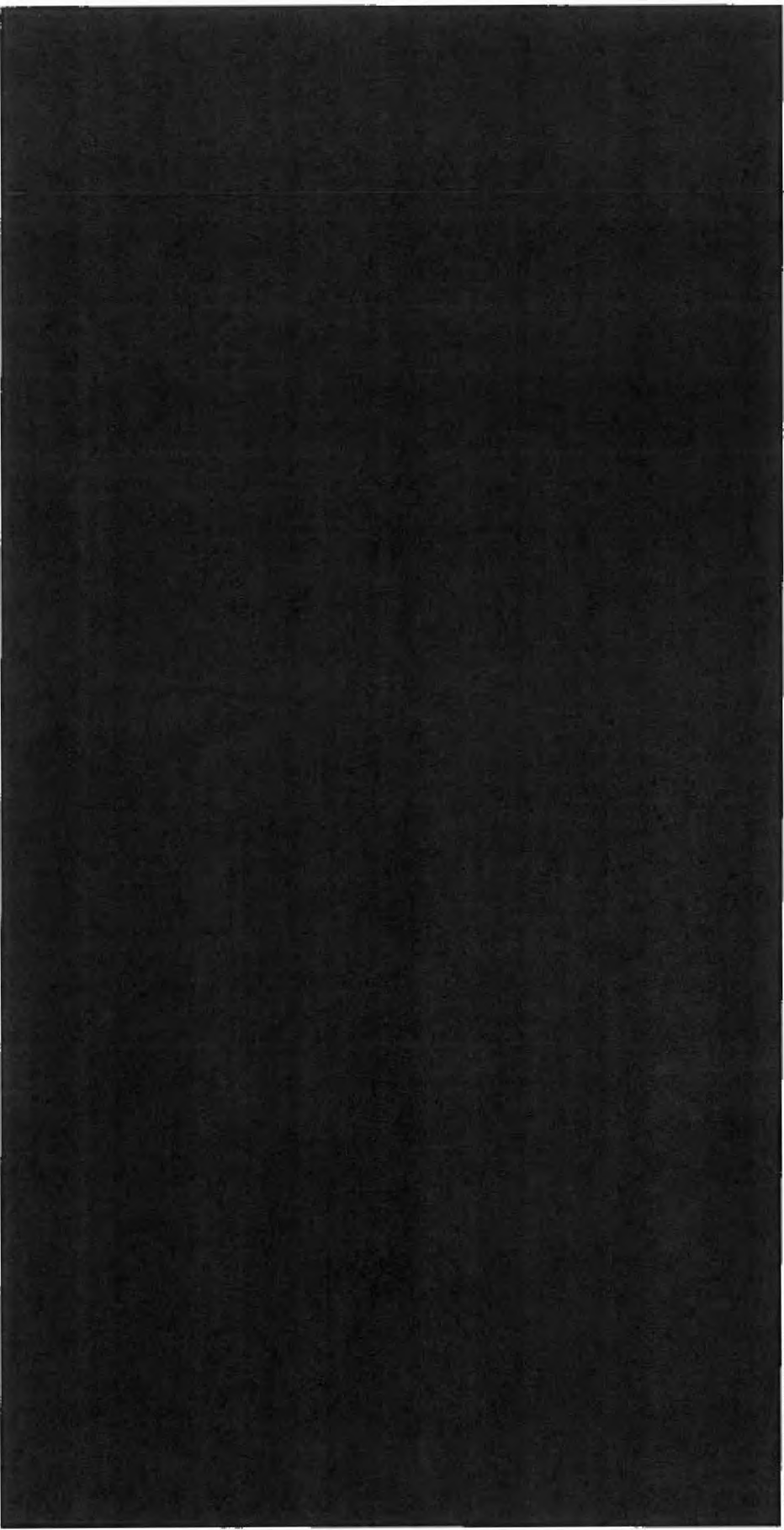
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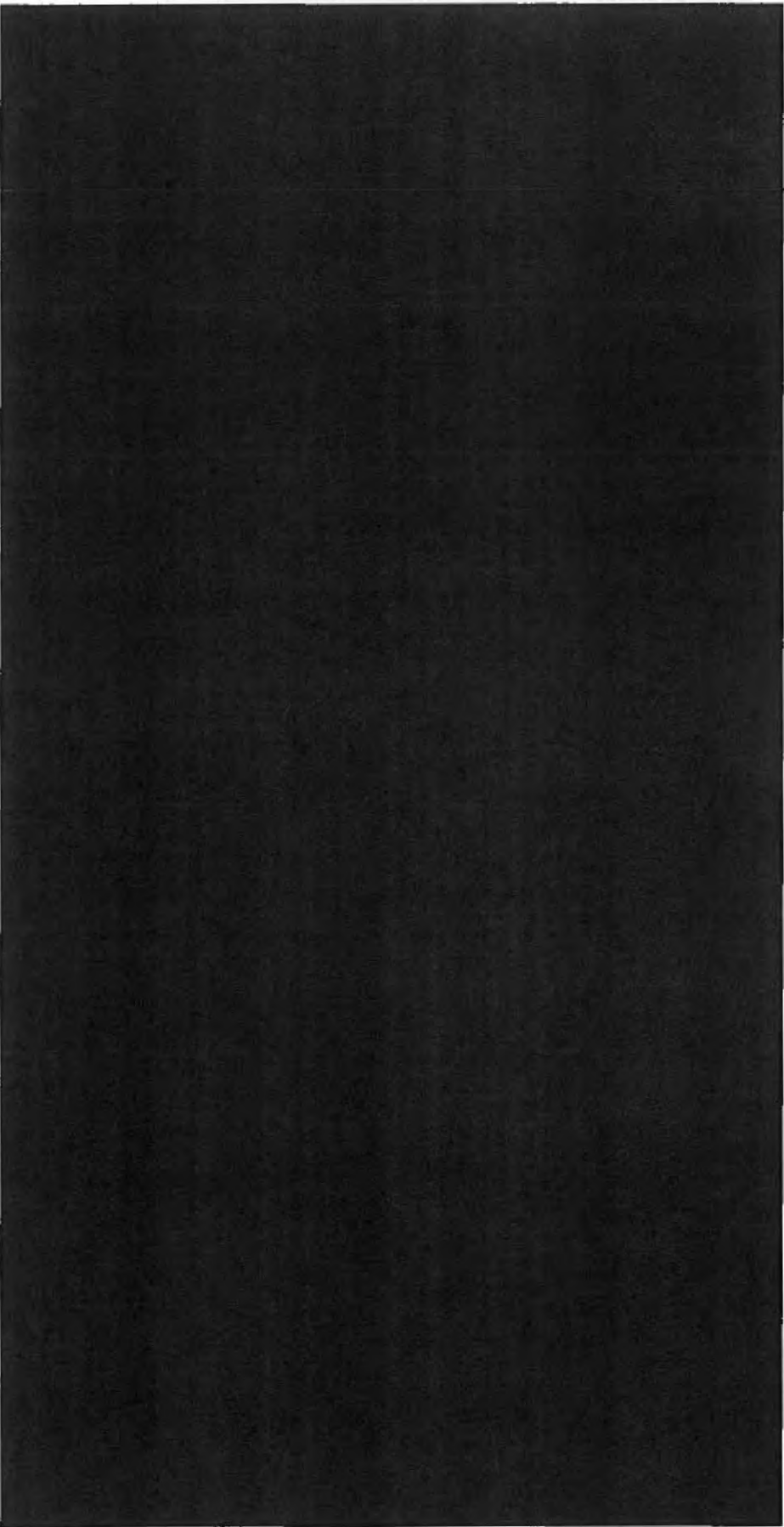
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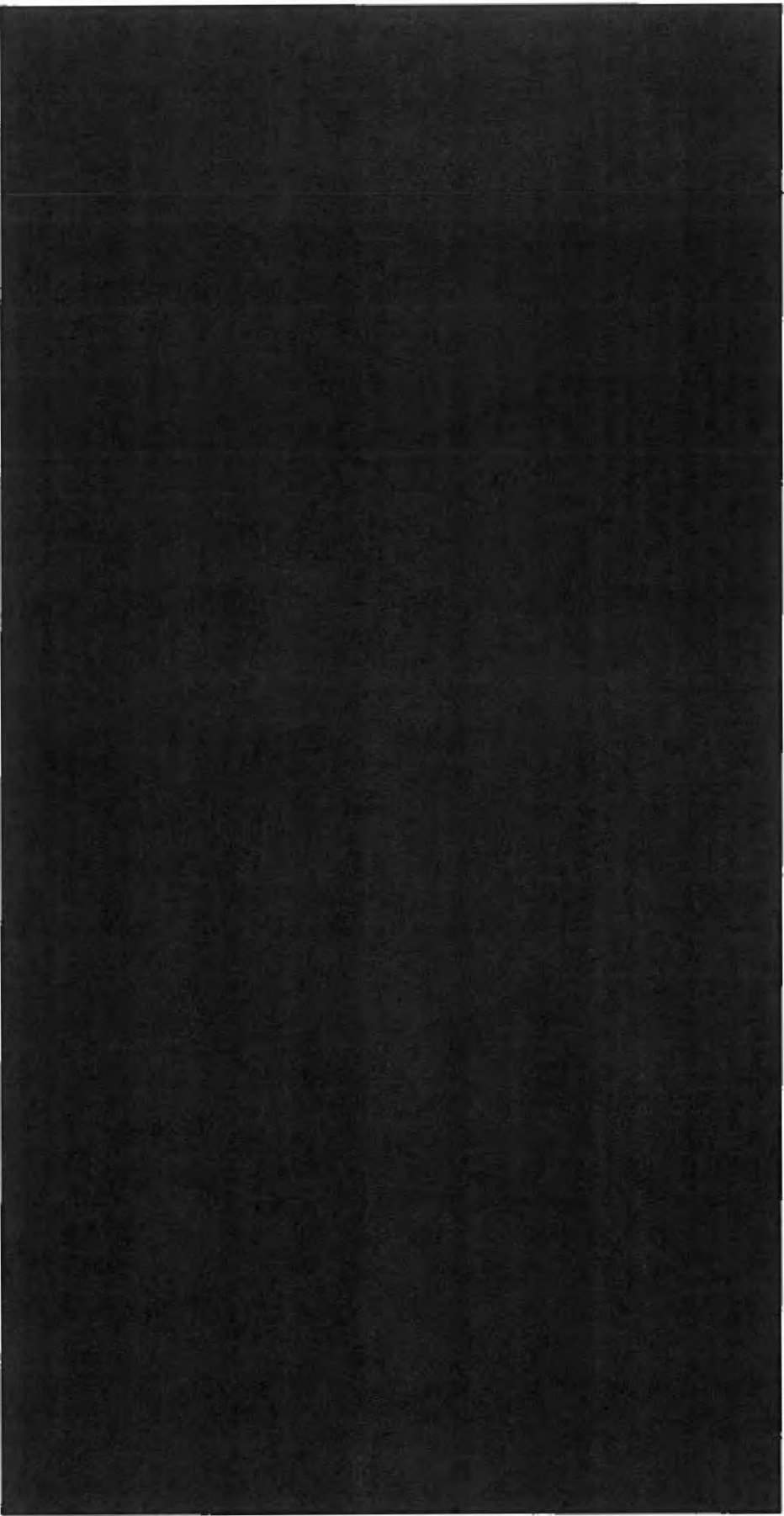


62/90

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03 December 2014

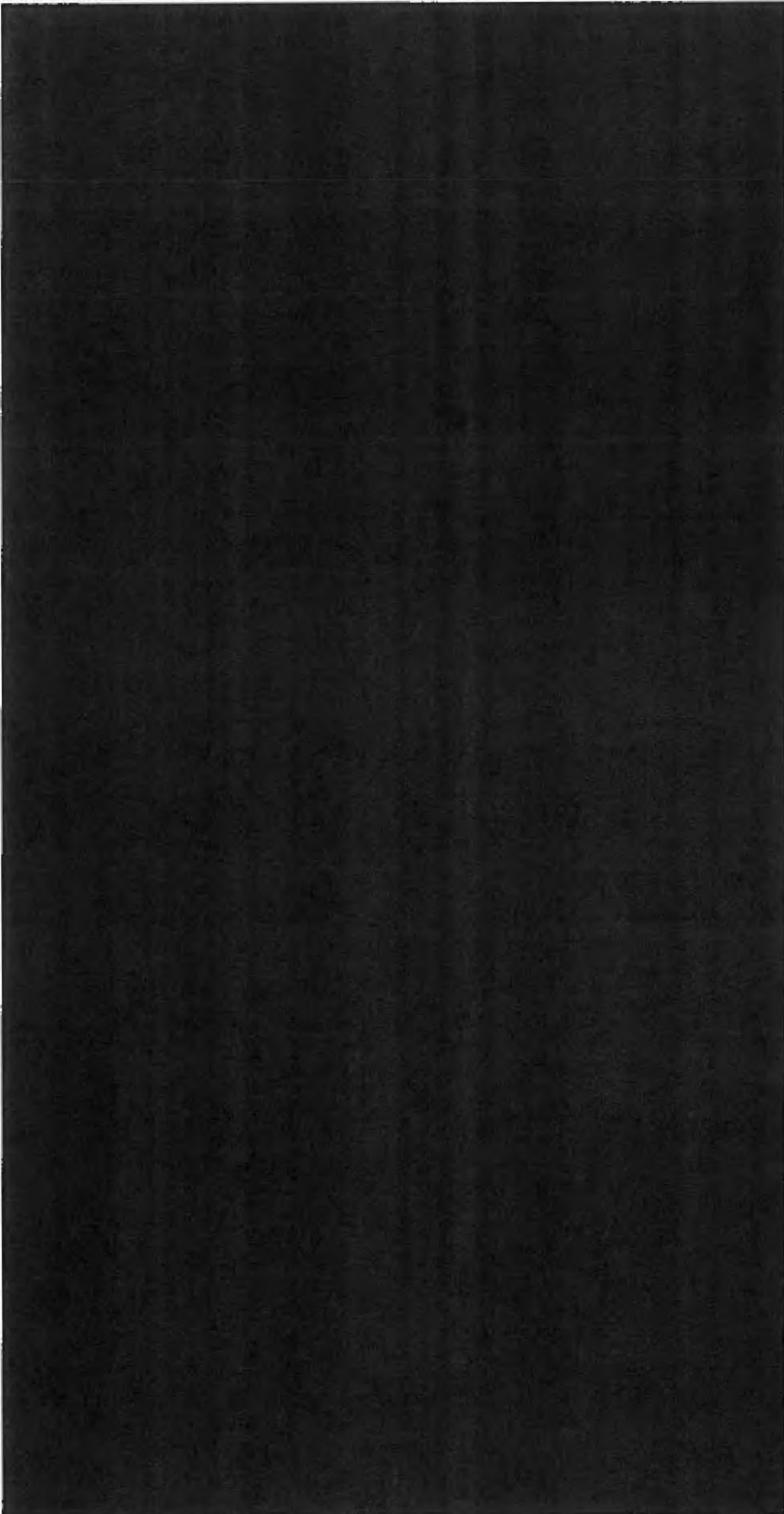


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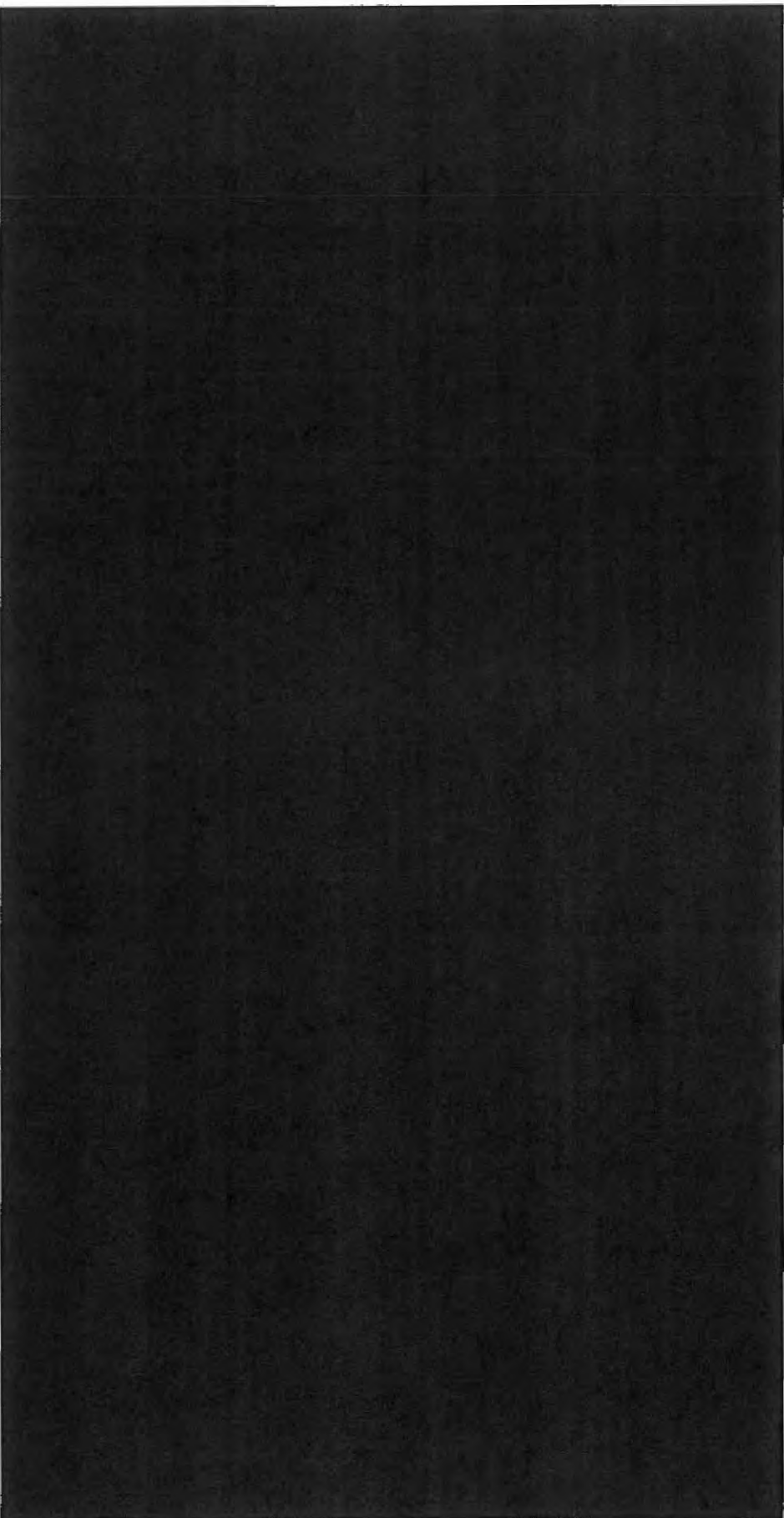


