Final Report

When a Soldier Falls: Reviewing the Response to MCpl Rick Wheeler's Accidental Death

December 20, 2004

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Foreword

1 The report, *When a Soldier Falls: Reviewing the Response to MCpl Rick Wheeler's Accidental Death* is huge – necessarily so given that it chronicles complex events over more than a dozen years. I have therefore taken the unusual step of preparing, in addition to an Executive Summary a more detailed but still abridged Report Summary. For those with a deep interest in this affair, neither the Executive Summary nor the Report Summary should replace a reading of the full Report. The full Report contains many details that cannot be encapsulated in the Summaries. More importantly, it sets out the text of, and explains, the many recommendations I make.

Executive Summary

2 On April 7, 1992, MCpl Rick Wheeler died during a training accident when he was run over by an armoured personnel carrier. The unsatisfactory aftermath of that tragedy has played out for more than a dozen years. It started with inadequate support being provided to MCpl Wheeler's wife, Christina, and to his father, Bill Wheeler. Christina Wheeler was informed of the death by a chaplain who had no connection to MCpl Wheeler, without the support of anyone from his unit. She was left alone for hours after being devastated by the tragedy. Bill Wheeler and his family, who had raised MCpl Rick Wheeler, were largely forgotten by the CF.

3 While the Assisting Officer assigned to support Christina did a commendable job in the days after the tragic death of her husband, the relationship did not last as he was replaced, not once, but twice. Many times she felt, with reason, as if she had been left alone. Of particular concern is that little support was provided to her where it was probably most needed – in the supply of information about exactly what happened. She craved information so that she could come to terms with the death of her husband, but found, at best, disinterest, and at worst, obstruction. In fairness, that obstruction was often tied to regulations, rules and to ungenerous interpretations of the law. Her frustration could have, and should have been lessened by a more sensitive appreciation of the importance of her need to know. In the end, distrust was built where there should have been a lasting bond.

4 Exactly what happened during the accident is still, to some extent, unsettled. This is, in part, because the initial investigation was defective. The chain of command failed to preserve either the accident scene or the integrity of witness observations. An amateurish attempt at investigation before the investigators arrived made matters worse. Then the Military Police took over. While the assigned Military Police investigator worked with the RCMP, that did not improve matters because the interest of the RCMP was confined to potential criminal fault. The Military Police investigation was unquestionably too abridged. Attention focused almost exclusively on those

who saw the accident, with little attention being given to potential responsibility on the part of those who were in command, or to more systemic safety issues. As a result, key witnesses, people who would become the centre of interest in later years, were not even interviewed.

5 The administrative investigation by the chain of command that followed was also inadequate. A Board of Inquiry should have been ordered. Instead, a Summary Investigation was conducted, trivializing in some measure the importance of the tragic event and compromising on the kind of investigation record that would be built. Worse yet, a junior officer, who was under the direct authority of persons who would subsequently become suspects was assigned to conduct it. Again, the focus of the investigation was too narrow, and key witnesses were not interviewed. Not only contrary to CF directives, but contrary to common sense, part of the blame was ascribed to MCpl Wheeler for not having stood up to signal the driver who, four seconds earlier, had turned in his direction amidst the noise and fog of simulated combat. This finding caused pain to the surviving family, and the decision to blame the victim deepened suspicion that the truth was not being told. After years of requests and applications for information, met by incomplete summaries and heavily edited reports, Christina Wheeler went public. Only then did she command the attention of the CF in her effort to get the whole story. It did not take long, once people began to listen, to appreciate that the Summary Investigation had been seriously flawed. In 1997, a Board of Inquiry was ordered.

6 That Board of Inquiry also failed. The composition of the Board was far from optimal. No-one with adequate expertise and senior command experience in mechanized infantry operations participated. Moreover, the Board members were, quite simply, inadequately trained to conduct a complex investigation. The Board of Inquiry was tasked, among other things, with finding who was responsible for the death of MCpl Wheeler. An Administrative Review Board was later to identify what it considered to be inappropriate attention by the Board of Inquiry to potential blame on the part of the chain of command. That meant that the focus became LCol (retd) Lapeyre. Because of an inadequate understanding of the significance of assigning even indirect responsibility for MCpl Wheeler's death to these men, the Board of Inquiry treated these men as ordinary witnesses. They were given no chance to

defend themselves before findings of responsibility were issued against them when the Board of Inquiry completed its report, findings of blame that would not withstand close scrutiny.

7 Those findings rested primarily on two foundations. The first foundation was the belief that these men allowed a "supervisory vacuum" to occur when Maj Semianiw absented himself from the base the day before the exercise, leaving no Chief Controller for the exercise. That finding was wrong. Capt (now LCol) Kaduck had in fact filled that role. There is no adequate explanation for this key error. The evidence of a "supervisory vacuum" was inconsistent, and the testimony supporting that finding was problematic on its face. No effort was made to clarify the issue and available evidence and information was missed.

8 The second foundation for the finding was the failure by these men to integrate existing safety orders into their training regimen. In fact, one of the identified orders did not apply. As for the other, there was no satisfactory proof that it had even been received by the unit at the time of the exercise. Indeed, the evidence suggested the contrary.

9 The Reviewing Authorities were alerted to deficiencies in the Board of Inquiry Report when the Report was scrutinized. To their credit, they were attuned to the impropriety of assigning blame in the absence of evidence that the identified failings contributed to the death of MCpl Wheeler, so reference to fault was excised before the Report was released. But the infirm findings that these men had failed in their duty were affirmed, notwithstanding that problems with those findings had been identified. Worse yet, and even though the Board of Inquiry which had found "indirect responsibility" had recommended against administrative action against the men, LCol (retd) Lapeyre was formally sanctioned. Then a media release was issued in 1998, over the objection of LCol (retd) Lapeyre, even though he had presented a solid foundation for concern, and wanted time to make his case as to why the Board of Inquiry was so wrong. His request was refused. The urge on the part of the CF to be open and accountable, ordinarily one to be applauded, was permitted to override the need to be fair. The reputation of LCol (retd) Lapeyre was harmed as a result. In the ensuing years, his retirement was not one where he could sit back in the knowledge that his career had been

appreciated. He was a man who, in what should have been the high point of his career, was depicted as having mismanaged an exercise in which one of his soldiers had died.

10 As for Christina Wheeler, she was stung by the delays in being advised of the results of the Board of Inquiry. She did not receive a copy of the Board of Inquiry Report in a timely fashion, and the information that was provided to her, while voluminous, was edited, and only a portion of what had been gathered. She received enough, however, to learn that, for the first time in the six years since the accident, failings by the chain of command had been identified. Suspicions of a cover-up seemed to be confirmed, and the response, the receipt of a letter of displeasure by LCol (retd) Lapeyre, with many pages of the Report being kept from her, seemed to be inadequate.

11 Within a year, the Board of Inquiry Report had been discredited. Major (now LCol) Kaduck came forward and confirmed that there had been no "supervisory vacuum," as he had acted as Chief Controller. The CF dithered, insecure about how to respond, and kept Mrs. Wheeler in the dark about this new development. Instead of simply confirming the new information, a CFNIS investigation was conducted into possible perjury charges against Maj Kaduck, whose new information was inconsistent with his testimony at the BOI, and the CF awaited the results before taking any corrective action. That investigation, of which Mrs. Wheeler was kept well apprised, rejected perjury charges as unsustainable but confirmed that the Board of Inquiry finding of a "supervisory vacuum" that had been publicized against LCol (retd) Lapeyre was wrong, dead wrong. No publication of this fact was undertaken. After many months of weak response, an Administrative Review Board was ultimately empanelled. Mrs. Wheeler, for her part, was left in the dark while that Board deliberated before ultimately eviscerating key findings by the Board of Inquiry. She was again advised of this, in summaries and edited documents – a mere bystander left to await word on a matter that meant a great deal to her. On September 4, 2003, LCol (retd) Lapeyre was cleared when the Board of Inquiry findings were officially amended.

12 As stories go, this is a sorry one, a tale of missteps and misjudgment, of inattention and insensitivity. Fortunately, it is also largely an historic story – things have improved appreciably as the CF has learned from hard lessons. The Lapeyre-Wheeler affair is an opportunity, however, to learn more. Gains made need to be systematized, and training needs to be improved. I provide

a host of recommendations in this Report intended to improve the manner in which investigations are done. As important, this is an opportunity to develop a comprehensive, central policy for supporting families of those who die or are seriously injured in the service of their country. To that end, I make a raft of recommendations.

13 I am pleased to report that the CF has accepted in principle the majority of the systemic recommendations contained herein. They have acknowledged that an overhaul of the process by which internal military investigations are conducted is required and a major review of the Board of Inquiry scheme has been promised. I have encouraged the CF to draw from the best practices of other militaries and from the civilian coroner's system in order to make this review as fruitful as possible.

14 The CF has also begun a widespread review of the casualty administration process with a view to improving how families of deceased CF members are treated. The measures undertaken as a result of this review will be underpinned by a national DND/CF policy on casualty administration.

15 It is always good that lessons are learned, but particularly unfortunate that lessons are so often learned by hurting others. That is what happened here. Christina Wheeler and LCol (retd) Lapeyre were harmed. If we learn from this, the CF will be better for it in the future, but these people will only be better in the future if they receive profound apologies, and reasonable compensation. Systemic changes and personal remedies together, can put a close to this disturbing affair.

Report Summary

1 Introduction

16 This is an investigation about investigations - a defective post-accident investigation, an unsatisfactory Summary Investigation and an infirm Board of Inquiry investigation, each of which produced discreditable findings and led to a flurry of blunders that only made matters worse. This Report is also about insensitivity – insensitivity in dealing with the family of a man who died in the service of his country. It ends with a host of recommendations. If implemented, these recommendations will build on appreciable progress that has already been made within the Canadian Forces. I am confident that these recommendations will help in the development of dependable systems and adequate training regimes so that future investigations are effective and fair. The recommendations will also help ensure that appropriate attention and sensitivity is provided in times of tragedy to members of what should be the Canadian Forces family. In these respects, the report is systemic.

17 Yet this Report is also very personal. It seeks to bring an end to a painful saga that has been more than a dozen years in the making, a saga that began on April 7, 1992 when Master Corporal (MCpl) Rick Wheeler was killed by an armoured personnel carrier during a training exercise at Canadian Forces Base Suffield, in Alberta. That tragic event was bound to cause pain for many, pain that could have been salved or ameliorated by quick answers and deft action. Yet because of defective investigations and inadequate support and bungled efforts to respond to the errors that had been made, that pain was made worse, not better. These events have taken a significant and unnecessary toll on a number of people, including, ironically, both those who sought accountability for the accident, and some of those who were held accountable. This report is intended not only to ensure that these problems never occur again, but to bring closure to those who have been harmed. Although the list of those harmed includes Bill Wheeler, MCpl Rick Wheeler's father, my primary focus, as it should be, will be on those who complained to me, in particular, Christina Wheeler, MCpl Rick Wheeler's widow, and LCol (retd) Jay Lapeyre, the Commanding Officer of 2 PPCLI at the time of the accident.

2 Inadequate Attention – Christina Wheeler

18 This is a composite report, as it deals with different kinds of complaints, brought by two complainants, arising broadly out of the same series of events. I want to deal first in this executive summary with the manner in which CF responded to Christina Wheeler after the death of her husband. I want to start here, even though it will require me to brush over matters developed in more detail below, because leaving her complaints to the end of the Report could create the impression that she is an afterthought, of secondary importance. It would not only be inaccurate to leave that impression. It would be cruelly ironic given that at the heart of her complaint is that, even though being told she was a member of the CF family, she was made at times to feel as if she was an afterthought, of secondary importance, if of any importance at all. The recommendations I make pertaining to Christina Wheeler's experiences are meant to ensure that no family members whose loved ones have perished in the service of their country are left to feel that way. An overarching or umbrella recommendation that I include in the Report is that a national policy be developed that includes all regulations pertaining to family support, and defines specific support responsibilities so that relevant benefits can be accessed. I am pleased to note that in response to my Office's findings and recommendations, the CF has accepted this important recommendation and has pledged a comprehensive review of its casualty administration framework.

19 In general, the issues surrounding Mrs. Wheeler's complaints can be organized, for the purpose of the executive summary, into four general categories, those relating to the initial contact, those relating to ongoing support, those relating to the provision of information, and those relating to the need for participation in inquiries and investigations. What pulls them together is that they all emanate from the sad reality that, while particular individuals did deal with Mrs. Wheeler in a sensitive and compassionate manner, the CF as a whole could have done better. She was left feeling alienated, abandoned, a feeling no family member of a soldier who dies in the service of their country should feel.

A. Initial Contact

20 After MCpl Wheeler died, the 2 PPCLI Adjutant was tasked with notifying Mrs. Wheeler. That proved to be a challenge. Every member of the CF is required to complete a Personal Emergency Notification (PEN) form, providing necessary notification details. The Adjutant noted that MCpl Wheeler's form was out of date. Mrs. Wheeler was not listed as the primary next of kin, and there was no contact information. He was aware of Mrs. Wheeler's employment, and using that information, he tried to confirm her location. Unexpectedly, he was connected directly with her. He advised her that there had been an accident, and that a chaplain would be coming by. Concerned about breaking the news over the phone, he refused to provide details. It took 45 panicked minutes before the chaplain arrived. The chaplain was not accompanied by anyone from MCpl Wheeler's chain of command, and was largely unfamiliar with MCpl Wheeler or his personal situation. Mrs. Wheeler found his brief visit to be unsupportive. When the chaplain left after a short time, Mrs. Wheeler was without military support from 3:45 p.m. until approximately 10:00 p.m. that evening, when Mrs. Wheeler's Assisting Officer arrived. The next evening, on his return to Winnipeg, the Commanding Officer, LCol (retd) Lapeyre, visited Mrs. Wheeler.

21 Mr. Bill Wheeler, MCpl Wheeler's father, was deeply troubled by the lack of support provided to him and his nuclear family by the CF. He was listed as the secondary next of kin on his son's PEN form and felt he should have been notified personally by the military. The CF cannot be blamed for not having done so, however, as Christina Wheeler offered to notify her father-in-law personally, and did so, but she was emotionally distraught and unable to provide the kind of details Bill Wheeler naturally wanted. Bill Wheeler was also disturbed that there was confusion about the funeral arrangements made by CF, notwithstanding that the Assisting Officer appropriately focused on Mrs. Wheeler's wishes as the primary next of kin. In an oversight that cannot be so easily understood, at no time did Bill Wheeler receive an expression of sympathy from the CF, until the memorial service at Suffield in 1998.

22 I will deal with a technical matter first. This episode, among other things, underlines the importance of maintaining accurate PEN forms. A new form has since been developed, which stresses the importance of the designation. Still, to increase the prospect that accurate information is stored, I make recommendations in this Report to ensure that periodic reviews of the PEN forms occur. The CF has agreed with these recommendations in principle, noting that annual reminders will be sent to members in their pay cheques. Given the importance of this issue, I am encouraging them to go further and find a means of ensuring that units periodically review these important forms with their members, to ensure that necessary changes are made.

23 More importantly, this account also reinforces the need to select appropriately, and to train properly, those who notify family members of tragedy. I am encouraged that there is now in place training programs to assist military chaplains. Ideally, though, the chaplain should be from the same unit as the victim so that the chaplain possesses relevant, personal information. Failing that the chaplain should be provided with as much background information as possible. Whenever possible, chaplains should be accompanied by a senior officer in order to convey adequately the solemnity of the response from the CF. Indeed, I recommend that the most senior officer available undertake the duty of notifying the next of kin. The CF has agreed with this recommendation and has indicated that this is indeed their policy. However my Office has been unable to find and no one within the CF has been able to point out any directive or order which makes this mandatory. Directions and guidelines should be put in place to ensure that the immediate next of kin receive ongoing assistance, as required, in the hours immediately after notification.

24 Technically, Bill Wheeler was not the primary next of kin. He was nonetheless the father. Personal notification by the CF of persons in such close relationships can be important, but it can also be a sensitive question whether the CF should undertake this personal role, when it might be better played by the primary next of kin. Given the need to consider context, I am recommending that the commanding officer of the deceased's unit assess, in consultation with the primary next of kin, what role the CF should play in notification. I also recommend that where the secondary next of kin is not notified by the CF, a follow up visit should be conducted by a senior member of the CF to offer condolences, support and assistance. I also recommend that "Liaison Officers" be assigned to provide support to secondary next of kin,

until shortly after the funeral. This can provide practical benefits to the secondary next of kin, while demonstrating appropriate support by the CF. I am pleased to note that the CF has accepted these recommendations.

B. Ongoing Support

25 As required by regulations, Mrs. Wheeler was assigned an Assisting Officer, whose task it was to provide ongoing support to the family. Mrs. Wheeler's first Assisting Officer did an excellent job, in spite of his admitted lack of training and experience. He demonstrated dedication and sensitivity, and continued to call Mrs. Wheeler even after his official function ended. In the years after her husband's death, however, Mrs. Wheeler had three Assisting Officers. The first two had to relinquish their duty due to overseas deployment. She ultimately abandoned the program in 1995 because of the lack of continuity and effectiveness.

26 The role of an Assisting Officer is an important one. The Assisting Officer should be experienced and knowledgeable. I am recommending that guidelines be adopted for the selection of such officers to ensure that this is so. I am advised that the availability and intensity of training of Assisting Officers varies within the CF. There should be a standard training module for Assisting Officers and I am recommending that this be part of officer training. A standard guide should also be made available to Assisting Officers. Given the variety of tasks encountered by Assisting Officers, they should be provided with access to specialists who can help them in assisting the families. To improve continuity, a backup system for Assisting Officers should be developed, and the needs of the family being assisted should factor in deployment decisions affecting the assigned Assisting Officer. The CF has accepted the majority of these recommendations and has pledged that these important issues will be dealt with in a comprehensive guide for assisting officers, which is already being worked on. I look forward to the production of the guide and am optimistic that it will prove to be a valuable tool in ensuring that families receive the high quality of support, which they are entitled to.

27 Among other problems encountered by Mrs. Wheeler, she had difficulty obtaining her husband's autopsy information from Provincial authorities. The legislation was confusing. As the following section chronicles in painful detail, she had problems accessing information from DND/CF as well. Many of those challenges arose from privacy and access to information legislation, again, a technical and confusing body of law, the application of which is largely affected by the judgment of the information holder.

28 In my view, CF has an obligation to assist family members to navigate the complexities of legislation that restricts access to information relevant to the death of their loved ones. I make a number of recommendations to achieve this. Included among those recommendations is that CF directives should direct that assistance be provided to families of deceased members in obtaining information from non-CF agencies, such as autopsy and coroner's reports. The CF should also make it easier to obtain information from DND/CF itself, by assisting with access to information requests, and taking a benevolent approach to the release of such information. I am mindful that DND/CF has taken the positive steps of allowing members to consent in advance to the release of personal information to people of their choice, but there have to be concerns about cases where this opportunity is missed because forms are not filled out or kept current. I have therefore supplemented that initiative with the foregoing recommendations. The CF has responded to these recommendations by promising the creation of a medical assisting officer to ensure that families are kept apprised of the deceased member's medical circumstances and to liaise with civilian health care providers and to be a source of up to date and accurate information. This officer will also liaise with other government authorities to expedite the release of information. These are encouraging steps.

29 I will continue to encourage the CF however to improve its approach to ensuring that families are provided with accurate and timely information after the death of a CF member. Although the CF has pledged to have its working group on casualty administration examine the possibility of producing a family information package guide, in my view this does not go far enough. A CF wide directive is required on this issue in order to ensure that families can discuss the death and its circumstances with the people who have first hand knowledge of the incident, including the members' colleagues, chain of command and those involved in investigating the death.

30 When a tragedy of this magnitude ensues, as a society we have learned the importance of grief counseling. Christina Wheeler had to take the initiative to ask for this kind of assistance. Then she then ran into problems accessing the Base to benefit from it. The CF should support family members by initiating an offer of grief counseling. A CF agency, whether it be the Chaplain General or otherwise, should be assigned the responsibility of providing access to a CF or civilian caregiver. Assisting Officers should be required to inform families of services available through local Military Family Resource Centres. Family members should also be issued Military Family Identification Cards, if they want them, allowing access to DND facilities in the aftermath of such tragedies. Information about resources available to surviving families should be provided on a website. In short, support should be more accessible, and so too should the information needed to tap it. The CF has agreed to address these issues as part of its comprehensive review of casualty administration issues.

31 Finally, ongoing support requires that appropriate recognition be given to the contributions made by the deceased member. It was not until May of 1998, six years after the accident, that a memorial service was held for MCpl Wheeler and a cairn was erected at the accident site in his honour. As one might expect, when it did occur, the ceremony and dedication was important to Mrs. Wheeler. It should have happened sooner. Other simple initiatives which can demonstrate the appreciation of the CF for the contributions of a deceased member should be undertaken. At the risk of appearing to micro-manage, I make recommendations in this Report relating to appropriate modes of recognition that should be considered and, in my view, be undertaken. These recommendations have for the most part, been well received and I am optimistic that they will be implemented in such a fashion that units will have the means to ensure meaningful recognition of the contributions of deceased members to the CF.

C. Information

32 In the two months after her husband's death, Mrs. Wheeler was seeking information. Few people visited her from the CF unless on official business, and she was not informed about the details of the accident. Without information, the seeds of suspicion that the facts were being intentionally held back were sown. In the absence of facts, she naturally began to rely on

rumour. She began to suspect a cover-up.

33 Although she knew that some sort of investigation was underway, no-one explained the nature of that investigation to her. When she first requested a copy of the Summary Investigation that had been conducted, she was informed that the report was at the review stage. She ultimately had to make a formal *Privacy Act* request to attempt to obtain report information, which she did in August 1992. In response she was furnished not with a copy but with a three page resume of the 50 page report. It concluded that her husband's "death was attributable to negligence by Canadian Forces personnel, including [her] husband, for failing to adhere to established safety and training procedures." This finding, which seemed to her to be, and was, preposterous, fueled her search for information.

34 As a result of her efforts, after close to a year, she finally obtained a heavily edited copy of the actual report. The editing contributed to her feeling that she was still being denied information. She was also unsuccessful in obtaining her husband's medical files, and she ran into hurdles in trying to get his autopsy report from the Province of Alberta. To demonstrate the pace at which information was uncovered by her, it is noteworthy that she did not succeed in obtaining a copy of the Military Police investigation report until the end of 1998.

35 The lack of information, coupled with the finding made against MCpl Wheeler as to his responsibility for his own death, inspired her to speak to the press about her case. She did so because she felt that no-one within the CF was listening to her. When the matter became public, she spoke with a witness to the event, whose version contradicted information she had received from the CF. The press interest in the case caused Maj Kaduck to contact her on behalf of the CF. The timing of that overture reinforced her belief that it was only the adverse press that had occurred, and not sincere interest by the CF in her welfare, that led to the overture.

36 This led to contact with BGen Meating, the Commander of 1 Canadian Mechanized Brigade Group. She also wrote to the Commander of Land Forces Western Area and the Minister of National Defence, requesting a reinvestigation. It was not hard to persuade BGen Meating that the Summary Investigation had been deficient. He recommended a reinvestigation, and a Board of Inquiry was convened.

37 On October 31, 1997, Mrs. Wheeler received a summary of the Board of Inquiry findings, exonerating her husband. A promised meeting to discuss the results and receive more detail was postponed while the chain of command deliberated on what to do with respect to two senior officers who had been implicated by the Board of Inquiry report. The delays she encountered led her ultimately to say:

38 My children and I have been treated like non-entities since the beginning. I was given a pension and swept under the rug – no answers, no accountability, no closure.

39 BGen Ross finally visited her and her children at their home on April 3, 1998. He formally apologized for the delay, and provided her with a 265 page summary of the 2,165 page report. Information released in the report about the involvement of senior officers (information that has since proved to be inaccurate) caused her to believe that the involvement of those officers had been withheld for years.

40 Unbeknownst to Mrs. Wheeler, by then the integrity of the Board of Inquiry report had fallen into question. Within a year, further doubt would fall on the Board of Inquiry findings. LCol Kaduck would change the account he gave to the Board of Inquiry, calling its key findings against the senior officers into question. Internal advice to notify her of this was not acted on.

41 By July, 1999, a perjury investigation (which ultimately found no basis for laying charges) was launched against LCol Kaduck, and it led to a general, criminal investigation of the accident. Mercifully, Mrs. Wheeler was kept well advised of developments by Insp Grabb of the CFNIS, who also traveled to Nova Scotia to brief Bill Wheeler. Mrs. Wheeler made a number of unsuccessful attempts to obtain the CFNIS report, succeeding only in May 2001, after a number of official requests, and serving a complaint with the Information Commissioner.

42 Ultimately, an Administrative Review Board would be conducted in 2003 into the findings of the Board of Inquiry. Mrs. Wheeler would not learn of this for some time. She was advised by my office after the CF asked that we alert her so she would not be surprised when approached. She was presented with a heavily redacted copy of that report in November, 2003.

43 In the meantime, Bill Wheeler also felt stymied in his ability to get information. He believed there was a cover-up underway. His frustration reached the point that, for a time, he threatened to begin a hunger-strike, agreeing to forego it only when learning that my office would endeavour to look into the affair.

44 It is evident that much of the suffering by Christina Wheeler and her family was a result of the failure to provide her consistently with timely, reliable information. I believe that since these events, the DND/CF has made some progress in furnishing better information to families, as the efforts of Insp Grabb illustrate, and the positive experiences of the family of another member of the CF who died in a training accident in 2002, show. This is in line with international trends towards openness and sensitivity, but the effectiveness of channels of communication is still largely dependent on the personalities involved. At present there is no single DND/CF policy designed to deal with the provision of information to families of members who die while on duty. Policies designed to secure access to information should be entrenched in regulations and orders as quickly as possible. I am recommending that, subject to legislation and operational security requirements, all relevant information about the circumstances of a death be furnished to families on a priority basis, as soon as it is available. Members should be directed to respond to questions candidly. I am also recommending that the Assisting Officer assigned to a family as the CF contact person assume responsibility for furnishing information about significant developments, including the implementation of recommendations after a BOI has reported.

45 The CF has responded to these recommendations with an expression of support, while at the same time noting that rules and regulations pertaining to the provision of information are well defined and that they will accommodate families "*within the limits of the applicable legislation.*" It is this type of approach which defined the experience of Christina Wheeler while attempting to gain access from the CF to documents related to the investigations of her husband's death and which became the root of much of her anger and frustration. I am concerned that it fails to recognize the point which has underpinned all of the recommendations pertaining to this issue: families of deceased members have a peculiar status and should be treated differently than members of the general public trying to access information

held by government. I firmly believe that the approach and the measures I am recommending do not run contrary to the government's legislative framework for protecting privacy and providing information to citizens.

46 There are examples from DND/CF, such as the 2002 Tarnak Farm Board of Inquiry into the deaths of four CF members during a friendly fire incident, where families were treated with the type of openness and transparency my report endorses. I have not been provided with any convincing arguments as to why someone who has lost a family member in an incident which has less public resonance should not be treated with the same consideration and sensitivity.

D. Participation

47 Although Mrs. Wheeler did not ask for the right, I am recommending measures to enable the participation of families in official inquiries relating to the military deaths of their next of kin. In my view, families of a deceased CF member should be notified immediately upon the decision to convene a Board of Inquiry. They should be furnished with the terms of reference, and should be empowered to discuss those terms before the Board of Inquiry begins. They should be advised of the right to apply for full standing at the hearing, as persons with a direct and substantial interest in the proceedings, and they should be free to appeal that decision to the CDS if standing is denied. Where, in the circumstances, full standing or the right to ongoing participation is denied, they should be kept informed of the progress of the Board of Inquiry to the greatest extent possible. When it is released, family members should be provided with a copy of the Board of Inquiry Report, if they so desire, and should be given an audience with the convening authority to discuss the Report or answer questions once it has been released.

48 The CF has pledged to amend its current regulations and directives to permit Presidents of Boards of Inquiry to allow the attendance of family members at proceedings. I applaud this response and note that this is in line with informal steps taken at a number of recent inquiries, such as that currently examining the death of Lt(N) Chris Saunders as a result of an incident on board HMCS Chicoutimi. The CF has expressed hesitation however in providing full standing and participation in Boards of Inquiry to family members and has noted the potential for delays and disruptions which this may cause, particularly where family members seek representation by non-

military lawyers. My investigators encouraged the CF and members of Judge Advocate General who will be involved in the CF's review of the Board of Inquiry Process to closely study the provincial coroner's system as an example of how such concerns can be effectively managed. The coroner's system is also an excellent example of the value which is achieved by affording families a voice in the process. In my view the advantages associated with including families and allowing them a voice in the process far outweigh the challenges cited by DND/CF officials about potential disruption to the proceedings.

E. Remedy

49 It is evident that the treatment of Christina Wheeler was not optimal. Indeed, it was, at times insensitive, and at others, even unfair. The recommendations I make cannot right the wrongs done to her. They are meant to prevent similar problems in the future. Having said that, I have recommended that she be provided by the CDS with a formal apology for the lack of support she received, and that the CDS ensure that Mrs. Wheeler receives adequate and reasonable compensation.

50 As I note in the report, the CF responded to this recommendation by indicating that they recognize the trials that Mrs. Wheeler has endured during the entire process. It has insisted however that military legal advisors must have a legal claim from Mrs. Wheeler, before any compensation can be provided. Mrs. Wheeler has provided the CF with a document outlining the toll which this ordeal has taken on both her and daughters. This has been done at great personal cost on her part. It is manifestly unfair to place the onus on Mrs. Wheeler to jump through additional bureaucratic hurdles in order to obtain the compensation she deserves, particularly given the unchallenged findings in my Office's report. I am calling upon the CDS to formally acknowledge the impact on Mrs. Wheeler and to instruct military legal advisors to ensure that she receive adequate and just compensation on an expeditious basis, so that she and her family can put an end to this lengthy saga.

3 The Investigation of Investigations

51 As can be seen, many of Mrs. Wheeler's concerns related to the manner in which the investigations into this case were conducted. She suffered as a result of how things were done. So, ultimately, did LCol (retd) Lapeyre. The balance of this Report Summary deals with problems that emerged during those investigations, and in their aftermath, and focuses on the treatment of LCol (retd) Lapeyre.

A. The Post-Accident Investigation

52 When MCpl Wheeler perished, the response was immediate. As was inevitable, three separate entities became involved - the unit chain of command, the Military Police, and the RCMP. In spite of the appropriate sense of urgency that was demonstrated, things went wrong.

53 First, the unit chain of command failed to secure the accident scene. The vehicle was moved. The area was even swept, not for trace evidence, but as part of the routine process of cleaning a training site after the conduct of exercises. A re-enactment was conducted, not by professional investigators, but under the direction of the Major who had been put in charge. Photos were taken, but only after the scene had been disturbed. Those photos have not been preserved, leaving only grainy photocopies for subsequent review. After the scene was swept, it was abandoned. The sweeping, the re-enactment, and the failure to secure the scene permanently destroyed it, compromising potential evidence and preventing a professional accident reconstruction from being done.

54 Second, the interest in determining whether criminal charges would be laid appears to have clouded the focus of the Military Police investigation. Little attention was paid to matters of intense interest to the military, including potential responsibility of those in command, and the impact that exercise design and administration may have played. Issues of systemic importance in preventing future incidents were left aside. Attention was paid only to direct witnesses to the accident, and the list of witnesses that was compiled and ultimately relied on by the RCMP was incomplete. No follow up was done on issues left open by witnesses, such as the absence of a crew commander for the armoured personnel carrier, or who was acting as Chief

Controller during the exercise, or the impact that modifications to the armoured personnel carrier, made to look like a Russian vehicle, had on driver visibility. These failings produced an inadequate investigation record.

55 Third, witnesses were not segregated. They were permitted to discuss among themselves what had happened before their own observations could be preserved. Indeed, a debriefing was conducted before most were asked to record their own knowledge.

56 None of these failings suggest that there was a cover-up. They were simply the result of inexperience and poor preparation. For example, the Canadian Forces Administrative Order that governed the investigation of deaths and serious injuries made no mention of preserving the scene. Clearly the unit chain of command cannot be faulted for failing to appreciate the importance of doing so. For his part, the Military Police corporal assigned to the investigation was young, under-trained, and too inexperienced to have undertaken the heavy responsibility of investigating a fatality.

57 Fortunately, things have improved since 1992. In preparing for this report I examined the criminal investigation that was conducted into another, more recent, training death, that of a Private who died tragically when a Light Armoured Vehicle (LAV) III in which she was an occupant overturned. The investigation conducted in that case by CF National Investigation Service (CFNIS), (which was created in September of 1997) was exemplary. Still, I see the need to make two recommendations relevant to initial investigations so as to systematize the gains that have been made. First, I recommend that it be mandatory in the case of all "on duty" deaths or serious injuries of CF members, that the CFNIS be called immediately – something that is not now required. Second, I recommend that a Defence Administrative Order and Directive direct the chain of command on how to preserve accident scenes and witness observations pending the arrival of CFNIS investigators, and that it direct the chain of command to avoid taking investigative steps without express CFNIS permission.

58 The CF has agreed in principle with these recommendations. Some concerns have been expressed however that instructions to witnesses in order to protect the integrity of the investigation may violate the Canadian Charter of Rights and Freedoms including the right to freedom of expression as well as other regulatory duties requiring reporting of wrongdoing. This concern is ill-informed and un-necessary. It reflects neither the intention nor in my view

the effect of my Office's recommendations. Investigators, lawyers and courts routinely caution witnesses not to discuss their evidence with others including members of the media in order to ensure that their recollections are not tainted and that the integrity of investigations and/or court proceedings is not sacrificed. I note for example the recent decision of the Board of Inquiry into incidents on HMCS Chicoutimi to require military members of the crew of HMCS Chicoutimi not to discuss their evidence before the inquiry with the media. Such limitations on the right to freedom of expression have been broadly recognized as acceptable in our society, particularly when they are only temporary and directly related to the public interest in effective investigation of serious incidents such as a deaths and ultimately the search for truth.

B. The Summary Investigation

59 It is now, and was at the time, mandatory in the CF to conduct an administrative investigation when a member dies other than as a result of wounds sustained in action. There are two forms such investigations can take. They can be done by way of Summary Investigation, or by Board of Inquiry. In essence, a Summary Investigation is a one person field investigation. A Board of Inquiry is a formal quasi-judicial hearing. In this case, the day after the accident, the Commanding Officer, LCol (now retd) Lapeyre decided to conduct a Summary Investigation. This, in my view, was a mistake. A Board of Inquiry should have been convened. The decision by LCol Lapeyre to hold a Summary Investigation was not warranted by his initial belief that the incident did not appear to raise complex issues, or by his interest in dispatch, or by the fact that a Board of Inquiry can always be called if and when it becomes apparent that a more rigorous process than a Summary Investigation is needed. A man died in a field accident. There were enough signals in the immediate aftermath to raise serious concerns about exactly what happened. Indeed, according to existing regulations, a Board of Inquiry is to be held in cases of "unusual significance or complexity." In my view, every death that occurs where there is an apparent connection to duty must be seen to be a matter of unusual significance. In terms of optics, choosing a Summary Investigation over the more concerted effort involved in a Board of Inquiry can be seen as trivializing the importance of the event, an event that will invariably be of momentous

consequence to the families of the deceased and to the military community. Boards of Inquiry are simply better equipped (if properly resourced and administered) to produce more comprehensive and credible results.

60 I recommend in this report that it be made mandatory to convene a Board of Inquiry to investigate unexpected, non-combat deaths that are duty related. I am pleased to report that the CF has accepted this important recommendation and has undertaken to amend applicable regulations and directives accordingly.

61 Even if a Summary Investigation could have been adequate in the circumstances, the Summary Investigation that was conducted into the death of MCpl Wheeler was not. It suffered from a number of short-comings. Most disturbing was the unreasonable conclusion that MCpl Wheeler bore partial responsibility for his own death for failing to stand up and alert the driver of his presence on the roadway. MCpl Wheeler was found to have committed "negligence of a minor nature," the same epithet used to describe the conduct of the armoured personnel carrier driver who drove at an excessive speed given his marginalized field of vision through the periscope he was using, and the Enemy Force Controller, who was found to have failed to instruct the driver adequately on where to stop the armoured personnel carrier. The finding made against MCpl Wheeler has since been disavowed by a Board of Inquiry, an Administrative Review Board, and now by my office. Even the officer who conducted the Summary Investigation now recognizes that his conclusion was wrong. This unfortunate finding caused immense grief to the family of MCpl Wheeler.

62 Quite simply, the Summary Investigation was doomed to failure. Despite his best efforts, the investigator was an inappropriate choice to conduct the investigation. He was simply too inexperienced to undertake an investigation of this import. Indeed, he was a junior officer who reported directly to those who were ultimately responsible for the training exercise. Even if he had conducted a flawless investigation, appearances alone would have cast a shadow over his report, which paid scant attention to the potential responsibility of his superiors. As indicated, the investigation was not in fact flawless, a reality attributable not to lack of effort or ability – the investigator did his best – but to inadequate training. For example, statements were taken in a written Q and A form, a technique that inhibits witnesses from providing full accounts. The interviews he conducted were

not sufficiently detailed. The scene was not visited, an undertaking that is important in gaining perspective even where that scene has not been perfectly preserved. Issues were missed, including, as indicated, command responsibility. Other issues were underappreciated. Insufficient attention was provided, for example, to who was in charge of safety and who was instructed to do what by whom. As a result, key witnesses were never examined, including LCol Lapeyre, and Maj (now Col) Semianiw and Capt (now LCol) Kaduck, who would become central players in the subsequent Board of Inquiry. Documents detailing Standard Operating Procedures, safety standards and protocols in force at the time, were not gathered and preserved. The failure to do so inhibited later inquiries into whether required standards had been observed on the day in question. In general, the Summary Investigation that was conducted was woefully inadequate.

C. Review of the Summary Investigation

63 When a Summary Investigation has been conducted, the convening authority and others in the chain of command will review the findings before the report, findings and recommendations are released. It is hoped that this review process will ensure that a Summary Investigation has been conducted properly. The reviews conducted in this case did not achieve that end. No-one questioned the choice to use the Summary Investigation mechanism in the case, and no-one expressed concern about the choice of investigator. LCol Lapeyre failed to comment on the finding made against MCpl Wheeler, even though it was a matter of importance and the finding was not supported by the evidence. Indeed, no-one caught CFAO 24-6, a rule that made it inappropriate to assign blame to MCpl Wheeler given that he did not die as a result of his own willful acts. The Commander of LFWA, for his part, commented on deficiencies in planning and supervision of the exercise, yet nothing was done about the failure of the Summary Investigation report to address these issues adequately. These failings are directly attributable, in my view, to a lack of clear direction as to what kind of investigation is appropriate in a case like this and what such an investigation should accomplish.

64 Naturally, the answer to the failings that occurred in the conduct and review of the Summary Investigation is proper training. Since the events surrounding the Wheeler case, the army has developed an Administrative Investigators Qualification course. This course provides an excellent

introduction to the basics of investigations. More can be done, though, a theme I return to below after describing the next failed Wheeler investigation, the Board of Inquiry.

D. Events Leading to a Board of Inquiry

65 Christina Wheeler was, with good reason, dissatisfied with the manner in which her husband's death had been investigated. After a newspaper article was published making her concerns public, the CF began to pay close attention. She was contacted on the direction of BGen Meating. She expressed anger at the finding that her husband bore partial responsibility for his own death. She was unhappy that only findings of minor negligence had been made, and that no-one in the chain of command had been held accountable. She was concerned that the minor administrative sanctions recommended may not have been carried out. Ms. Wheeler was concerned, as well, by inconsistent reports she was receiving about where the Enemy Force Controller, who had purportedly been directing the armoured personnel carrier with hand signals, had in fact been standing. In short, there was little to give her any confidence that matters had been dealt with appropriately.

66 BGen Meating recognized the merit in her concerns. He recommended that the investigation be reopened. On August 15, 1997, more than five years after the tragic death of MCpl Wheeler, a Board of Inquiry was finally convened.

E. The Board of Inquiry

67 Col J.J. Selbie was appointed chair of the Board of Inquiry. The Board issued its report on October 31, 1997. While it can be credited for repudiating any suggestion that MCpl Wheeler bore partial responsibility for his own death and for making some good findings and recommendations, the Board of Inquiry produced a flawed report. Its key conclusions proved ultimately to be either wrong or indefensible. This is, in my view, not only attributable to inadequate training and expertise on the part of the Board, but to the failure to respect the requirements of fair process that, if honoured, increase the prospect of accurate fact-finding.

1. The Factual Errors

68 I am not an appeal body. It is not my function to second guess the factual findings that were made by the Board of Inquiry. I am, however, intensely interested in the processes that were used, and those processes contributed to the holdings that were made. As will be seen, I am convinced that those processes, inadequate as they were, contributed to erroneous findings. I can say with confidence that the findings were erroneous without fear of overstepping my mandate because, in the wake of new evidence and the complaints of LCol (retd) Lapeyre, the Chief of the Land Staff, LGen Mike Jeffery, on May 2, 2002, convened an Administrative Review Board to examine "the relevancy, thoroughness, and accuracy of the findings and recommendations" of the Board of Inquiry. The factual errors I describe, were identified by the Administrative Review Board in its report of January 28, 2003.

69 The matters of controversy relate to the roles played by LCol (retd) Lapeyre and to Maj (now Col) Semianiw. The Board of Inquiry found each of the men to be indirectly responsible for the death of MCpl Wheeler. At the heart of those conclusions were two findings of fact. The first and most notable finding was that when Maj Semianiw, who was the Chief Controller absented himself from the base on the day of the exercise, a "supervisory vacuum" had been created as no-one had been assigned to replace him. The second underlying finding was that no-one, in the conduct of safety training, had paid regard to two orders in force at the time relating to the use of armoured personnel carriers. Neither of those factual findings should have been made.

70 We now know that the "supervisory vacuum" finding was simply wrong. Capt Kaduck had, in fact been assigned the role of Chief Controller upon Maj Semianiw's departure. While Capt Kaduck had testified before the Board of Inquiry that he was unsure about whether he assumed this role, after the release of the Board of Inquiry Report he contacted LCol (retd) Lapeyre, confirming that he had in fact been so assigned. As a result of his late disclosure, a CFNIS investigation was conducted to determine whether Capt Kaduck could be charged with perjury as a result of his Board of Inquiry testimony. That investigation found that no charges were warranted because there was no proof that Capt Kaduck knew at the time of his testimony that

he had been the Chief Controller. The CFNIS investigation did confirm, however, that Capt Kaduck had held that role. The Board of Inquiry had been wrong in holding there had been a "supervisory vacuum."

71 Of course, the Board of Inquiry cannot be faulted for not anticipating Capt Kaduck's subsequent epiphany. The fact is, however, that the manner in which the decision that there was a "supervisory vacuum" was arrived at is disconcerting. As the Administrative Review Board pointed out, the Board of Inquiry made a hard finding that there had been a "supervisory vacuum" on the basis of conflicting evidence, in the face of Capt Kaduck's own uncertainty as to whether he had assumed that role. The Administrative Review Board also noted that the key witnesses relied on to make this finding had been internally inconsistent, while those whose contrary evidence was rejected had not been internally inconsistent. It is not my role to question credibility findings made by a Board of Inquiry but I can say three things. First, the Board of Inquiry failed to provide clear and transparent reasons for making the credibility findings it did. Had it attempted to articulate its reasoning, its error may have been identified. Second, even though the Board of Inquiry must have appreciated the importance of the issue, it failed to ensure that it had all available evidence on the matter. Other witnesses, who ultimately assisted in clarifying the matter, were not called. Moreover, the Board of Inquiry failed to consider that, by practice and unit standards, Maj Semianiw's next in command, Capt Kaduck, was duty bound to assume that role. Third, no significant effort was made by the Board of Inquiry to determine whether a Chief Controller was even required for an exercise of this type, or to identify how the absence of a Chief Controller would have contributed to the death of MCpl Wheeler. It is my view that the Board of Inquiry could not have made the findings that it did if it had an appropriate understanding of the high caliber of proof required before adverse findings are made against individuals.

72 As far as the finding that those in charge of the exercise failed to apprise the men of specific safety regulations then in force relating to the operation of armoured personnel carriers, two documents were given emphasis. The first, directive Force Mobile Command Order 25-15 was misunderstood by the Board of Inquiry. I agree with the Administrative Review Board that this order does not apply to the use of armoured personnel carriers during exercises. It sets out the protocol for driver training.

73 The second document, Operational Training Policy Directive 107 proscribing a distance of 50 metres between armoured personnel carriers and dismounted troops, may, in fact, have been overlooked improperly as found. The problem is there was no adequate proof of this. There was, at best, conflicting evidence that it had been received by the unit prior to the exercise. There was direct evidence from Maj Semianiw that it had not been, and the circumstantial evidence suggesting it was, was weak. Unfortunately, the Board of Inquiry was hampered by the failure of the Summary Investigation to ensure that copies of all applicable rules, regulations, orders and procedures in force at the time of the accident be preserved. To prevent this kind of lacunae of information from happening again I have recommended that in cases of serious injury or death, all such documents be identified and retained as part of the record of any administrative investigation. That being said, the nature of the evidence that was available to the Board of Inquiry in this case was inadequate to support the finding made. I agree with the Administrative Review Board in that regard.

2. Procedural Shortcomings

74 In my view, the factual errors that were made are attributable, in large measure, to procedural failings that occurred during the Board of Inquiry.

a) The Composition of the Board of Inquiry

75 The Board of Inquiry was not constituted appropriately. At least one member of the Board of Inquiry should have had subject matter expertise in the operation and command of a mechanized infantry battalion. None did. A contrast between the conclusions of the Administrative Review Board, which had the required expertise, and the Board of Inquiry, which did not, demonstrates that some of the findings and recommendations made by the Board of Inquiry betray a failure to appreciate the realities of the conduct of mechanized infantry exercises. This caused the Administrative Review Board to observe that "it would have been preferable" for the Board of Inquiry to have had a senior infantry Subject Matter Expert. I would go farther. Not only would it have been preferable, a Subject Matter Expert *should* have been appointed. The QR&O dealing with selection of Board members requires that where the investigation involves technical or professional skill or knowledge,

where practical, at least one Board member should have the qualifications. I do not believe that adequate respect for that requirement was demonstrated in the composition of this Board of Inquiry.

b) Procedural Unfairness

76 LCol (retd) Lapeyre agreed to attend the Board of Inquiry, but due to other commitments, arranged to testify on the last day, and to arrive the night before his testimony. When he arrived, he was provided with some of the documents that the Board of Inquiry was relying upon. Needless to say, his opportunity to review those documents was scant, given the time available. Apart from this indulgence, he was treated as an ordinary witness. Yet when the Board of Inquiry Report was released the very next day, he was found to have been indirectly responsible for the death of MCpl Wheeler. It should be obvious that LCol (retd) Lapeyre was given no adequate opportunity to defend himself.

77 It is an understatement to say that by the time LCol (retd) Lapeyre testified, he was the subject of suspicion by the Board. He testified on the last day. The Board of Inquiry Report was released the following day. As if that is not enough to show that he took the stand under personal peril, one Board member acknowledged in a discussion with one of my investigators that LCol (retd) Lapeyre's testimony really did not change things, and that there was some deliberation before his testimony about whether it was even necessary to hear from him. In my view, his peril would have been obvious to the Board of Inquiry from the outset. The Board of Inquiry was interested in determining responsibility, and it was empanelled in part because the Summary Investigation had paid inadequate attention to responsibility on the part of those in command.

78 At the time this Board of Inquiry was established, it was a matter of discretion whether a Board of Inquiry witness should be warned of the risk of adverse findings against him and accorded procedural safeguards. The Enemy Force Controller and APC driver were given this indulgence and were allowed to hear the testimony of other witnesses, to ask questions, to be re-examined and to make submissions. The BOI president explained that LCol (retd) Lapeyre was not similarly treated because of his limited availability and because, as a retired member, he was no longer subject to administrative penalties. These explanations are not persuasive. They reveal a misunderstanding of the nature of adverse findings and the impact they can

have on reputation. They also demonstrate an inadequate appreciation of the importance of procedural protections on the part of those who will be affected directly by the disposition of military tribunals. Without notice, standing and time to prepare, LCol (retd) Lapeyre was left unable to defend himself. To make matters worse, the Board did not even put questions to him that would have alerted him to the fact that they were contemplating adverse findings against him.

79 This is not simply a matter of fairness. Had LCol (retd) Lapeyre been alerted properly to the risks he was under and the issues of importance, and had he been granted standing, the factual errors that were made in this case might well have been avoided. He would have been highly motivated to set the record straight. That opportunity was lost.

c) Relevant Recommendations

(i) Relating to Adverse Findings

80 Since the 1997 Board of Inquiry, a new DAOD, 7002-4, gives detailed direction on the meaning of adverse inferences, and requires if, at any time prior to or during a Summary Investigation or Board of Inquiry, it appears likely that anyone, member or not, will be adversely affected by the evidence, the President of the Board shall provide written notice to them, and those persons shall be given access to relevant evidence, the right to be present during the hearing, the right to give a concluding statement or to call and recall witnesses, and to have counsel.

81 These protections are so important that the DAOD should be amended to deal with those cases that might fall through the cracks. I am recommending that the DAOD be revised to require those Review Authorities who oversee the results of Boards of Inquiry and Summary Investigations to ensure that any person likely to be affected by the results was furnished with these rights. If the person has not been given these rights, no adverse action should be taken until that person has had a meaningful chance to respond. Moreover, it is imperative that all considerations about participation be recorded so that the Reviewing Authority can determine whether this requirement has been respected. The DAOD should be amended to require that complete records be kept of all discussions that have taken place about standing, and that

reasons must be recorded for all standing decisions that are made. I am pleased to report that the Judge Advocate General has accepted these recommendations to improve the military justice system.

(ii) Relating to Training

82 Whenever people fail systems, the solution lies in improved training. The dictates of procedural fairness, in particular, are not always instinctively recognizable. They are the product of experience, but nonetheless, they are the foundation for just and accurate results.

83 Again, I applaud the establishment, subsequent to this Board of Inquiry, within the army, of the Administrative Investigator Qualification course. It is a good start. Still, even more intensive training than that now being undertaken should be provided. I understand that there are many ways to deliver education. I make some observations in this regard in the Report, but will refrain from making formal recommendations on precise modes of delivery. I have recommended that at least one member of any Board of Inquiry convened to investigate a death, have completed a formal training course in investigative techniques and procedural fairness. I have also recommended that prior to the start of any Board of Inquiry which is examining a death, the president and all members of the Board receive a refresher training package. No more justification need be offered for these recommendations than what has already been said about the failings that occurred in this important case.

84 I am pleased to report that in response to my Office's findings and recommendations in this case the CF has announced a comprehensive review of the BOI system aimed at overhauling the entire process and creating an internal centre of excellence to provide advice and resources to Boards of Inquiry. Subsequent to the issuance of my Office's interim report, officials of my Office were also invited to present on our recommendations from a lessons learned perspective to members of the Board of Inquiry convened to examine the incidents on board HMCS Chicoutimi, which led to the death of Lt(N) Chris Saunders. I am encouraged by the CF's positive response to my Office's findings and recommendations and I am hopeful that the review of the Board of Inquiry process will lead to real and long term improvements in the quality of internal military investigations.

(iii) Related to Expert Assistance

85 In the case of Boards of Inquiry into serious injury or death, to reflect the importance of such inquiries, more than general training is needed. I recommend that in such cases, the convening authority should be obliged to appoint a person with expertise in the conduct of complex investigations to assist the Board of Inquiry. These experts should not be confused with the Subject Matter Experts already provided for by existing regulation. I am contemplating persons who are expert in the conduct of complex investigations. These experts will typically not be Board members, and should assist the Board in its undertakings. To be sure, there is expense associated with this proposal. As this case demonstrates, however, the costs of not tapping expertise, and getting things wrong, will be even greater.

86 The CF has agreed with this recommendation and has pledged that this will be examined as part of the review of the Board of Inquiry process. I have also noted that this practice has been informally adopted through collaboration with the CFNIS in recent complex Boards of Inquiry, including the Tarnak Farm and the Chicoutimi BOIs.

F. The Reviewing Authority

87 As with Summary Investigations, a Board of Inquiry Report is subject to review. The Reviewing Authorities are responsible for ensuring that the Board has been completed in accordance with its terms of reference and that evidence supports its findings. When the Reviewing Authorities examined this Board of Inquiry Report, a problem was detected. It was noted that no causal connection had been established between the identified failures on the part of LCol (retd) Lapeyre and the death of MCpl Wheeler. Appropriately, the decision was therefore made to remove the finding of "indirect responsibility." Still, the underlying factual findings were affirmed. As a result, the decision was made to deliver a "letter of displeasure" to LCol (retd) Lapeyre.

88 In spite of the modification made to the Board of Inquiry Report, it is clear that the Review failed. For the reasons described above, the Report was palpably deficient. Flaws in the Report were not lost on staff members of the Directorate of Land Personnel who assisted in the Review. They identified deficiencies in the evidence, subjective findings, conflicting evidence and weak conclusions. The flaws they identified should have been

sufficient to require a reconvening of the Board of Inquiry. The failure by the Reviewing Authorities to reconvene the Board enabled the flawed Report to become official. Without question, it was the Review failure that permitted much of the damage that has been occasioned to LCol (retd) Lapeyre to be done.

G. The Publication of the Report

89 LCol (retd) Lapeyre immediately challenged the conclusions made by the Board of Inquiry. He asked for the release of the Report to be delayed while he could make his case. His request was denied because of the perceived public interest in its release. On April 3, 1998, six years after the death of MCpl Wheeler, a CF media release reported the findings without naming LCol (ret) Lapeyre, but describing his office. The press put two and two together. He was identified in the published press reports. While the finding of "indirect responsibility" had been omitted, it was made public that displeasure had been expressed over his conduct in connection with an exercise in which a man died. If not formally so, LCol (retd) Lapeyre had effectively been implicated in the death of a man under his command. A comment made by BGen Ross and reported in the media exaggerating the import of a letter of displeasure was also published, reinforcing the atmosphere of fault. The reputation of LCol (retd) Lapeyre was harmed.

90 I have already commented that the Report should not have been released, given its apparent failings. It follows that the release of the Report should have been delayed as requested by LCol (retd) Lapeyre. Indeed, even if the frailties of the Report had gone unnoticed before the protest, LCol (retd) Lapeyre gave specific reasons for his request for delay, which warranted reconsideration. In refusing the request for delay, LGen Leach stated, "It is now time to make this incident public, learn from and be accountable for our mistakes." The desire for more openness, accountability and transparency is laudable - I have spent considerable energy promoting these values. Yet where, as here, there is reason to believe that persons may not be fairly being held to account, the desire for accountability and transparency provides no justification for public acceptance by the CF of the responsibility of its officers. The demonstration of openness and accountability by CF in this case, was done at the expense of LCol (retd) Lapeyre, and it was done in the face of real foundation to doubt the fairness of the findings. Ultimately, an

Administrative Review Board had to be empanelled, the Report recalled, and then in September 2003, amended. The demonstration of accountability proved to be as illusory as it was harmful.

H. The Delay in Rectification

91 It was not until September 4, 2003, four and one-half years after LCol Kaduck first accepted that he had been the Chief Controller during the exercise, that the Board of Inquiry Report was amended to exonerate LCol (retd) Lapeyre. I accept LCol (retd) Lapeyre's complaint that the delay in responding to his complaints and correcting the error was manifestly unreasonable. I part company in this regard with the finding of the Administrative Review Board, but the matter seems clear to me.

92 Initially, in March of 1999, when LCol Kaduck first came forward, there were mixed opinions within CF as to how to respond. In spite of apparent legal advice to give the benefit of the doubt to LCol (retd) Lapeyre, concern by LGen Leach about whether he should credit LCol Kaduck's admission over the findings of the Board of Inquiry delayed matters. Nothing was done to clear him, although enough doubt had been cast to cause an order to be issued in April for copies of the Board of Inquiry Report that had been distributed for training purposes to be destroyed. Yet no public acknowledgment was made that doubt had been cast on the findings of the Board of Inquiry.