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03 December 2014**

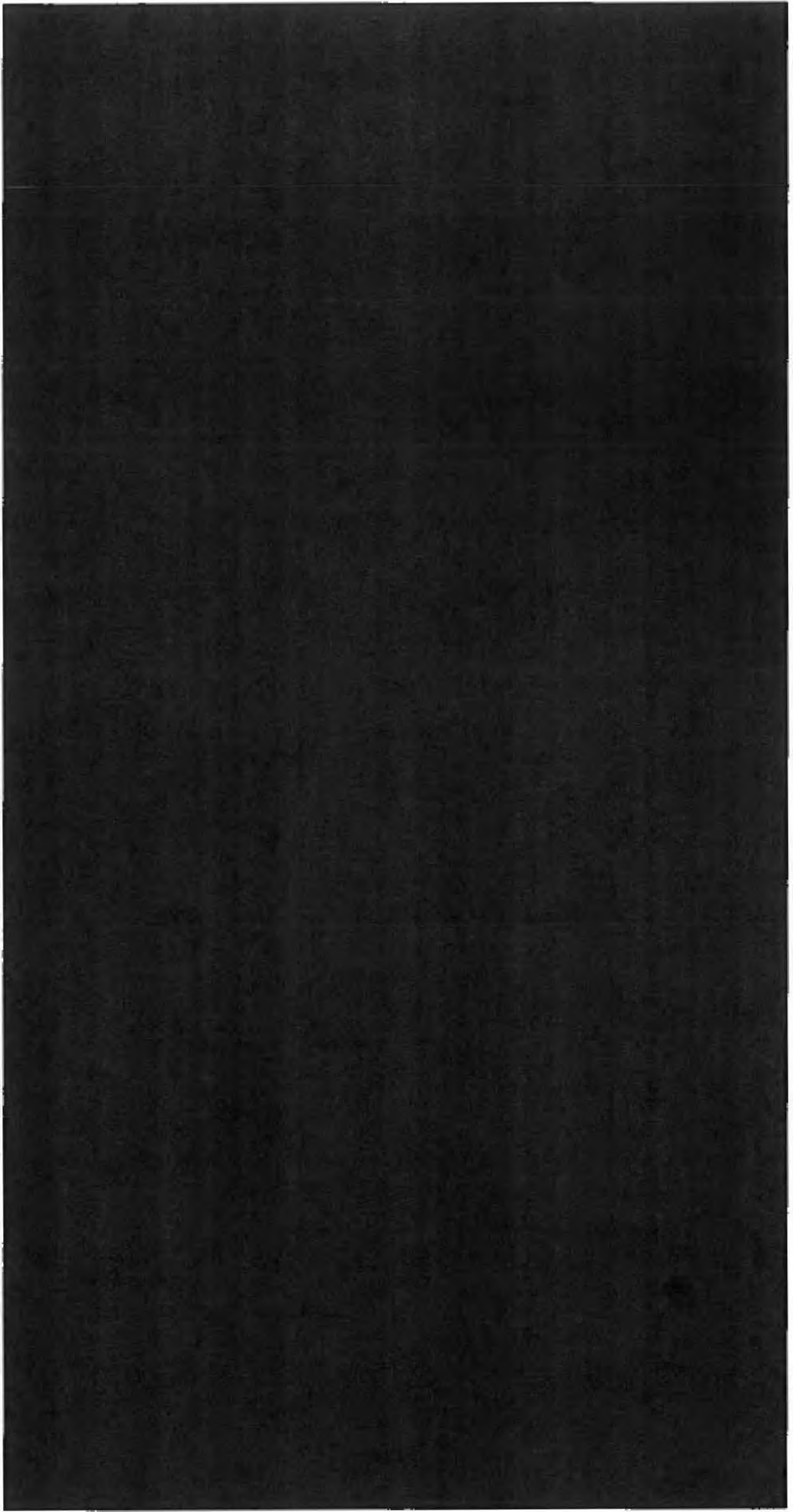


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03 December 2014**

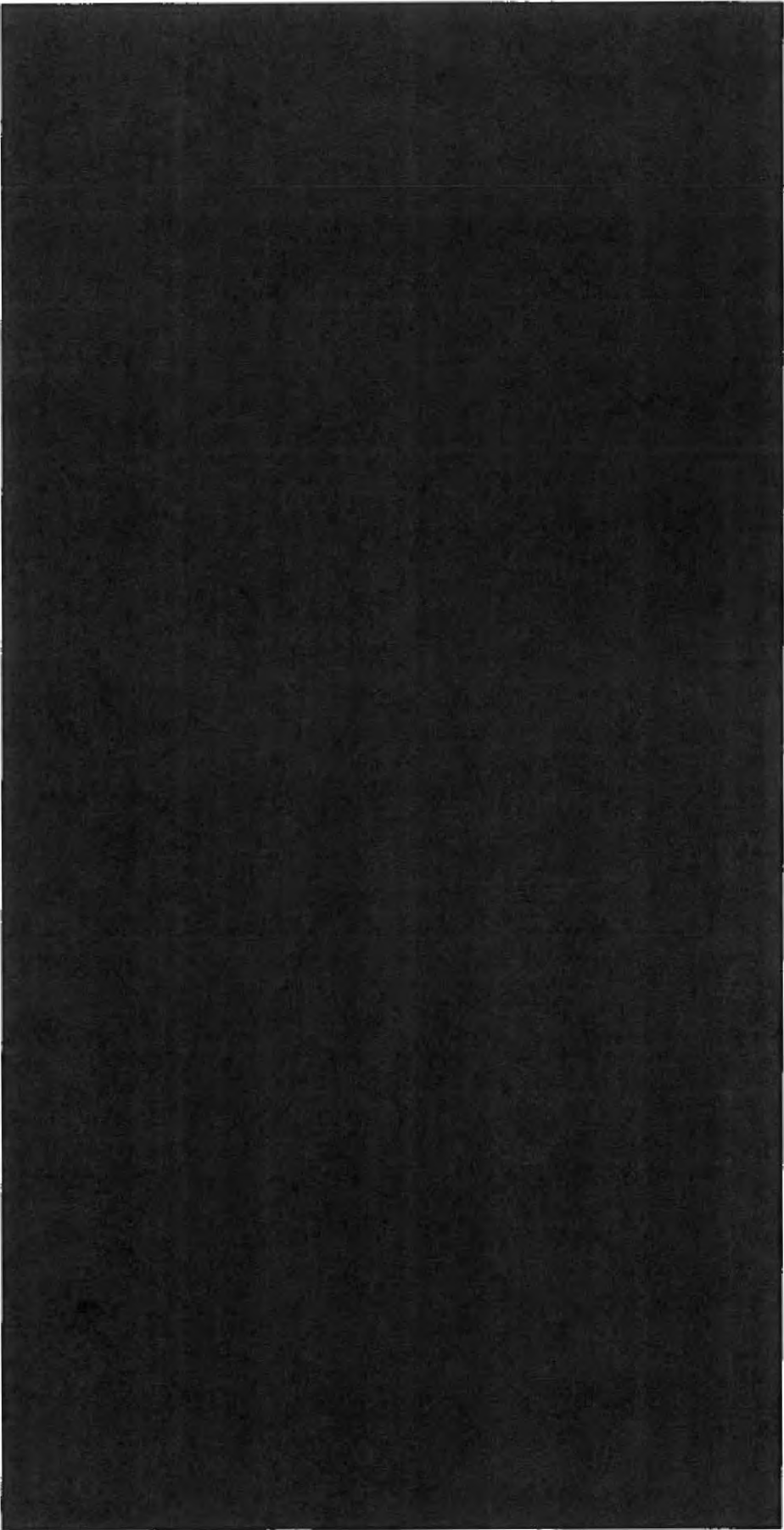


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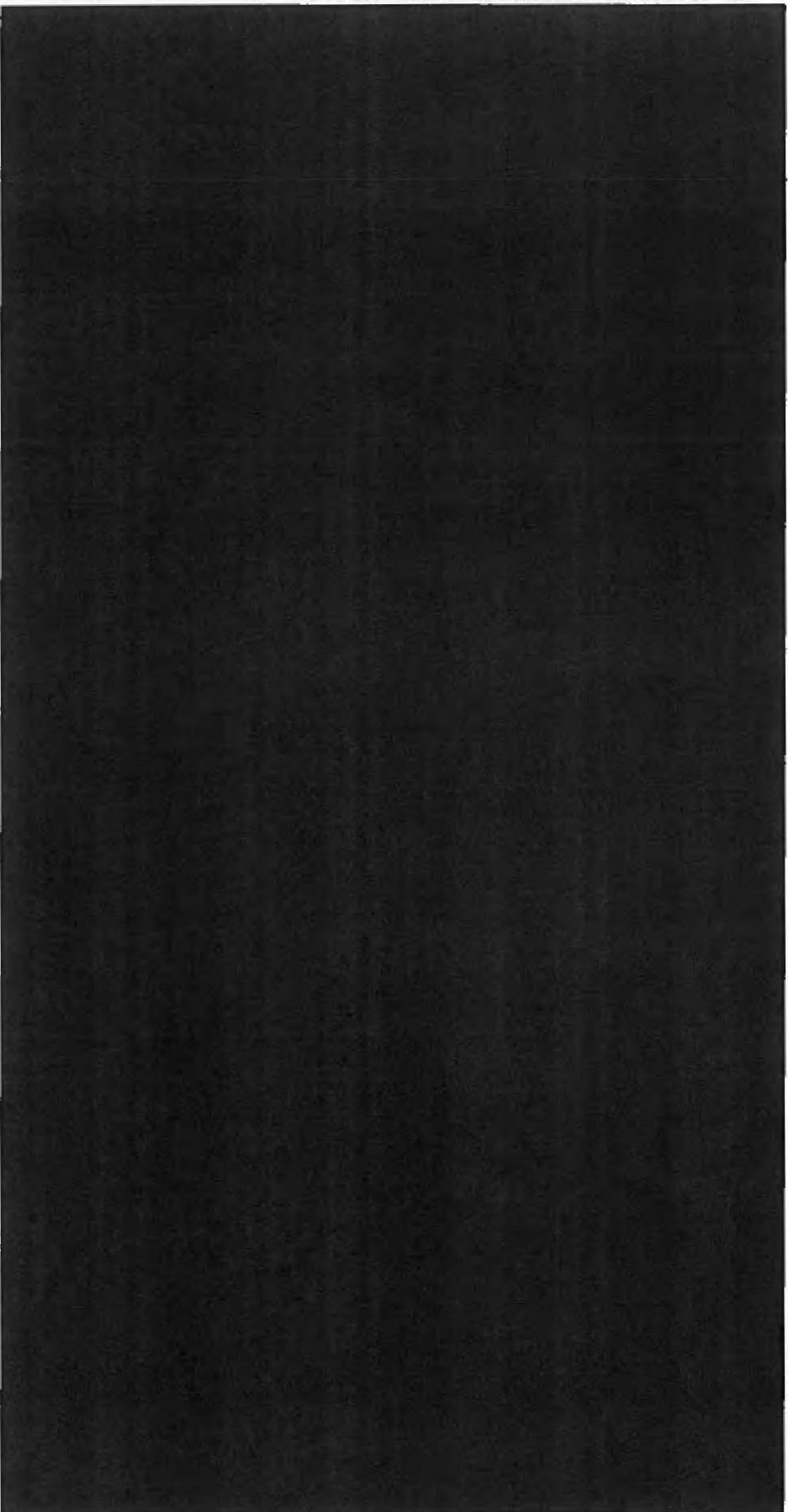