93 By December of 2000, there was no need to be concerned any longer about the veracity of LCol Kaduck's acknowledgement. CFNIS had completed their investigation and had determined that he had, in fact, been the Chief Controller – the central Board of Inquiry conclusion about a supervisory vacuum was demonstrated to be wrong. During the next year and a half, little was done. An offer by LGen Jeffrey to convene a review board, and an offer of mediation were made to LCol (retd) Lapeyre, but he declined. He saw it as an issue of leadership, and had lost faith in the internal processes. It was not until May 3, 2002, when LGen Jeffrey convened the Administrative Review Board which ultimately undid the damage. Its report was completed on January 28, 2003. It took five further months before the CLS wrote to the CDS, acknowledging that the Board of Inquiry Report had been inaccurate. On September 4, 2003, four months after that, the Board of Inquiry's findings were ultimately amended.

94 In my opinion, the chain of command had the information necessary to remedy the injustice before the decision was taken to launch a criminal investigation. The urgent decision to recall the reports provides support for this. Given the specious nature of the initial findings of the Board of Inquiry, once LCol Kaduck acknowledged his role, that should have been enough to give the benefit of the doubt to men whose reputations had been sullied and who were obviously anguished by the error that was made. Even if it had been prudent to wait for the CFNIS investigation, and then to conduct an Administrative Review Board or other process, there was still no sense of urgency demonstrated. It took more than fifteen months after the CFNIS investigation result to empanel the Administrative Board of Review, and months after that Review to make things right. The delay was unfair, and unnecessary. It added to the damage that was done.

I. Recommendations Relating to LCol (retd) Lapeyre

95 LCol (retd) Lapeyre does not walk away from these events entirely unsullied. His decision in 1992 to convene a Summary Investigation was a poor one, and the failure of that initial investigation caused many of the problems that have since been occasioned. Yet the material question is not about his role in that investigation. It is about his role in the events leading to the death of MCpl Wheeler and the way those issues were examined by the CF in 1997 and thereafter. It is in that important context that LCol (retd) Lapeyre was treated in a profoundly unfair manner. The Board of Inquiry came to improper and damaging findings, but what is most important here is that it did so in large measure because it did not respect the dictates of procedural fairness. Without ascribing any animus to the Board of Inquiry, its lack of familiarity with basic notions of fairness caused it to veritably ambush LCol (retd) Lapeyre. Then the Review Authorities failed him. While they can be credited for removing the language of blame from the report, they had reason to be concerned with the findings that they endorsed, findings that would, by implication, link LCol (retd) Lapeyre to the death of MCpl Wheeler. He was further failed when the decision was made to release the report after he raised important issues about its legitimacy. Then the damage done to him was perpetuated for years because of indecision and delay. Given the multiple failings in spite of his vigilant efforts to set the record straight, I recommend two things in his case. First, the Chief of the Defence Staff should issue a formal apology on behalf of the CF in respect to the systemic failures that have caused unfair treatment to LCol (retd) Lapeyre. Second, he has

experienced extreme stress, anxiety and frustration, none of it of his own making. He should be compensated.

96 In response to my recommendations the CDS has replied that the "DND/CF recognizes the trials that LCol (retd) Lapeyre had endured." The CF insists however that it has no authority to provide compensation to LCol (retd) Lapeyre unless he submits a formal legal claim, which they indicated would receive the same "sympathetic consideration" as any other meritorious claim. In my view this response is inadequate in light of the findings and recommendations outlined in my Office's report.

97 The unfair treatment of LCol (retd) Lapeyre and the stress he has suffered is deserving of an apology at the highest level. His entitlement to compensation should not be left to rest solely in the hands of military legal advisors. The harm occasioned LCol (retd) Lapeyre has been well documented, it is difficult to see why any formal legal claim is necessary, particularly when I note that the former Chief of the Land Staff had already extended to LCol (retd) Lapeyre an invitiation to mediate his complaints. I am calling upon the Chief of the Defence Staff to issue the necessary instructions to ensure that LCol (retd) Lapeyre receives reasonable compensation which is commensurate with the degree of unfair treatment outlined in my Office's report, as well as the internal Administrative Review Board findings.

4 General Observations on Appearances

98 One of the most troubling aspects of this saga is that it produced a profoundly broken trust between the CF and two persons with whom it should have built strong and lasting relations. Trust has been broken between Christina Wheeler, and the CF, in whose service her husband died. Trust has been broken between LCol (retd) Lapeyre, and the institution he spent his career serving. In each case, the trust was broken not just by the errors that occurred – mistakes happen and can be rectified. Trust was broken by delay in responding, and ultimately, through an unattractive coincidence of factors that would naturally undermine confidence in fair dealing. In light of this, it would be remiss of me not to make some general observations about the importance of conduct that avoids the perception of partiality or impropriety. Much of the rancour and pain that was caused as this case laboured through its various stages occurred because of optics. Actions were undertaken that were insensitive to appearances.

99 Even though no foundation for blame on the part of those in command has been established in this case, the Wheelers and others came to apprehend a cover-up. They did not do so idly. Warning signs were there. The decision to conduct a Summary Investigation instead of a Board of Inquiry into the death of MCpl Wheeler; the decision to assign a junior officer who was subject to the command of those who oversaw the fateful exercise and whom he should have been investigating; the release of a Summary Investigation Report that focused only on the immediate players and not on the command structure; the temporary posting of the Enemy Force Controller, one of the key witnesses, during the investigation; the provision of partial summaries and heavily edited reports; and the unwitting decision to assign then Maj Kaduck, who would be a key witness at the BOI, to accompany Board of Inquiry members to the base and to liaise with Christina Wheeler about whether the Summary Investigation should be re-opened, all conspired to create an inaccurate but nonetheless debilitating aura of cover-up. These kinds of things fueled the call for accountability, and the belief that a mode of self-protection was operating.

100 LCol (retd) Lapeyre, who bore the brunt of that search for accountability, can for his part, be forgiven for believing that there was abuse of authority and harassment, if not a full blown conspiracy to scape-goat him, even though I do not believe any such abuse, or harassment, or conspiracy existed. His

concerns became magnified by his anger and frustration, but they were fed by a number of incidents. After the Board of Inquiry had been convened, but prior to it being conducted, BGen Ross, the convening authority for that Board, referred during a seminar, to the Wheeler incident as an example of the failure of command supervision. The seminar was attended by Col Selbie, who BGen Ross had appointed as President of the Board. Then the decision of the Board of Inquiry to render its findings only one day after LCol (retd) Lapeyre testified, coupled with its refusal to adjourn matters, reinforced his perspective that the fix was already in. The revelation that Maj Kaduck met privately with Col Selbie during the hearing, after he testified and before he was recalled to testify again about whether he had been Chief Controller, can only add to the concern, particularly given that the manner in which Maj Kaduck would ultimately testify may have been discussed during that meeting.

101 These examples of actions and circumstances that create an aura of cover-up, bias, partiality or impropriety, even in the complete absence of cover-up, bias, partiality or impropriety, are too diverse to yield a structured recommendation. Suffice it to say that common sense and reflection, with sensitivity to the sensibilities of those who are affected by investigations and decisions, can go a long way to preventing appearances from becoming tarnished. Common sense and sensitivity can keep trust from being broken even where circumstances are strained. It has long been understood that "justice must not only be done, it must be seen to be done." In this case, for the reasons described above, neither justice nor the appearance of justice were adequately achieved. It is time to set things right and get onto a path that will prevent similar problems in the future.

102 As has become the practice, the Office will review the implementation of these recommendations and report on the progress that has been made. In this case, we intend to do so 18 months after the release of this report.

Note to Readers

Military Ranks and Titles

103 In recounting events, this report refers to members of the Canadian Forces (CF) by rank and, sometimes, title or position held. We have made every attempt to use the rank and title in place at the time in question. For example, the ranks mentioned in relation to the events of 1992 are those held by individuals at that time, while ranks referred to during the Board of Inquiry (BOI) in 1997 are those held by individuals at the time of their testimony before the Inquiry.

Introduction and Summary of the Facts

1 Introduction

104 My Office was approached by Mrs. Christina Wheeler and retired Lieutenant-Colonel (LCol) (retd) J.L. (Jay) Lapeyre, with complaints arising from the 1992 accidental training death of Master Corporal (MCpl) Rick Wheeler. The accident, as well as the ensuing Summary Investigation (SI), the Board of Inquiry (BOI), and the findings against Rick Wheeler and Jay Lapeyre, all predated my mandate. However, given the complex nature of this case, its wide-ranging implications, the number of people in the Department of National Defence/Canadian Forces (DND/CF) with connections to the file, and the complainants' distrust of internal military processes, I decided to seek the Minister of National Defence's approval for a pre-mandate investigation, which was granted.

105 This investigation covers issues that have arisen since the accident of April 7, 1992. It is one of the most extensive and complex investigations undertaken by my Office to date. It deals with fundamental and important issues, such as how the CF investigates deaths of its members, and the treatment of surviving family members.

106 It became apparent that the two complainants raised issues that were quite different, and even at odds with each other at times. Nonetheless, Mrs. Wheeler and LCol (retd) Lapeyre both raised issues that required a thorough review of everything that happened from the time the exercise was planned to the present. As a result, we decided it would be more efficient to review the two complaints together.

107 I believe that we have been able to thoroughly investigate and answer the complaints, even when some of the interests conflict, and to do so independently, as required by my mandate. In fact, I feel that Mrs. Wheeler's and LCol (retd) Lapeyre's complaints are complementary in a sense, in that

they represent two of the legitimate interests which must be balanced in the policies and practices, the fact finding and the dissemination of information regarding investigations.

1.1 Complaints

108 This investigation was undertaken as a result of two separate complaints, both pertaining to the fatal military training accident, which claimed the life of MCpl Rick Wheeler on April 7, 1992. The training exercise, known as Exercise Surging Rage, took place at Canadian Forces Base (CFB) Suffield, Alberta.

109 A complaint was received from Christina Wheeler, MCpl Wheeler's widow. She expressed concerns regarding the accident itself, and the completeness and appropriateness of the initial military investigation, which was a SI conducted by members of the unit involved in the training accident. Her complaint also raised issues relating to how the CF treated her and her family. Mrs. Wheeler's complaints to this Office are discussed and analysed in this report, Families.

110 A complaint was also received from retired LCol (retd) Lapeyre, MCpl Wheeler's former Commanding Officer (CO). LCol (retd) Lapeyre expressed concerns relating to the purpose and thoroughness of a second military investigation into MCpl Wheeler's death — the BOI conducted in 1997. His complaint raised issues relating to how the CF treated him and other CF members during and after the BOI. LCol (ret) Lapeyre's complaints are discussed and analysed in this report.

111 Both complaints raised issues about how the CF investigates training casualties. In keeping with my Office's mandate to contribute to substantial and long lasting improvements in the welfare of members of the DND/CF community, this investigation and report have focused on systemic issues and problems as opposed to actions of individuals. It is beyond my Office's mandate to make findings of culpability with respect to individuals

or to assess the potential for criminal liability arising from MCpl Wheeler's death. The findings and recommendations contained in this report are made with a view to improving the system for current and future CF members and their families.

1.2 Investigation

112 This case was assigned to my Office's Special Ombudsman Response Team (SORT), which was created in 2001 to handle all complex and major systemic investigations undertaken by my Office.

113 The investigation included a comprehensive assessment of the original incident in which MCpl Wheeler was killed and all subsequent CF investigations and reviews related to his death. The focus of the investigation was to review the actions of DND/CF from the time of MCpl Wheeler's death until today and to identify any shortcomings in the process. We also examined recent developments in how DND/CF responds to unexpected duty related deaths to determine whether the system has been improved.

114 During this investigation, SORT investigators reviewed the notes and reports from the initial Military Police (MP) and Royal Canadian Mounted Police (RCMP) investigations, as well as the 1992 Summary Investigation and 1997 Board of Inquiry and subsequent Canadian Forces National Investigation Service investigation. Other documentation reviewed included the planning documents for the training exercise in which MCpl Wheeler was killed; maps and photographs of Canadian Forces Base (CFB) Suffield; the Alberta Medical Examiner's autopsy report; correspondence between Mrs. Wheeler and the DND/CF; media reports about the accident; correspondence, memoranda and notes related to the review of the 1992 Summary Investigation, as well as the 1997 Board of Inquiry, including complaints raised by LCol (retd) Lapeyre and others and the full report of the 2003 Administrative Review Board.

115 The SORT reviewed all documentation provided by the complainants and conducted extensive interviews with each of them, as well as other members of the Wheeler Family. Also interviewed were: members of MCpl Wheeler's unit who witnessed the accident and its aftermath; the police investigators who were called to the scene immediately after the accident; members of MCpl Wheeler's unit involved in notifying Mrs. Wheeler of the death and

assisting her with arrangements and other details; the Investigating Officer who conducted the Summary Investigation in 1992; the senior commanders who reviewed the Summary Investigation; the journalist who assisted Mrs. Wheeler in bringing public attention to her campaign to reopen the investigation; the senior officers involved in the decision to reopen the investigation, by way of a Board of Inquiry, in 1997; the President of the 1997 Board of Inquiry; the senior officers who reviewed the Board of Inquiry; two potential witnesses who were not called to testify at the Board of Inquiry, but who LCol (ret) Lapeyre suggested had additional information which could clarify some of the Board's findings; CFNIS investigators who investigated the accident and possible perjury at the Board of Inquiry; and CF officers who were involved in the Administrative Review Board.

116 The SORT also gathered information with respect to the procedures and regulations from 1992, which governed the investigation of training deaths and the treatment of the members of the deceased's family and compared them with those currently in place. Investigators also met with those in charge of new institutions charged with investigations and providing services to CF members and their families, since the death of the MCpl Wheeler. These officials included the Deputy Provost Marshal in charge of the Canadian Forces National Investigation Service; the Director, Casualty Support Administration; and the section head, Family Policy Team of the CF's Directorate Quality of Life.

117 The investigation also focussed on examples of more recent military fatalities in order to examine whether processes and practices have improved since MCpl Wheeler's death. To this end, the case of the friendly fire deaths in Afghanistan in 2002 was examined including the subsequent Board of Inquiry, which investigated those deaths and its findings and recommendations. Because of the similarities with the circumstances of MCpl Wheeler's case, the investigation also examined the case of the accidental training death of a CF private, who was killed when a Light Armoured Vehicle overturned at CFB Petawawa in 2002. Investigators requested and received the CFNIS report on the accident and death, and met with the unit commander and former adjutant. The private's family was also interviewed and shared their experiences in dealing with the CF.

118 Given that the issues surrounding accidental training deaths such as that of MCpl Wheeler were not unique to Canada, SORT also researched and obtained information from other countries with respect to best practices in the investigation of military deaths and in providing services and support to surviving family members. We found that Canada was not the only country struggling with some of these issues. In recent years, similar challenges have been faced – and in some instances creatively and sensitively dealt with – by the United States, the United Kingdom, Australia, and the Netherlands. Investigators met with defence attachés and other officials from these countries, and reviewed their relevant practices, or recommendations for changes. From the UK, we examined the structure of a newly-created body responsible for investigating training deaths. From Australia and the Netherlands, we drew on principles for the purpose and practice of investigations, and the importance and benefits of openness and transparency when dealing with surviving family members. From the US, we looked at an excellent example of a comprehensive approach to casualty administration.

119 In total, over 120 individuals were interviewed and over 25,000 pages of documentation reviewed during the course of this investigation. The investigation took significantly longer to complete than originally anticipated. This was due to the complexity of the issues involved, the amount of time elapsed since the accident and the on-going Administrative Review Board process, which was not completed until late 2003. In reviewing the earlier investigations conducted by the CF, we concluded that time constraints may have restricted the depth and breadth of previous conclusions and recommendations. Accordingly, we took the time that was needed to thoroughly investigate and analyse the many issues raised so that we could determine, not only whether the Wheeler family and LCol (retd) Lapeyre were treated fairly, but also to make recommendations that will ensure similar cases are treated in an improved fashion in the future.

120 The investigation was overseen by the Director, SORT, Mr. Gareth Jones. Throughout the process, invaluable advice and assistance was provided by my Office's Special Advisors Gary Furrie and George Dowler, drawing on their extensive experience and contacts in the CF. Legal guidance and advice was also provided by Ombudsman counsel, Aviva Farbstein.

121 Finally, an interim report was prepared for release to the Wheeler family and LCol Lapeyre, as well as those DND/CF officials who possess the authority to implement my recommendations, in order to obtain their feedback in writing. In this case, given the nature of the issues dealt with in the report, where it was felt that an individual may view comments in the report about them or their actions as being potentially adverse, those individuals were also provided with a copy of the relevant portions of the report, in order to provide their comments.

122 All of the comments and feedback provided on the Interim Report were reviewed and considered in preparation of this Final Report. Copies of responses to the Interim Report have been included with the Final Report, where individuals wished to have their comments noted as part of the public record. In some cases, personal information about other individuals has been severed from the responses in order to protect their right to privacy.

123 As part of the process of reviewing the Interim Report, I was able to discuss the recommendations in this report with DND/CF officials. I am pleased to say that the Department agreed to implement many of the recommendations contained in the Final Report. The Department also informed me of two major reviews which will be looking into the two areas identified in this report as requiring systemic changes: the CF Board of Inquiry and casualty support systems. I am pleased that these reviews will take place, and confident that some of the lessons and recommendations from this case will be able to assist the review processes.

124 There are also some areas in which we continue to disagree. Where this is the case, I have summarized the Department's response to the Interim Report, and explained why I still consider the recommendation to be important. The full text of the DND/CF response to the Interim Report can be found at Appendix D.

2 Summary of the Facts

2.1 Background Information

2.1.1 MCpl Rick Wheeler

125 MCpl Rick Wheeler was born in Nova Scotia. In 1982, at the age of 19, he joined the CF in Halifax. As part of the entrance requirements, he was given a routine medical examination, and it was determined that he was fit to take on the military occupation of infantryman, a physically demanding occupation.

126 He underwent initial training at CF Recruit School Cornwallis, after which he was posted to the Third Battalion, Princess Patricia's Canadian Light Infantry (3 PPCLI) at CFB Esquimalt in British Columbia. He served with the Second Battalion (2 PPCLI) at CFB Baden Soellingen, Germany, beginning in 1986, and returned with 2 PPCLI to Winnipeg, Manitoba in 1988. During his posting to Germany, he gained a significant amount of experience in a mechanized unit. With 2 PPCLI in Winnipeg, he served for two years in the unit transport platoon, followed by a stint as a rifle section commander and, in his last year, as line detachment commander in the signal platoon.

127 MCpl Wheeler is survived by his wife, Christina, and two daughters.

2.1.2 PPCLI

128 The PPCLI was formed in 1914. The regiment served in both world wars and the Korean War. It was split into three battalions between World War Two and the Korean War. The PPCLI has also served in all of Canada's major peacekeeping operations since Korea, more recently as part of Operation Apollo in Afghanistan in 2002, and Operation Palladium (Bosnia) in 2003. In December 2002, 2 PPCLI received a Commander-in-Chief's unit commendation for its actions in the Medak Pocket, in the former Yugoslavia, in 1993. 3 PPCLI, in 2003, received the same honour for its actions in Afghanistan.

129 Today, the regiment consists of two mechanized battalions (1 PPCLI and 2 PPCLI) and a light battalion (3 PPCLI). 1 PPCLI and 3 PPCLI are located at Garrison Edmonton, Alberta, and 2 PPCLI is stationed at its new garrison at CFB Shilo, Manitoba. The three battalions are now part of 1 Canadian Mechanized Brigade Group, formerly 1 Canadian Brigade Group, under the command of Land Force Western Area (LFWA).

2.2 Exercise Surging Rage

2.2.1 Preparation and Planning

130 In the spring of 1992, 2 PPCLI was preparing for Exercise Rendezvous 92, a national training exercise held in April at CFB Wainwright, Alberta. As part of the preparations, 2 PPCLI participated in a unit exercise, Exercise Surging Rage, from March 24 to April 8, 1992 at CFB Suffield, near Medicine Hat, Alberta. CFB Suffield is used extensively as a training ground by the CF and by visiting British troops.

131 The CF, and in this instance the army, has rules and regulations that govern training to ensure that objectives are reached, standards are maintained and resources are provided. These are supplemented by lower-level policies and procedures, and finally, by plans that coordinate and control activities for individual exercises.

132 The unit's exercise plan for Exercise Surging Rage included a General Instruction and a number of annexes that contained the Administrative Instruction, A and C Company Training Programmes, Combat Support Platoons Training Programme, Ammunition Allocation and Map Distribution. Within the Company Training Programme was a subordinate general instruction detailing the conduct of a 48-hour Battalion Group exercise and the Master Events List. The 2 PPCLI Exercise Surging Rage General Instruction referred to the following applicable regulations:

133 • 1 CBG Standard Operating Procedures (SOPs) of December 13, 1988;

134 • 2 PPCLI SOPs of November 15, 1989;

135 • Force Mobile Command (FMC) Infantry Battle Task Standards of May 1985;

136 • Canadian Forces Publication (CFP) 301 (1) Land Formations in Battle; (2) The Battle Group in Operations; (3) Ranges and Training Safety; and

137 • CFB Suffield Range Standing Orders.

138 The exercise plan was written and directed by Major (Maj) Walter Semianiw, the Operations Officer of 2 PPCLI, with the assistance of other members of the unit, including Captain (Capt) Tony Kaduck, the Officer Commanding Combat Support Company. Maj Semianiw and Capt Kaduck visited CFB Suffield to view the training area on February 3 and 4, 1992. The exercise plan was completed and signed by LCol J.M. Lapeyre, the CO of 2 PPCLI.

139 Copies of the documents were sent to the Operations Officer at CFB Suffield on February 18, 1992. On March 5, 1992, a coordination conference was held in Winnipeg, but attendance was not recorded.

2.2.2 The Exercise Plan

140 Exercise Surging Rage involved three phases: Phase 1 comprised the deployment of vehicles, equipment and advance party personnel to Suffield from March 19 to 23, 1992; Phase 2 involved the conduct of field training; and Phase 3 entailed the redeployment of vehicles and equipment to Wainwright and remaining personnel to Winnipeg from April 8 to 15. Phase 2 was divided into two parts. The first ran from March 24 to 30 and required the participation of A Company and other elements. C Company and other elements of the unit were then to repeat the same schedule and exercises from April 1 to 7.

141 According to the schedule, Day 1 (i.e., March 24 for A Company and April 1 for C Company) was dedicated primarily to preparations, maintenance, inspections, briefings and deployment to the field. Late on Day 7 saw the redeployment to the camp from the training area, and the cleaning of equipment and vehicles. The time in between was devoted to practical combat training.

142 Discounting the days devoted primarily to travel or maintenance, the training part of Exercise Surging Rage was planned for six days (Days 2 to 6 inclusive and part of Day 7). Days 2 and 3 were devoted to training on the individual to platoon levels, and the remaining days to Company and Battalion Group training, with a controlled Enemy Force being provided for the Battalion Group training. Planned training included both range firing and dry training. The latter included battle procedure practice, advance-to-contact and hasty-attack drills.

143 Details of the Battalion Group training were set out in the Master Events List, a kind of script depicting a series of continuous events, each explained with an indication of enemy and friendly action. Final coordination of Master Events List activities was achieved at daily operations briefings, held under the control of the exercise Chief Controller.

144 The Exercise Office of Primary Interest for the Battalion Group training was LCol Lapeyre. The exercise Chief Controller was Maj Semianiw. According to the General Instruction, each platoon was to have a designated controller. For C Company's force-on-force portion of the exercise, a lieutenant was the Enemy Force Controller, and Capt Kaduck was the Friendly Force Controller.

2.3 The Exercise and Fatal Accident

145 On April 7, the Master Events List required C Company, the Friendly Force, to mount an attack against an Enemy Force defending a mock village in the training area of CFB Suffield. In addition to the Enemy Force Controller, the Enemy Force was made up of 9 members, drawn from various platoons of Combat Support Company. The Enemy Force had an armoured personnel carrier (APC). No live ammunition was used; a battlefield environment was simulated through the use of smoke pots and thunder flashes, and control staff observed the action and determined casualties.

146 When the attack took place, the APC was hidden in a dry riverbed to the east of the village, the Enemy Force Controller was between the APC and the village, and the remainder of the Enemy Force occupied defensive positions in the village. Under heavy attack by C Company, the Enemy Force withdrew through the village. On the signal of a private stationed on the roof of the church, the APC driver began driving the APC toward the village as part of a

counterattack. The Enemy Force Controller believed that he was controlling the APC's movements with hand signals; however, the APC drove past him into the village. MCpl Wheeler was, at the time, simulating a casualty by pretending to be dead or severely injured on one of the main roads running through the village. The APC turned onto the road, narrowly missing two other members of the Enemy Force, and ran over MCpl Wheeler.

147 The APC driver was not aware that he had run over anyone. He continued driving, until Capt Kaduck's driver caught his attention and stopped him. Emergency first aid was administered to MCpl Wheeler, and a "No Duff" (real) casualty message was sent over the radio network. MCpl Wheeler was airlifted by a visiting British Forces helicopter to the nearest hospital, the Medicine Hat Regional Hospital. MCpl Wheeler was declared dead on arrival, at 10:53 a.m. Mountain Standard Time.

2.4 Post-Accident Investigation

148 After the accident, the proper authorities were informed. The RCMP was the lead investigative agency. The CFB Suffield Military Police (MP) were contacted, and a Military Police corporal was assigned to the case. He went directly to Medicine Hat Regional Hospital, and interviewed hospital personnel. He subsequently returned to CFB Suffield, where he met with the RCMP constable assigned to the case.

149 LCol Lapeyre appointed a major to take the necessary action at the accident site. The remainder of the exercise was called off, and the major in charge of the accident scene told the witnesses to the accident to wait for investigators to arrive. The exercise photographer asked to be taken up in a helicopter, from which he took aerial photographs of the scene. The major in charge ordered a re-enactment of the accident. Since the APC driver was in shock and unable to drive the APC during the re-enactment, another member drove it. The re-enactment was photographed, as well as the reported positions of all involved at the time of the accident.

150 The RCMP constable went to CFB Suffield with the MP corporal. They did not go to the scene of the accident, since they were told that the equipment had been moved. The major in charge of the accident scene provided the two investigators with a witness list he had compiled, along with statements from the witnesses and two rolls of film of the re-enactment.

151 The RCMP and MP investigators interviewed Capt Kaduck's driver on April 7. The next day, statements were taken from the APC Driver, the exercise photographer, another member of the Enemy Force, and the Friendly Force Umpire. (Umpires, part of the control staff, were responsible for, among other things, observing the action and telling participants if they were dead or injured.) The MP corporal identified these individuals as the only ones with pertinent information, based on the witness list and statements of witnesses provided to him.

152 The MP corporal concluded his investigation on April 9, citing the noise and confusion inherent to the exercise and poor visibility from the APC as the main reasons for MCpl Wheeler's accidental death. He noted that it was unusual for a driver to operate an APC by himself, as well as the fact that driving hatches-down with the modifications to the APC restricted the driver's vision. In his report, he did not address the issue of whether there should be criminal or service charges arising from the accident. The MP report was forwarded up the chain of command and accepted as complete at NDHQ, Criminal Investigation Service on June 1, 1992.

153 The RCMP constable concluded his investigation on April 29, 1992 and filed a report with the RCMP, which read:

154

> It is the investigator's opinion that noise, light, smoke and possible confusion inherent in this type of exercise would contribute to this accident in that Rick Wheeler would not be aware of the approaching armoured personnel carrier. Further to these factors, the APC was being operated with only one crewmember looking through a periscope system which would severely limit his field of vision. Normally an APC operated in this configuration requires two crewmembers each looking through a separate periscope system. The APC was further modified by having the trim vane out and covered to simulate an enemy tank. This restricted the operator's forward and downward view of the roadway. It is the investigator's further

> opinion that no criminal action is warranted in light of all circumstances. The Canadian Armed Forces is conducting their own investigation to determine if any internal action can be taken.

155 Aside from the photographs and the witness statements, there is no first-hand evidence from the accident scene. There was no formal site investigation by a trained investigator who was not involved in the training exercise. The scene was not preserved, and the equipment was moved into the Suffield camp for onward movement to CFB Wainwright as originally planned.

156 The exercise photographer told my investigators that he does not remember exactly what he did with the film he shot that day, but that, in the normal course of operations, he would have given them to the major in charge of the accident scene, who would then have taken them to be developed. According to the MP report, the major in charge of the accident scene handed the film to the MP on the day of the accident. The film was developed, but the exercise photographer has been unable to track down the negatives. In addition, the whereabouts of any original photographs are unknown; poor-quality photocopies of some of the original photographs are the only remaining photographic record of the scene. According to the MP corporal, the photographs should be with the MP report.