67/90

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03 December 2014

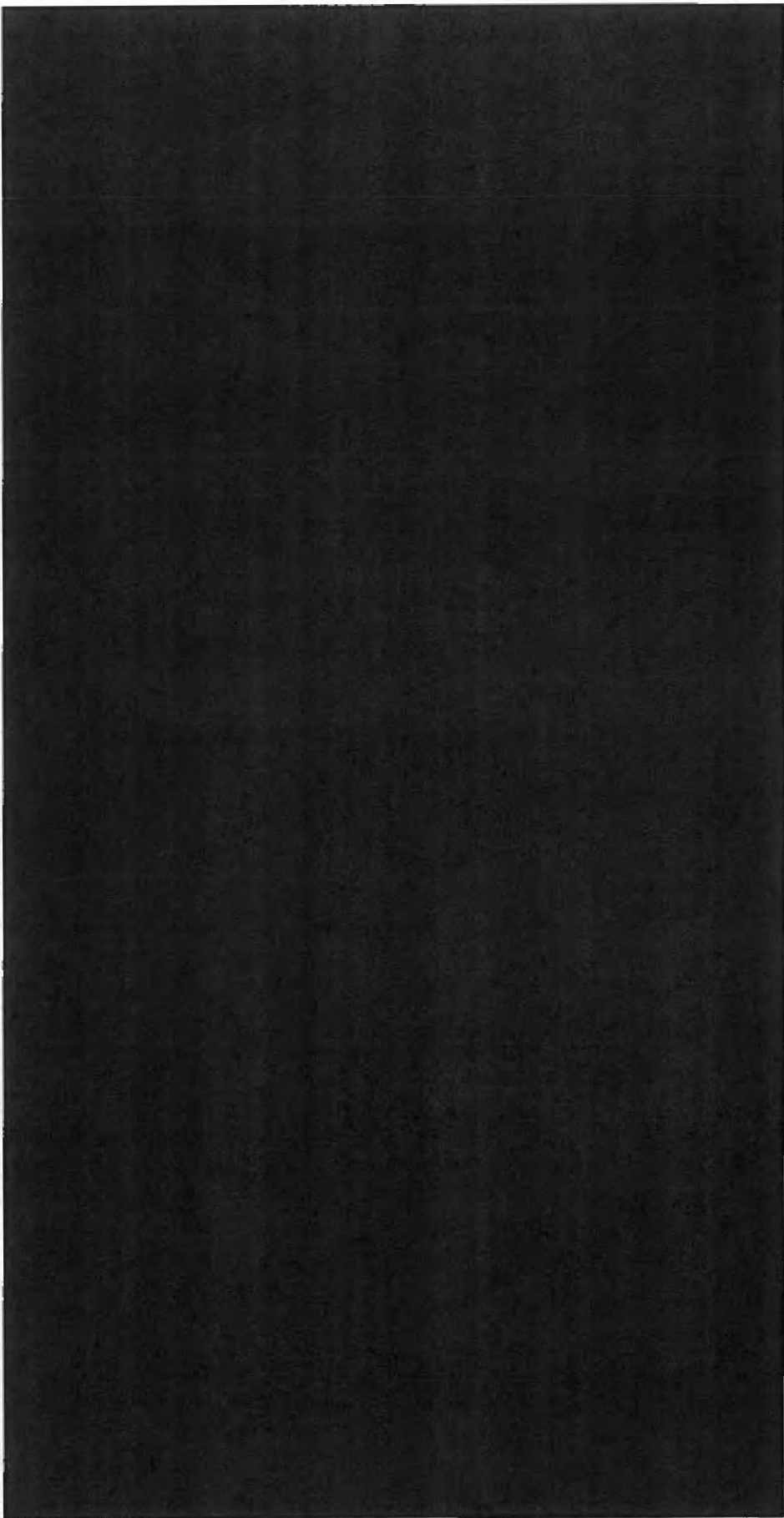


68/90

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03 December 2014**

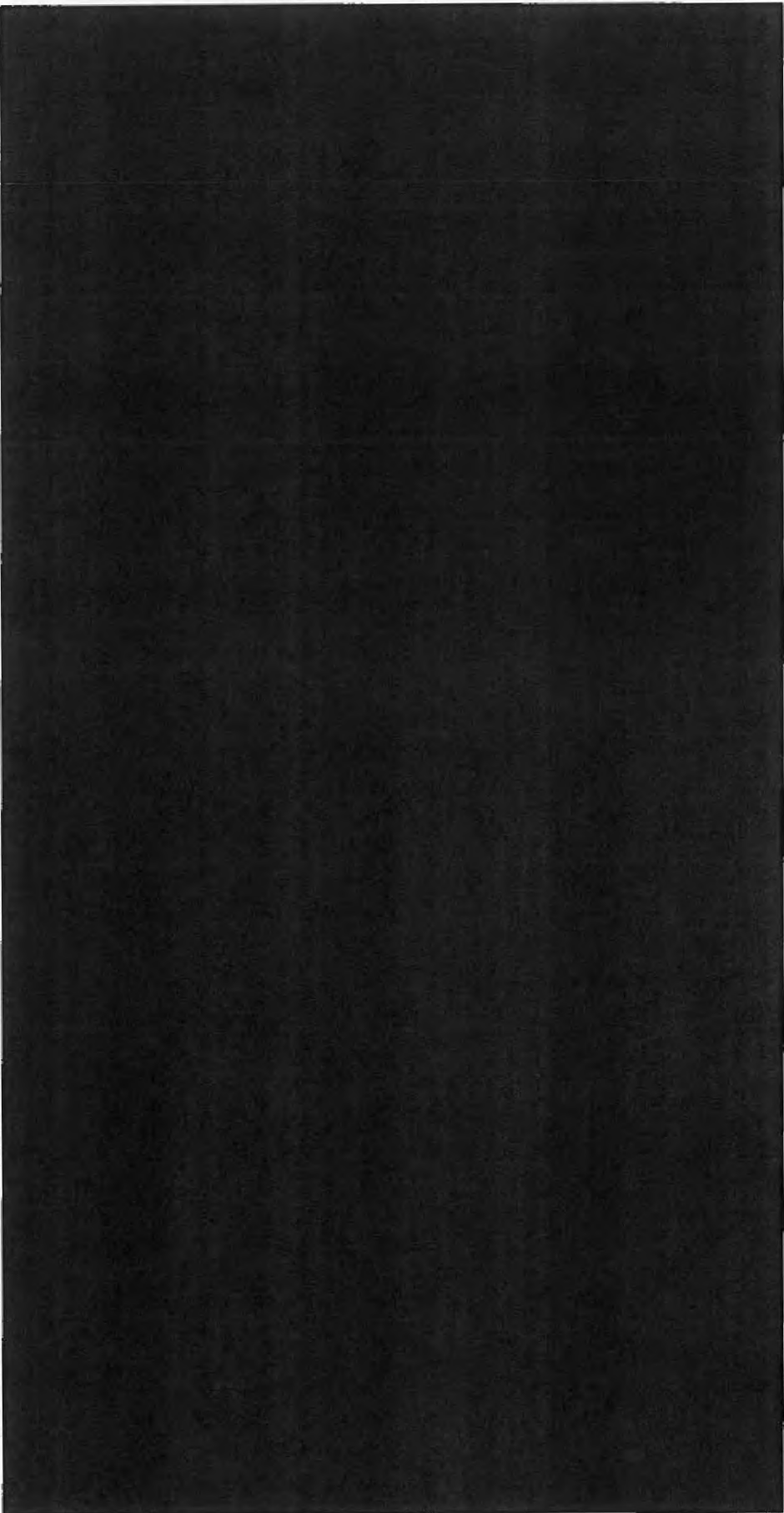


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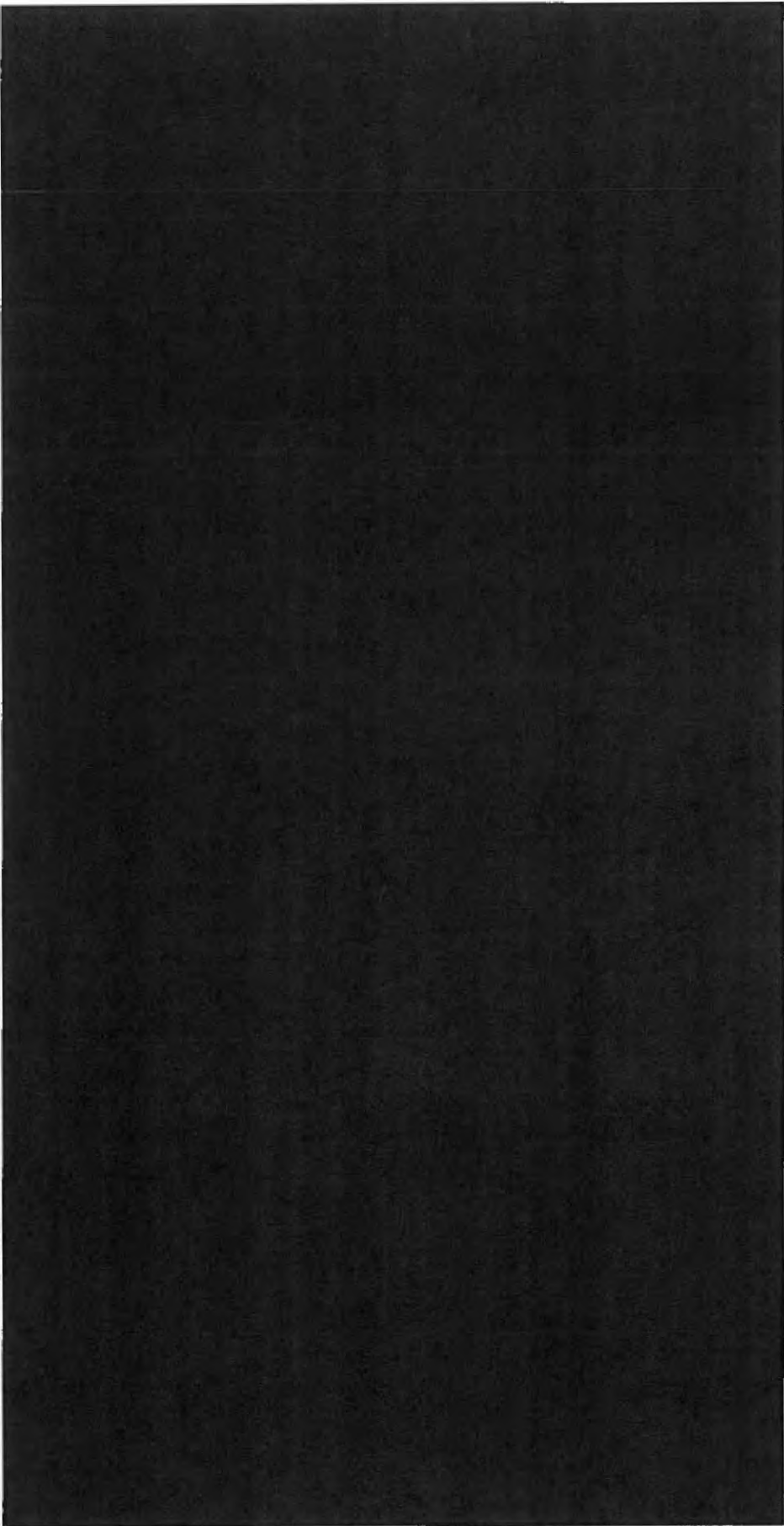


7/0/90

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03 December 2014**

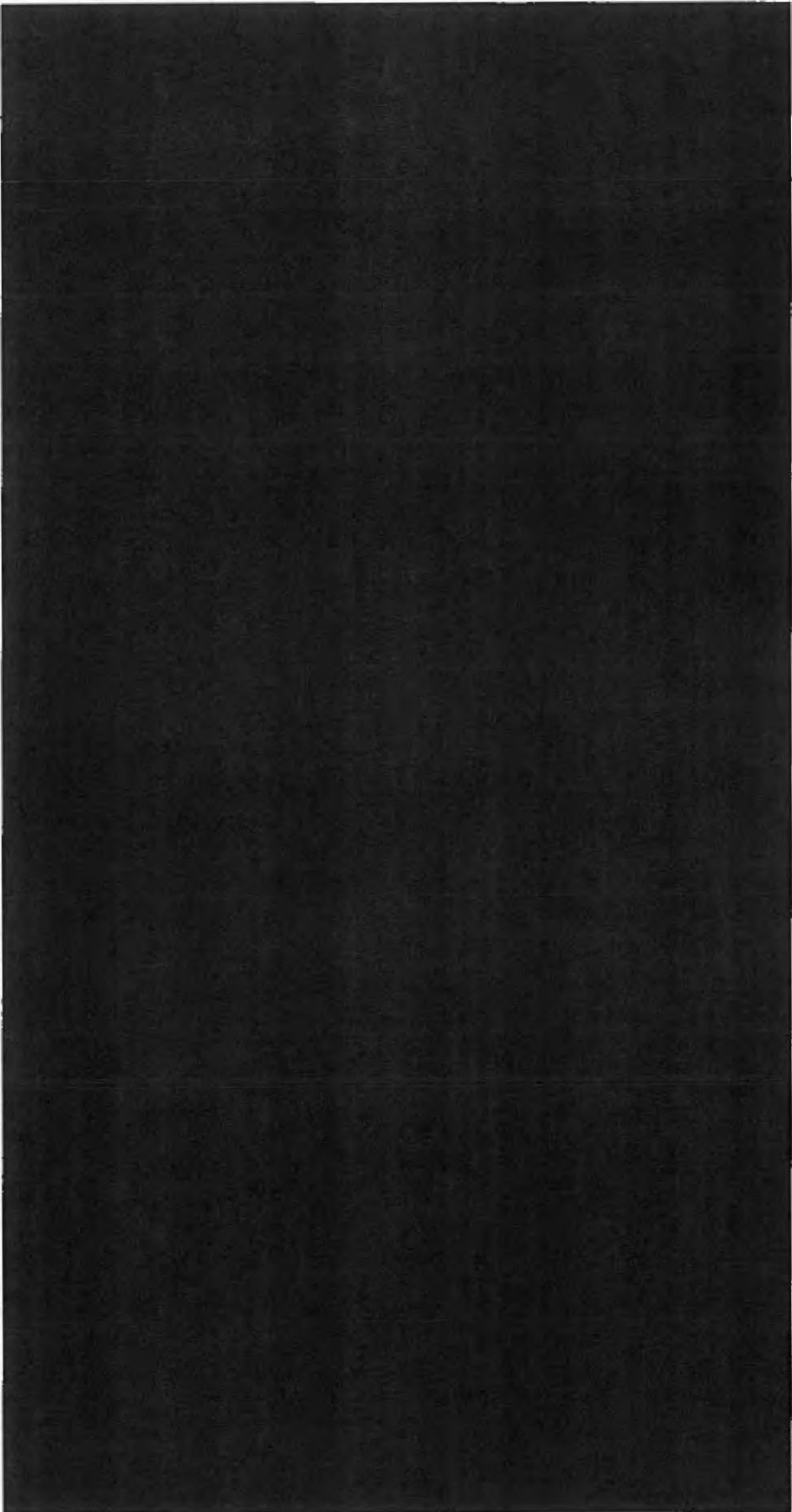


71/90

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03 December 2014

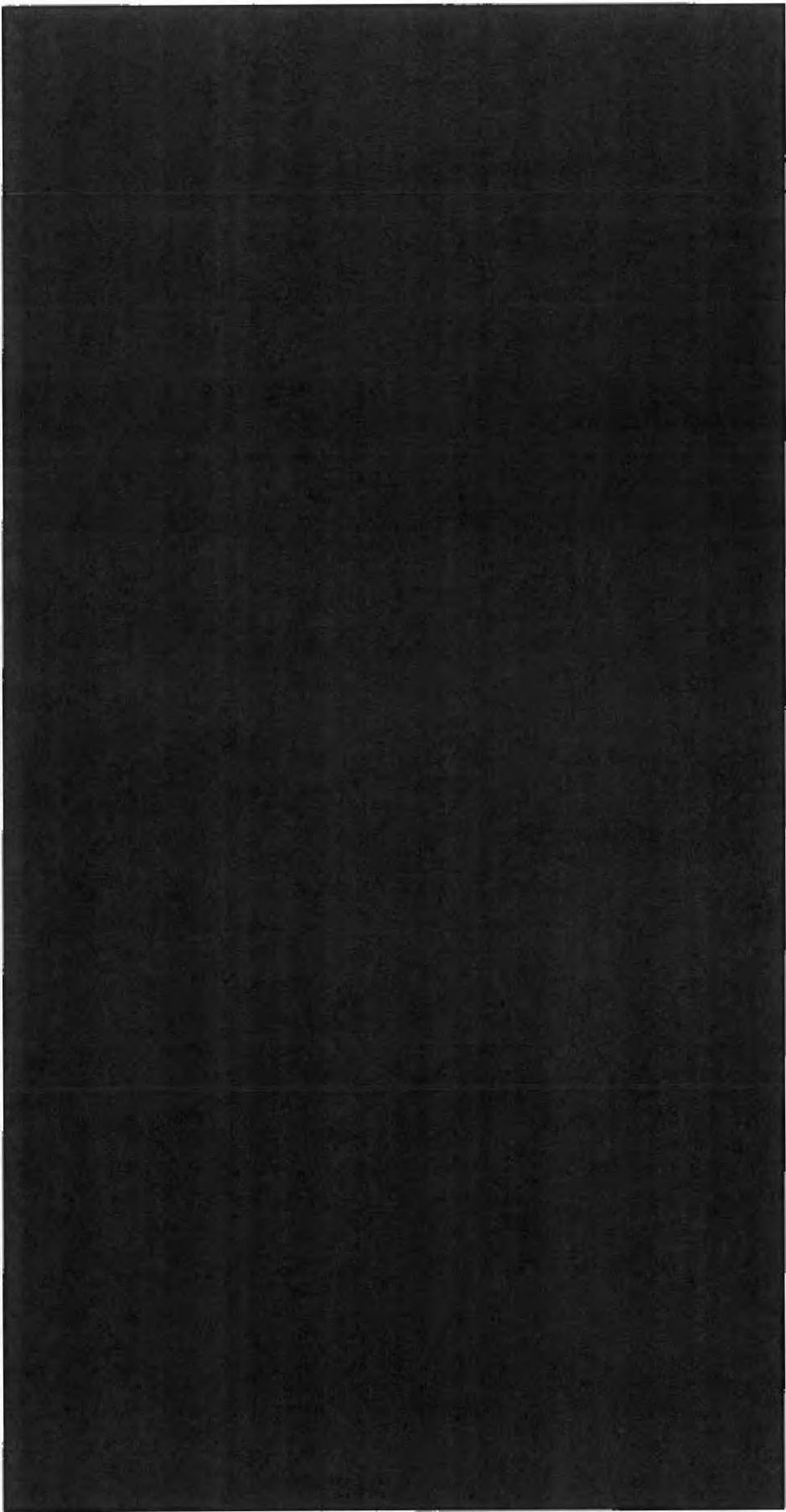


72/90

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**2120-20-2-4/2011-019
03 December 2014**



73/90

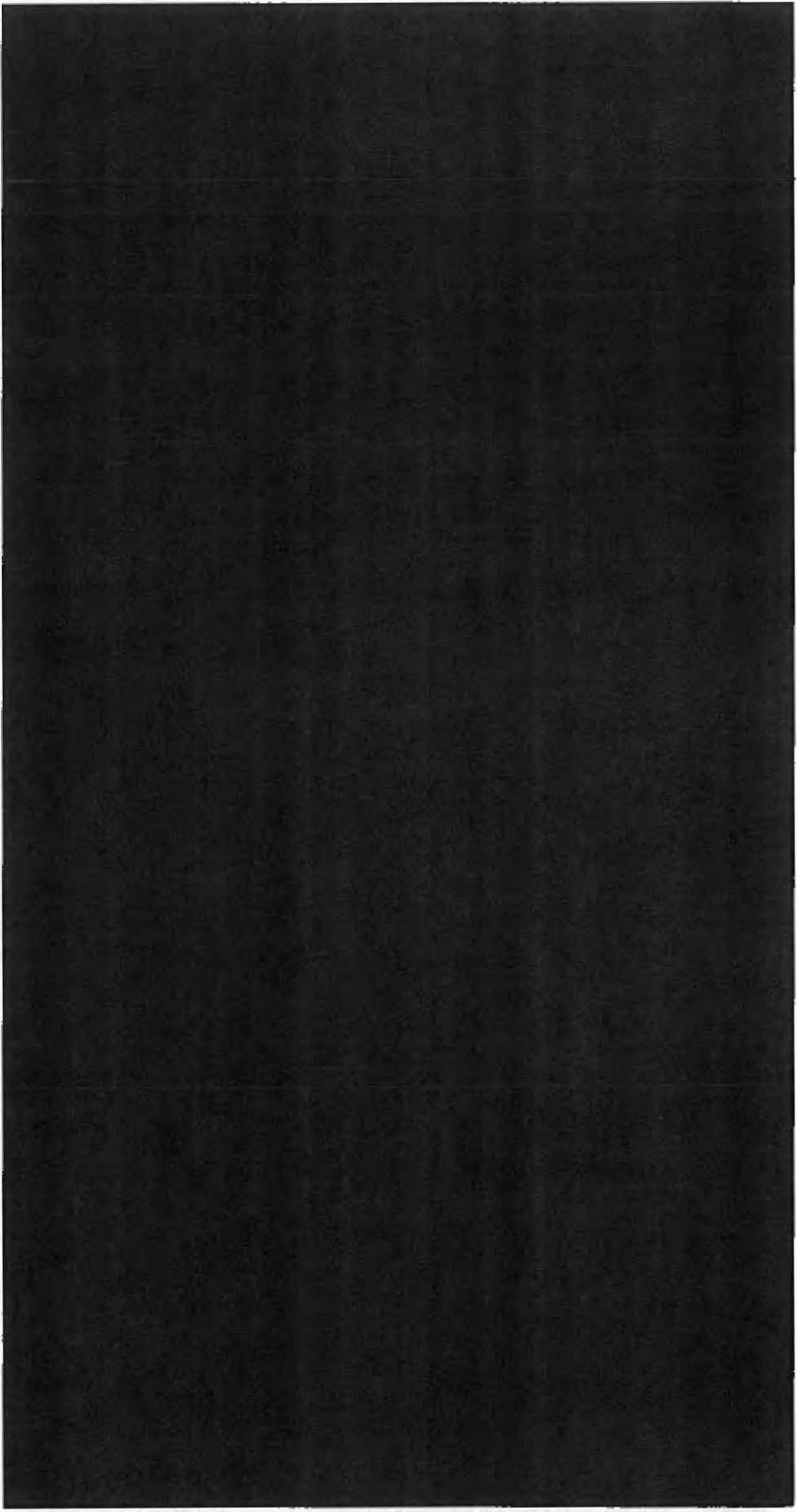
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74/90

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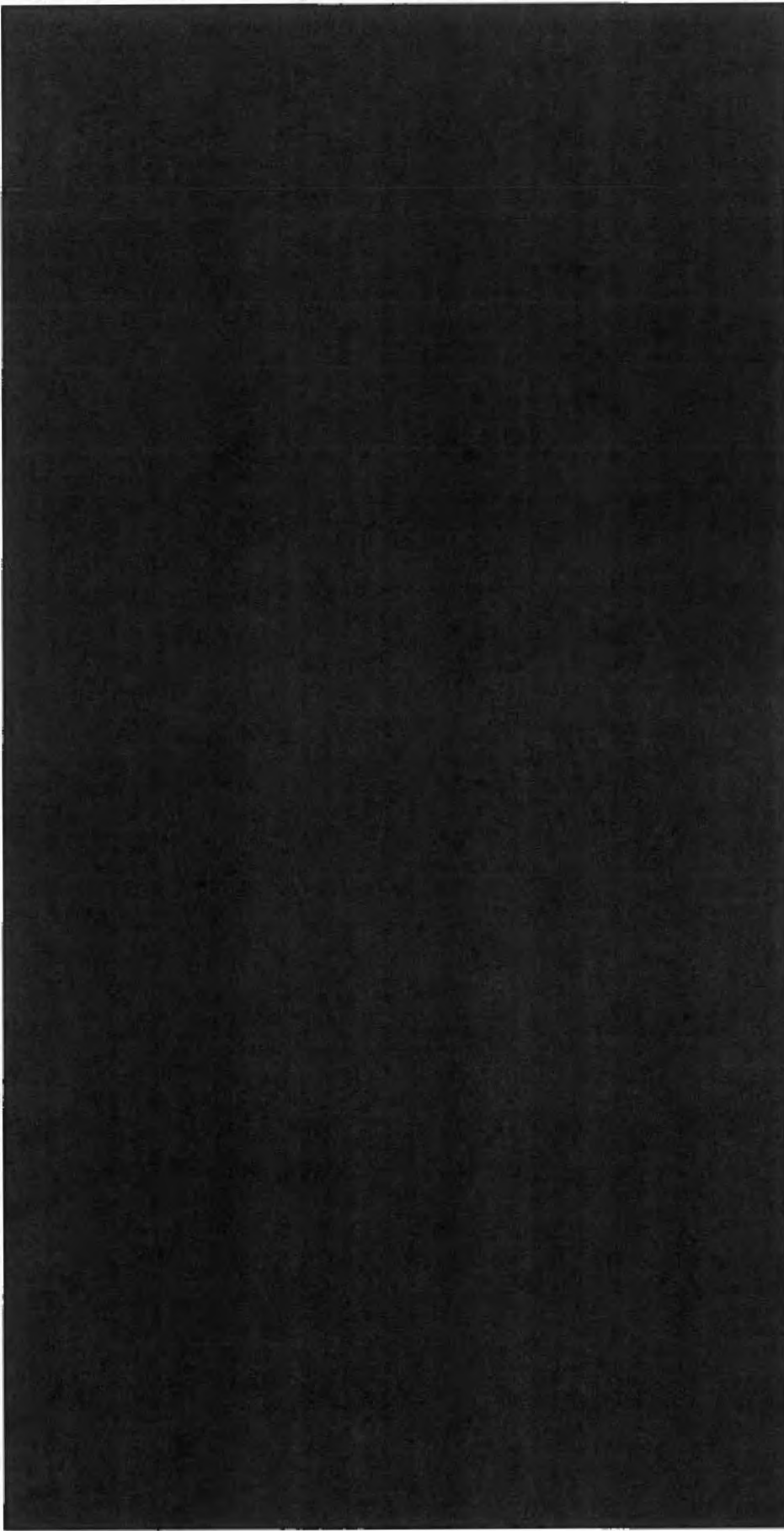
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75/90