2.5 The Summary Investigation

157 Article 21.46 of the *Queen's Regulations and Orders* (QR&O) requires that an SI or BOI be held whenever a CF member is killed or seriously injured. Findings are required under article 21.47, as to the cause of the injury or death; whether the member was on-duty at the time of injury or death; whether the deceased or injured member, or anyone else, was to blame for the injury or death; and whether the injury or death was attributable to military service. Article 21.48 requires that all investigations into deaths include a statement about whether a claim for compensation has been made or is likely to be made against the Crown.

158 The choice of whether to hold an SI or a BOI is usually left to the discretion of the CO. Normally, this decision is based on such considerations as the gravity and complexity of the issues and events leading to the accident, and the

amount of time and resources required to come to a satisfactory determination of the cause of the incident. An SI is usually more cursory, while a BOI takes longer but is more formal and thorough.

159 LCol (retd) Lapeyre told my investigators that he had asked his adjutant to find out from the Judge Advocate General (JAG) what kind of investigation was required. He said that, at the time, he did not believe it would be appropriate to begin a BOI, since the battalion was leaving for a major exercise within 15 days, and he was scheduled to leave 2 PPCLI within 60 days as part of a normal change of command. As a result, when the Adjutant told him that it was possible to conduct an SI, that is what he ordered.

160 The former 2 PPCLI Adjutant told my investigators that he checked, not with the JAG, but with the 2 PPCLI Chief Clerk, and they determined an SI was an appropriate option. The former Adjutant stated it was their belief that the primary purpose of the SI would be to confirm MCpl Wheeler had been on duty at the time of his death. A finding as to whether a death or injury occurred while a CF member is on duty is important in determining which benefits are available to the member or the member's surviving family.

161 Immediately following MCpl Wheeler's death, as required by regulations, 2 PPCLI sent a "Significant Incident Report" to Force Mobile Command Headquarters. The message indicated that there had been an accident resulting in a death, that it had not been investigated and that the member's next of kin had not been notified. Updated messages were sent as information became available. A communiqué dealing with the investigation of MCpl Wheeler's death was sent on April 8, 1992 from NDHQ to Land Force Western Area Headquarters, 1 Canadian Brigade Group Headquarters and 2 PPCLI. In it, NDHQ stated it would require the results of either a BOI or an SI, pursuant to QR&O 21.46, for approval by the Chief of the Defence Staff (CDS). It also further requested a synopsis of initial findings "to determine pensions entitlement for widow." On the same day, LCol Lapeyre signed the terms of reference for the SI. He appointed the 2 PPCLI Assistant Adjutant, a lieutenant, as the SI investigator.

162 The findings of the preliminary investigation conducted at the scene were transmitted from 2 PPCLI to NDHQ on April 9. The report stated the death was an accident that occurred during a dry training exercise; that MCpl Wheeler was on the ground, feigning death; and that the APC driver did not

see him and ran over him. It ended with the initial finding: "MCpl Wheeler was on duty at the time of accident and the accident was attributable to mil svc [military service]." In a further preliminary report sent on April 21, the following information was added: "The driver [of the APC] was down in his hatch and there was no crew comd [commander]." Other information about the accident was a repetition of the earlier message, adding that an SI was ongoing and was awaiting the RCMP investigation, the autopsy report and the death certificate. It also indicated that no disciplinary action or administrative action had been taken. The message did, however, indicate: "DND sp [support] to Wheeler Family has been first rate …" It outlined the particulars of financial compensation Mrs. Wheeler was to receive and acknowledged that the Wheeler family (wife and father) had expressed interest in seeing the results of the investigation.

163 The SI investigator had received instruction in conducting investigations as part of his normal CF training and had conducted other SIs into minor incidents, such as injuries and loss of equipment. He had never investigated an incident as serious as an accidental death with the potential for assigning blame for so serious an occurrence or for highlighting problems in safety and command procedures.

164 The SI investigator told my investigators that he mentioned to the Adjutant that it might be better to have someone of a higher rank conduct the investigation, since he was of the same rank as one of the people whose actions were potentially under scrutiny. However, he said that he did not feel that his rank was an issue in the investigation since his task was to find facts, and any consequences, such as disciplinary action, were the responsibility of LCol Lapeyre.

165 The SI investigator was given the original statements collected during the MP and RCMP investigations. He interviewed the original witnesses further, where he needed clarification, and he also interviewed others who had not been questioned immediately after the accident. Meanwhile, soon after he returned to Winnipeg, the Enemy Force Controller had been sent on temporary duty to CFB Gagetown. As he recalls, he was sent there on one and a half weeks' notice, as an instructor. A large number of CF members, particularly reservists, are sent to Gagetown in the summer for training, and

units from around the country send instructors to assist the permanent staff. The SI investigator said that the Enemy Force Controller's temporary relocation was not a problem for his investigation, since he was available by telephone.

166 The SI findings relied on the statements of the Enemy Force Controller, the APC driver, the two Enemy force members who had narrowly missed being hit by the APC seconds before it hit MCpl Wheeler, Capt Kaduck's driver, the exercise photographer, the private who had been stationed on the roof of the church, three other members of the Enemy Force, two medical assistants who had administered first aid, and the Friendly Force Umpire. The SI investigator did not visit the site of the accident, but did have diagrams of the site drawn by witnesses, as well as the photographs taken during the training exercise and after the accident.

167 The SI investigator concluded the SI on June 24, 1992. He told my investigators that the investigation was completed before then, but he waited for the medical reports on MCpl Wheeler before concluding the investigation. When the investigation was completed, it was approved by LCol Lapeyre and then sent for review up the chain of command.

2.5.1 Findings of the Summary Investigation

168 In six pages, the SI Report briefly described the accident and the events leading up to it, summarizing the facts from the witness statements (which were themselves attached as annexes to the report).

169 The SI Report cited three factors that led to the accident in which MCpl Wheeler was killed. The first was confusion about the APC driver's orders for and role in the Enemy Force manoeuvres. The second was lack of a crew commander, who would have been able to guide and caution the APC driver. The final factor was the APC driver's driving; the SI Report notes that he had been admonished about his driving habits throughout the exercise.

170 The SI found that MCpl Wheeler was on duty at the time of his death and that his death was attributable to military duty. It explained that MCpl Wheeler died when the APC drove over him and detailed the cause of death. The report also cited three individuals as responsible for the death: the Enemy Force Controller, the APC driver, and MCpl Wheeler himself. The report states:

171 > … responsibility for the death can be attributed to the negligence of a minor nature of the following personnel:

172 > 1. [The Enemy Force Controller] for failing to provide a crew commander for the APC, for not ensuring that [the APC driver] was clearly aware of the specific location where the APC was to stop, and for adding a counter-attack dimension to the final attack scenario;

173 > 2. [The APC driver] for driving using periscopes and at a speed which did not allow him time to see MCpl Wheeler, and for not ensuring that he was aware of the specific location where his APC was to stop; and

174 > 3. MCpl Wheeler for failing to stand up and to alert the driver of his presence on the roadway, regardless of the fact that he (MCpl Wheeler) was feigning death at the time.

175 As required, the SI Report notes that there had been no offer of or claim for compensation for MCpl Wheeler's death and that a claim against the Crown by his surviving family members was a possibility. It also mentions that MCpl Wheeler had diminished hearing abilities, noting that his H3 rating may have contributed to "his slow reaction to the approaching APC."

176 "H3" refers to MCpl Wheeler's hearing, according to the CF medical assessment system, which ranks CF members for a series of six health factors. The standards are used to assess recruits and the continued employment of CF members. The best possible rank is 1. Each military occupation has minimum standards, and H3 is acceptable for MCpl Wheeler's occupation (infantryman); it meant that, as of his last hearing test, he could hear sounds of less than 50 decibels with either ear. Had he fallen to H4, he would no longer have been qualified as an infantryman.

177 The SI Report also made recommendations based on the investigation:

178 a. that the following corrective measures be implemented if APCs are to be used in close proximity to dismounted troops:

179 (1) that the crew commander must be employed with APCs, in accordance with FMCO [Force Mobile Command Order] 24-15, and that Battalion Standing Orders be amended to reflect this policy;

180 (2) that drivers be required to drive with their heads up out of the hatch while in close proximity to dismounted troops; and

181 (3) that the importance of alerting drivers of tracked vehicles to one's presence on the ground be continually stressed at every level of command;

182 b. during training using a scripted scenario, every reasonable effort must be made to rehearse vehicle routes and make all players aware of these routes; and

183 c. no disciplinary action be taken.

184 The SI Report lists Maj Semianiw as the exercise Chief Controller, as described in the General Instruction. The fact that he had left CFB Suffield before the accident was not mentioned in the report, nor was the question of who had been acting as Chief Controller in his absence. Determining the Chief Controller at the time of the accident did not become an issue until the BOI in 1997.

2.5.2 Review of the SI Report: Tracing the Approval

185 According to information available to this Office, the Adjutant of 2 PPCLI requested that a draft of the SI Report be reviewed prior to its completion. The review was conducted by the staff officer for Administration and Personnel of 1 Canadian Brigade Group Headquarters. On May 30, 1992, he sent comments for consideration by LCol Lapeyre as requested. He suggested the inclusion of a reference to certain safety regulations. He also recommended that the following should be determined: (1) the Enemy Force

Controller's location; (2) who authorized the absence of a crew commander; and (3) MCpl Wheeler's hearing rating, as confirmed by documents. After incorporating these comments, the SI investigator forwarded the complete report to LCol Lapeyre.

186 On June 25, 1992, LCol Lapeyre wrote a covering memorandum in which he agreed in substance with the findings and recommendations of the SI Report. In essence, LCol Lapeyre confirmed that MCpl Wheeler was on duty at the time of the accident and that his death was attributable to military service. As mentioned above, the SI Report allocated responsibility for the death to the Enemy Force Controller, the APC driver, and MCpl Wheeler himself. However, LCol Lapeyre's memorandum did not repeat the finding of the SI, which attributed responsibility to MCpl Wheeler for his own death.

187 LCol Lapeyre concurred with the SI's recommendations and noted that he had directed that the Battalion Standing Orders be amended accordingly. LCol Lapeyre also recorded that administrative action had been taken against the Enemy Force Controller (a reproof) and the APC driver (a recorded warning) as a result of their negligence. A reproof is an administrative action used for conduct that is reprehensible but not serious enough to warrant charges. A recorded warning is an administrative action aimed at informing a member of a deficiency in his conduct of performance, and at giving him a chance to improve on that deficiency. He wrote:

188

> While it is clear that the Canadian Forces was responsible for MCpl Wheeler's tragic death, and that two individuals were negligent, I do not believe that disciplinary action is warranted, nor that it would be productive.

189 The SI Report, with LCol Lapeyre's covering memorandum, was then sent to the Commander of 1 Canadian Brigade Group, Brigadier-General (BGen) Barry Ashton. BGen Ashton reviewed the report, and his comments of July 6, 1992 read:

190

> I have reviewed this summary investigation and concur with the comments and recommendations made by the Commanding Officer Second Battalion Princess Patricia's Canadian Light Infantry.

191

> Master Corporal Wheeler was participating in an authorized field training exercise at the time of the accident. His death is therefore attributable to military service.

192 The autopsy report and the findings of the inquest are not available at this time and will be forwarded upon receipt.

193 From 1 Canadian Brigade Group, the report went to Land Force Western Area Headquarters in Edmonton, where it was reviewed by Land Force Western Area Commander, Major-General (MGen) de Faye. MGen deFaye wrote an opinion on the SI on August 15, 1992. Although he concurred in part with the comments of the SI investigator, LCol Lapeyre and BGen Ashton, the last two paragraphs of his review set out areas in which his opinion differed from the findings:

194 In my opinion deficiencies existed in the planning, conduct and supervision of the specific training serials of Exercise Surging Rage on 7 April 1992. Safety provisions of FMCO 24-15 paragraphs 18 and 19 were neglected. Command and control over the execution of the specific serials were unsatisfactory. To prevent or reduce unnecessary training risks that could result in similar situations, Commander 1 CBG [Canadian Brigade Group] shall ensure safe training regulations are enforced. Training shall be conducted only when adequate resources and supervision have been assigned to the task.

195 I am also concerned that Master Corporal Wheeler, an experienced soldier, did not react to the approaching Armoured Personnel Carrier. The weather and visibility conditions were good, although I did note that his hearing category was H3. Final disposition of this investigation should await the autopsy report.

196 As the report went up the chain of command for review, the comments of each subsequent reviewer were also being sent back down the chain. The report and the comments of the review authorities were sent to NDHQ, and Army Headquarters in St Hubert was simply informed. According to CF regulations, the CDS is the "approving authority" and all other individuals who review it before it gets to the CDS are called "review authorities." The file was received at Directorate, Personnel Legal Services at NDHQ on August 26, 1992. On October 1, 1992, BGen Ashton directed the CO of 2 PPCLI to "ensure that his officers and Non-Commissioned Members (NCMs) were made aware of all safety regulations pertaining to their training and that these regulations were followed." Finally, the SI Report was reviewed and approved by Director of Personnel Legal Services (DPLS) on behalf of the CDS, on July 14, 1993.

2.6 The CF and MCpl Wheeler's Family

2.6.1 Notification and Initial Arrangements

197 Immediately after the accident, LCol Lapeyre contacted the Adjutant, part of the rear party (members of the battalion who had remained in Winnipeg while the battalion conducted Exercise Surging Rage). He directed that MCpl Wheeler's primary next of kin be advised of the accident. The contact information on MCpl Wheeler's file was out of date, and while the Adjutant was attempting to locate Mrs. Wheeler by telephone, he was inadvertently connected with her. He chose not to inform her of the death over the telephone, and instead informed her that there had been an accident involving her husband, and that a chaplain was on the way to talk to her.

198 Mrs. Wheeler estimates that it took approximately 45 minutes for the chaplain to arrive. She told my investigators that the chaplain left immediately after advising her of her husband's death.

199 Mrs. Wheeler was assigned an Assisting Officer from her husband's unit, whose responsibilities included assisting her with funeral arrangements, and providing information and assistance with items such as pensions, benefits and other administrative details. The Assisting Officer met with Mrs. Wheeler in the evening of April 7, 1992. They discussed funeral arrangements, and how to inform MCpl Wheeler's father of the death. Mrs. Wheeler decided to call her father-in-law herself.

200 Both MCpl Wheeler's father and his widow were unhappy about the way they were treated after the death. Mr. Wheeler was not pleased with the handling of the funeral, and the lack of official contact from the CF. Mrs. Wheeler was upset about the lack of support from the chaplain who had visited her, the seeming indifference of her husband's battalion as a whole, her inability to access counselling services, being required to return some of the military equipment her husband had kept at home, and lack of information about her husband's accident.

2.6.2 Release of Information

201 After the funeral, Mrs. Wheeler was left with many questions about her husband's death. She had tried, unsuccessfully, to get answers immediately after his death, and she had no better luck later on. To get information from the SI, she had to make a formal request under the *Access to Information Act*. She received a copy of the SI Report, but most of the information it contained was severed (removed from the copy provided to her as personal information exempt from disclosure). The coroner's report, as the product of an Alberta Medical Examiner, had to be obtained separately from the provincial authorities.

202 Mrs. Wheeler also attempted to get information informally from members of MCpl Wheeler's unit who had been at CFB Suffield for the training exercise, but she got conflicting stories from different members of the battalion. There were also a number of unit personnel changes immediately after MCpl Wheeler's death: LCol Lapeyre and Maj Semianiw were scheduled for transfer, while the Enemy Force Controller was sent on temporary duty to CFB Gagetown for the summer. These changes, and the difficulties Mrs. Wheeler encountered in obtaining information, helped fuel her belief that the CF were covering up the truth behind her husband's death.

2.7 Events between the SI and the BOI, 1992–97

203 In 1992, when MCpl Wheeler died, Christina Wheeler was employed full time. According to Mrs. Wheeler, her work schedule was demanding, and she was often required to work evenings or weekends. After MCpl Wheeler's death, Mrs. Wheeler found that maintaining her work schedule and being the sole parent to her children became increasingly difficult. As a result, Mrs. Wheeler resigned from her position and moved back to her hometown. She says that she felt her daughters needed her full-time attention, and that the move would provide her with support from her family and friends.

204 During this time, she continued to press the CF for information about the accident. The limited portions of the SI Report that she was given included the statement that MCpl Wheeler was partly responsible for his own death. This finding upset Mrs. Wheeler and she was determined to clear her

husband of blame for his death. She found out that Canadian Forces Administrative Order (CFAO) 24-6 required wilful disobedience of orders, wilful self-inflicted wounding, or vicious or criminal conduct before a CF member could be held responsible for his own death. Learning this, she wrote to CF officials and the Minister of National Defence, demanding that her husband be absolved of responsibility.

205 In October 1996, the *Calgary Herald* featured a story by Bob Bergen about a CF member killed in a training accident at CFB Suffield in 1995. In the story, Mr. Bergen revealed that the actual cause of his death was different from the cause cited in the CF investigation. The article caught Mrs. Wheeler's attention, and she contacted Mr. Bergen. In February of the following year, her story appeared in newspapers across the country. After the articles, the renewed interest in MCpl Wheeler's death made it possible for Mrs. Wheeler to obtain new information about the accident and present it to the CF. Due mainly to her efforts, the CF decided in 1997 to convene a BOI to reinvestigate MCpl Wheeler's death.

2.8 The BOI

2.8.1 Decision to Call the BOI

206 Christina Wheeler, dissatisfied with the results of the SI, continued to demand that the investigation be re-opened.

207 In early 1997, former Chief Justice Brian Dickson was chairing an independent inquiry into the military justice system within the CF — the Special Advisory Group on Military Justice and Military Police Investigation Services (the Special Advisory Group). Mrs. Wheeler wrote a letter to the Special Advisory Group, outlining the case and her concerns with the manner in which it had been investigated. Her letter to the inquiry was reported in the press and listed in the annex of written submissions in the Special Advisory Group's Report.

208 Bob Bergen's first news article appeared on February 23, 1997. Shortly after it appeared, Mrs. Wheeler's first Assisting Officer contacted her. Mrs. Wheeler said he asked for her permission to give the CF her telephone number so they could contact her.

209 After the article appeared, Mrs. Wheeler came into contact with a former colleague of MCpl Wheeler's. This former colleague had not been interviewed by the MP or RCMP, although he was one of the Enemy Force members who had been narrowly missed by the APC before it hit MCpl Wheeler. On April 3, 1997, Mrs. Wheeler received some maps of the site from MCpl Wheeler's former colleague, as well as a new diagram indicating the placement of people and equipment at the time of the accident. MCpl Wheeler's former colleague drew the diagram in 1997, based on his recollection of the day of the accident. It showed the Enemy Force Controller in a different location from the one in the photographs of the re-enactment of the accident, as well as from the one that the Enemy Force Controller had described to the SI. Mrs. Wheeler was eventually able to use this new information to push for a new investigation.

210 At that time, Capt (now Maj) Kaduck was the staff officer for Operations, reporting to the Commander 1 Canadian Mechanized Brigade Group, BGen Meating. In response to the growing awareness of the issue, BGen Meating had had Maj Kaduck telephone Mrs. Wheeler on April 1, 1997. Maj Kaduck asked her if she was satisfied with the information she received about her husband's death and if there was something else she felt she needed.

211 Mrs. Wheeler replied that she was not satisfied with the information she received concerning the accident. Secondly, she expressed her discontent with the fact that no one had been held accountable for her husband's death, except for minor negligence: no disciplinary action had ever been taken, nor had the incident been formally addressed. She also explained her complete dissatisfaction with the SI Report, in particular with its holding MCpl Wheeler accountable for his own death, contrary to the regulations.

212 In addition, Mrs. Wheeler said that MCpl Wheeler should not have been on the exercise at all, given his hearing rating. She pointed out what she believed to be inconsistencies in the Enemy Force Controller's statements, and the fact that safety regulations were not followed during the exercise. Mrs. Wheeler told Maj Kaduck that, if the CF wanted to help her, the chain of command should be held accountable for MCpl Wheeler's death, and that she would like an inquiry into the entire matter.

213 At the end of the conversation, Maj Kaduck said he would inquire into giving her access to a full report of the SI and her husband's medical records. He also undertook to find out if the way in which the investigation was conducted could be addressed, along with the possibility of re-opening it.

214 On May 27, 1997, Mrs. Wheeler contacted Maj Kaduck to follow up on their earlier conversation. He told Mrs. Wheeler that, unless she had new information, the investigation would not be re-opened. When Mrs. Wheeler informed him that she did have new information about where the Enemy Force Controller was at the time of the accident, he advised her to write to BGen Meating, stating the nature of the new information, as well as the fact that she wished for the investigation to be re-opened. On May 28, 1997, Mrs. Wheeler wrote to BGen Meating and MGen Bruce Jeffries (Commander of Land Force Western Area) followed by a letter to the Minister of National Defence on July 7, 1997.

215 On July 10, BGen Meating (the Commander, 1 Canadian Mechanized Brigade Group) wrote a letter to MGen Jeffries, in response to MGen Jeffries' request for him to determine whether Christina Wheeler's dissatisfaction with the SI was warranted. BGen Meating commented on the superficial nature of the SI and its resulting failure to adequately address the facts surrounding the incident. He mentioned inconsistencies in the Enemy Force Controller's testimony that were not satisfactorily dealt with. He also questioned the decision to assign a junior officer, from within the unit, as the investigating officer. Finally, BGen Meating expressed his view that the reviews of the SI Report were insufficient. He outlined five main issues raised by Mrs. Wheeler, as follows:

216 1. Mrs. Wheeler had not been provided with a complete, unsevered copy of the SI.

217 2. The SI incorrectly and contrary to regulations assigned blame to MCpl Wheeler for his own death.

218 3. Safety regulations had been violated, but no one was held accountable.

219 4. The administrative actions taken (a reproof and recorded warning) were inappropriate considering the gravity of the incident.

220 5. The evidence revealed inconsistencies; the evidence of one member was not considered. He also felt that the accident might not have occurred had the Enemy Force Controller been an effective guide for the APC driver.

221 In his closing remarks, BGen Meating explained that the investigation left many questions unanswered, which cast a poor light on the administration of military procedures. He suggested that the lack of disciplinary proceedings could warrant re-opening the investigation or, at a minimum, an admission that the SI's findings were questionable. However, he acknowledged that the statute of limitations had expired, preventing disciplinary action under the *Code of Service Discipline*. BGen Meating recommended:

222 1. re-opening the investigation, formally and publicly;

223 2. absolving MCpl Wheeler of blame; and

224 3. ensuring that administrative action was taken against the Enemy Force Controller and the APC driver, as recommended by the SI.

225 Mrs. Wheeler was provided with a copy of this letter. Mr. Bergen also obtained a copy of the letter. Shortly afterwards, BGen Ross became the new Commander of Land Force Western Area. In the following weeks, various newspaper articles featured Mrs. Wheeler, her story and quotes from BGen Meating's letter, including his findings and recommendations.

226 On August 6, 1997 BGen Ross contacted Mrs. Wheeler. BGen Ross stated that he had received her letter along with BGen Meating's reply. He told Mrs. Wheeler that he had concerns about the SI surrounding questions of accountability, leadership during the exercise and who, if anyone, could or should have prevented dangerous activities. He agreed with Mrs. Wheeler that her husband should not have been found responsible for his own death. BGen Ross informed her that, as a result of his concerns, and after a discussion with the Commander of Land Force Command, Lieutenant-General (LGen) Maurice Baril, he (BGen Ross) would convene a BOI.

227 In his interview with my investigators, BGen Ross stated that, when he arrived at his new job in July 1997, he began investigating Mrs. Wheeler's complaints. He said that he could not understand why the CF had not provided answers to the family's questions, nor could he comprehend why

nothing was done to rectify the situation. BGen Ross mentioned that he felt that the climate in the military had changed considerably since 1992 as a result of various other incidents, including the Somalia Inquiry, which made it more likely that action would be taken to correct the problems with the SI.

228 BGen Ross told my investigators that he had four main concerns about the SI: that a conflict of interest may have tainted the SI, since the investigator was a junior officer from within the unit overseen by LCol Lapeyre; that the authorities responsible for reviewing the SI had accepted the report uncritically; that the investigation did not answer questions raised about safety; and that MCpl Wheeler had been found partly responsible for his own death.

229 BGen Ross was in close contact with Mrs. Wheeler before convening the BOI. He wrote to her on August 6, 1997, expressing his intention to call the Board and to appoint Col Selbie as its president. The portions of the letter dealing with the goals of the BOI read:

230

> … I would like to express my sincere regret that such a tragic incident took place and that the causes and accountabilities associated with it remain inadequately addressed … The Board will have wide and comprehensive terms of reference … I want to reaffirm my resolve to have the circumstances of your husband's death fully investigated and the appropriate follow-up action taken.

231 BGen Ross also committed to meeting with Mrs. Wheeler and reviewing the findings and recommendations of the BOI soon after the report was due. When the Board was convened, BGen Ross sent Mrs. Wheeler a copy of its terms of reference.

2.8.2 Convening the BOI

232 The primary purpose of the BOI was to "investigate and report on the circumstances surrounding the death of MCpl Wheeler at CFB Suffield …" BGen Ross, Commander of Land Force Western Area, approved the terms of reference for the BOI on August 15, 1997. The Board was given a reporting deadline of October 31, 1997.

233 The convening authority for the BOI was Commander of Land Force Western Area, BGen Ross. The terms of reference appointed Col J.J. Selbie and Maj S.A.A. Johnson as a member and the safety expert. Col Selbie was the Base Commander of CFB Shilo, and Maj. Johnson had experience in the artillery, but no infantry experience. A third Board member, a major with infantry experience, was appointed in the terms of reference, but due to a scheduling conflict, was replaced by Capt J.D. Price, on August 29, 1997. Capt Price had limited experience with mechanized infantry operations and training. A legal advisor was also appointed to assist the Board, a major with the Judge Advocate General.

234 The BOI was directed to make findings about: the adequacy of planning and control for the exercise; the adequacy of safety regulations, and whether or not they had been violated during the exercise; the responsibility of the chain of command or any other personnel for the accident; and whether the corrective action recommended after the SI was adequate. The BOI was also instructed not to make findings about disciplinary matters.

2.8.3 BOI Investigation

235 The Board drew up a plan for the BOI, which called for an investigation in five stages:

236 1. Gathering of documentary evidence.

237 2. Site visit to CFB Suffield in the company of Maj Kaduck and the major who had been put in charge of the accident scene in 1992, to enable construction of a model of the site to facilitate witness testimony.

238 3. Interviewing people identified as having witnessed the accident, but who were not interviewed for the SI. The goal of this stage was to "allow early identification of any new information or identification of any additional witnesses that may have been overlooked during the first investigation."

239 4. Interviewing principle witnesses, such as command staff. It was noted that the APC driver would be required to help reconstruct the APC for "visibility trials."

240 5. Additional interviews, as required.

241 The investigation phase of the BOI was to end on October 17, which would have given the Board two weeks to digest the information gathered, make findings and write a report, including recommendations.

242 The Board drew up a list of witnesses based on the witnesses interviewed in 1992 and other accounts of the incident, including the MP investigation and the statements written at the direction of the major put in charge of the accident scene, immediately after the accident. The Board also decided to examine the officers in command, something that had not been done in 1992, and sent out a general request to all Land Force areas for general distribution, asking anyone with information about the accident to contact them.

243 Before they testified at the BOI, witnesses were sent a questionnaire. It dealt with the witnesses' background, their role in the exercise, and their understanding of the way things were to unfold and of command and safety issues, along with some more specific questions.

244 The BOI heard from 23 witnesses. One Enemy Force member (the one who had been stationed on the roof of the church during the exercise) was unable to attend the inquiry but provided the Board with a written statement. The BOI also heard from the Base Surgeon at CFB Shilo, as an expert witness on medical issues. Most of the witnesses were heard between October 7 and 20. LCol (retd) Lapeyre, however, was unable to go to Winnipeg until October 29. Arriving very late at night, he was the last witness to testify, on October 30, 1997.

245 The Enemy Force Controller and the APC driver were allowed to hear the testimony of the other witnesses and to ask them questions. They were also re-examined at the end of the testimony and allowed to make statements to clarify their positions. It is usual practice to exclude witnesses from such proceedings to ensure their testimony is not influenced or tainted by what they hear. However, because the Board was sensitive to the possibility of adverse findings against them, they were allowed to hear the evidence against them, in accordance with article 21.10 (4) of the QR&O.

246 LCol (retd) Lapeyre's late arrival meant that he testified after the Board had almost completed its investigation, while it was in the process of writing the report and finalizing findings and recommendations.

2.8.4 BOI Findings

247 The BOI's findings were in accordance with its three main terms of reference: exercise planning and control; safety; and responsibility. Because there was a great deal of overlap, particularly in the first two sections, exercise planning and control will be discussed together with safety.

2.8.4.1 Exercise Planning and Control, and Safety

248 The BOI found that the exercise was generally well planned. A sufficient amount of preparation went into planning, and the Master Events List and other exercise documents were adequate. However, the BOI noted that, while the general instruction for the conduct of the 48-hour battalion exercise called for an Enemy Force platoon to be drawn from reconnaissance and anti-armour platoons, it was in fact an *ad hoc* group of nine individuals (and a Controller), primarily from signals and intelligence.

249 The BOI held that not all of the applicable safety instructions and regulations were included or referred to in the exercise documents. The Board found that safety instructions that should have been included in the exercise documents were not included; existing regulations about the use of armoured vehicles in training exercises were neither included nor referred to. In addition, the Board found that command staff did not include the necessary safety notices in exercise briefings, but instead left much to the discretion of the troops. "This approach was insufficient to prevent the death of MCpl Wheeler," the BOI concluded.

250 The BOI specifically mentioned Force Mobile Command Order (FMCO) 24-15, which required armoured vehicle drivers to be guided by crew commanders or ground guides, and 1 Canadian Brigade Group Operational Training Policy Directive (OTPD) 107, which required that armoured vehicles keep at least 50 metres away from dismounted troops. It found that the Enemy Force Controller breached FMCO 24-15 by not appointing a crew commander and by not effectively guiding the APC from the ground. The Board also found that OTPD 107 would have been breached by the Enemy Force Controller's intended route for the APC (which would have brought it within 20 to 30 metres of the dismounted troops), and that it was breached when the APC driver continued driving despite seeing dismounted troops around his APC.

251 The Board held that these safety instructions addressed the dangerous activities that led to the accident. The Board also examined CF-wide policies, particularly CFP 304-003/TS-OA1 (Training Safety) and 304-001 (Training for War). It found that the Training Safety guidelines dealt only with live-fire training exercises and that, while the Training for War guidelines did refer to dry training exercises, the relevant sections were not obligatory. The Board concluded:

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> Regulations intended to prevent accidents of the sort under investigation did exist, however, their disparate origins and relative inaccessibility to those responsible for their application and enforcement limited their effectiveness. Such regulations need to be standardized across the army and concentrated in a section of a sufficiently well known, accessible and authoritative publication.

253 According to the BOI, the planned exercises were also generally well executed. The exercise Chief Controller (Maj Semianiw) "exercised positive control over the execution of all activities generated by the [Master Events List]" by keeping in contact with the Enemy and Friendly Force Controllers and by holding daily control briefings.

254 However, based on testimony that demonstrated some confusion as to who replaced Maj Semianiw as exercise Chief Controller, the BOI found that Maj Semianiw's departure from CFB Suffield created a "supervisory vacuum."

255 The Board also found that the addition of the counterattack by the Enemy Force to the sequence of events in the Master Events List, including the use of the APC in the counterattack, was not well planned or executed. The Board accepted the Enemy Force Controller's testimony that Maj Semianiw had instructed him to insert a counterattack if practical and safe. Maj (now Col) Semianiw testified that he did not recall giving that instruction but could not conclusively say that he had not. The BOI also accepted the Enemy Force Controller's explanation that he did not inform the Chief Controller of the change in plan, because he was not certain who the Chief Controller was. They found that, had Maj Semianiw been present or his replacement clear, the Enemy Force Controller would have told him about his plan for a counterattack, which would have given Maj Semianiw an opportunity to modify the counterattack plan and make it safer.

256 The Board noted that the Enemy Force Controller's briefings to the Enemy Force were relaxed discussions about what he expected the force to do, as opposed to formal orders, and that the Enemy Force Commander (MCpl Wheeler) was primarily acting as a rifleman, as opposed to a commander. They found that this amounted to insufficient supervision of the Enemy Force. They pointed specifically to the confusion about the route of the APC, based on the fact that the Enemy Force Controller gave three separate briefings, possibly with ambiguous information: one to all Enemy Force members except for the APC driver; individual briefings to Enemy Force members in the village about which buildings they were to occupy; and one to the APC driver at the starting location of the APC. They also cited the fact that the Enemy Force Controller was not able to act as an effective ground guide for the APC because he was also directing the men at the same time. They concluded that "[b]y becoming overly involved in the actual execution of the defence, [the Enemy Force Controller] was not able to adequately supervise the safety of either the enemy force, or the enemy force APC."

257 The BOI found that, aside from members of the Enemy Force, none of the supervising officers were in a position to identify the risk posed by the APC or to act to prevent the accident, since no one outside of the Enemy Force knew of the plan to launch a counterattack. The Board found that supervision for the exercise was adequate and that, aside from the Enemy Force Controller, supervisory staff were in proper positions. Despite this, by the time they saw the APC, it was too late for them to do anything to prevent the accident.

258 The BOI found a number of things that the Enemy Force Controller could have done to minimize the risks: he could have appointed a crew commander, and he could have assigned a more cautious and experienced APC driver. In addition, if he had been acting effectively as a ground guide, the Enemy Force Controller would have been in a position to stop the APC driver once it became apparent he was headed for the dismounted troops. The Board concluded that:

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> [The Enemy Force Controller] possessed enough information, and was a sufficiently experienced officer, to have identified the risks. He should have ensured a more effective method of controlling the APC, or not ordered [the APC driver] to conduct the counterattack … [the

> Enemy Force Controller] was the principal person identified who could have effectively intervened once the APC was committed to the counterattack.

260 The BOI also looked at the actions of the APC driver. It found that, despite the modifications to the APC, which already reduced his visibility, he drove with the hatches down, relying on his periscopes. Furthermore, he continued on his course after he noticed the dismounted troops next to the APC. The Board concluded that "he could have had the presence of mind, once he turned into the village, to stop the vehicle when he became aware that dismounted personnel were close to his APC, while his visibility was restricted."

261 The Board recreated the modifications to the APC and measured the effects of various configurations on the driver's field of vision. They found that operating the APC with the seat down caused the greatest reduction in visibility. In the BOI's recreation of the scene, once the driver turned the corner, he had only one second to notice a prone figure where MCpl Wheeler was located, before that figure was obstructed by the forward blind spot. As a result, while finding that the modifications to the APC to make it look like a Russian APC were at least tacitly endorsed by LCol Lapeyre and Maj Semianiw, the Board did not believe that these modifications contributed significantly to the accident. More important was the lack of a crew commander and the decision to drive hatches-down.

262 The BOI found that, generally, the members of the Enemy Force were too inexperienced to be able to identify the risks involved in the intended use of the APC and that they trusted the Enemy Force Controller to control the APC. The Board noted that MCpl Wheeler did have experience around armoured vehicles but, since they did not know what his understanding of the plan was, they made no comment about whether he should have been alert to the possible dangers.

263 Finally, the Board looked at the issue of MCpl Wheeler's hearing. It found no record that MCpl Wheeler's hearing was as bad as Mrs. Wheeler reported it to be. Consequently, there was no basis upon which to disqualify MCpl Wheeler from his duties as a member of the Enemy Force. All the witnesses agreed that they considered MCpl Wheeler to be "fit, competent and alert" and generally able to serve in the infantry. The BOI also questioned the role

that hearing loss would have played, noting that two Enemy Force members managed to get out of the way of the APC at the last moment; according to their statements, both members saw the APC before they heard it.

2.8.4.2 Responsibility

264 Four people were found to be responsible for MCpl Wheeler's death. The Enemy Force Controller and the APC driver were found directly responsible, and LCol Lapeyre and Maj Semianiw were found indirectly responsible.

265 The Enemy Force Controller's responsibility consisted of failing to ensure that the actions of the Enemy Force were undertaken safely. The Board found that this could have been done by ensuring that all those involved knew the intended route of the APC; ensuring that the APC had a crew commander or effective ground control; monitoring the movement of the APC to prevent it from entering an unsafe area; ensuring that the APC did not go within 50 metres of dismounted troops; ensuring that members of the Enemy Force were adequately briefed on the dangers of operating near armoured vehicles; and identifying possible risks associated with using the APC in the counterattack. Some of these shortcomings amounted to breaches of applicable safety and training regulations, while others were contrary to what would be expected of someone acting in the capacity of Enemy Force Controller.

266 The APC driver was held responsible for deciding to drive the APC with his seat down, requiring him to use periscopes to see where he was going. In another finding, the BOI concluded that the decision to drive hatches-down was the main impediment to the driver's range of vision. Furthermore, despite his limited field of vision and the unexpected presence of dismounted troops, the APC driver did not stop the APC to ensure that it was not a danger to the troops in the vicinity. The Board elsewhere concluded that there were no regulations specifically requiring either of these actions on the APC driver's part, but felt that he should have had "the presence of mind" to undertake them nonetheless.

267 LCol Lapeyre's indirect responsibility flowed from deficiencies in promoting adequate safety. The BOI held that he did not ensure that the exercise instructions adequately addressed safety issues, and that the instructions omitted safety regulations in force at the time, which would have addressed

the events leading to the accident. The Board also found that LCol Lapeyre did not ensure adequate supervision was in place when Maj Semianiw left CFB Suffield.

268 Maj Semianiw's indirect responsibility was also related to lack of direction about safety. The Board found that, as the senior member of the control staff chain of command, he did not ensure that the members under his command were aware of and complied with applicable safety regulations designed to prevent the kind of accident that killed MCpl Wheeler.

269 The BOI also examined whether or not the recommendations made by the SI had been implemented. A number of the SI's recommendations about implementing safety procedures were deemed unnecessary, since they repeated regulations already in place. The Board approved of the recommendation that vehicle routes be rehearsed to ensure that everyone involved in an exercise knows about them, but noted that the proposed changes to 2 PPCLI's standing orders were never made, having been lost in the shuffle when LCol Lapeyre left the unit.

2.8.5 Review and Approval of BOI Report

270 Review authorities are required to ensure that a report complies with regulations governing inquiries as well as the terms of reference, and that any findings are based on the evidence. They have the choice of either concurring or not concurring with the findings of the inquiry; if they do not concur, they must note the reasons. In addition, they may refer questions back to the BOI for further clarification and they can ask the BOI to reconvene if "further evidence, corrections or amendments are required" (CFAO 21-9, paragraph 38). As the report is sent up the chain of command, each level is responsible for implementing the recommendations that are in its purview.

2.8.5.1 BGen Ross (Commander of Land Force Western Area)

271 The BOI report was first sent to BGen Ross, Commander of Land Force Western Area, who had convened the BOI. His letter of November 19, 1997 begins, "I concur with the findings and recommendations of the enclosed BOI Report and I commend the President and his members for their efforts in conducting a very thorough and professional inquiry."

272 He then listed the key factors leading to the accident that caused MCpl Wheeler's death: the external modifications to the APC; the addition of "an impromptu counterattack"; confusion as to who was acting as Chief Controller in Maj Semianiw's absence; LCol Lapeyre's failure to ensure proper control staff was in place during Maj Semianiw's absence; the Enemy Force Controller's failure to brief the Friendly Force control staff about the addition of the counterattack; the fact that the APC driver was inexperienced and did not have a crew commander; the fact that the APC driver was not clear about the APC's intended route; the APC driver's decision to drive with the seat down; the Enemy Force Controller's (mistaken) assumption that the APC driver was responding to his direction; the Enemy Force Controller's position, which did not allow him to properly control the APC; and the speed of the APC, along with the sharp turn which gave the APC driver "only a few seconds … to detect the soldier lying on the road immediately to his front and for the soldier on the ground to react to the threat of the approaching APC."

273 BGen Ross reiterated the findings about the orders that were breached, specifically FMCO 24-15 and 1 Canadian Brigade Group OTPD 107. In addition, he agreed with the Board's recommendation that CFP 304-003/TS-OA1 (Training Safety) should cover situations like the 1992 exercise, and should specifically cover: safety procedures for dry training exercises, based on CFP 304-001 (Training for War); direction on use of live enemy forces; suggested make-up of safety and control organizations; responsibilities of exercise directors and control personnel, including the CO; regulations on the use of pyrotechnics, vehicle and driving safety, and force-on-force contact in dry training; and the two existing regulations on armoured vehicle safety (FMCO 24-15 and 1 Canadian Brigade Group OTPD 107).

274 BGen Ross committed to implementing the following procedures in Land Force Western Area: during force-on-force dry training, the driver or crew commander of armoured vehicles must have unrestricted vision of the vehicle's intended route; all units must conduct safety briefings before all training activities, whether live-fire or dry; and all units will include, as part of their exercise instructions, the following safety paragraph:

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> During training activities where a live enemy force is being used, armoured vehicles will stand off a minimum of 50 metres when there is doubt as to the EXACT location of dismounted troops. Positive

> control must be maintained from the time the vehicle begins to move until it comes to a complete stop. Positive control is defined as a crew commander, ground guide, or a crew commander lead vehicle, which is in direct communication with the driver (through voice, radio or hand signals), and has a clear view of the route over which the armoured vehicle must travel. The person exercising positive control is responsible for the safe movement of the vehicle.

276 He concluded that MCpl Wheeler's death "was the direct result of poor judgement, incomplete and confusing orders and the lack of positive control and supervision on the ground." He found that LCol Lapeyre, as CO, bore "ultimate responsibility," primarily for failing to ensure that there was a clear replacement Chief Controller who was properly briefed. He also found that, had Maj Semianiw been present for the final day of training, or if he had properly and clearly appointed someone to act in his place, "this tragedy may have been avoided." BGen Ross found that the Enemy Force Controller and the APC driver had been directly responsible for MCpl Wheeler's death, but that they had not been grossly or wilfully negligent in their actions.

277 The BOI did not recommend any disciplinary action. BGen Ross recommended, based on the BOI report, what he considered to be appropriate sanctions. He noted that the Enemy Force Controller and the APC driver had already been given a reproof and a recorded warning, respectively, and that the accident had affected them personally. He also observed that the time limits for laying charges (under the *Code of Service Discipline*) had expired. As a result, he felt that no further action should be taken against either of them.

278 By this time, LCol Lapeyre had retired and therefore BGen Ross suggested a letter of censure as "the only action available" against him. A letter of censure is an official letter detailing an error or omission. In 1997, it was no longer an official sanction recognized by CF regulations. BGen Ross recommended a reproof against Col Semianiw, "for failing to properly supervise the safe conduct of the training." A reproof is an official document recognized by the CF as an administrative disciplinary measure.

279 BGen Ross reaffirmed that MCpl Wheeler was not responsible for his own death and that it had been reasonable for him to believe that the APC was being properly controlled. He stated that members of the section were not

clear on the APC's route and that, after the APC turned the corner, MCpl Wheeler would have had only four seconds to realize the APC was headed toward him and take appropriate action.

280 BGen Ross also recommended that, in future cases, only officers of "the appropriate rank and experience" be appointed as investigators and that they not come from within the same unit to avoid the appearance of influence by their COs. He also directed that a memorial cairn to MCpl Wheeler be erected at the accident site, with a dedication ceremony by members of 2 PPCLI.

2.8.5.2 Director Land Personnel

281 BGen Ross forwarded the BOI Report and his comments to NDHQ, where the staff of the Director, Land Personnel (DLP) reviews all investigations for compliance with regulations and their terms of reference. The DLP review was forwarded to the CLS on January 26, 1998. It reviewed, not only the BOI Report, but the original SI Report into MCpl Wheeler's death and the reasons for the decision to convene the BOI.

282 The DLP review's primary purpose was to summarize the BOI Report and make recommendations to the CLS, on which the CLS would base his comments. It summarized the findings of the BOI and the steps taken by Land Force Western Area to implement some of the recommendations. It also contained reviews of the Land Force Western Area's recommendations for action to be taken based on the BOI Report, along with assessments of those recommendations. The DLP review's recommendations and comments are as follows:

283 • The DLP agreed with the recommended revision and consolidation of training safety regulations, and undertook to direct a review of CFP 304-003/TS-OA1 (Training Safety).

284 • The DLP did not agree with the recommended action against LCol (retd) Lapeyre. The review agreed with the finding that LCol (retd) Lapeyre "failed to ensure that the exercise control staff was adequately supervised on departure of Maj Semianiw"; however, it did not find a "causal connection" between this failure and the accident, and disagreed with the finding of indirect responsibility for the accident and death. Instead of the administrative reprimand (or letter of

censure) recommended by the Commander of Land Force Western Area, the DLP suggested the CLS send a letter to LCol (retd) Lapeyre directly. It suggested that the letter outline the findings of the BOI and include the observation that "… it is not clear from the evidence obtained that (what appears to be inadequate supervision) was causally connected to the accident."

285 • Regarding the recommended reproof against Col Semianiw, the DLP instead suggested a letter from the CLS, which would not be retained in Col Semianiw's file, or a personal interview between Col Semianiw and a senior Land Staff officer: "For both LCol Lapeyre and Maj Semianiw, although their actions were in some measure questionable or deficient, there is no evidence to show a direct or indirect causal effect toward MCpl Wheeler's death."

286 • The DLP review agreed with the finding of direct responsibility on the part of the Enemy Force Controller and the APC driver, and the recommendation that no further action be taken against them.

287 The review concluded:

288 > It is the opinion of DLP staff that this accident resulted from a lack of positive control at various levels, combined with poor judgement, lack of direct supervision and incomplete orders, as previously commented by the Board and Comd [Commander] LFWA [Land Force Western Area] regarding the Exercise Staff. As is the case in most serious accidents, several factors, circumstances and timing, when combined, contributed to this unfortunate accident. DLP recommends that CLS accept the findings of the Board and the recommendations provided by Comd LFWA, less the recommendations for a letter of censure to LCol (retd) Lapeyre and a reproof for Col Semianiw.

2.8.5.3 LGen Leach (Chief of the Land Staff)

289 The BOI Report was next reviewed by the CLS, Lieutenant-General (LGen) Bill Leach. LGen Leach's comments on the report are in his letter of March 5, 1998. He concurred with the BOI Report and with the comments of BGen Ross, except for the findings of indirect responsibility on the parts of LCol (retd) Lapeyre and Col Semianiw, writing "I am of the opinion that although

LCol Lapeyre and Col Semianiw erred in their supervisory duties, their respective failures do not amount to 'indirect responsibility.'" He stated that "follow up action" was required with the two senior officers but did not agree the letter of censure and reproof were appropriate.

290 LGen Leach agreed with the recommended changes to the training safety guidelines. He noted that the "breakdown in positive safety control occurred between [the Enemy Force Controller] and [the APC driver]" and concurred with the recommendation that no further action be taken against them. He agreed with the finding that MCpl Wheeler was not to blame for his own death and would have reasonably expected the APC to be operated in a safe manner.

291 LGen Leach undertook to review the training safety guidelines, and to issue a Land Forces General Directive stressing the importance of detailed safety briefings before every training exercise and the duty of exercise controllers to provide troops with clear safety instructions. He also undertook to issue letters to LCol (retd) Lapeyre and Col Semianiw indicating that they were found by the BOI evidence to have "erred in [their] supervisory duties."

292 The CLS review of the BOI then went to the CDS, along with the BOI Report and the comments of all the review authorities. The CDS, Gen Baril, signed LGen Leach's review, indicating his concurrence and approval. LGen Leach also got Gen Baril's approval to release the findings of the BOI to Christina Wheeler.

293 LGen Leach wrote letters to both LCol (retd) Lapeyre and Col Semianiw. His March 18, 1998 "letter of displeasure" to LCol (retd) Lapeyre summarized the findings of the Board. LGen Leach also wrote:

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> It is the conclusion of the Board, supported by myself and the CDS that you erred in your supervisory duties. However, I disagree with the Board conclusion that your actions amounted to "indirect responsibility" for Master Corporal Wheeler's death. I reached that conclusion because it was not clear from the evidence of the Board that inadequate supervision by you, or the supervisory vacuum created on the departure of Maj Semianiw from the exercise, had a direct causal connection of this fatal accident. The CDS is in agreement with this assessment.

295 Finally, the CDS has directed that you be formally advised of the findings of the Board and made aware that your performance in relation to this tragic accident has been found to be deficient. This letter responds to that direction.

296 LGen Leach also indicated his intention to release LCol (retd) Lapeyre's name and a statement that he had erred in his supervisory duties to the public as part of the public release of information about the BOI's findings.

297 LGen Leach's letter to Col Semianiw stated that the CDS had accepted the findings of the BOI and the recommendations of the Commander of Land Force Western Area, as amended by LGen Leach's comments. He quoted from the BOI findings, then concluded:

298 You erred in your supervisory duties. However, I have disagreed with the Board conclusion that your actions amounted to "indirect responsibility" for MCpl Wheeler's death … The CDS is in agreement with this assessment.

299 He specified that the findings did not reflect Col Semianiw's "general performance as an officer." In addition, LGen Leach advised Col Semianiw that the results of the BOI and the final determination that he had erred in his supervisory duties would be made public and that a copy of the letter would go on his personnel file. Col Semianiw signed the letter, acknowledging that he had received and read it.

2.8.6 Issues Arising from the BOI

2.8.6.1 Release of Information and Media Reports

300 LCol (retd) Lapeyre and Col Semianiw were advised in the letters they received about the BOI that the report would be made public. However, there was very little time between the letters and the release of the information. In a letter to the CLS dated March 20, 1998, LCol (retd) Lapeyre requested that the CF delay the release until he had time to read it and to give him time to make clarifications. His request was not granted.

301 On April 3, 1998, Army Public Affairs issued a media release, entitled "Military apologizes to Soldier's Widow," describing the findings of the BOI and the actions against the senior officers:

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> … It was also determined that two senior officers — the officer in charge of the range that day, and the unit commanding officer — erred in their supervisory responsibilities … The senior officer still in the military has been personally served with a formal letter of counselling by the commander of the army and this letter placed on the officer's personnel file. The second senior officer involved has since retired, and was hand-delivered a formal letter of displeasure advising him of the results of the BOI and its findings.

303 Although Col Semianiw and LCol (retd) Lapeyre were not mentioned by name in the news release, they were named in the version of the report released to the Wheeler family. They were also named in three letters released by the CF to Mrs. Wheeler along with the BOI Report: letters written by Col Selbie, BGen Ross and LGen Leach, which were added to the BOI as it was reviewed. As a result, the two officers were named in media reports as early as April 7, 1998. An article by Bob Bergen stated:

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> … the long-awaited report of a new investigation into the … death of Master Cpl Rick Wheeler found two senior officers guilty of failing to ensure safety procedures were followed properly. One of them, Col Walter Semianiw, left the ill-fated exercise to go house hunting the day before Wheeler died and left no one else in command, the [Calgary] Herald reports … In that report, [BGen] Ross found that Semianiw and retired Lt-Col J.M. Lapeyre … erred in their supervisory duties during the exercise. He found Lapeyre didn't provide proper supervision of control staff and that Semianiw … left amid confusion over who was in control. Ross determined that amounted to indirect responsibility for Wheeler's death. Lt-Gen Bill Leach, the Forces chief of land staff, said while the pair clearly failed in their supervisory duties he overturned the conclusion that their failures amounted to indirect responsibility. Lapeyre was issued a letter of displeasure in retirement and Semianiw … was issued a similar letter that will be placed on his personnel file.

305 The CF's position was that Mrs. Wheeler had a right to receive the information and that she was within her rights to share the information she got with the media. In a memo to the CLS dated October 30, 1998, a DLP staff member acknowledged that the media reports exaggerated the effects of the BOI on LCol (retd) Lapeyre and Col Semianiw. He wrote:

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> … though unfortunate and frustrating to the member and former member, [this] is something that is beyond the control of the CF. They must recognize that it is a hard reality, in this day of Access to Information and close scrutiny of the CF, that officers in positions of command are not only held to account internally for the execution of their command, but they may also be subject to public scrutiny and criticism.

307 In addition, the BOI Report and other letters were distributed to 1 Canadian Mechanized Brigade Group units. The purpose of this distribution was to allow the units to learn from the accident, and to emphasize the importance of proper exercise preparation and conduct. LCol (retd) Lapeyre complained about the fact that his personal information was repeated in media reports and about the distribution of the BOI Report within the army. He complained about the release and the distribution, both within the CF and to the Privacy Commissioner.

2.8.6.2 Clarification and Reply

308 The CF did not immediately address LCol (retd) Lapeyre's and Col Semianiw's issues with the BOI and its findings. Both men questioned the composition of the BOI, particularly the lack of a member with expertise commanding a mechanized infantry unit.

309 LCol (retd) Lapeyre believed that the President of the BOI was negligent in his duties. He also suggested that Maj Kaduck's involvement with the file at 1 Canadian Mechanized Brigade Group (prior to the BOI) influenced his testimony before the BOI. LCol (retd) Lapeyre and Col Semianiw complained that they had not been allowed to sit in on the testimony of other witnesses who gave evidence against them, or to call testimony in their favour. LCol (retd) Lapeyre complained that, despite his request, the BOI would not delay his testimony to give him time to prepare. LCol (retd) Lapeyre and Col Semianiw also questioned the findings that certain regulations (FMCO 24-15

and 1 Canadian Brigade Group OTPD 107) applied to the exercise and that there had not been a replacement Chief Controller during Maj Semianiw's absence. Both men pressed their issues with the CF, LCol (retd) Lapeyre in a series of letters to the CLS, and Col Semianiw by electronic mail with DLP staff.

310 As a result of their repeated questions and requests, the CLS, LGen Leach sent a request for clarification to Col Selbie on July 14, 1998, along with the correspondence from LCol (retd) Lapeyre and Col Semianiw. He requested that Col Selbie answer the concerns expressed in the correspondence, based on the testimony and other information obtained by the BOI. Col Selbie summarized the questions and responded in an eight-page letter dated August 28, 1998.

311 On December 7, 1998, LGen Leach wrote to Col Semianiw and LCol (retd) Lapeyre and provided them with an unedited copy of Col Selbie's response (only the legal advisor's comments were withheld on the basis of solicitor-client privilege). He advised them both that the letters on their files were informative in nature, not administrative or disciplinary, and would be retained as a record of their interviews about the BOI's findings.

2.9 After the BOI

2.9.1 Maj Kaduck's New Information

312 On March 6, 1999, LCol (retd) Lapeyre received an unsolicited telephone call at his home from Maj Kaduck. Maj Kaduck told him that he now believed he had been acting as Chief Controller on April 7, 1992. LCol (retd) Lapeyre asked him to provide him with a letter setting out his statement in writing.

313 On March 16, 1999, Maj Kaduck wrote to LCol (retd) Lapeyre, stating that he had testified honestly before the BOI based on his recollections at the time. However, he was now certain that he had replaced Maj Semianiw as Chief Controller during his absence and regretted that the Board had read too much into his testimony.

314 LCol (retd) Lapeyre forwarded the information and the letter to the CF. In a memorandum to the JAG dated March 25, 1999, the DLP section head for Personnel Services referred to Maj Kaduck's letter. He wrote that the new information brought into question the finding of a "supervisory vacuum" and asked for opinions or comments. After some consultation, it was decided that the matter should be referred to the CFNIS for a formal investigation.

2.9.2 CFNIS Investigations

315 In a letter to the CF Provost Marshal, dated May 10, 1999, in which he included supporting documents, LCol (retd) Lapeyre also requested an MP investigation into what he called "intolerable harassment … by senior officers as the result of comments made in public, documents circulated relating to the BOI and lack of resolve in taken action based on evidence provided by the complainant."

316 LGen Leach also wrote the Provost Marshal on June 3, 1999, asking for her advice. He expressed concern about whether the letters he wrote to Col Semianiw and LCol (retd) Lapeyre were still justifiable, in light of the new information. He also wanted the input of the Provost Marshal and the JAG as to how to weigh the new information.

317 On June 4, 1999, the Provost Marshal informed LCol (retd) Lapeyre that she had directed a review of the information that he had provided, with the aim of ascertaining if the allegations warranted an investigation.