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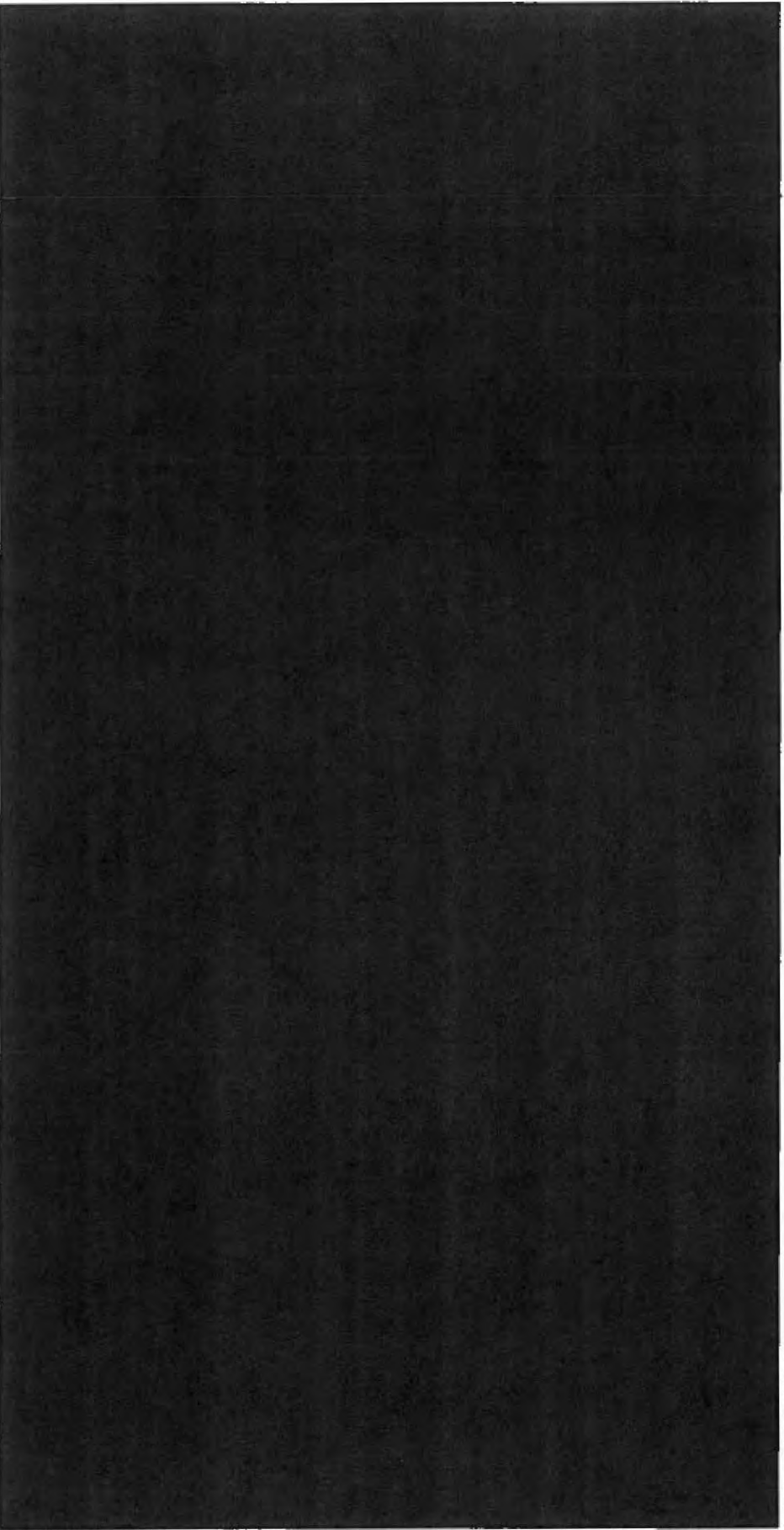


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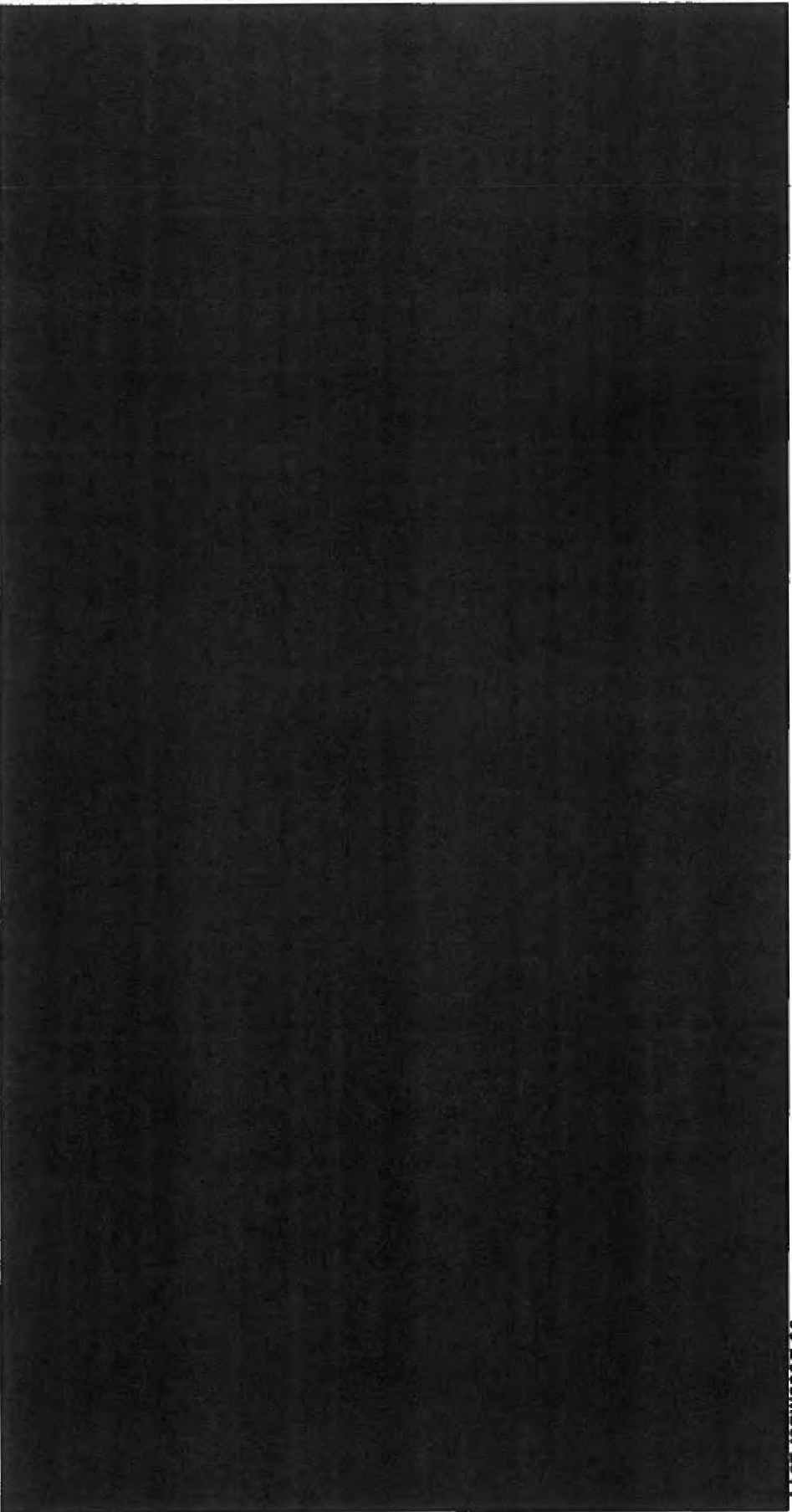


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78/90

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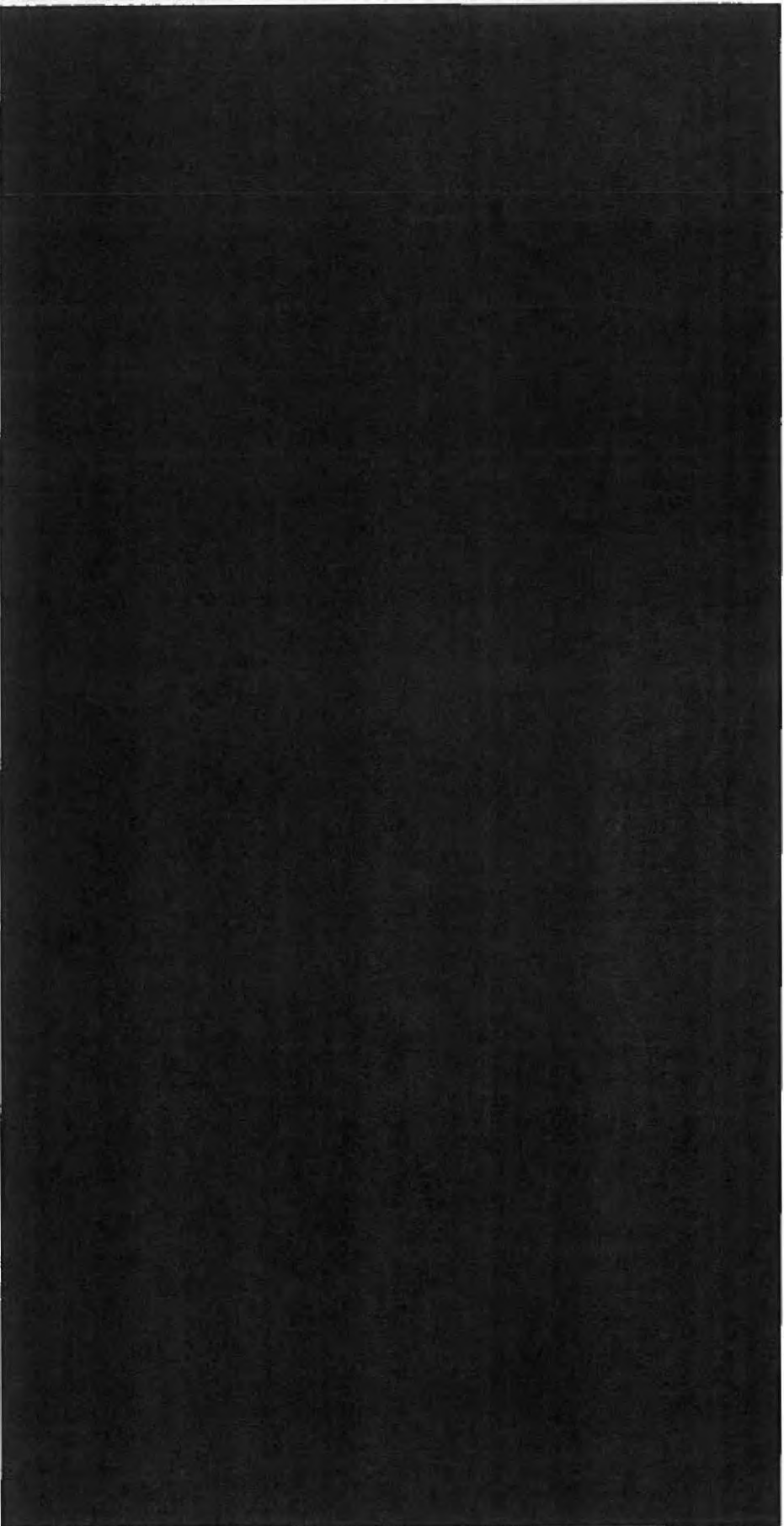
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79/90

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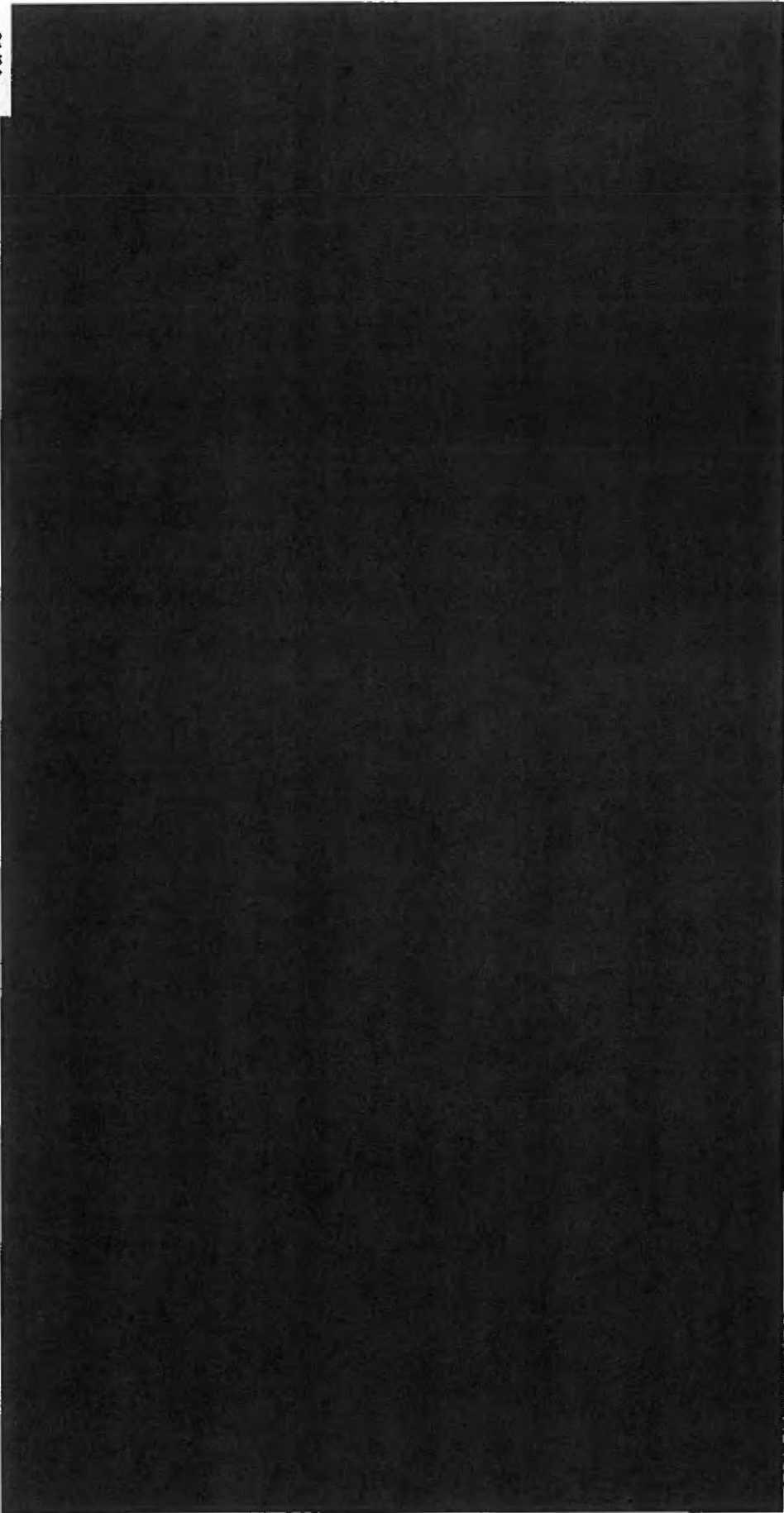


80/90

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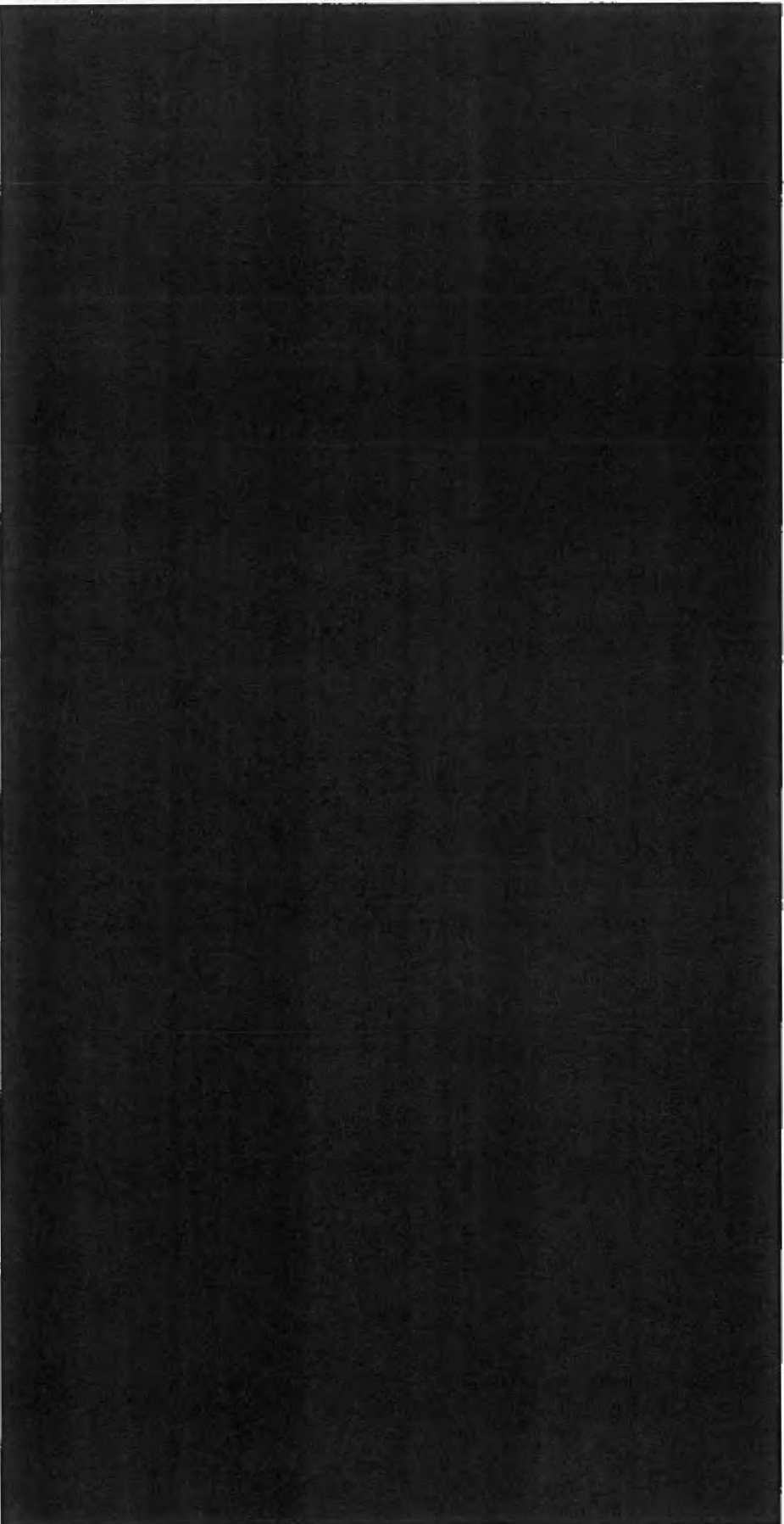


81/90

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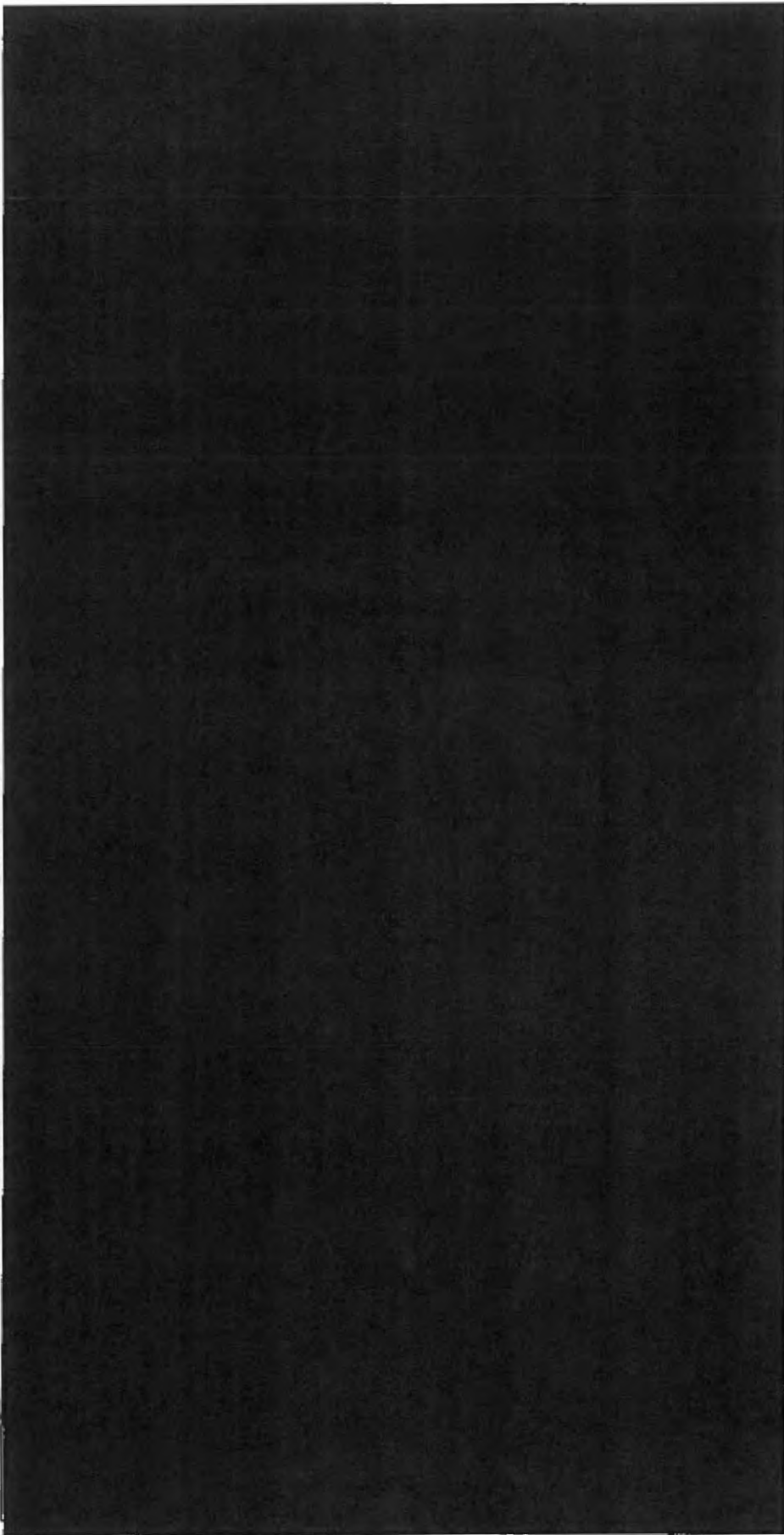


82/90

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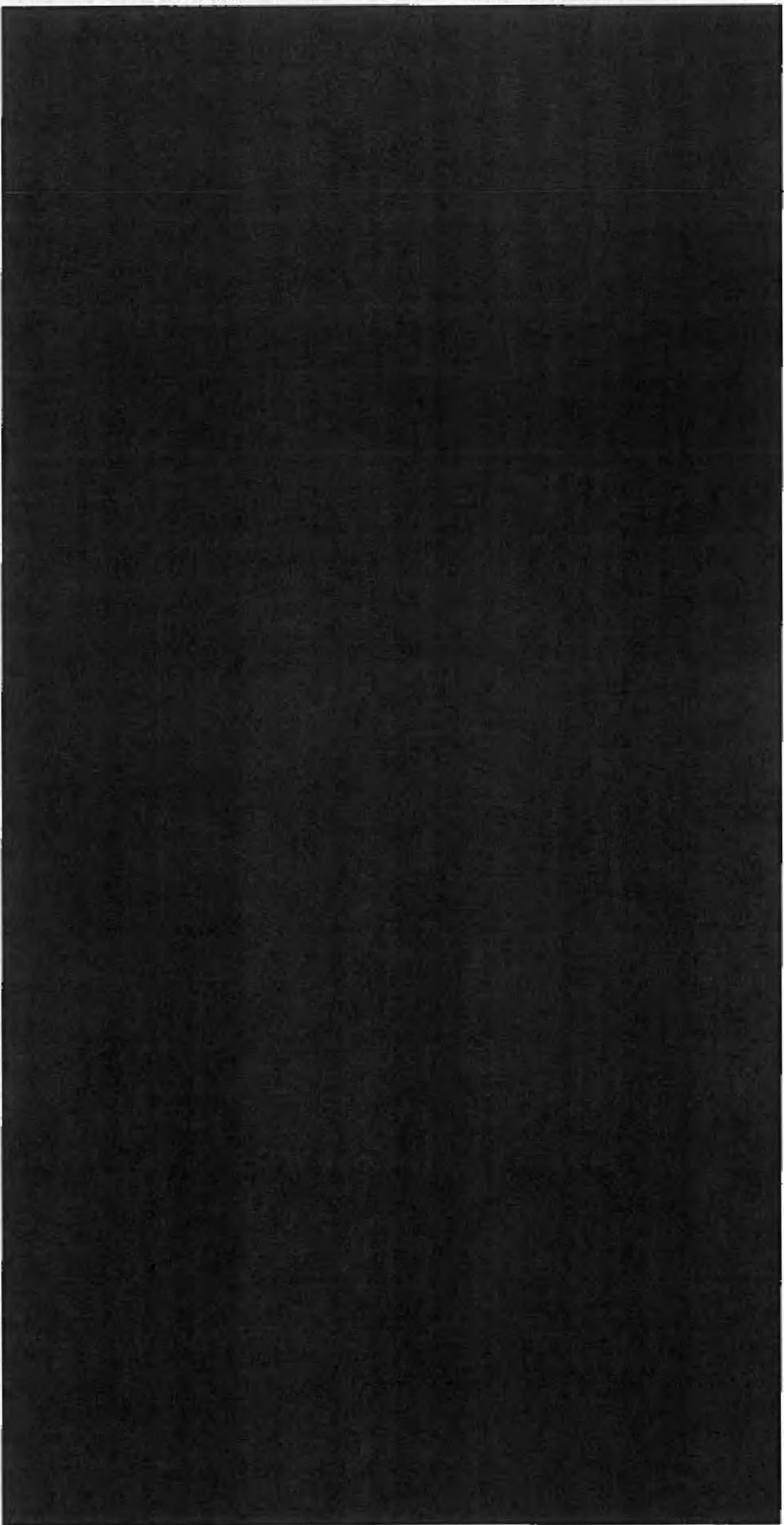


83/90

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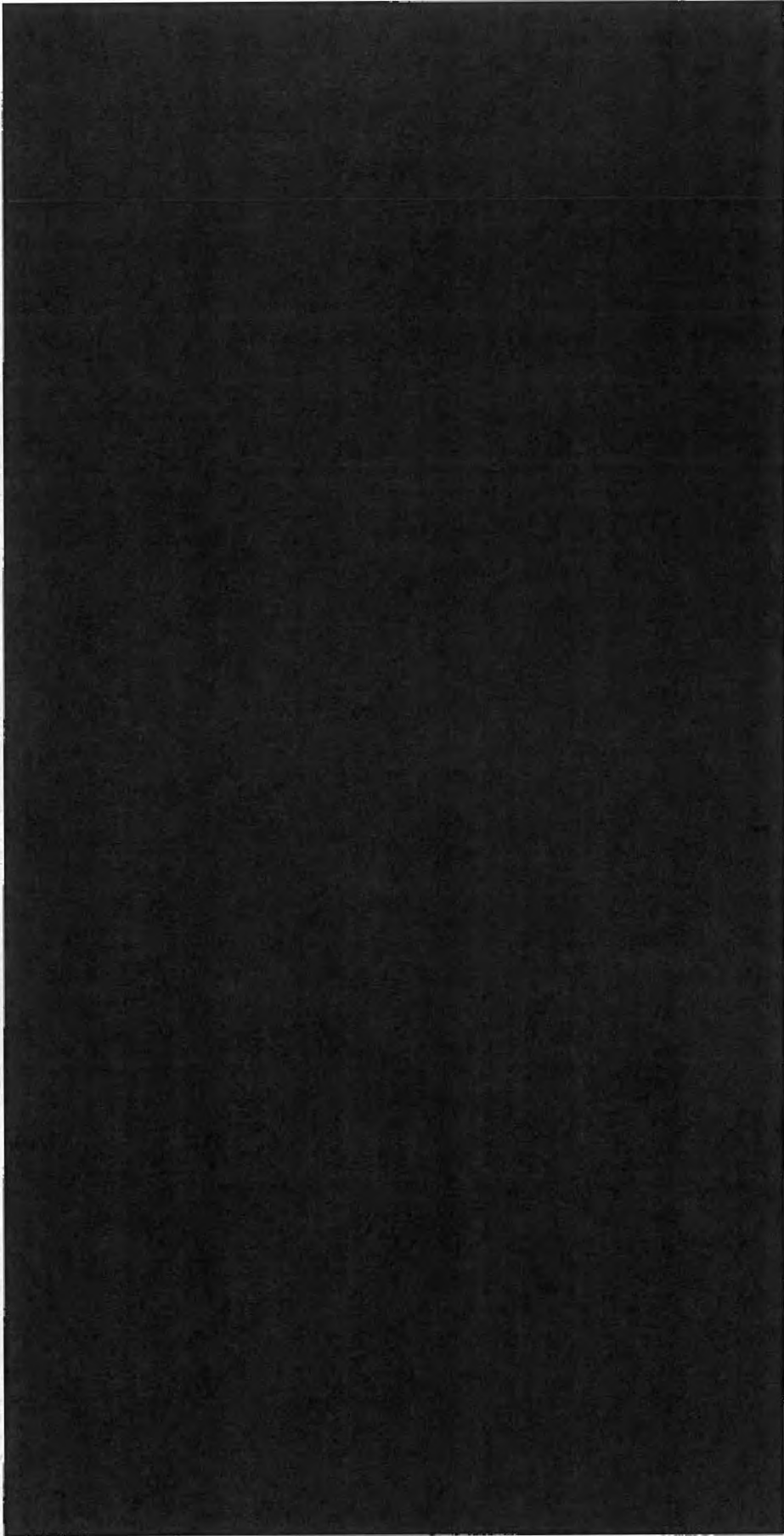


84/90

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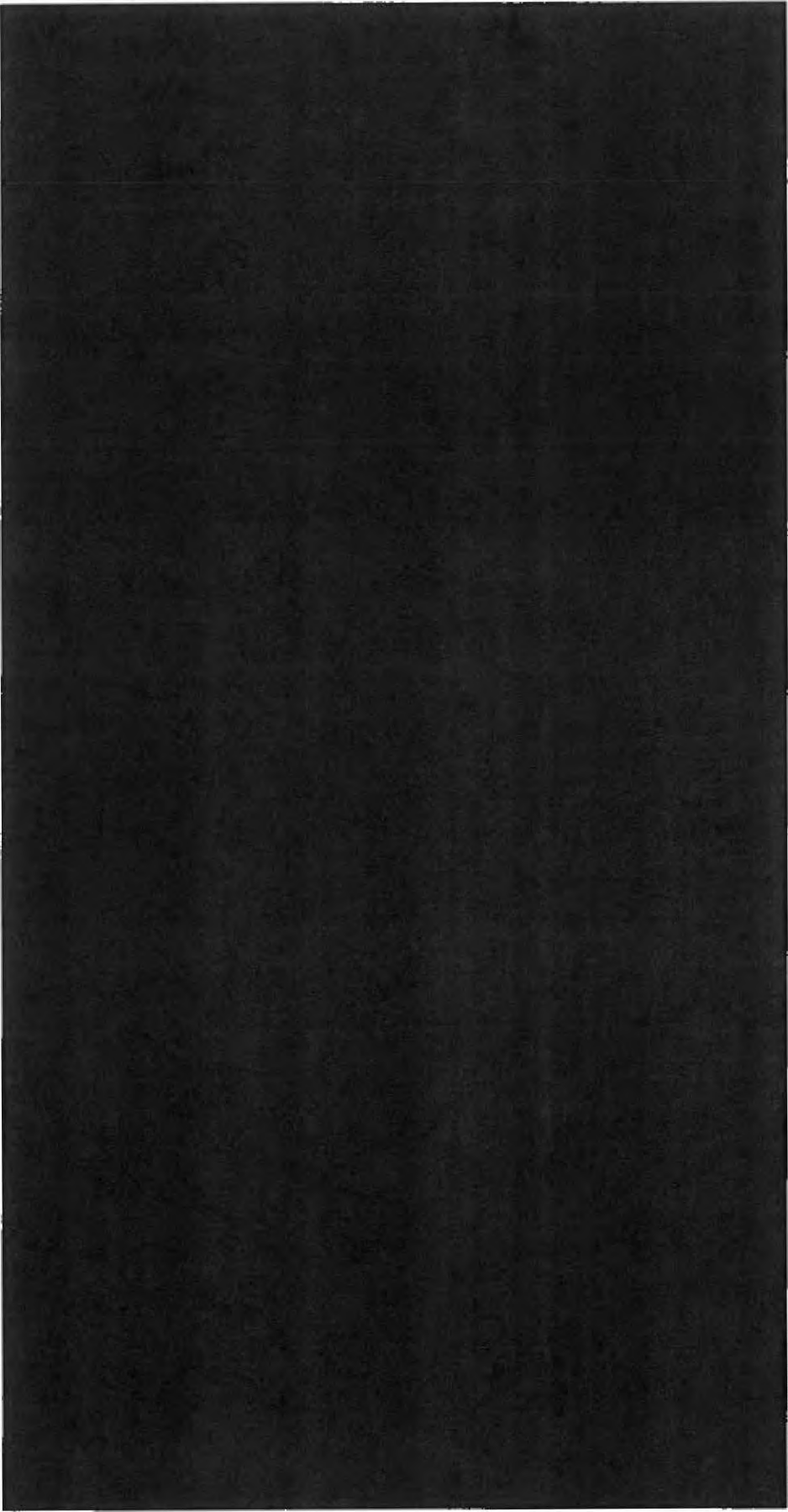


85/90

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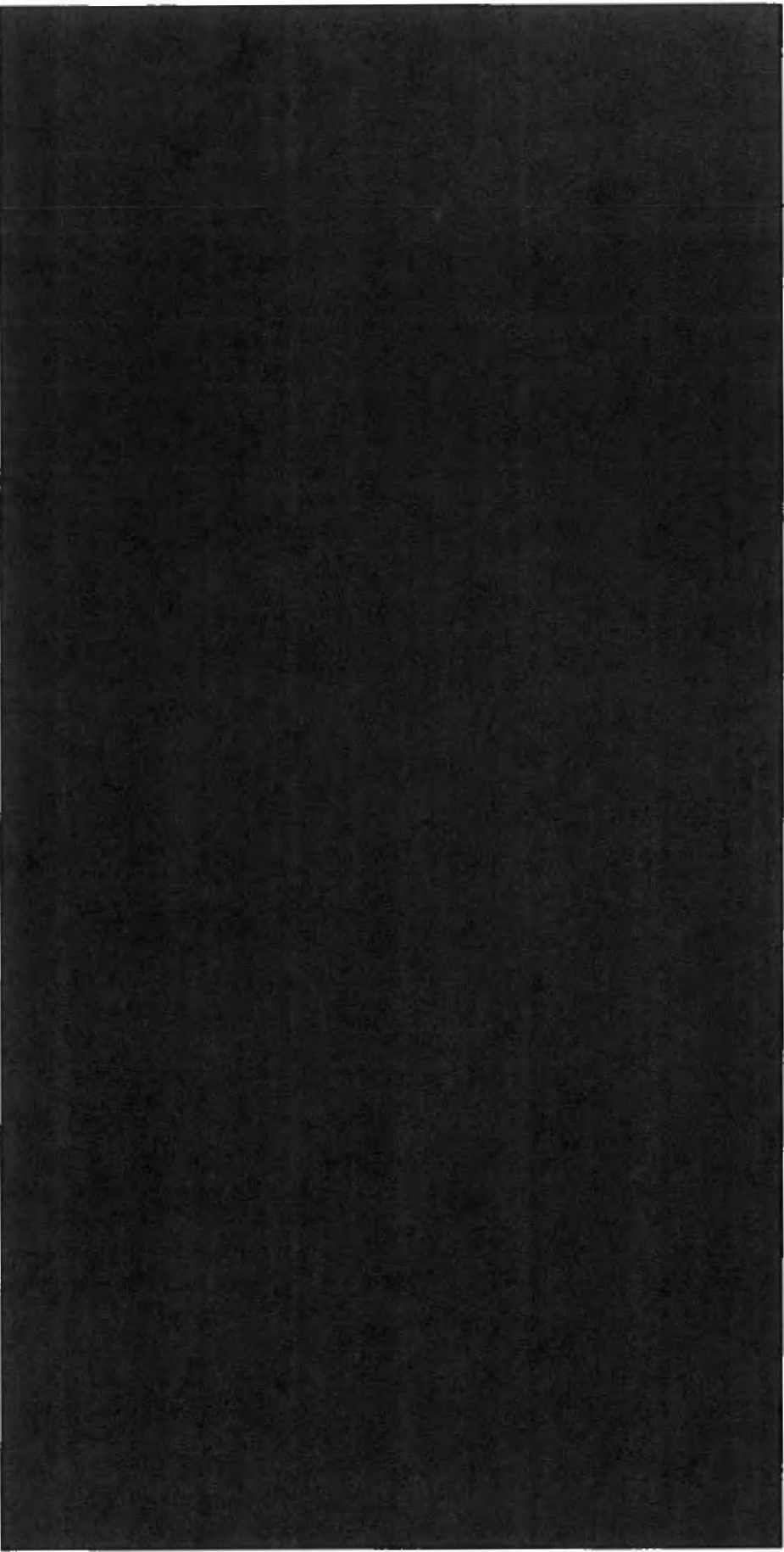