318 In early July 1999, the Provost Marshal informed the Chief of the Land Staff and LCol (retd) Lapeyre that she had directed an investigation into the whole file. Inspector (Insp) Russ Grabb of the CFNIS Sensitive Investigation Detachment was assigned to look into possible perjury charges against Maj Kaduck, possible criminal or other charges against the people directly or indirectly involved in the accident itself, or against the CF as an organization. He was also asked to ascertain whether the evidence collected and presented during the MP investigation, the SI or the BOI could be used to substantiate a prosecution seven years after the event.

319 On March 3, 2000, Insp Grabb wrote to LCol (retd) Lapeyre confirming that his investigation would concentrate on the accident itself and the perjury allegations. He noted that allegations of shortcomings on the part of the BOI

and harassment fell under the administrative umbrella or were civil matters to be pursued privately in the courts. For example, LCol (retd) Lapeyre had complained to the Privacy Commissioner about DND's release of his personal information to the media and to the units of 1 Canadian Mechanized Brigade Group; Insp Grabb felt that the Privacy Commissioner was the appropriate authority to investigate those issues.

2.9.2.1 Criminal Investigation of the Accident

320 Insp Grabb conducted the investigation into possible criminal charges stemming from the accident itself. He told my investigators that he encountered a number of difficulties due to problems with the way the accident and previous investigations had been handled.

321 Most of the difficulties flowed inherently from the seven-year time lapse between the accident and the CFNIS investigation, and from shortcomings in the previous investigations. In 1992, the initial investigations by the MP and the RCMP did not include a proper examination of the death scene by trained investigators, while the SI was assigned to an inexperienced junior officer.

322 Insp Grabb produced a time-line setting out all the events that led to MCpl Wheeler's death and the actions taken afterwards. In addition, Insp Grabb considered the possibility of charging the CF as an organization. He met with an Alberta senior Crown prosecutor who had been involved in the prosecution after the Westray mining accident that killed 26 miners in Nova Scotia in 1992 and so had experience with criminal charges against organizations.

323 Insp (now Superintendent) Grabb told my investigators that he and the Crown prosecutor had considered a range of charges that could still be brought in relation to the accident. However, in the prosecutor's opinion there was insufficient evidence to proceed with any charges; she advised that she would not prosecute on the limited evidence available.

2.9.2.2 Perjury Investigation of LCol Kaduck

324 The CFNIS investigation determined that there was no evidence that LCol Kaduck intended to provide false evidence. It did determine, however, that LCol Kaduck's claim to having been Chief Controller on April 7, 1992, was true.

325 When my investigators interviewed LCol Kaduck, he told them that the misunderstanding arose because the BOI asked him if he remembered being briefed about acting as Chief Controller, or if he remembered the responsibility being formally handed over to him. He said that he could not recall a formal briefing or hand-off. However, he said, when he began to think about his actions on that day, he realized that, regardless of his answer to the Board's questions, he had been acting as Chief Controller; that is why he came forward to correct his previous statements. He also said that, had he been asked about specific things he did on that day and what they implied about his duties, he would have been able to tell the Board that he had been acting as Chief Controller.

326 While the CFNIS investigations did not lead to the laying of charges, they did reach the important conclusion that, on April 7, 1992, Capt Kaduck had been acting as Chief Controller for the exercise. It was understood that the conclusion would have repercussions on the BOI's findings and recommendations.

2.9.3 Administrative Review Board

2.9.3.1 Background

327 The CFNIS conclusions brought into question the validity of the BOI findings and recommendations, particularly with regard to Col Semianiw and LCol (retd) Lapeyre. On September 3, 2000, LCol Kaduck wrote directly to the CLS, stating that he had been Chief Controller on the day of the accident and asking the CLS to formally absolve Col Semianiw and LCol (retd) Lapeyre. At

this time, Col Semianiw and LCol (retd) Lapeyre were corresponding with the CLS and the DLP about their concerns. LCol (retd) Lapeyre also noted in his correspondence that the members of the Wheeler family were not being informed of developments in which they clearly had an interest.

328 Even without knowing about the CFNIS conclusions, Mrs. Wheeler and MCpl Wheeler's father were not satisfied with the BOI. Christina Wheeler was concerned that the BOI, which had been convened to investigate her concerns about the SI, had not addressed all of the issues she had raised. In addition, she still had complaints about the way in which she had been treated by the CF after her husband's death. Neither was Bill Wheeler satisfied with the BOI into his son's death: in June 1998, he had threatened a hunger strike to protest the way the CF investigated serious incidents. Their concerns were known to the CLS.

329 Mrs. Wheeler and LCol (retd) Lapeyre both made formal complaints to my Office, independently of each other. In such a case, in which the events pre-date my mandate, the Minister of National Defence must approve the investigation. While LCol (retd) Lapeyre mentioned the possibility of an investigation by the Ombudsman's Office to CLS staff in September 2000, Col Semianiw continued pressing his case from within the CF, through e-mails and informal inquiries with the DLP.

330 In March 2001, the CLS informed Col Semianiw, LCol Kaduck and LCol (retd) Lapeyre he would conduct a "final review" of the case. In the fall of 2001, the CLS offered to go to formal mediation with Col Semianiw, to attempt to resolve the issues they had raised. Col Semianiw agreed, and we understand that the process was ongoing at the time my Office published this report. In January, 2002, LCol (retd) Lapeyre considered the CLS' offer of formal mediation; he rejected this option, saying he had lost confidence in the CLS and the CF, and was relying on my Office to investigate his concerns.

331 In May 2001, I informed the CLS by letter that the Minister of National Defence had given me authorization to conduct an investigation into the complaints by LCol (retd) Lapeyre and Mrs. Wheeler. In March 2002, I confirmed to the CLS that my investigation was well under way and sought

his cooperation in providing information. In April 2002, the CLS wrote to me re-emphasizing his support for my investigation and informing me that he was required to convene an Administrative Review Board (ARB) to investigate LCol (retd) Lapeyre's concerns.

2.9.3.2 The ARB's Terms of Reference

332 LGen Jeffery, who had succeeded LGen Leach as CLS, convened the ARB on May 3, 2002. He told my investigators that he spent a considerable amount of time in selecting members of the ARB to ensure that they would be credible to LCol (retd) Lapeyre. In the end, he appointed BGen Mitchell, then-Commander of Land Forces Atlantic Area as the President. The remaining members were Col Brough and Col Peters. BGen Mitchell and Col Peters were both former Directors of Infantry. Lieutenant-Commander (LCdr) Allard (the DLP staff officer for this case) was the ARB Secretary.

333 Its terms of reference instruct the ARB to:

334 > examine the concerns raised by LCol (Retd) Lapeyre pertaining to the conduct of the 97 BOI (ref A) which investigated the circumstances surrounding MCpl Wheeler's death. The ARB is also mandated to advise the CLS on the relevancy, thoroughness, and accuracy of the findings and recommendations of the 97 BOI and subsequent actions.

335 The ARB was instructed to rely on documentary evidence, specifically the SI Report, the BOI Report, the two CFNIS investigations and the Privacy Commissioner's findings as a result of LCol (retd) Lapeyre's complaint to the Privacy Commissioner in 2000. Review Board members were also provided with the correspondence from LCol (retd) Lapeyre and internal DND/CF documentation related to the case. They were asked to detail and discuss LCol (retd) Lapeyre's issues, along with their conclusions and the basis for their conclusions. The CLS directed the ARB to address specific issues as part of or in addition to its examination of LCol (retd) Lapeyre's issues, as follows:

336 - whether the BOI's findings that affected LCol (retd) Lapeyre are supported by the evidence gathered by the BOI;

337 - whether the BOI's recommendations that affected LCol (retd) Lapeyre are supported by the BOI's findings;

338 • whether the minutes of the BOI proceedings contained all of the Board's evidence, and whether that evidence was complete and accurate;

339 • the impact of subsequent information on the BOI's findings and recommendations, as well as on BOI reviews;

340 • whether the "follow-on reviews" and subsequent actions were complete and appropriate;

341 • any "procedural, systemic, personal or other irregularities and deficiencies" and their causes; and

342 • whether it is necessary to re-investigate the matter or any part of it.

343 As LGen (retd) Jeffery told my investigators, the purpose of the ARB was to:

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> ensure that I [had] a clear understanding of the report of an independent body in terms of that complexity, in terms of what had happened with the recommendations as to whether the right things had been done, whether some of the claims that had been put forward on this case [were] valid or not, so I [could] then look at this in a holistic way and … at the very least to know whether there [were] some things I should be changing. This is not just about this case. There is a whole range of potential outcomes of this, in terms of how the case has been handled.

345 The terms of reference called for the ARB to report by July 15, 2002. Due to the complexity of the issues, however, extensions were requested and granted, allowing the ARB the time to do a more thorough review. The final report was presented to the CLS on January 28, 2003.

2.9.3.3 ARB Review and Findings

346 According to the ARB Report, the members, secretary and legal advisor were provided with all the documentary evidence, which they reviewed individually. After that, they met for discussions, during which:

347 [k]ey issues were identified, evidence analysed and initial findings outlined. Through frank and open discussion and continuous review and cross-referencing of documentary evidence, eventual agreement was reached on the key issues, findings and proposed recommendations.

348 The report notes that its findings were affected by the fact that the BOI was held five years earlier and the event had occurred five years before that. As the BOI Report mentioned, the memory of witnesses years after the fact is not always great. The report also noted that it was difficult to find some of the orders, directives and other documents mentioned in the previous investigations.

349 The ARB identified nine issues based on correspondence from LCol (retd) Lapeyre. They are described individually below.

350 In general, the ARB supported some of LCol (retd) Lapeyre's complaints. Specifically, it found that the BOI had not extended LCol (retd) Lapeyre the procedural protection required by QR&O 21.10 (4); that the BOI's fact-gathering and analysis were deficient (particularly in failing to call certain key witnesses); and that it appeared to focus inordinately on blaming the senior officers. The ARB agreed with LCol (retd) Lapeyre that his reputation was negatively affected by the way in which the BOI was conducted and the subsequent actions of the CF, and recommended that the harm he suffered be reflected in any settlement between him and the CF.

2.9.3.3.1 Issue 1: Exercise Preparation

351 The BOI had determined that the exercise planning documents did not include certain required safety paragraphs or references. It had recommended that exercise safety regulations prohibit armoured vehicle drivers from relying only on periscopes in situations using a live enemy force and had also recommended the amalgamation of exercise safety regulations. In their review of the BOI Report, the CLS and CDS found that LCol (retd) Lapeyre had erred in his supervisory duties, attributed in part to inadequate safety instructions for the exercise. LCol (retd) Lapeyre took issue with some of these findings, and disputed the existence at 2 PPCLI and applicability of some of the regulations to which the BOI referred.

352 The ARB could not locate all of the 1992 safety regulations and orders. As a result, one of the recommendations it made was to "freeze" relevant documents when there is a serious accident to aid in future investigations.

353 Based on the documents it was able to obtain, the ARB concluded that FMCO 24-15 applied to driver training, not to the conduct of collective training exercises; however, it stated that it was well-known that positive control and proper guidance of armoured vehicle drivers was expected.

354 The ARB noted that the BOI had not conclusively proved that 1 Canadian Brigade Group OTPD 107 had been received at 2 PPCLI in time to be incorporated into the exercise plan. The ARB contended that "undue emphasis was placed by the 97-BOI on non-compliance with this directive without sufficient proof of its receipt within 2PPCLI in time for inclusion."

355 The ARB found that the exercise instruction was "a production of above average quality at the unit level"; that "[s]afety issues were adequately addressed"; and that, as a result, part of the basis for the finding that LCol Lapeyre erred in his supervisory duties was no longer supportable. The ARB therefore recommended "[a]ppropriate measures should be taken to correct the impression that LCol Lapeyre's exercise planning was deficient in terms of safety related control."

356 The ARB Report pointed out that relying solely on exercise documents and other written records to determine the "training environment" in a unit can be problematic. The report noted that the BOI appeared to take a "checklist" approach to safety and command issues. It recommended a more holistic approach that would allow the experience and "command climate" of a specific unit to be taken into account.

357 According to the ARB Report, investigations have a dual purpose: to determine what happened with a view to learning from past events and actions, and to determine responsibility and accountability for what went wrong, possibly with a view to assigning blame. It states that the two purposes must be carefully balanced to "ensure the development of a disciplined, accountable leadership cadre, all the while nurturing an institutional, learning climate that fosters risk-taking and experimentation and extracts maximum learning from every opportunity." The ARB found

that, in 1997, the BOI overly emphasized blame. The Review Board recommended that the Army Culture Project consider how to balance accountable leadership and assignment of blame.

358 The Review Board also took issue with some of the changes to training regulations the BOI recommended. It did not agree that a safety control staff should be required for all dry training exercises or that armoured vehicle drivers should never drive hatches-down in collective training exercises. The ARB did agree with the BOI's recommendations aimed at ensuring positive control and guidance of armoured vehicle drivers and at safety around dismounted soldiers whose location is not known.

359 Turning to the implementation of the BOI's recommendations, the ARB identified the need to ensure that doctrine and training staffs are provided with portions of investigation reports related to safety regulations. Accordingly, it recommended that portions of the BOI be sent to the Director Army Training and that the annual amendment process for the army's Operational Training Safety Manual include the BOI's recommendations, supported by the ARB.

360 Finally, the ARB recommended that convening authorities (who convene and set the terms of reference for investigations) "should insist on a balanced assessment from investigations" that would help them reach conclusions about the effectiveness of their subordinate commanders in a broader context.

2.9.3.3.2 Issue 2: Exercise Conduct

361 The ARB looked at three issues highlighted by previous investigations: the finding that the general safety briefings were unsatisfactory, particularly the failure to remind participants of the dangers of operating APCs around dismounted troops; the addition of a counterattack at the last minute, without briefing the safety control staff, and its unsafe conduct; and the modifications to the APC that restricted the driver's field of vision.

362 One of the reasons the BOI found LCol Lapeyre indirectly responsible for MCpl Wheeler's death was that only two members had been aware of the 50-metre stand-off rule, which indicated a lack of information about safety around APCs. The BOI found the Enemy Force Controller responsible for adding the unplanned counterattack without briefing control staff. It also found that, had a Chief Controller been present, the plan might have been

discussed and possibly altered or discarded; this was the basis for finding Maj Semianiw indirectly responsible, by leaving CFB Suffield without clearly providing for a replacement Chief Controller. Finally, the BOI found that the modifications to the APC did not significantly affect the driver's field of vision, compared with the decision to drive hatches-down. Based on the BOI's findings, the CLS and CDS found LCol (retd) Lapeyre and Maj (now Col) Semianiw had erred in their supervisory duties.

363 The ARB found that the BOI did not have sufficient evidence, based on the safety briefings he provided, to conclude that LCol Lapeyre was indirectly responsible for the accident. The ARB pointed out that the Enemy Force Controller and the APC driver both claimed to have been aware of the 50-metre rule and the need for positive control of the APC and that "they chose to ignore those regulations." The ARB did find that LCol Lapeyre "may have erred in his supervisory responsibilities by not providing the safety briefings"; however, "the gravity of this relatively minor mistake appears to have been exaggerated by the 97-BOI."

364 The ARB argued that the content of safety briefings may vary depending on the experience and knowledge of the unit, and noted that constant repetition of information that is already known may cause boredom and therefore reduce the effectiveness of safety briefings. Rather, it stated, "COs should be encouraged to use appropriate judgement in such matters and should not be unduly admonished after an accident for missing a 'check in the box'." The ARB believed that the BOI should have focused more on the "command climate" within the unit instead of on briefings and safety paragraphs.

365 As for the addition of the counterattack, the ARB considered the BOI to have exaggerated the importance of what was a minor change within the scope of the exercise and the Master Events List. Following from the fact that the BOI had found that Maj Semianiw had authorized the Enemy Force Controller to add the counterattack, the ARB found that Maj Semianiw had properly left the implementation of such a counterattack to the Enemy Force Controller. The ARB concluded that the planning requirements the BOI suggested for "a minor countermove of only one APC" were excessive in this context.

366 The ARB stated that it was the Enemy Force Controller's duty to ensure that the counterattack was conducted safely. The ARB found that his execution of the counterattack was unsafe because he did not walk the route with the

driver or guide him properly. They also found the APC driver had failed to drive safely by relying on periscopes and "apparently" driving with excessive speed.

367 As a result, the ARB concluded that fault had been properly attributed to the Enemy Force Controller and the APC driver, that the cosmetic modifications to the APC were not inherently dangerous and that it would not be proper to assign blame to their superiors for tacitly accepting the modifications.

368 The ARB did not support the BOI's conclusions that briefing the other safety controllers or the presence of Maj Semianiw or a replacement Chief Controller could have prevented the accident. According to the ARB, the unsafe situation developed in the execution of the counterattack, which was the Enemy Force Controller's responsibility.

369 Finally, the ARB recommended that the parts of the CLS's March 18, 1998 letter to LCol (retd) Lapeyre that dealt with the issue of safety briefings "be reviewed and amended as necessary."

2.9.3.3.3 Issue 3: Exercise Chief Controller

370 The BOI's findings about the absence of a Chief Controller and the consequences of the "supervisory vacuum" were crucial to the findings against Col Semianiw and LCol (retd) Lapeyre; they were also immediately identified as problematic by those concerned. LCol Kaduck's statement that he had been acting Chief Controller was the impetus to revisit the investigations into the accident.

371 The ARB begins by pointing out that the BOI did not have access to the evidence that emerged later, which clearly showed that Capt Kaduck was acting as Chief Controller. It also notes that the exercise control staff, in which the Chief Controller was an important figure, was not required by the training safety regulations for dry-fire exercises. As a result, the ARB questioned the BOI's emphasis on the Chief Controller's role as an indirect cause of the accident.

372 The ARB found that LCol Lapeyre had authorized Maj Semianiw's house-hunting trip, knowing Maj Semianiw had named a replacement. While the BOI indicated that the hand-over was not thorough enough, the ARB could not conclude that a more thorough hand-over would have prevented the

accident. Again, the ARB found that the problems with the counterattack were in its execution, which had been the Enemy Force Controller's responsibility to conduct safely.

373 The ARB did not understand why the BOI accepted Maj Kaduck's testimony that he did not recall being handed the duties of Chief Controller as opposed to Col Semianiw's statement that he had handed his duties over before his departure. It also questioned the BOI's finding of indirect responsibility on the part of LCol (retd) Lapeyre, given conflicting evidence about the Chief Controller hand-over and lack of evidence that the absence of a replacement Chief Controller caused the accident. Given the time that had elapsed since the BOI, however, the ARB was unable to come to any conclusions about the BOI's reasoning.

374 The ARB concluded that "there was *no evidence* of a lack of supervision of the exercise control staff by the CO" (emphasis in original). LCol Kaduck's subsequent information, confirmed by the CFNIS and accepted by the ARB, led the ARB to conclude that:

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> [i]t was therefore reasonable for LCol Lapeyre (Ret'd) to expect, and for the CLS to order, a review of the 97-BOI findings and recommendations, as well as any subsequent administrative and disciplinary actions that were taken based on the 97-BOI's work.

376 As a result, the ARB recommended that the portions of the CLS's letter to LCol (retd) Lapeyre that dealt with supervision and the appointment of a Chief Controller "be reviewed and amended as necessary."

2.9.3.3.4 Issue 4: Conduct of the 1997 BOI

377 The ARB considered four main complaints by LCol (retd) Lapeyre with regard to the conduct of the BOI: the failure of the Board to extend him procedural protections; the inadequate time the Board gave him to prepare his testimony; the BOI's failure to call certain witnesses, particularly those who could have clarified the issue of a replacement Chief Controller and testified as to which orders and regulations applied to which training situations; and the lack of a Subject Matter Expert among the Board members and advisors.

378 The ARB found that the BOI made an adverse finding against LCol (retd) Lapeyre in holding him indirectly responsible for MCpl Wheeler's death. The ARB quoted QR&O 21.10 (4), which reflects "the procedural fairness rule that any person whose interests are at stake as a result of the inquiry has a right to see all the evidence that may be prejudicial to him/her and to respond to it." The report noted that, while the QR&O is permissive rather than directive, "the 97-BOI did not have sufficient grounds *not* to offer procedural protection" (emphasis in original). It continues:

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> At the point where 97-BOI members determined that there could be adverse findings, LCol Lapeyre (Ret'd) should have been informed and the 97-BOI proceedings should have been extended as necessary to allow his full participation, including the review of testimony. One of the most important responsibilities of the 97-BOI was to ensure the fairness of the process, and this was clearly not achieved.

380 The ARB did not support LCol (retd) Lapeyre's complaint that he did not have sufficient time to prepare for his BOI appearance, because there was simply no way to establish the truth of his allegation so long after the event.

381 The ARB concluded that the BOI should have considered additional key witnesses and evidence. In particular, it agreed with LCol (retd) Lapeyre that the testimony of the 2 PPCLI training officer, the administrative company commander and the Brigade staff officer for Operations Plans and Training would have been helpful. The ARB concluded that this testimony "would have enabled [the BOI] to reach more balanced and better substantiated findings."

382 As for the question of a Subject Matter Expert, the ARB agreed that, although it was not essential, it would have been preferable if the BOI had appointed a senior infantry Subject Matter Expert. It noted that the Board would have benefited from insight into infantry culture, either by appointing a Subject Matter Expert or by calling witnesses with equivalent experience and expertise.

383 ARB members included an observation on the "related, over-arching issue" of finding fault and assigning blame. They felt it was important to note that the 1997 BOI was influenced by events at the time, such as the Somalia Inquiry. The ARB Report states:

384 The entire CF was under pressure to "clean up its act" with strong media emphasis on preventing senior officers "getting off scot-free". Public opinion seemed to demand that senior officers more often be held responsible for the CF's wrongdoings and mistakes. The tendency within DND in 1997 seemed, from our observations as serving Officers at the time, to be shifting more towards finding fault and laying blame. The 97-BOI was, we believe, caught up in the midst of that trend and might have felt obliged to lay blame upon senior personnel for MCpl Wheeler's death.

385 Overall, the ARB agreed with LCol (retd) Lapeyre that the BOI's conduct had not been fair to him for a number of reasons. It recommended that these conclusions should be recognized in the settlement of his complaints.

2.9.3.3.5 Issue 5: Expressing Opinions and Disclosure of Personal Information

386 LCol (retd) Lapeyre complained about the release of the BOI to the public and some public statements made about him by BGen Ross. Part of the complaint alleged that, before he convened the BOI, BGen Ross had made public comments to the effect that there had been a cover-up in MCpl Wheeler's death. He voiced his concerns to the CF and made a formal complaint to the Privacy Commissioner in 2000.

387 The ARB could not substantiate LCol (retd) Lapeyre's contention that BGen Ross had accused him of a cover-up before convening the BOI. It had access to an April 24, 1999 letter from a retired lieutenant colonel who had been present at the Land Force Western Area leadership seminar in September 1997. The letter described BGen Ross' criticism of LCol Lapeyre. The ARB noted that BGen Ross was never given the chance to respond to the contention, and determined that the matter should be investigated further, acknowledging that it would be a difficult task so long after the fact.

388 The ARB found that the BOI Report and the letters had been released to Mrs. Wheeler in accordance with the *Privacy Act* and that LCol (retd) Lapeyre's complaint was therefore not substantiated. This finding echoed that of the Privacy Commissioner.

389 The ARB also looked into the way in which the BOI was disseminated to 1 Canadian Mechanized Brigade Group units. It accepted the reason given for the distribution of the report, namely for information and training purposes

with the aim of preventing such accidents in the future. The ARB agreed with the Privacy Commissioner's findings that the distribution of the report was consistent with the purpose for which the information was collected. The Review Board did not agree with the Privacy Commissioner that the three letters that were distributed with the report constituted a violation of the *Privacy Act*. It found that they were "an integral part" of the BOI Report and further noted that they were to LCol (retd) Lapeyre's benefit in that they clarified the ultimate finding of the CLS and the CDS with regard to his level of accountability for the accident, by reducing his level of responsibility.

390 The ARB recommended guidance for the disclosure or sharing of personal information within the CF, preferably in the form of a Defence Administrative Order and Directive (DAOD). It also recommended that the effects of the dissemination of the information on LCol (retd) Lapeyre's reputation be considered when redressing his concerns.

391 The ARB also looked into LCol (retd) Lapeyre's complaint about the destruction of the BOI Report and correspondence within 1 Canadian Mechanized Brigade Group. Once the basis for the BOI's findings were called into question, NDHQ ordered the units to destroy their copies of the BOI Report and the letters; LCol (retd) Lapeyre complained about both the initial distribution of the material and its later destruction. The ARB noted that the order to destroy the documents was prompted by new information, which might affect the contents and findings of the documents. The report stated that the ARB did not understand why LCol (retd) Lapeyre objected to the destruction of the documents and could not support his complaint in that regard.

392 LCol (retd) Lapeyre had also complained about comments senior officers made to the media following public release of the BOI Report. The ARB did not support this complaint, agreeing with the Privacy Commissioner that the comments were personal opinions that did not violate the *Privacy Act*.

393 Finally, the ARB examined the effects on LCol (retd) Lapeyre's reputation of the release of the BOI's findings and the recommended action of the CLS, approved by the CDS. It found that LCol (retd) Lapeyre's reputation *had the potential* to be damaged by the release of the information to Mrs. Wheeler and within 1 Canadian Mechanized Brigade Group. It also determined that LCol (retd) Lapeyre's reputation *had* been damaged by media reports about the

BOI and its findings, but it was not able to determine the source of those reports. It therefore recommended that appropriate measures be taken to address the damage to LCol (retd) Lapeyre's reputation.

2.9.3.3.6 Issue 6: The CF's Actions after the BOI

394 The CLS had asked the ARB to deal with this issue, along with LCol (retd) Lapeyre's complaints that the CF delayed addressing his concerns, ignored them and was not willing to properly investigate the issues he raised. Specifically, the Review Board looked at the "degree of due diligence exercised by the CF" in dealing with LCol (retd) Lapeyre's complaints and the way in which new evidence was handled once it came to light.

395 LCol (retd) Lapeyre began raising issues about the BOI in March 1998, when he was first informed of the Board's report and findings. The ARB looked at three distinct time periods between the release of the BOI Report and convening the ARB:

396
- *May 5, 1998 to December 7, 1998*: On May 5, 1998, LCol (retd) Lapeyre acknowledged that he had reviewed the BOI's evidence and disputed the composition of the Board, its findings and disclosure to the public. The CLS sought legal advice and passed LCol (retd) Lapeyre's concerns on to Col Selbie, president of the BOI, asking him to clarify his position. Col Selbie responded on August 28, and LCol (retd) Lapeyre was informed of the response on December 7. The ARB considered this to be a timely and appropriate response given the information available to the CLS at the time.

397
- *March 16, 1999 to March 16, 2001*: On March 16, 1999, LCol (retd) Lapeyre faxed the CLS a copy of LCol Kaduck's letter stating that he believed he had been acting as Chief Controller on the day of the accident. The CFNIS initiated two formal investigations within four months, which the ARB considered reasonably timely. The CFNIS final report was concluded on December 27, 2000, and the CLS was briefed at the end of February 2001. On March 16, 2001, the CLS informed LCol (retd) Lapeyre that he had directed a final review (by the DLP) and would inform him of the results when they were available. The ARB questioned why the CFNIS investigations took 17 months but concluded that the CLS was correct in not proceeding with his own investigation so as not to interfere with the CFNIS

investigations. It also found that the CLS's actions before and after the CFNIS investigations were generally timely, with the possible exception of a delayed response to a letter from LCol (retd) Lapeyre, which the ARB felt may not have required a response.

398 • *March 17, 2001 to December 21, 2001*: The CLS ordered a final staff review in March 2001, which was completed by the DLP on June 18, 2001. Meanwhile, LCol (retd) Lapeyre pursued his complaint through the Minister of National Defence and my Office. When he met with the CLS on June 20, 2001, it became clear that he was looking elsewhere for a solution. Based on LCol (retd) Lapeyre's mistrust of an internal solution, the CLS offered mediation as an option on December 21, 2001. LCol (retd) Lapeyre refused this offer in January 2002. The ARB felt that this time-line was reasonable, especially considering the effects of events of September 11, 2001 on the priorities of the CLS and his staff.

399 Overall, the ARB could not support LCol (retd) Lapeyre's complaints about delay and unwillingness to investigate his concerns.