86/90

PROTECTED B

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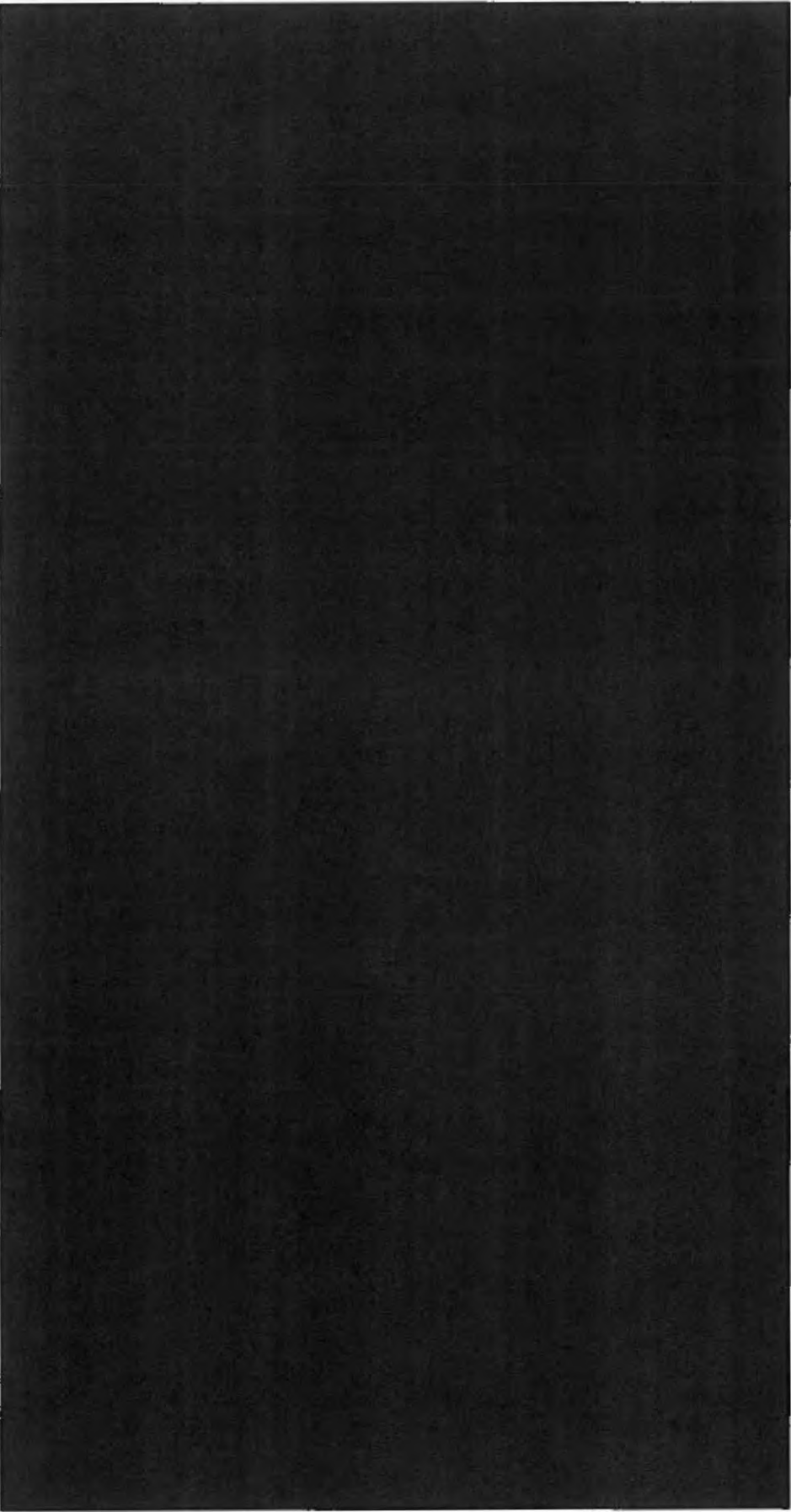


87/90

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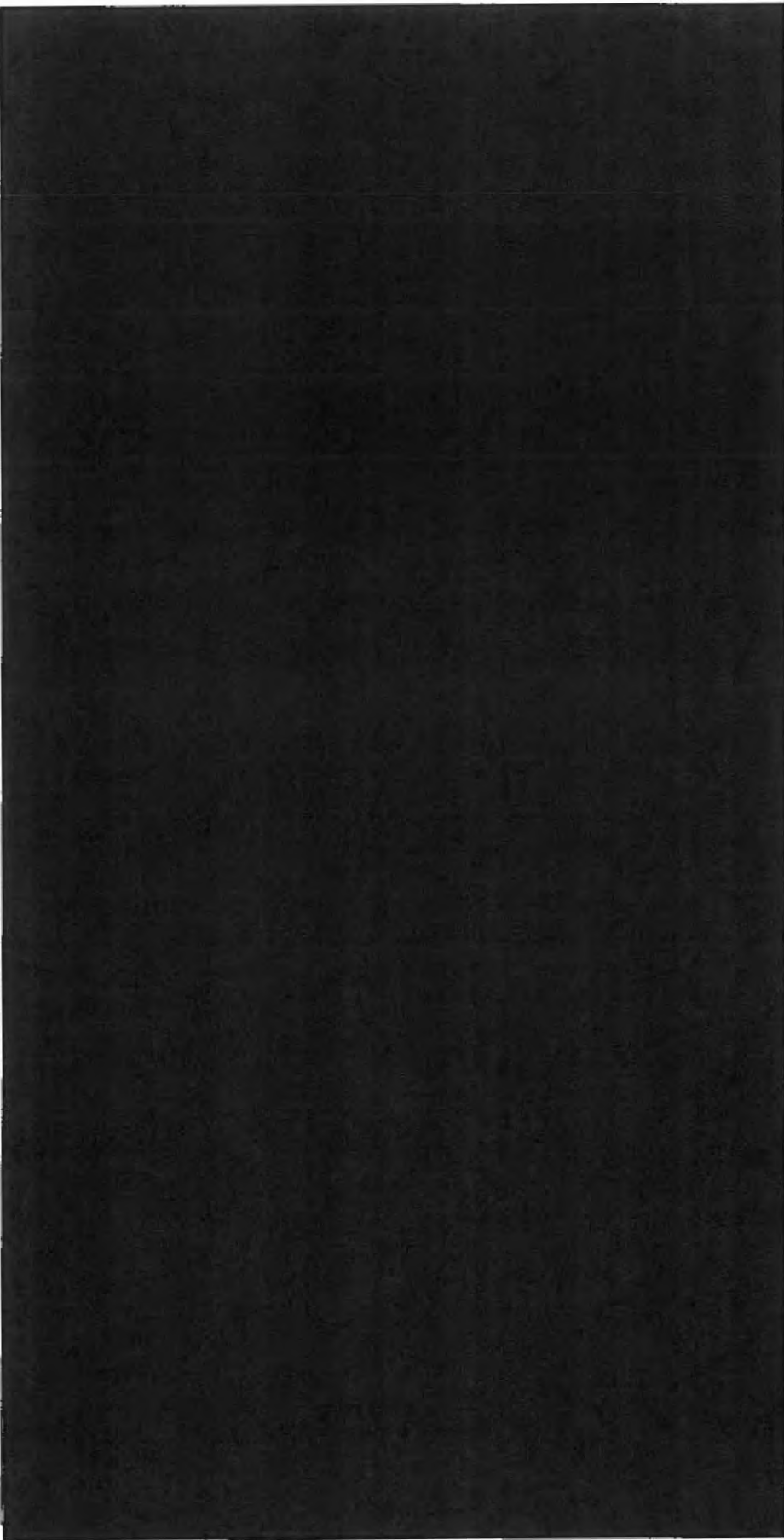


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PROTECTED B

PROTECTED B

**2120-20-2-4/2011-019
03 December 2014**



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PROTECTED B

PROTECTED B

**2120-20-2-4/2011-019
03 December 2014**



90/90

PROTECTED B

Military Police
Complaints
Commission



Commission d'examen
des plaintes concernant
la police militaire

Chairperson

Président

December 22, 2014

Colonel R.P. Delaney, CD, OMM
Canadian Forces Provost Marshal
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, ON K1A 0K2

Re: MPCC 2011-004 - Fynes

Colonel Delaney:

Thank you for your Notice of Action dated December 3, 2014 and received December 16, 2014, in response to the Commission's Interim Report MPCC 2011-004 concerning the Fynes Public Interest Hearing.

We are in the process of preparing the Final Report which will be distributed to the complainants, the subject Military Police members, as well as departmental officials. As per the practice of the Commission in public interest cases, the Final Report will be made public through posting on the Commission's website.

As you may be aware, it is the Commission's practice to include the response from the Notice of Action in our Final Report. I note you have classified your Notice of Action as "Protected B". We respectfully request that you remove the classification so that the Notice of Action may be included in the public Final Report.

Should you wish to discuss this matter further, feel free to contact me at (613) 947-5686, or a staff member from your office may contact my General Counsel, Ms. Julianne Dunbar at (613) 943-5592.

Thank you for your attention in this matter.

Sincerely,

Glenn M. Stannard, O.O.M.
Chairperson

Canada



PROTECTED B

National Defence

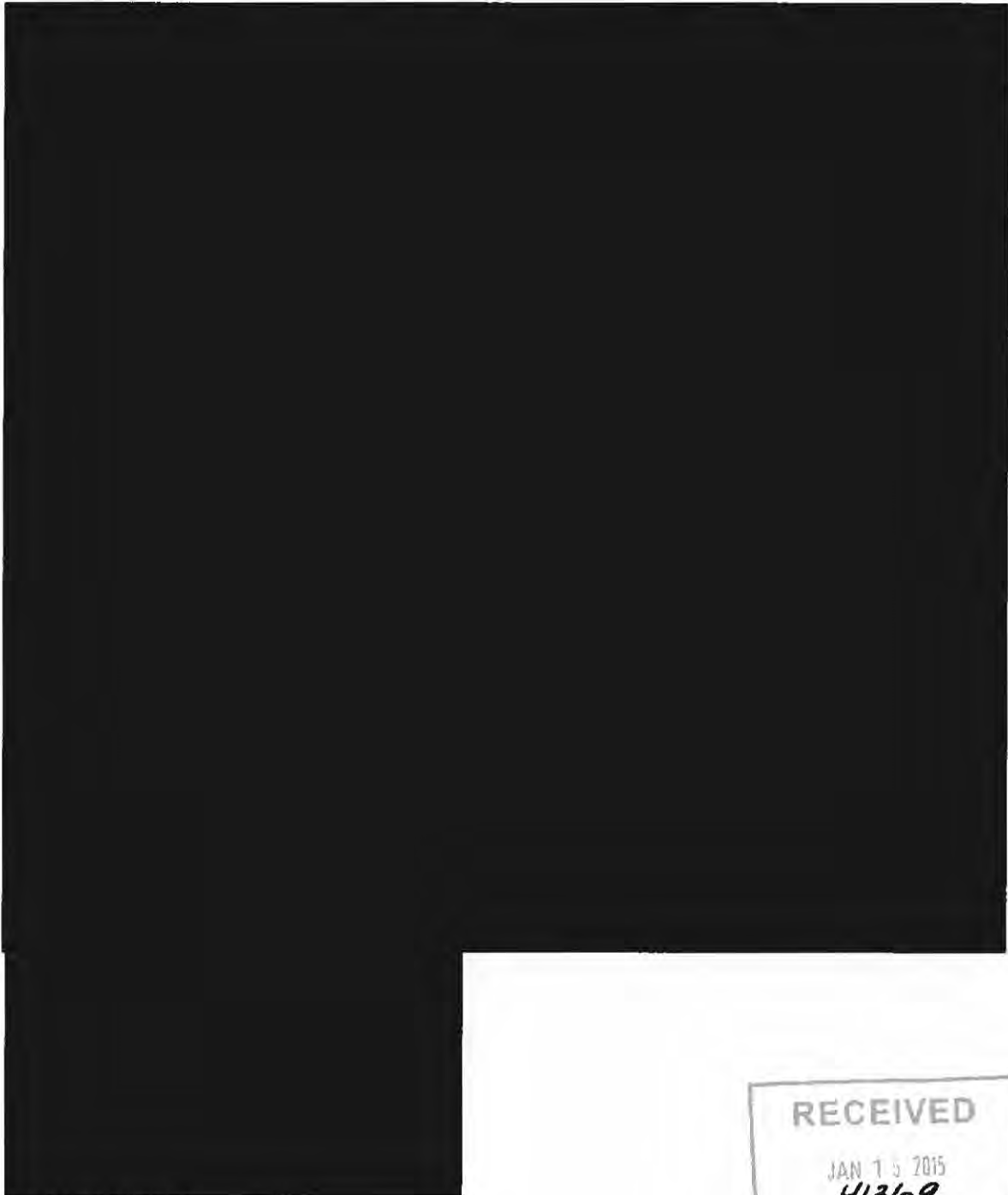
CANADIAN
MP

Canadian Forces Provost Marshal and
Commander Canadian Forces MP Gp
2200 Walkley Road
Ottawa ON K1A 0K2

Défense nationale

PM
CANADIENNE

Grand Prévôt des Forces canadiennes et
Commandant du Gp de la PM des Forces canadiennes
2200, chemin Walkley
Ottawa ON K1A 0K2



PROTECTED B

Canada

RECEIVED
JAN 15 2015
41369
Military Police Complaints Commission
Commission d'enquête des B.P.M.C.
concernant la Police militaire

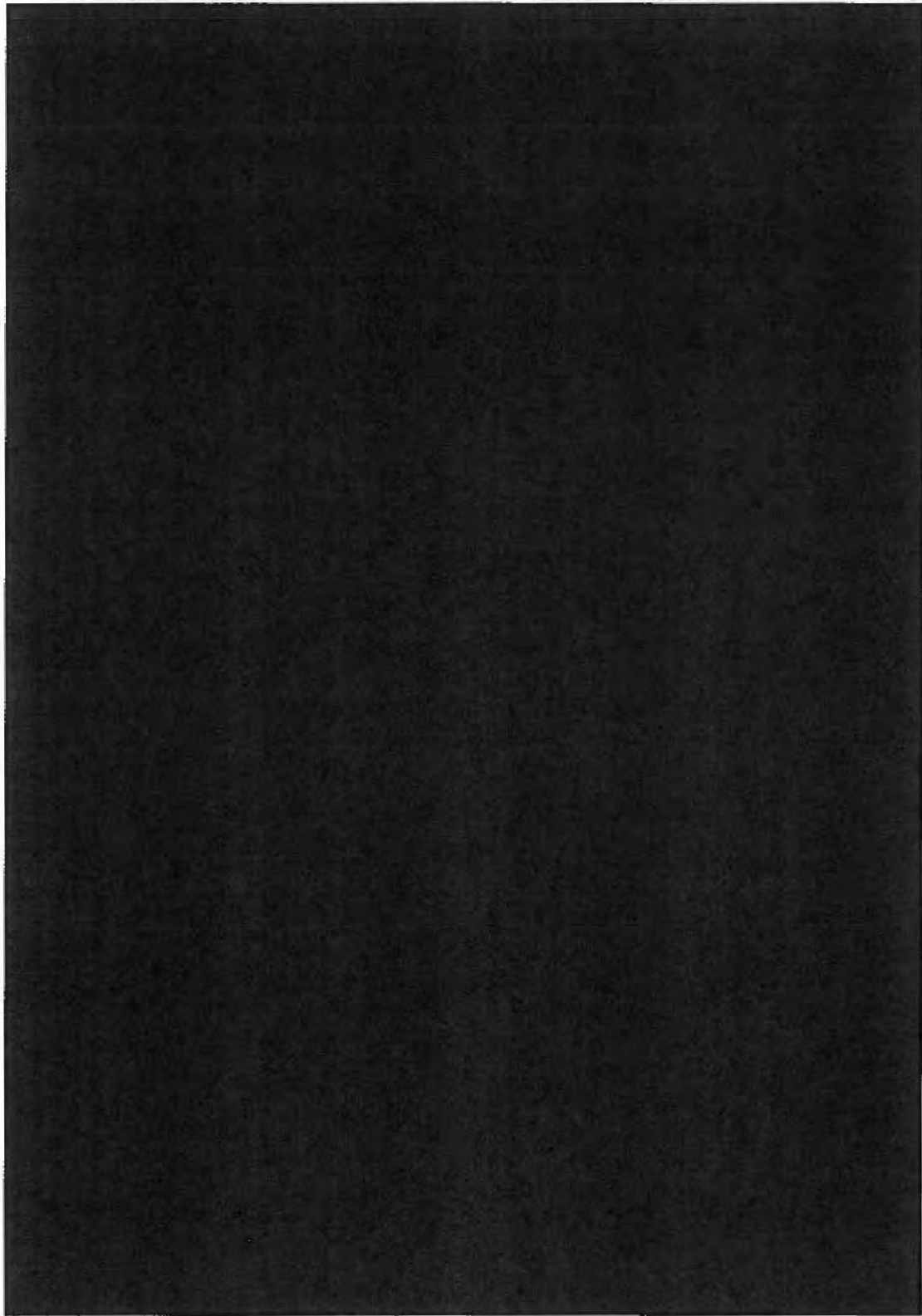
**Military Police
Complaints
Commission**



**Commission d'examen
des plaintes concernant
la police militaire**

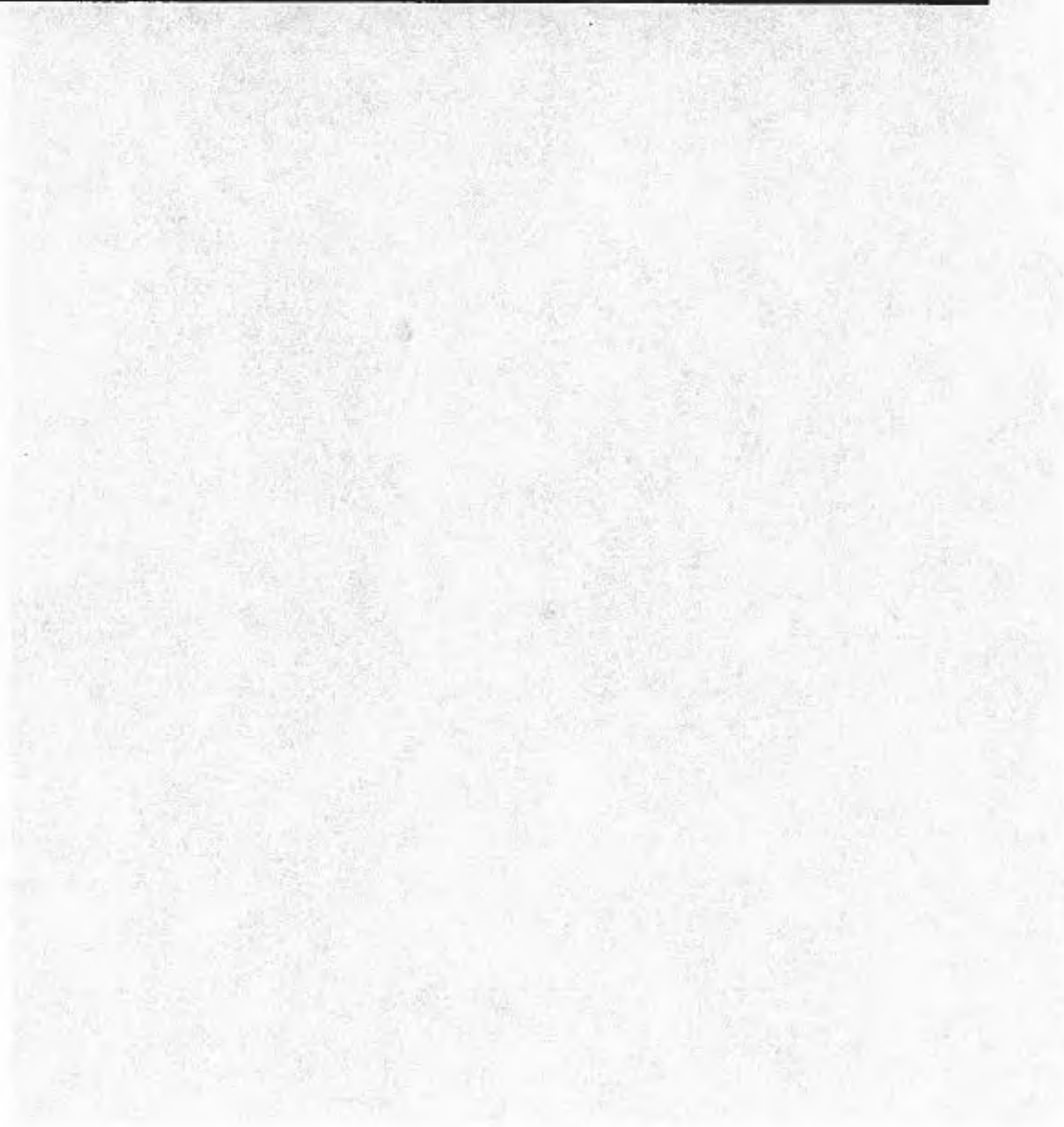
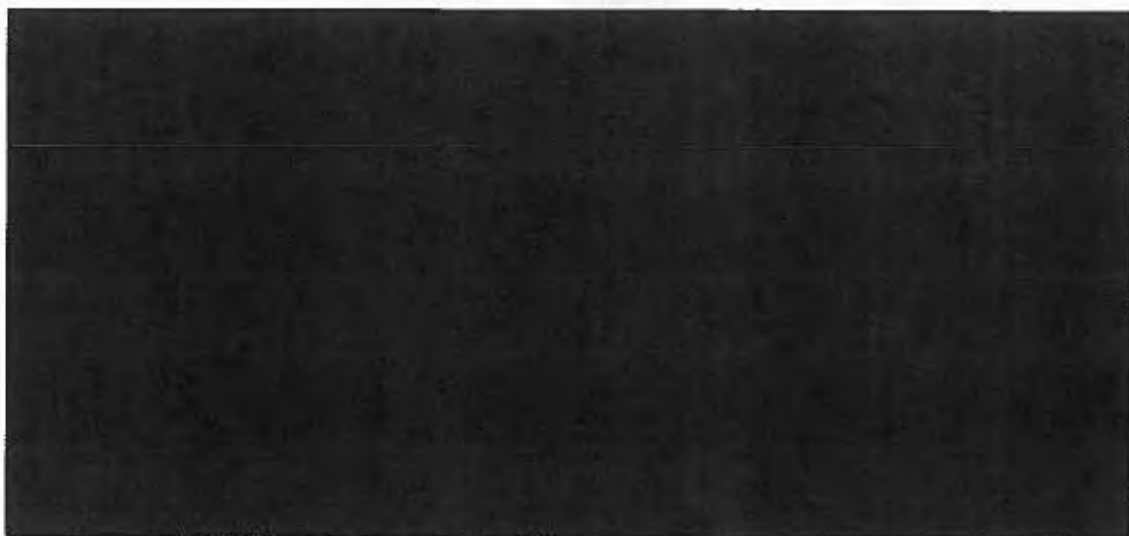
Chairperson

Président



Canada

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PROTECTED B



National Defence

**CANADIAN
MP**

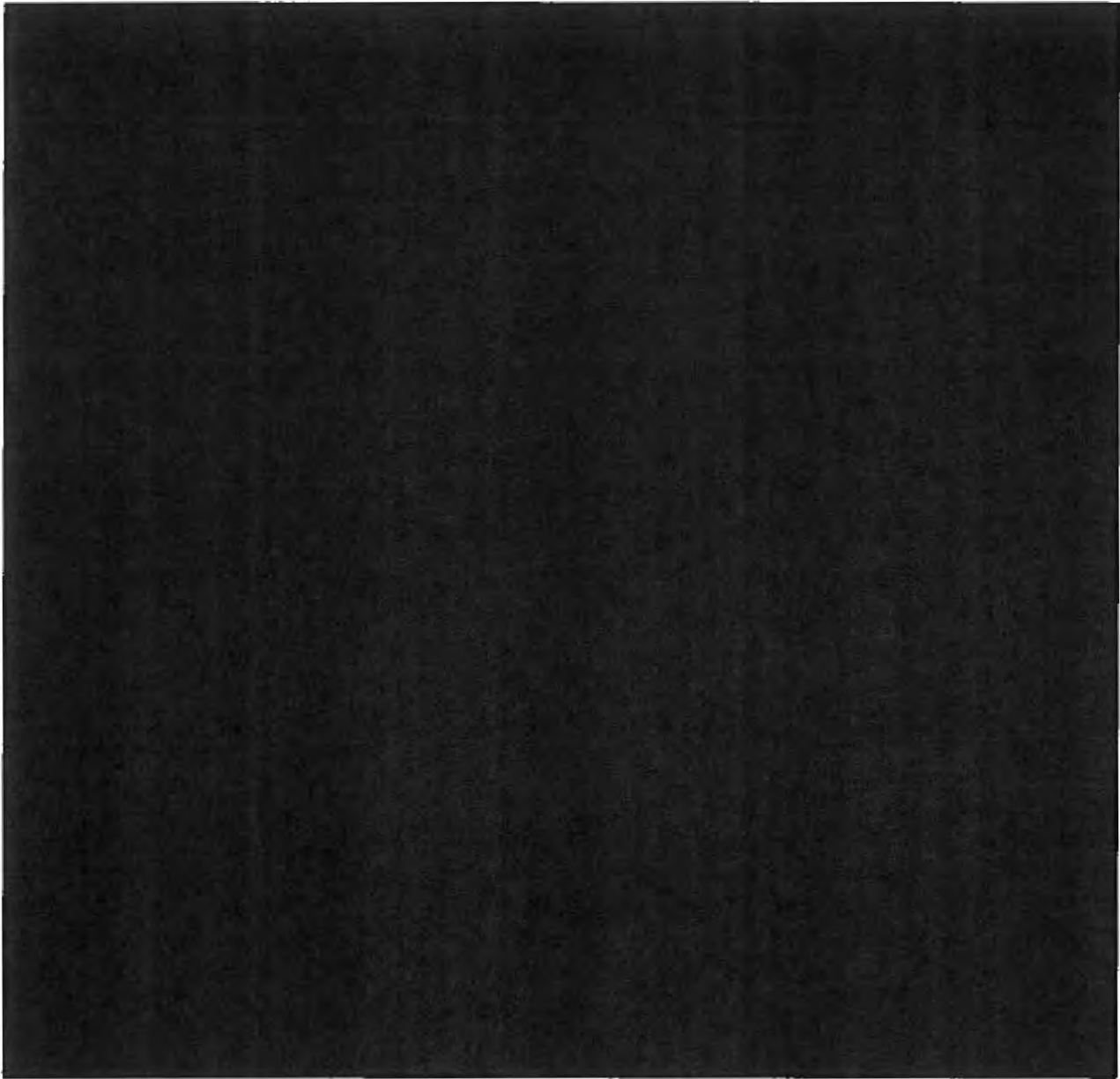
**Canadian Forces Provost Marshal and
Commander Canadian Forces MP Gp
2200 Walkley Road
Ottawa ON K1A 0K2**



Défense nationale

**PM
CANADIENNE**

**Grand Prévôt des Forces canadiennes et
Commandant du Gp de la PM des Forces canadiennes
2200, chemin Walkley
Ottawa ON K1A 0K2**



PROTECTED B

Canada

Military Police
Complaints
Commission

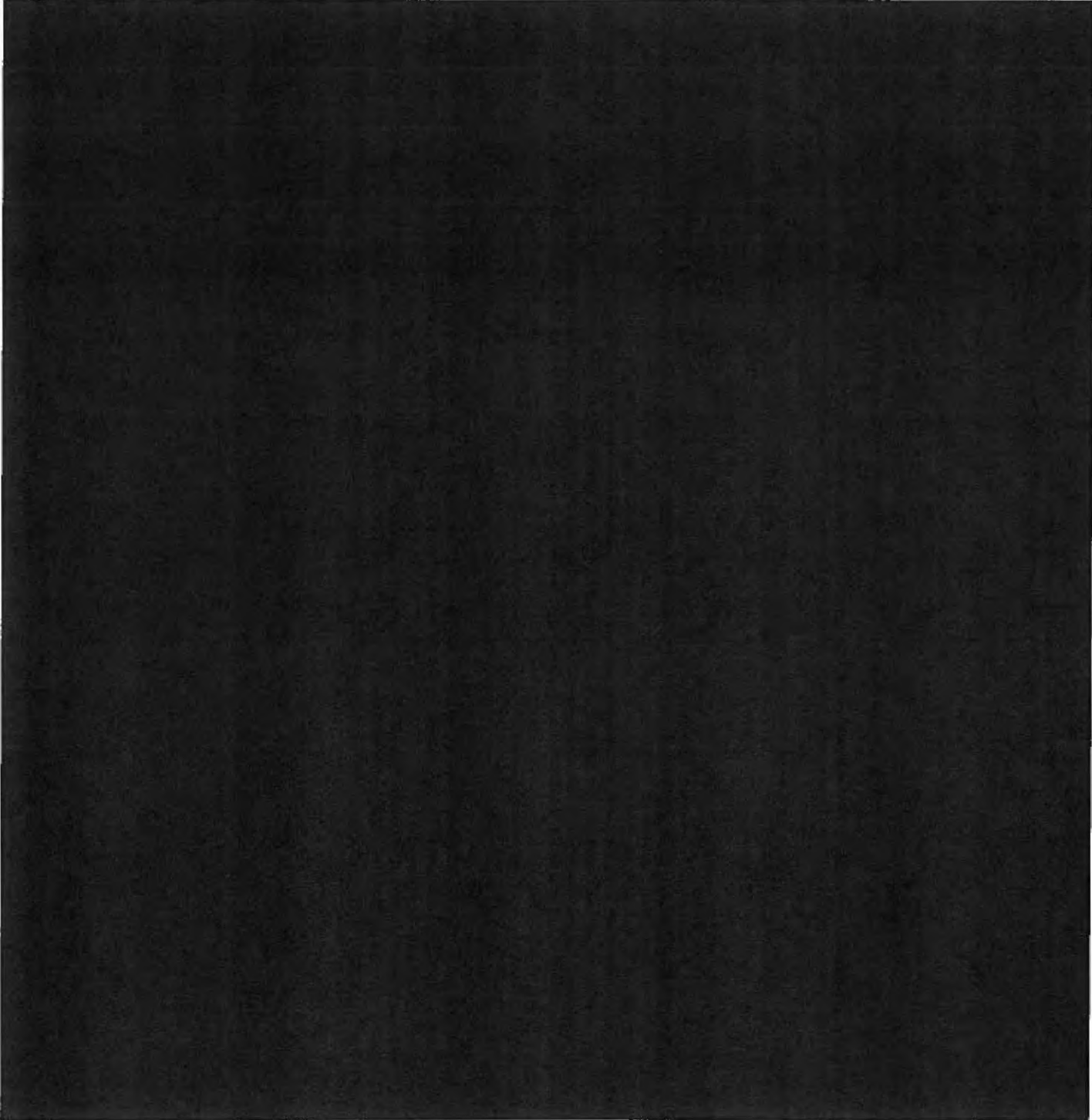


Commission d'examen
des plaintes concernant
la police militaire

Chairperson

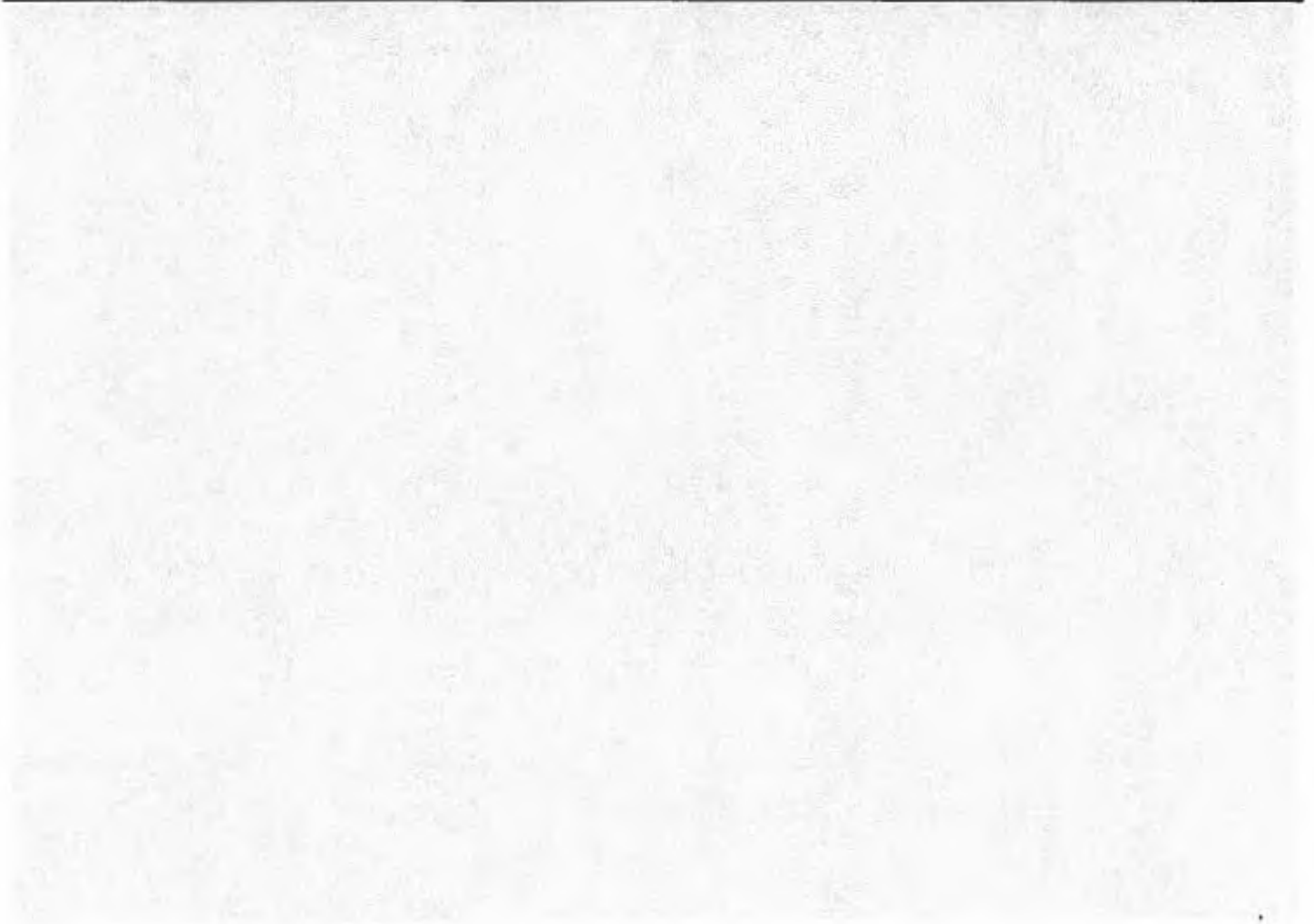
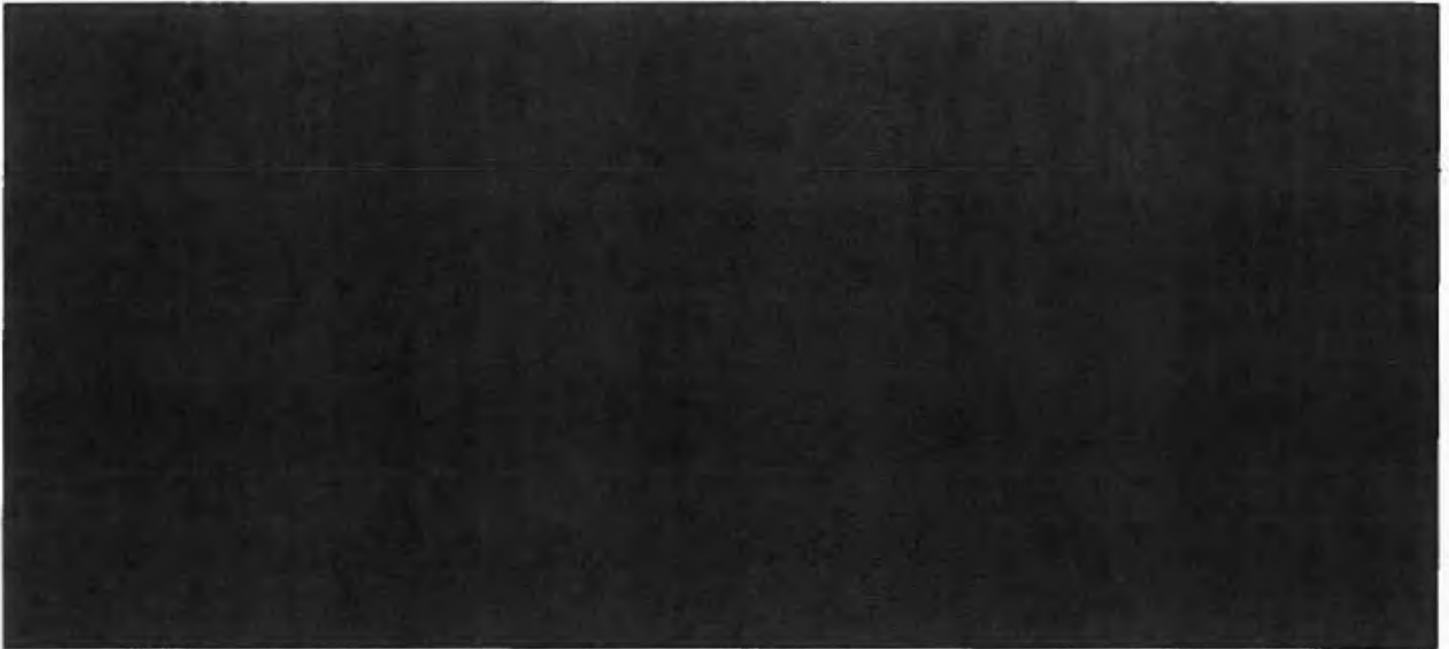
Président