2.9.3.3.7 Issue 7: Maj Kaduck's Involvement with the 1997 BOI

400 The ARB looked at two main issues concerning LCol (retd) Lapeyre's complaints about Maj Kaduck's involvement with the BOI: the allegation that Maj Kaduck's involvement in the planning stage of the BOI was inappropriate; and the allegation that Maj Kaduck's knowledge as a result of his involvement affected his testimony. The ARB confirmed that Maj Kaduck had had contact with Mrs. Wheeler prior to the BOI being convened, but noted that he was not involved in the review of the BOI Report. The ARB was unable to conclude that Maj Kaduck's actions were inappropriate; it also found no evidence that his testimony was affected by his contact with Mrs. Wheeler. As a result, the ARB did not support LCol (retd) Lapeyre's complaint with regard to Maj (now LCol) Kaduck.

2.9.3.3.8 Issue 8: Investigative Processes

401 Under this issue, the ARB looked into Mrs. Wheeler's complaint that the 1992 SI was not conducted properly and LCol (retd) Lapeyre's similar complaint about the BOI, including his allegation that the BOI was procedurally flawed. The ARB had the benefit of the new information — LCol Kaduck's statement,

as confirmed by the CFNIS, which emerged after the BOI. The Review Board found a number of problems with both the SI and the BOI, which it examined together to reach conclusions about how the accident as a whole was investigated.

402 The ARB identified five principles of investigations, under which it examined the problems with the way MCpl Wheeler's death was investigated:

403
- *Investigative means:* The investigative means should suit the gravity and complexity of the incident being investigated. The ARB found that a BOI would have been more appropriate than an SI in 1992, since it would have allowed "a more thorough examination of the circumstances of the accident when the evidence was fresh and facts could be firmly established." It also found that, even in 1992, the choice to convene a SI was "highly unusual" and not common practice. The five years that elapsed from the time of the accident to the convening of the BOI made it difficult to gather fresh, reliable evidence.

404
- *Conflict of interest:* Investigations should not be convened or investigated by anyone with a personal interest in the results. The ARB found that it "should have been evident from the outset" that LCol Lapeyre's responsibilities put him in a position of potential conflict of interest as the convening authority for the SI.

405
- *Independence:* Investigations should be conducted by someone at arm's length from the chain of command or any other party who could influence the outcome of the investigation. The ARB found the SI investigator appointed by LCol Lapeyre 1992 did not have "the necessary knowledge, experience, and independence to meet the assigned mandate."

406
- *Procedural fairness:* Persons who may be adversely affected by the findings of an investigation should be given the opportunity to contradict or correct evidence and to present their case to the investigators. The ARB also noted that this principle is even more important in high-profile investigations, the results of which are likely to become public. The ARB found that the BOI had not extended procedural fairness to LCol (retd) Lapeyre.

407 • *Sound and thorough fact-gathering:* Reasonable fact-gathering processes should be used to ensure that evidence is complete, accurate and reliable. The ARB found that, in 1992, inadequate fact-gathering led to the improper conclusion that MCpl Wheeler was partly responsible for his own death. Similarly, in 1997, the BOI's failure to call certain witnesses, and some unfounded conclusions, indicated inadequate fact-gathering processes. The ARB also noted the responsibility of review authorities to ensure that findings are supported by solid evidence, as well as to adhere to other principles of investigations. It found that the review authorities for the 1992 SI did not attempt to correct the conflict of interest, the lack of independence or the shortcomings in the investigative process.

408 The ARB pointed to DAOD 7002, *Boards of Inquiry and SIs*, issued in February 2002, as a good source of guidance for investigators on procedural fairness. In addition, the ARB recommended that the army train investigators in the basic principles of good investigations.

2.9.3.3.9 Issue 9: The Regimental System and Army Culture

409 This issue concerned Mrs. Wheeler's complaints about her treatment by the military after her husband's death. The ARB noted that the treatment of family members after the death or serious injury of a CF member depends a great deal on the member's individual unit. Mrs. Wheeler received little official support from the unit after her husband's death.

410 The ARB pointed out that, although the unit was preoccupied with a major exercise, a change in command and imminent deployment to the former Yugoslavia in 1992, it is important to maintain good contact between a deceased member's unit and his or her surviving family, both to promote cohesion within the unit and to assist the family with its needs. It urged the army to "recognize and support the requirement that units have a responsibility to properly support the family of any soldier killed or seriously injured while a member of that Regiment." In particular, it recommended that the Army Culture Project confirm the responsibility of units and COs to the families of members, and consider whether additional resources are needed to fulfil this responsibility. It also recommended that the army provide guidance to personnel on the importance of maintaining the trust of members' families.

2.9.3.4 Since the ARB

411 In a letter to the CDS, Gen Henault, on May 29, 2003, the CLS (LGen Jeffery) informed him of the conclusions reached by the ARB and sought approval for amendments to the BOI. The CLS noted that the results of the ARB and the CFNIS investigation compelled an amendment to the findings endorsed by their predecessors and indicated that, if the CDS approved the proposed amendments, he would engage the Canadian Forces Legal Advisor and the JAG to address the closure of the complaints.

412 The CDS responded on September 4, 2003, approving the conclusions and recommendations, and directing that the BOI record be amended. He agreed that the CLS would inform LCol (retd) Lapeyre and Mrs. Wheeler of these amendments and attempt to resolve any outstanding issues with them.

413 On November 5, 2003, LGen Hillier, the new CLS, wrote to LCol (retd) Lapeyre and Mrs. Wheeler, notifying them of the results of the ARB and of the revised findings recently approved by the CDS. The letters also noted that copies of the ARB Report had been prepared for them, severed according to the provisions of the *Privacy Act*.

414 On November 20, 2003, the Commander of Land Force Western Area, met with Mrs. Wheeler and her daughters. He provided them with the letter from the CLS and a severed copy of the ARB Report.

415 On November 19, 2003, the DLP met with LCol (retd) Lapeyre to provide him with the documents. The CLS had asked the DLP to assist with the resolution of any outstanding issues LCol (retd) Lapeyre might have. LCol (retd) Lapeyre reviewed the ARB Report and sought clarification on some of the content. After a series of e-mails between LCol (retd) Lapeyre and the DLP, the DLP asked LCol (retd) Lapeyre, on May 5, 2004, if he would be willing to go to mediation to resolve the outstanding issues. LCol (retd) Lapeyre indicated his desire to defer any mediation until my Office completed its investigation and report into his complaint.

Analysis of the Events of April 7, 1992

3 The Exercise and Fatal Accident

416 Given that more than 12 years have passed since MCpl Wheeler's death, it is not possible to accurately determine what happened on that day, nor was it the intent of this investigation to do so. Nonetheless, it was important to the investigation to have as accurate an understanding of the events of April 7, 1992 as possible. Not including my investigation, there have been two military police investigations (in 1992 and 1998–99) and two administrative inquiries (in 1992 and 1997), during which participants in the exercise and witnesses to the accident were interviewed.

417 The events described in this section have been compiled from all available documentation, particularly witness statements taken by investigators in the days immediately following the accident. My investigators also reviewed the documentation from the 1992 SI, and the 1997 BOI, and have conducted interviews with members of both the Friendly and Enemy Forces who took part in the exercise, as well as of other CF personnel who were in the immediate vicinity of the incident when it occurred. In some instances, these interviews were the first time some individuals had been asked detailed questions about what had happened and why. (Any clarifications provided by participants or witnesses since the 1992 investigations have been noted as such.)

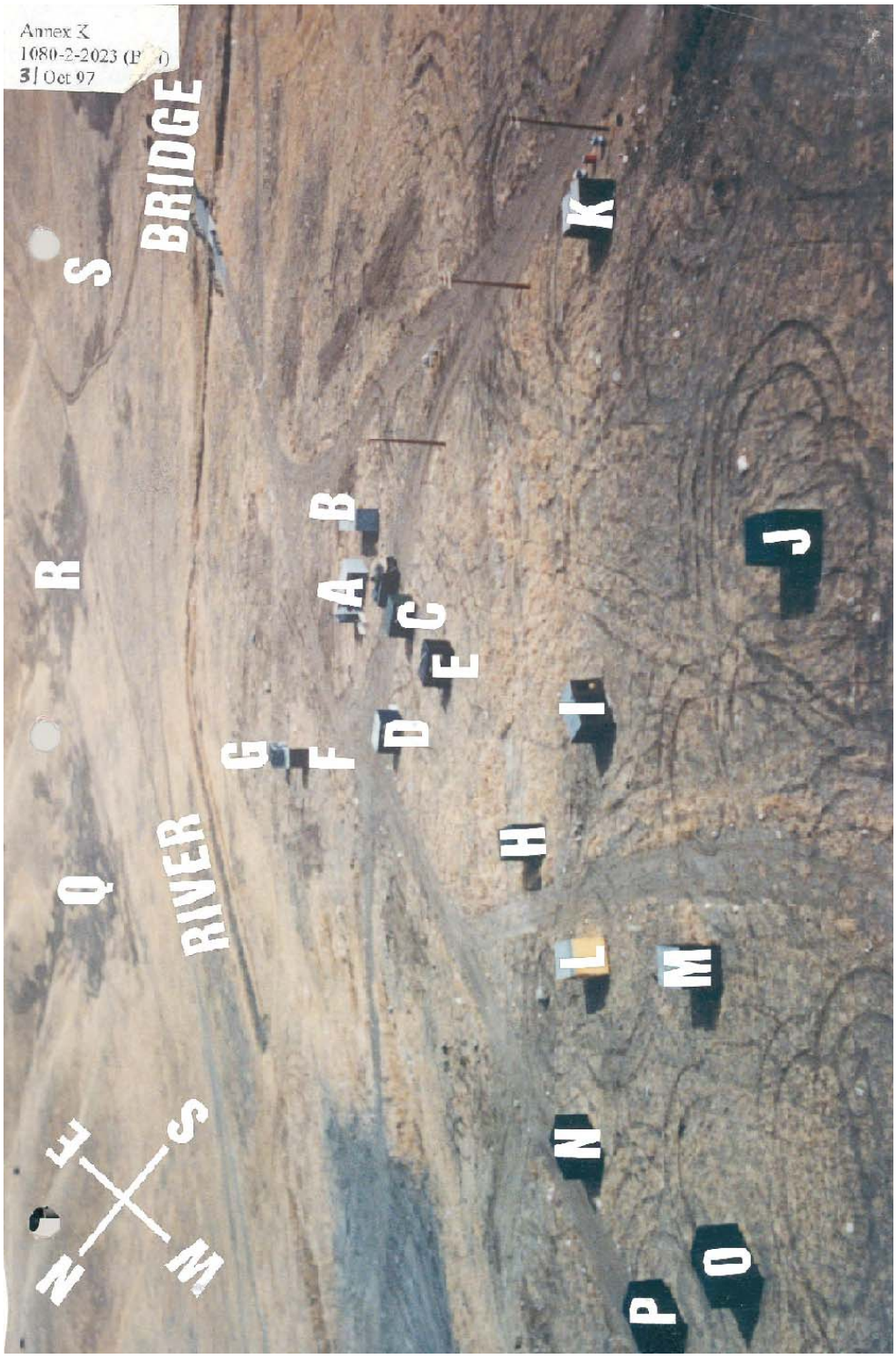
418 As a general rule, statements made closest to the event itself most accurately reflect what actually happened**.** In this case, however, due to the incomplete MP investigation, the most contemporaneous statements do not address many of the questions identified by later inquiries into the incident. As a result, my investigators have had to supplement those initial findings with information provided by witnesses well after the actual incident. This is problematic, since memories fade or may be coloured by subsequent discussions of the event. The most I can accomplish, therefore, is to identify those facts that are not in dispute, and to record those disagreements that continue to exist. I cannot, for example, evaluate the correctness of the findings of direct responsibility against the APC driver , or the Enemy Force Controller and have made no attempt to do so.

3.1 Overview of Exercise Surging Rage

419 Exercise Surging Rage was a 2 PPCLI training exercise conducted at CFB Suffield from March 24 to April 8, 1992. The purpose of the exercise was to conduct live-fire and tactical field training at the section, platoon and company levels in preparation for the unit's participation in a national exercise to be held the following month. Elements of the unit participating in the exercise were A Company, C Company, parts of Combat Support Company, Battalion Headquarters and Administration Company.

420 The Suffield phase of the exercise was conducted in two parts, with A Company and other elements training from March 24 to 31, and C Company and other elements training from March 31 to April 8, 1992. Each part began with live firing and progressed to dry training, with the first day of the dry training under the control of the company commander and the remaining two days of training under battalion control. During the battalion-controlled training, a live Enemy Force was provided consisting of a Controller and nine members from various sections, including MCpl Wheeler for the second part.

421 The battalion-controlled dry training was scheduled by a Master Events List, which detailed various scenarios to be encountered by the Friendly Force. One of the serials called for the Friendly Force to mount an attack against a village defended by the enemy. When attacked, the Enemy Force was to remain and fight, unlike in previous serials, when members would disengage and withdraw to a new position. The attack took place in the area of CFB Suffield called Dunelm Point, which was set up to look like a small village. There was a dry riverbed, partly trenched, representing a river, which curved around the village forming its north and east boundaries. Other structures simulated a bridge and various buildings of the village, including a church with a tower (designated Building A on the photograph produced at the BOI which follows). There were two main roads which, according to the photograph produced at the BOI, run from east to west through the village and towards the bridge, and through the village in a roughly north-south direction. The intent was that the Friendly Force would approach from the south.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422 After the accident, an aerial photograph of the village was taken, and the 1997 BOI later labelled the buildings. BOI witnesses referred to this photograph in their testimony.

423 Since this was designated a dry training exercise, there was no live ammunition involved; the battlefield environment was simulated through the use of smoke pots and thunder flashes in place of both the Friendly and Enemy Force's artillery. Umpires, part of the control staff, were designated to observe the action and determine casualties, which involved telling participants if they were dead or injured. Friendly Force participants designated as casualties were expected to act as their injuries dictated and to withdraw from action if they were designated seriously injured or dead. Enemy Force members were to determine their own casualties and were not necessarily required to play dead or injured if the action warranted it.

424 An extensive control structure was established for the exercise to ensure that training objectives were achieved. Control staff were controlled by the Operations Officer for 2 PPCLI, Maj Walter Semianiw, who was designated Chief Controller. Control staff were responsible for the following:

425 • safe conduct of exercise activities for their sub-unit or element;

426 • painting the battle picture for their sub-unit or element;

427 • conducting battle simulation; and

428 • designating casualties and prisoners of war.

3.2 Events of April 7

429 C Company was the last scheduled sub-unit to take part in the exercise, and arrived at CFB Suffield on March 31. During the first seven days (March 31 to April 6), no major incidents were experienced. The final phase for C Company began as scheduled on April 7 (Day 8). As outlined in the Master Events List, the Friendly Force, consisting of the majority of members of C Company, were to attack the small village being held by an Enemy Force. The Enemy Force personnel were equipped with standard infantry personal weapons, and supported by an APC.

430 The 2 PPCLI Intelligence Officer, a lieutenant, was designated the Enemy Force Controller, with MCpl Wheeler as the Enemy Force Commander. The Enemy Force consisted of MCpl Wheeler and eight other members, one of whom was also acting as the exercise photographer and therefore did not always participate as a combatant. Although the Enemy Force was made up of fewer people than normal in this type of situation, it was responsible for conducting activities as detailed in the Master Events List so that training objectives were achieved. The Enemy Force Controller was responsible to the Operations Officer, Maj Semianiw.

431 The Enemy Force was using the *Soviet Minor Tactics Pamphlet* as a guide for their operations. To add realism to the exercise, on the initiative of the Enemy Force, modifications were made to the APC to make it look more like a Soviet vehicle. These modifications, however, reduced visibility from the APC. Indications are that these modifications had at least tacit approval from the senior officers. The Enemy Force Controller told the BOI in 1997 that he had Maj Semianiw's approval for the changes; Maj (now Col) Semianiw testified that he recalled seeing the APC with the modifications before the start of the exercise.

3.2.1 The Enemy Force Controller's Briefing to Enemy Force

432 Prior to the attack, the Enemy Force assembled in the village and, according to most witnesses, were briefed by the Enemy Force Controller on the tactics to be used in its defence. Based on the information gathered by my investigators, the Enemy Force Controller instructed a private to hide in the church tower, and then directed the APC driver to return to the APC, which was concealed in the riverbed. The APC was to remain there until the driver observed the private on the roof of the church stand and fire at the Friendly Force, at which point the APC was to launch a counterattack.

433 The remainder of the Enemy Force were to defend the village from occupied buildings to the southwest, slowly falling back to the eastern boundary of the village. According to most witnesses, the Enemy Force Controller gave the Enemy Force a rough idea of the plan and sent the APC driver to the APC while he continued to brief the rest of the members.

3.2.2 The Accident

434 The defence of the village initially went as planned, with the Enemy Force falling back to the village centre near the church. According to witnesses, it was roughly at that point that MCpl Wheeler simulated a casualty by throwing himself to the ground along a track south of the east west road. According to some accounts, he was within 15 feet of advancing Friendly Forces when he did this.

435 At about the same time, the private stationed on the roof of the church stood up and began "firing" at the Friendly Force as he had been instructed, and, on cue, the APC driver began driving the APC toward the village. He stopped the APC and began firing at the Friendly Force with his rifle. The Enemy Force Controller said that, at that point, he got the APC driver's attention and motioned for him to move toward the village.

436 The APC driver started driving toward the village. The Enemy Force Controller said that he turned back to survey the battle for the village and, when he next saw the APC, it was going too fast (he estimated that the speed was 20 kilometres per hour) and farther into the village than he had directed.

437 The APC approached the village along the main east-west road and turned left onto the secondary track, heading in the direction of MCpl Wheeler, who was feigning death. It passed close by two Enemy Force members who were standing on the same road. The Enemy Force member who was taking photographs of the exercise saw the APC come around the corner so close to the two members that he stated, "half a step further and they would be dead or seriously injured."

438 After narrowly missing the two members, the APC continued on, subsequently running over MCpl Wheeler who was still lying on the ground, fatally injuring him.

439 After the APC struck MCpl Wheeler, Capt Kaduck's driver chased it and managed to get the APC driver to stop. Everyone involved in the exercise did what they could to attend to MCpl Wheeler's injuries and radioed in a "No Duff" (real) casualty. MCpl Wheeler was airlifted by a visiting British forces' helicopter to the nearest hospital in Medicine Hat, where he was pronounced dead on arrival, at 10:53 a.m. Mountain Standard Time. The autopsy report

stated the cause of death was a "massive laceration of liver and upper right lung due to compression of chest and upper abdomen." The Alberta Medical Examiner also found a fracture to the left side of MCpl Wheeler's skull.

3.3 Analysis

440 Unfortunately, we cannot conclusively say exactly what occurred immediately prior to the time MCpl Wheeler was killed. There are somewhat conflicting accounts of key events, including the briefing and the sequence of events at the time of MCpl Wheeler's death. What follows is a review of the main issues that emerged in this case, and key statements made by witnesses at various times. Various witnesses recalled events with varying degrees of clarity and certainty, which is completely understandable given the passage of time.

3.3.1 Issue of the Chief Controller

441 Although Maj Semianiw was the Chief Controller for Exercise Surging Rage, he had sought, and received, prior approval from LCol Lapeyre to leave CFB Suffield on April 6, to conduct a house-hunting trip.

442 From interviews conducted five years after the accident, it appears that not all participants understood who replaced Maj Semianiw as Chief Controller after his departure. Some members involved in the exercise (including Maj Semianiw) believed Capt Kaduck had assumed the role.

443 The 1997 BOI took the Enemy Force Controller's and Capt (now Maj) Kaduck's testimony to mean they believed the responsibility had been given to "Call Sign Zero," the Duty Officer in the Battalion Command Post. When the BOI first put the question to the Enemy Force Controller, he said he believed it had been given to Capt Kaduck, but later in his testimony, he appeared convinced that it had been given to the duty officer at Call Sign Zero.

444 In 1997, Maj Kaduck first stated to the BOI that the responsibility had been given to the duty officer at Call Sign Zero, but then asked for the opportunity to clarify some of the points he had made. He stated:

445 With respect to the question posed by the Board as to whether I had assumed the duties of chief controller upon the departure of Maj Semianiw, while I answered this question in the negative, upon further reflection I believe that my answer should have been 'I do not remember.' As I have no specific memory of either being appointed chief controller nor of any other individual receiving this appointment when Maj Semianiw departed.

446 In a letter to LCol (retd) Lapeyre dated March 16, 1999, Maj (now LCol) Kaduck stated that he was now certain that he was the Chief Controller on the day of the accident. He stated the same thing in a letter sent directly to the CLS, dated September 3, 2000.

447 When asked by the BOI if he had briefed Capt Kaduck prior to leaving CFB Suffield, Col Semianiw stated that he could not specifically recall a hand-off brief, but that it was something he would have done. He said, "an Ops O [Operations Officer] can't walk out of an exercise without having told people what's going on and without having briefed people, and without having told his CO." He also said he recalled telling Capt Kaduck that he was preparing to leave and that he would speak to LCol Lapeyre before leaving.

448 In 2002, Col Semianiw told my investigators he remembered a coordination conference the night before his departure:

449 … there was a co-ordination conference the evening of the 6th. I had left at 5 o'clock, the co-ordination conference happened that evening with OC [Officer Commanding] Combat Support by Kaduck, that's in [the Friendly Force Umpire's] testimony … and even in [the Enemy Force Controller's] testimony. But there was a co-ordination conference to co-ordinate the activities for the next day. So, we had established the fact that I was going to leave, that Captain Kaduck was going to take over. On that date, at about 5 o'clock, I went and I saw the CO after the last attack, after everything was done and that I was satisfied, that things were calm, I went to see the CO and I said, "I'm leaving." He said, "see you later." I went and I saw Captain Kaduck, I said, "I'm leaving, see you later."

3.3.2 Deviation from Master Events List

450 On the morning of the accident, the Enemy Force Controller decided to conduct a counterattack against the Friendly Force.

451 Based on the available evidence, the Enemy Force Controller instructed a private to hide in the church tower, and told the APC driver to return to the vehicle and drive toward the village when he (the driver) saw the private stationed on the church tower stand and fire at the Friendly Force. The remainder of the Enemy Force were to begin defending the village from occupied buildings to the southwest and slowly fall back to the buildings at the eastern boundary of the village, one of which was the church. The plan called for the APC to launch a counterattack, which was to be signalled by the shooting from the church tower.

452 There was no such counterattack when A Company went through the exercise, and C Company had, until then, used the APC primarily to transport troops in between engagements.

453 In 1992, the SI investigator asked the Enemy Force Controller why he had deviated from the Master Events List and included a counterattack in the exercise. He replied:

454

> The Commanding Officer and the Ops Officer had given liberty to amend the MEL [Master Events List] within the realms of safety and realism in accordance with trg [training] requirements, i.e., if something was called for but unsafe, don't do it.

455 In 1997, the Enemy Force Controller told the BOI that Maj Semianiw "liked counterattacks," and that he had supervised an unplanned counterattack earlier in the exercise. The Enemy Force Controller told the BOI that, when A Company conducted the exercise at Dunelm Point, Maj Semianiw had suggested a counterattack for the same serial with C Company. He said he had been reluctant to do so because his force was under-manned, but he had decided to include it at the last minute at the insistence of four members of the Enemy Force, including MCpl Wheeler and the APC driver. The Enemy

Force Controller told the BOI that the four members had gone to the village site ahead of the rest of the Enemy Force and had hidden the APC in the riverbed, which was close enough to the village to make a counterattack more practical.

456 When interviewed by my investigators, the Enemy Force Controller said, "The counterattack was my supervisory idea and MCpl Wheeler had set it up."

457 The APC driver told the BOI he remembered hiding the APC in the riverbed, but he could not remember if he had arrived at Dunelm Point before all of the Enemy Force.

458 At the BOI, when asked if he had told the Enemy Force Controller to include a counterattack in the defence of Dunelm Point, Maj Semianiw replied he did not remember recommending the addition. He said he believed that only the CO (LCol Lapeyre) could have authorized changes to the Master Events List.

3.3.3 Briefing to Enemy Force

459 Prior to the attack on the village, the Enemy Force Controller assembled Enemy Force personnel in the village and conducted a briefing on how the exercise was to be conducted. Normally, he would have given those instructions through the Enemy Force Commander (MCpl Wheeler), but it appears that, due to the small number of participants, he gave the instructions directly to the Enemy Force members.

460 It is unclear if MCpl Wheeler was present at the briefing, which took place 30 to 60 minutes prior to the attack. Since the only instructions in the Master Events List were to "remain and fight," the briefing is key to understanding what happened next. Unfortunately, none of the investigations that occurred in the immediate aftermath of the incident focused on exactly what was said by whom, to whom, in detail. For example, it is unclear exactly at which part of the briefing the APC driver was present, or what route the APC was to follow during the counterattack.

461 The Enemy Force Controller, in response to specific questions asked of him by the SI investigator in 1992, could not list the Enemy Force members present at the briefing.

462 The APC driver said that he had been at the briefing, but, when the SI investigator asked if all members had been present, replied: "I'm not sure." He did indicate his certain belief that three individuals were there: the private who was stationed on the church roof, the exercise photographer, and one of the two members who narrowly missed being hit by the APC seconds before it hit MCpl Wheeler.

463 When asked about the briefing, the last member referred to by the APC driver stated: "I wasn't at the briefing; I was moving a Jeep into position between two buildings. I knew we were to counterattack after withdrawing." He said that, as far as he knew, everyone but him was at the briefing.

464 The private stationed on the church roof also said he had not been at a general briefing, in response to the SI investigator's question:

465 Q. Were any specific instructions given to [the APC driver] about the role of the APC in the attack?

466 A. No, I just got my own instructions.

467 The other Enemy Force Member narrowly missed by the APC seconds before it hit MCpl Wheeler, and two other members each told the SI investigator they had been at the briefing, but they were not asked if they remembered who else was there.

468 The exercise photographer said there had been a briefing "[a]t the church, about 30 minutes before the battle." However, he was not asked about his participation in the briefing or who else had been present.

469 When the remaining surviving member of the Enemy Force to be interviewed was asked, he said instructions had been given to the group, and "everybody was there, I guess."

3.3.4 Route of the APC in the Counterattack

470 The Enemy Force did not have much time to plan their defence of the village and counterattack. According to most witnesses, the Enemy Force Controller gave some members of the Enemy Force a rough idea of the plan and then sent the APC driver to the APC while he continued to brief the rest of the members.

471 It is important to note that the witnesses did not agree on what was the APC's intended route in the counterattack.

472 Soon after the accident, the Enemy Force Controller wrote out a statement by hand, describing the exercise in general. However, he did not describe the Enemy Force's plan, noting only, "other than the general Exercise Instruction for the whole exercise no formal written instructions were given." He told the SI investigator that, after briefing the rest of the Enemy Force, he had gone to where the APC was hidden, where he gave the APC driver further instructions.

473 The SI investigator asked the Enemy Force Controller for more detail:

474 Q: Had the enemy section been briefed on how the battle would develop?

475 A: Yes, to withdraw to the church and adjacent building, and when [the private stationed on the church roof] stood up in the church steeple to counter-attack.

476 Q: Were specific instructions given to the APC driver?

477 A: Yes …

478 Q: What were the instructions to the driver?

479 A: To come out of the river bed to the north of the village, stop between the river bed and the village, pop out of his hatch, fire a few rounds and feign death.

480 These are the same instructions that the Enemy Force Controller described to the BOI in 1997. When asked by the BOI what route he had instructed the APC driver to follow, he referred to the map being used by the BOI and replied: "To G and F, the other side of the street behind the two buildings … To the north side of the track running east and west, sir, to the north of G and F."

481 He also remembered details about making sure that the APC was positioned so that the APC driver would be able to see the church tower. Further questioning by the BOI led the Enemy Force Controller to say he had sent the APC driver back to the APC early so the APC's position would not be revealed to the Friendly Force.

482 In 1992, the APC driver told the SI investigator he had been at the group briefing in the village, where he got his orders from the Enemy Force Controller. When asked if he had been briefed separately at the APC, he said he had not.

483 In his statement to the RCMP investigator on April 8, 1992, the APC driver described his instructions as follows:

484

> [the Enemy Force Controller] instructed me to remain hidden in a river bottom until the [unintelligible] was backed up to a church. My indication to move forward into the town site was when I observed a sniper positioned on the church open fire. My instructions were to be the final counter charge. I was not instructed to follow any route. I pulled the APC out of the river bank so I could see the battle take place and know when to move forward into the countercharge … I felt it was up to my discretion as to what route I took during the final counter charge and felt I would have been stopped if it was unsafe for me to proceed.