Via E-Mail



Canada

.../2





National Defence

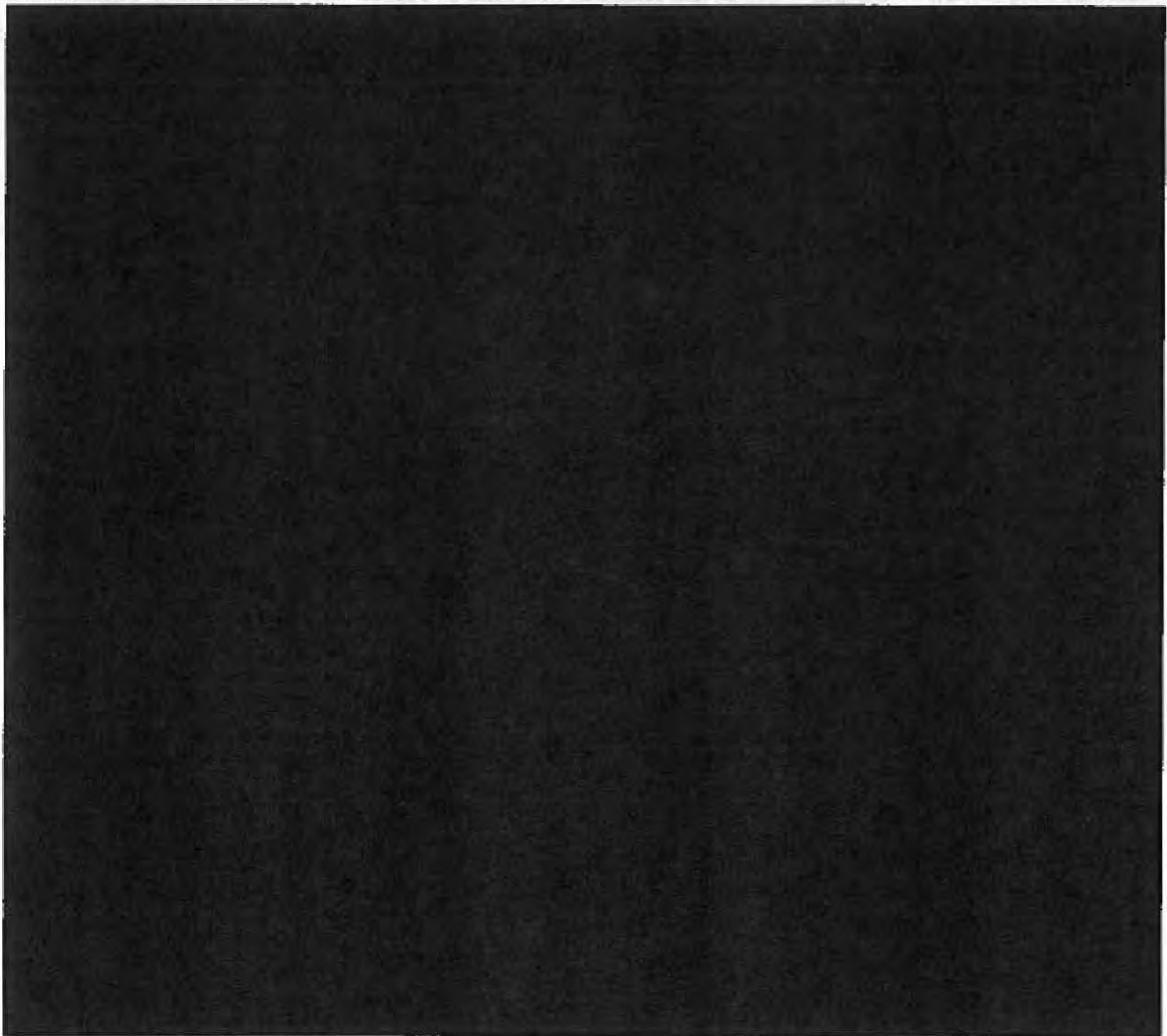


Canadian Forces Provost Marshal and
Commander Canadian Forces MP Gp
2200 Walkley Road
Ottawa ON K1A 0K2

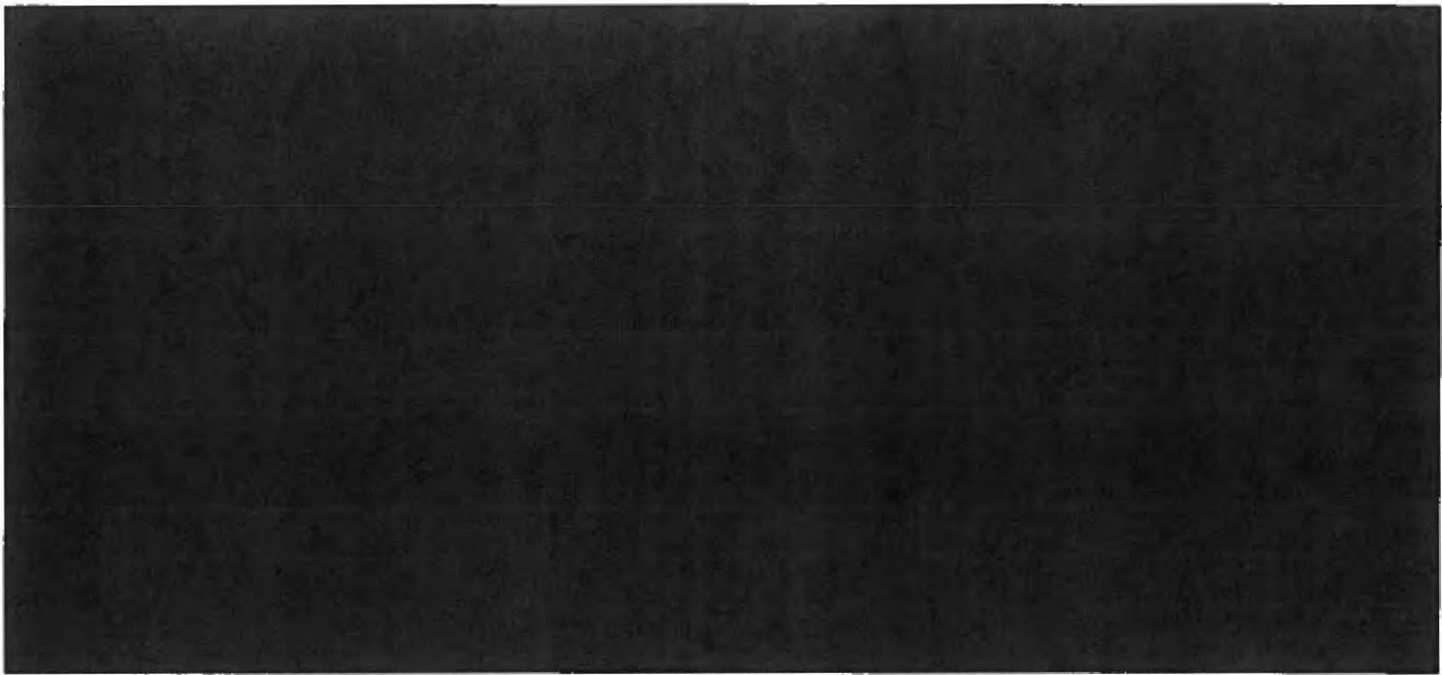
Défense nationale



Grand Prévôt des Forces canadiennes et
Commandant du Gp de la PM des Forces canadiennes
2200, chemin Walkley
Ottawa (Ontario) K1A 0K2



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FEB 06 2015
42084
Military Police Equipments Commission
Commission de l'équipement des plaintes
criminelles la Police militaire



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FEB 06 2015
42084
Military Public Complaint Commission
Commissariat de plaintes des militaires
Département de la police militaire



National Defence

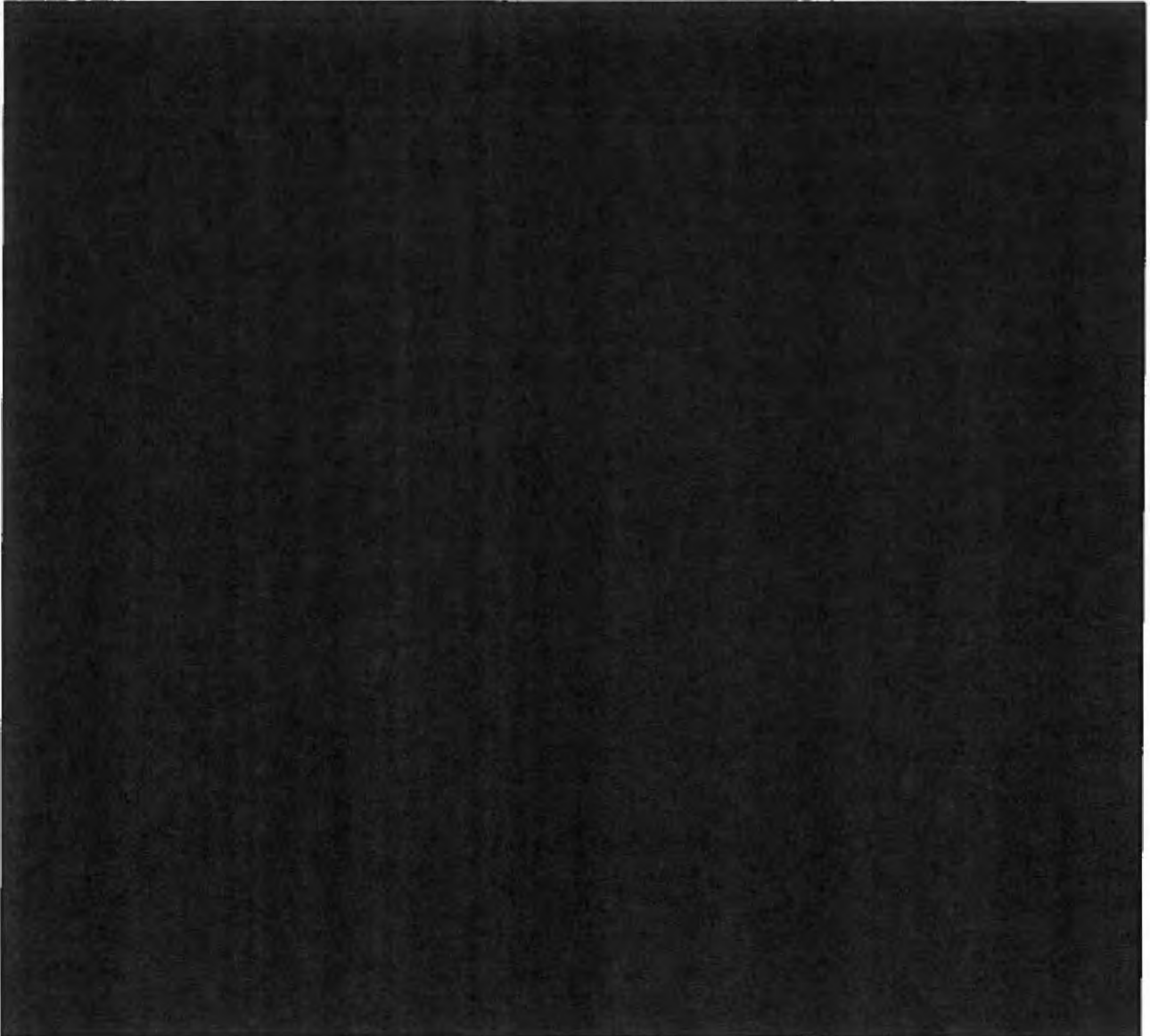
CANADIAN
MP

Canadian Forces Provost Marshal and
Commander Canadian Forces MP Gp
2200 Walkley Road
Ottawa ON K1A 0K2

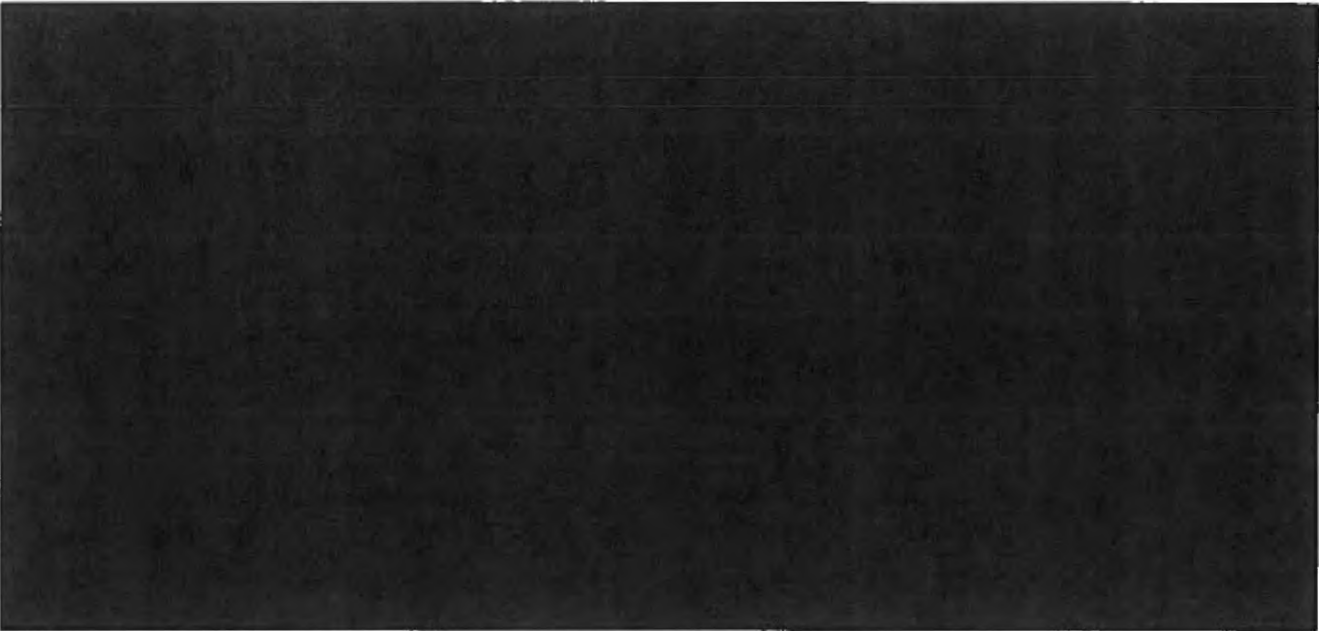
Défense nationale

PM
CANADIENNE

Grand Prévôt des Forces canadiennes et
Commandant du Gp de la PM des Forces canadiennes
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Ottawa (Ontario) K1A 0K2



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FEB 11 2015
42085
Military Police / Gendarmes militaires
Commissariat d'enquête des plaintes
reçevant la police militaire



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MAR 11 2015
42085
Military Personnel Services and Commission
Central Postal Directory

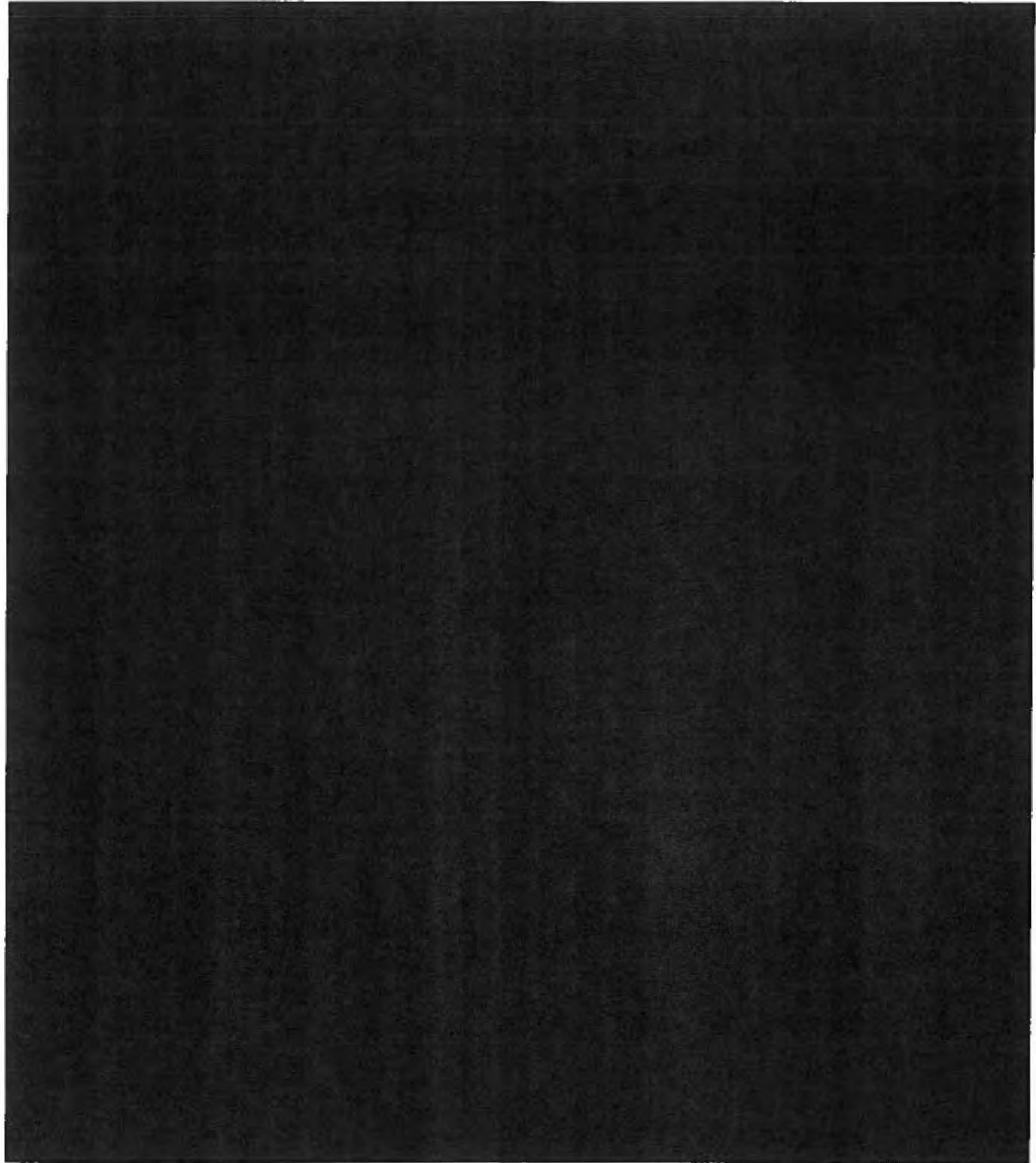
Military Police
Complaints
Commission



Commission d'examen
des plaintes concernant
la police militaire

Chairperson

Président



Canada