485 When the SI investigator asked him if he was told to drive the APC into the town, the APC driver replied: "No. I was not given any specific direction, but that is where the enemy was."

486 In 1997, the APC driver's testimony to the BOI included many references to his attempts to forget the entire exercise in the intervening years. He stated, "there are only certain things that I haven't been able to forget, and most of it starts from the time that I was parked to the time that I was finished. The rest I was able to erase."

487 When answering the BOI's questions, he said that he could not remember getting specific instructions about the route, or even his objective. He testified:

488

> Well, I know the route I took, sir, but I can't remember if it was – if that's the route I was assigned, or if that was just the only obvious route …

489

> But I do know that I wasn't instructed to turn north and I turned south, just to be crazy. If I was given specific instructions, I would have followed them.

490 The APC driver told the BOI he believed his instructions came from the Enemy Force Controller during an individual briefing. He also mentioned a number of details about the briefing at the APC (such as where the Enemy Force Controller was standing — "… at the ridge itself while I was putting the vehicle away"), which match the Enemy Force Controller's account of that briefing. He stated that he could not recall being at the group briefing and that he doubted he had been given his instructions along with the rest of the Enemy Force, because "then they would know when I was coming, and from talking with them after the accident, some of them didn't know I was coming."

491 The APC driver told the BOI that he had assumed the rest of the Enemy Force knew what he would be doing: "I was under the assumption they all had been briefed as well as that the counterattack was going to be launched."

492 The BOI later allowed the APC driver to review his written statements from 1992, before again asking him about the location of the briefings. He indicated that the 1992 statements were likely more reliable and that, while he didn't remember a group briefing, he believed there had been one. He also said that he specifically remembered the Enemy Force Controller standing on the ridge talking to him, but after reading his 1992 statement, he speculated that they might have been discussing matters unrelated to his instructions for the counterattack.

493 One member of the Enemy Force was primarily functioning as the photographer during the exercise. On April 8, 1992, he gave a statement to the RCMP, stating:

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> I knew that the enemy plan was to withdraw then counterattack. At that point the APC was going to come up from the low ground point where it was hidden. After the counter attack, all the enemy troops were going to die and the APC was going to make a final attack and then stopped [sic] which would have ended the operation.

495 In his testimony at the BOI in 1997, he explained what he understood the APC's route would be: "It would basically come down that track between A, B and C, or maybe between C, just come down, go east towards K and stop."

496 The private stationed on the church roof told the SI investigator:

497 > I think [the APC driver] was supposed to come up and pick up enemy survivors and take off. From what I understood from talk after the incident, I thought [the APC] was supposed to go down the track behind the church. It was sort of confused, no-one really knew where [the APC] was supposed to go.

498 He did not testify at the BOI, but did reply to a preliminary questionnaire the BOI used to identify witnesses with relevant information. He responded to the question about the APC's role as follows:

499 > … in my understanding, [the APC] was to be kept in background waiting and to be called forward after the attack to pick up the members of the enemy force for a hasty withdrawal. The APC was to come up from the rear of our position and to remain to our rear in waiting for us to mount-up.

500 When my investigators interviewed him in 2002, he stated that he had not been surprised to see the APC in the village and implied that it was there to pick up troops. When asked whether he had played a role in signalling the start of the counterattack, he replied that he could not remember.

501 In 1992, a member of the Enemy Force stated that he was present at the briefing. In his statement to the SI investigator, he said he was not sure how far the APC was supposed to come up to the village, but that the Enemy Force Controller had advised it would be part of the counterattack. In 1997, when he testified at the BOI, he stated, "to my knowledge, sir, there was nothing given in the briefing for what route to take for when the carrier comes up" and "the [APC] was supposed to come up for a counterattack and just make a quick ride up and go back."

502 Another member of the Enemy Force also stated that he was present at the briefing given by the Enemy Force Controller. He recalled being briefed that the APC was to go to the east side of the village. When asked what direction was given to the APC driver, he replied: "The general understanding was that [the APC driver] was to stay out of town and go east." He added:

503 > While we were withdrawing through town, we thought that the APC would stop behind the buildings and turn out into the field and fight the counter attack. It was never supposed to come down the lane in front of the buildings, so we were surprised to see it there.

504 In response to specific questions by the SI investigator, the same member gave the following answers:

505 Q: Where was the APC supposed to stop?

506 A: Behind the church and adjacent building.

507 Q: When did he [the Enemy Force Controller] say that?

508 A: I think it might have been during the battle.

509 In 1997, in his BOI testimony, the same member maintained, "I was not told of the vehicle coming anywhere near the town."

510 In 1992, another member of the Enemy Force told the SI investigator that during the briefing the Enemy Force Controller advised them the APC would do the "last bit" of the counterattack. He stated that the Enemy Force Controller did not provide the APC driver with a route during the briefing, but said, "I guess he was told later." This member did not know where or if the Enemy Force Controller ordered the APC to stop at any particular point during the counterattack.

511 When the exercise photographer testified at the BOI, he stated that the APC driver had been given two possible routes, both of which were "away from the troops." He also testified there had been a group discussion about what the APC should do in the counterattack:

512 > I do recall the conversation that came up was the direction of the APC and we all talked about that, we all said, well, you know, I think he should just stay where he is because there's troops advancing; I think he should turn or go straight. There was a lot of conversation about that, and then we finally decided that after the counterattack, [the APC driver] was supposed to head towards the west and then make a turn either north or head back towards where the bridge was.

513 In 1992, one of the two members narrowly missed by the APC seconds before it hit MCpl Wheeler told the SI that his understanding after the briefing was that the APC would take the route it did, but that it would not enter the village until after the counterattack had concluded. He said that he and the other member narrowly missed by the APC were surprised when the APC turned the corner and came into the village. In 1997, he testified at the BOI that he believed the APC would stay behind the buildings until after the counterattack.

514 In 1992, the other member narrowly missed by the APC seconds before it hit MCpl Wheeler said he was not present at the briefing, but understood he was to counterattack after initially withdrawing. The SI investigator asked him whether he was aware of any specific instructions given to the APC driver about the role of the APC in the upcoming attack, to which he replied, "After the accident, I heard from [the Enemy Force Controller] that the APC was to stop before reaching the village." Asked about the group's general understanding about the role of the APC, he replied: "It was confused, a split consensus on where the APC should have gone."

515 At the BOI in 1997, the same member testified that he thought the plan might have been for the APC to come through the village. After further questioning by the BOI, he admitted that he might be basing his belief on the APC's actual route, rather than on his limited memory of the planned route.

3.3.5 APC Visibility/Control

516 The modifications to the APC to simulate a Soviet armoured vehicle, apparently approved by senior officers, reduced the visibility of the driver. This limitation was compounded by the driver driving "hatches down," further limiting his vision to the field of vision permitted by the fitted periscopes of the vehicle. This greatly limited his ability to see immediately in front of the vehicle and its flanks. The APC driver said that he had done this on his own initiative to add realism to the exercise; as he told the SI investigator, "in a real battle I wouldn't want to get my head shot off."

517 The APC driver testified at the BOI, and repeated to my investigators, that he had mentioned his concern over the lack of a crew commander to the Enemy Force Controller. When asked, the Enemy Force Controller told the BOI that the driver might have mentioned it, but he could not remember for certain.

518 Immediately after the accident, the Enemy Force Controller stated that he had decided to act as a ground guide and had positioned himself behind the church next to the road, which allowed him to keep an eye on the battle and direct the APC. He stated that he had directed the APC with hand signals, and when the APC appeared to be following his directions, he believed it was because the driver had established visual contact with him. He noticed that the APC driver was driving hatches down, but was not concerned because of his belief that the driver was following his hand signals.

519 During the re-enactment after the accident in which members of the Enemy Force indicated where they had been at the end of the exercise, the Enemy Force Controller indicated his position was behind the church (building A), south of the road from the bridge.

520 At the BOI, the Enemy Force Controller stated that, when the APC passed him, he was looking towards the river, and the vehicle passed to his left:

521

> I am here on the south edge of the track and he [the APC driver] went flying by me full speed, hatches down … I was standing at the junction. I moved from my eastern location west towards the village so I would be between the soldiers and the vehicle that was supposed to be on the north side of the track.

522 The Enemy Force Controller then said that he turned around, and the APC "went flying by my right-hand side to the north of me."

523 The APC driver, on the other hand, told the various investigations that he was not aware of the Enemy Force Controller's attempts to guide him and proceeded on his own, following the most logical route.

524 The Enemy Force Controller later told my investigators that he had not actually been in the position indicated in the photographic recreation of the scene. He explained that he was more concerned with the state of his troops than with placing himself with accuracy for the photos: "My guys were in shock. I'm in shock. I have guys crying. I'm not going to march 15 metres down the road so, off you go, 'click,' there he is way over there. So, no, I was not there." However, he did not clearly specify where he had been standing, saying that he had been on the move and could not say for certain where he had been at a particular time.

525 The APC driver testified to the BOI that the Enemy Force Controller had been "over by F with his Iltis." He also testified that when he reached building G, the Enemy Force Controller was on his right-hand side. Years after the accident, a former colleague of MCpl Wheeler's came forward and told Mrs. Wheeler that the Enemy Force Controller had not been where he said he was. In 1997, that member said:

526 … the Iltis was in this area with [the Enemy Force Controller].

527 Q: You say "in this area", you are referring to area of building G?

528 A: Sorry, yeah, yeah, east of G.

3.3.6 The Accident

529 The APC driver estimated in his statement to the RCMP that he was driving between 8 – 12 miles per hour when he entered the villages. He indicated that he felt this was a reasonable speed if he had to stop. Witnesses to the accident provided a wide range of estimates of the speed of the APC, ranging from 15 kilometres per hour to 20 miles per hour. All witnesses, however, seemed to agree that the APC was going at a relatively fast rate of speed. Even those who provided estimates of speed in the lower range, indicated that they felt the speed was excessive given the location. According to the Enemy Force Controller, the APC driver had been warned previously to drive with more caution. The APC driver disagreed with the Enemy Force Controller about the number of warnings he had been given, but he agreed he had been warned once to drive more slowly.

530 The APC continued approaching the village along the main east-west road, turning left onto the road where MCpl Wheeler lay feigning death. It passed extremely close to two other members of the Enemy Force, narrowly missing them. One of the two stated that he did not notice the APC until it nearly hit him, nor did he hear the warning that the other was shouting at him. The other member stated that he was "shocked" when he saw the APC enter the mock village, since that was not, to his knowledge, part of the plan.

531 Members of the Friendly Force engaged in the battle were also surprised to see the APC come into town. The majority of the witnesses interviewed were not expecting the APC to enter the village during the battle phase of the exercise.

532 There appears to have been a consensus among witnesses that it took approximately 30 seconds from the time the APC entered the village to when it struck MCpl Wheeler. They also agreed that, while it was a clear day, there was a lot of smoke and dust in the air from the battle simulation, as well as a lot of noise from the battle and the various vehicles around the village. Witnesses said they were unable to see or hear the APC until just before it came upon them.

533 The APC driver said he was aware that there were members of both the Enemy and the Friendly Force along the side of his route, but he did not notice nearly hitting the two Enemy Force members. As a result, he continued along the road not realizing that MCpl Wheeler was lying on the ground in front of him, ultimately running over him. He told the RCMP:

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> … when I saw the sniper open fire, I moved forward onto the roadway. I moved forward to the battle and turned left onto a roadway in front of the church. C company was on my right and on my left. I was providing cover for them. When I turned left I checked my speed which was between 8 and 12 mph. I had all the hatches down and was driving by looking out the periscopes. I did not have a crew commander in the vehicle and felt this was a reasonable speed if I had to stop … With the [trim vane] down my vision down in front of the APC was obstructed for 10 to 12 feet directly in front of the vehicle. My vision was further obstructed by having to look through the periscopes and due to the amount of smoke which was discharged. The smoke was not heavy and I could see the end of the street but had to look harder to see everything. As I turned onto the street I could see the men from C company and along the sides of the road. As I progressed farther down the road I would lose sight of the men along the side of the APC and was concentrating on what was in front of me.

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> I did not see anything in front of me and continued down the roadway ... I pulled left into a field and popped my seat up so I could see if I was being charged by C company. I reached for my rifle when [Capt Kaduck's driver] ran towards me and said that I had ran [sic]

> over somebody he told me to stay in my vehicle and he ran back to the accident site. I dropped the ramp on the APC so they could get the first aid kit and I stayed in my vehicle.

536 Capt Kaduck's driver saw the APC strike MCpl Wheeler and, after catching up with it, managed to get the APC driver to stop the vehicle. He was the first witness identified and interviewed by the police investigators. In a statement given to RCMP on April 7, 1992, he described his view of the accident:

537

> I observed Rick Wheeler … throw up his hand and act like he had been shot, Rick then lied [sic] on the ground as if he was dead. I looked away from him for approx 1.5 min watching the battle. When I looked back Rick was still laying in the same position laying across a trail or roadway. I observed an APC with hatches down approach from behind some buildings and continue onto the roadway towards Rick, the APC was travelling at approx 20 km/h. When I realized what was happening it was too late. The left track of the APC drove over Rick's torso. The APC continued past Rick, I ran towards Rick and then ran towards the APC. I flagged the driver down and advised the driver he had run over someone, he said "No I did not. I did not see anybody."

538 The incident was also witnessed by a number of other members, including the Friendly Force Umpire. He stated that he saw the APC begin moving at about the same time as MCpl Wheeler threw himself to the ground. He lost sight of the APC briefly, until it appeared between two houses, accelerated and drove over MCpl Wheeler. The APC continued on toward several soldiers who were lying prone. Capt Kaduck's driver, who was assisting the Friendly Force Umpire, stopped the APC by flagging it down. In his statement to the RCMP on April 8, 1992, the Friendly Force Umpire stated:

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> … at this point of the operation the enemy APC was to come out and pick up the remaining survivors … and get away. Why did the driver come between the company's line and the enemy's line, I don't know. I can only explain it by saying that he must have misjudged the position of his troops because normally he should have stayed behind his troops and as they were withdrawing they would have got in the APC and get away. It appears to be a surprise to everyone when the APC came around the corner.

540 The Friendly Force Umpire also mentioned that the APC is usually operated by a driver and a crew commander. However, he could not say with certainty that a crew commander would have prevented the accident. His description of the accident matches the descriptions given by the APC driver and Capt Kaduck's driver. Not having been present when the Enemy Force was planning its counterattack, he could not explain the APC driver's actions.

541 In 1992, the exercise photographer said he believed that the APC was going 15 to 20 kilometres per hour, and that the APC driver was in the hatches down position, without a crew commander. He also stated that he took aerial photos after the accident and then photographed the accident reconstruction, which took place under the supervision of the major who had been put in charge of the accident scene. In 1997, the exercise photographer told the BOI he believed that the APC driver had followed the route he was supposed to take, but that the timing of the counterattack was not coordinated between the APC and the ground troops. He attributed the accident to the lack of coordination of the sequence and timing of the counterattack.

542 Another member of the Enemy Force gave a statement to the RCMP on April 8, in which he described how he and MCpl Wheeler had at one point been in the same building during the battle. However, he had run across the street to the church as MCpl Wheeler provided him with cover from a smoke grenade, after which he lost sight of MCpl Wheeler. He stated:

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> I heard gunfire from behind me and turned to return fire. I heard [the Enemy Force Controller] yell counter attack several times and knew at that time the APC was to move forward to our position and drive down the roadway in front of us. I moved back towards the front of the building and the roadway. I saw [an Enemy Force member] between the church and the building I was positioned at -- he was taking photos of the battle.

544

> I was lying in the prone position at the corner of the church returning fire across the street. I saw Rick laying across the roadway simulating he had been shot. I saw the APC coming down from my right down the roadway. The APC was travelling at approx 10 to 15 mph and was approx 10 to 15 feet away from Rick … The APC continued down the roadway and the left track ran over Rick's chest area.

545 This member had also noted that the driver was in the hatches-down position and that, while the day was clear, there was smoke and loud gunfire, as well as other APCs moving in the area. He said that he, the exercise photographer, and the Friendly Force Umpire ran towards MCpl Wheeler, to check on him.

3.4 Analysis and Observations

546 Witnesses to the accident recalled events with varying degrees of clarity and certainty; considering the passage of time, this is completely understandable. Consequently, it would be unfair, 12 years after the fact, to attempt to draw definitive conclusions about the conduct of any one individual and its relationship to MCpl Wheeler's death. There are some general observations however, that can be drawn about the circumstances leading up to MCpl Wheeler's death, based on an analysis of the statements taken from those directly involved in the training exercise.

547 There is no evidence that MCpl Wheeler gave any instruction in his capacity as Enemy Force Commander that contributed to his death. It is also clear that first-hand witnesses felt that the APC was traveling at an excessive speed as it went through the mock village. There was also no ground guide in front of the vehicle as it entered the village and that many of Enemy Force members did not expect the APC to take the route that it did, at the time that did. I cannot say with any great certainty however, the extent to which any of these factors contributed to or caused MCpl Wheeler's death.

Investigation of Deaths in the CF

4 Initial Investigations of Deaths and Serious Injuries

548 The death of Master Corporal (MCpl) Wheeler was initially investigated by three separate entities: the Royal Canadian Mounted Police (RCMP), the Military Police (MP) and the Second Battalion, Princess Patricia's Canadian Light Infantry (2 PPCLI) chain of command. The RCMP investigation, undertaken on behalf of the Alberta Medical Examiner of the Province of Alberta, was completed in conjunction with the MP investigation. The primary focus of the RCMP / MP investigations appears to have been to determine whether there was evidence that a criminal offence may have been committed.

549 In addition to criminal investigations, Canadian Forces (CF) regulations require an administrative investigation into a death to determine pension eligibility and the cause of an accident. If it is determined that faulty procedures or practices caused or contributed to an accident, the administrative investigation is responsible for making recommendations to remedy them, with a view to preventing similar accidents in the future. The administrative investigation conducted by 2 PPCLI involved two phases. In the first phase, an investigation was conducted at the scene of the accident under the command of the major who had been put in charge of the accident scene, immediately after the incident. This phase included a re-enactment, aerial photography and collection of statements from a number of witnesses. In the second phase, a Summary Investigation (SI) was begun within 24 hours of the incident. The decision to hold an SI, as opposed to a BOI, was made by LCol Lapeyre. The Assistant Adjutant of 2 PPCLI was appointed the SI investigator.

4.1 Investigations into MCpl Wheeler's Death

4.1.1 2 PPCLI Investigation at CFB Suffield

550 The Officer Commanding, Administration Company, a major who was to be put in charge of the accident scene, happened to be very close to the scene when the incident occurred. He immediately requested an ambulance be called over the administrative radio net. At the same time, Capt Kaduck requested an evacuation helicopter.

551 Shortly after the incident occurred, the major was put in charge of the accident scene. He decided to stage a re-enactment of what had happened. The exact time this took place is unclear, except that it was between approximately 10:30 a.m. and 2:00 p.m. He instructed the exercise photographer to take photographs of the re-enactment. The Armoured Personnel Carrier (APC) had been moved, probably back to its original position. The exercise photographer was also instructed to take aerial photographs of the scene using the helicopter that had transported MCpl Wheeler to Medicine Hat. This was done prior to the re-enactment, according to the photographer. The major who had been put in charge of the accident scene stated to my investigators that he advised LCol Lapeyre of his intentions to conduct the re-enactment and have aerial photographs taken.

552 In addition, several witnesses to the incident were ordered to submit handwritten statements of what had happened. There are conflicting accounts of who ordered this to be done. The major put in charge of the accident scene stated that he did not give the order; in fact, he felt that the request for statements "would come from higher. I had those soldiers there for the purpose of a re-enactment and I considered that my contribution if you will. There was going to be an investigation." He assumed that the C Company Commander "would have been tasked to get statements from his people who had been involved."

553 It is unclear how witnesses and potential witnesses were identified. Those who were identified remained at the scene pending the re-enactment. The remainder of the battalion returned to the Base. There are conflicting accounts of when and where the statements were written. In any case, the witnesses were not segregated.

554 According to the MP who conducted the CF criminal investigation, the major in charge of the accident scene brought two rolls of film and "the names and statements of personnel who had witnessed the accident" to the MP detachment at Canadian Forces Base (CFB) Suffield at about 2:30 p.m. that day. It is unclear exactly who had been identified as witnesses, other than the five CF members who were subsequently interviewed by the MP and RCMP — the APC driver, the Friendly Force Umpire, the exercise photographer, Capt Kaduck's driver, and another member of the Enemy Force.

555 The major in charge of the accident scene's actions appear to have been the only attempt to preserve and secure evidence, and to identify witnesses to the incident. At some point very shortly after the helicopter left with MCpl Wheeler on board, the area was "swept" by members of 2 PPCLI, in accordance with standard procedures for cleaning up a site after an exercise has concluded. Sweeping involves picking up debris, such as used cartridge cases, discharged pyrotechnic devices and other material, deposited during the exercise. These items, which may have had some evidential value, were not mapped prior to being moved, nor is there any record of them having been retained for possible examination by investigators. The duty officer at Call Sign Zero, who was a friend of MCpl Wheeler's, told my investigators, "once the helicopter had left, we basically got right on with sweeping quickly through the village picking everything up." Prior to leaving CFB Suffield, he went to the site where MCpl Wheeler had been run over. He states that there was no sign that an accident had occurred.

556 After the re-enactment had been completed, the participants left the training area, leaving the scene abandoned.

4.1.2 The RCMP Investigation

557 At 11:13 a.m. on April 7, the assigned RCMP constable was informed of "a fatal training accident." He went to CFB Suffield, arriving at 11:49 a.m. Neither he nor another RCMP officer who assisted him visited the scene

where the incident occurred until one or two days later, according to the MP corporal. The reason for the delay is unclear. It is also unclear if they viewed the APC. No forensic investigation was conducted by the RCMP, either of the scene or of other possible locations.

558 The RCMP took statements from five CF members who were involved in the incident — the APC driver, the Friendly Force Umpire, the exercise photographer, Capt Kaduck's driver, and another member of the Enemy Force. Capt Kaduck's driver was interviewed at 1:57 p.m. on the day of the accident. The remaining interviews were conducted the following day. All the interviews took place at the MP building at CFB Suffield.

559 The RCMP constable completed his final report on April 29, 1992. He wrote that the "apparent manner of death" was accidental and that "no criminal action is warranted in light of all the circumstances. The Canadian Armed Forces is conducting their own investigation to determine if any internal action is to be taken." The report was approved by a supervising RCMP officer.

560 A copy of the report was forwarded to the Alberta Medical Examiner.

4.1.3 The Military Police Investigation

561 The MP detachment at CFB Suffield was informed of the incident at 10:25 a.m., approximately 15 minutes after it occurred. The MP corporal assigned to the case went to the Medicine Hat hospital. On arriving, at about 11:40 a.m., he learned that MCpl Wheeler had been pronounced dead. He viewed the body, noting MCpl Wheeler's clothing and visible injuries. He then returned to CFB Suffield, where he met with the RCMP constable at about 1:00 p.m. He was present for Capt Kaduck's driver's interview.

562 The major who had been put in charge of the accident scene arrived at the MP detachment at about 2:30 p.m. He provided the MP corporal with a list, entitled "names and statements of personnel who had witnessed the accident." In his final report, the MP corporal wrote that the five witnesses interviewed were identified as the only ones with pertinent information, based on the list provided.

563 The major who had been put in charge of the accident scene also provided the MP with two rolls of film of photographs taken prior to and after the accident.

564 After Capt Kaduck's driver's interview finished at 2:58 p.m., both the MP and RCMP investigations appear to have concluded for the day. There is no record of further investigative activity on that day in the reports of either organization. The MP corporal did not visit the scene that day, nor was there any apparent attempt to locate and secure physical evidence from any other place. There was no forensic investigation of the scene.

565 The investigation continued the following day. The MP corporal attended the post-mortem examination at Medicine Hat hospital at 9:00 a.m. on April 8. He was also present at the MP detachment later that day for the RCMP interviews of the remaining witnesses.

566 No other investigative steps were taken. No other witnesses were interviewed. There was no follow-up of issues that had already been identified by witnesses, including the absence of a crew commander and the modifications to the APC that may have affected visibility. The MP corporal's final report was completed on April 24, 1992. It set out a chronology of what had happened and appended the statements of the five witnesses who had been interviewed by the RCMP. He made no observations as to potential culpability. The report noted that the death was accidental. The report was also signed by the MP corporal's supervisor, the Warrant Officer in charge of MP operations at Suffield. The Area Security Officer sent the report to the CF Director General Security at National Defence Headquarters (NDHQ) for review. On June 7, 1992, NDHQ advised the MP section at Suffield that no further action was required on the case.

4.1.4 The Summary Investigation

567 The terms of reference for the SI were approved, and the investigator appointed in April 8, 1992. The SI investigator was given the witness statements collected during the police investigation of the accident. He re-interviewed some of those witnesses, as well as some other Enemy Force members and the medical assistants who had administered first aid to MCpl Wheeler. These interviews were completed in a written, question-and-answer format. The APC driver was given written questions to answer on

three separate occasions during the SI. Several others, including the Enemy Force Controller, were interviewed twice. The Enemy Force Controller, who was clearly a subject of the investigation, was transferred to Gagetown in late April 1992, while the SI was still under way. The SI investigator did not interview LCol Lapeyre, Capt Kaduck or Maj Semianiw.

568 The SI investigator did not visit the site of the accident, but had access to the diagrams of the site drawn by witnesses, as well as the photographs taken during the training exercise and after the accident. He reviewed a number of documents, including Force Mobile Command Orders related to APC driver training, and the exercise plan for Exercise Surging Rage.

569 It appears that a draft copy of the report was sent to 1 Canadian Brigade Group Headquarters in late May of 1992. The reviewer at brigade headquarters, the staff officer for Administration and Personnel, returned it to 2PPCLI in a letter dated May 30, seeking clarification on a number of issues, including the safety provisions in the exercise instruction, the Enemy Force Controller's location at the time of the accident, and who had authorized the APC to be operated without a crew commander. He also requested documents confirming MCpl Wheeler's hearing, and instructed that Operational Training Policy Directive (OTPD) 107 be considered in the investigation and included with the final report. The SI investigator conducted further interviews to clarify the issues raised.

570 The SI Report was submitted on June 24, 1992. The SI Report cited three factors that led to the accident in which MCpl Wheeler was killed: confusion about the APC driver's orders and about the role of the APC in the Enemy Force manoeuvres; the lack of a crew commander; and the APC driver's driving.

571 The SI found that MCpl Wheeler was on duty at the time of his death and that his death was attributable to military duty. The report also cited three individuals as responsible for the death: the Enemy Force Controller, for failing to provide a crew commander, not ensuring the APC driver was aware of where the APC was to stop, and for adding the counter-attack; the APC driver, for driving by using periscopes and at a high speed, and for not ensuring he was aware of where the APC was supposed to stop; and MCpl Wheeler, for "failing to stand up and alert the driver of his presence on the roadway."

572 The SI Report noted that there had been no offer of or claim for compensation for MCpl Wheeler's death, and that a claim against the Crown by his surviving family members was a possibility. It also mentioned that MCpl Wheeler had diminished hearing abilities, noting his H3 rating, which might have contributed to "his slow reaction to the approaching APC."

573 The SI Report also made the following recommendations:

574 a. that the following corrective measures be implemented if APCs are to be used in close proximity to dismounted troops:

575 (1) that the crew commander must be employed with APCs, in accordance with FMCO [Forces Mobile Command Order] 24-15, and that Battalion Standing Orders be amended to reflect this policy;

576 (2) that drivers be required to drive with their heads up out of the hatch while in close proximity to dismounted troops; and

577 (3) that the importance of alerting drivers of tracked vehicles to one's presence on the ground be continually stressed at every level of command;

578 b. during training using a scripted scenario, every reasonable effort must be made to rehearse vehicle routes and make all players aware of these routes; and

579 c. no disciplinary action be taken.

580 The SI Report lists Maj Semianiw as the exercise Chief Controller, as described in the exercise General Instruction. The fact that he had left CFB Suffield before the accident was not mentioned in the report, nor was the question of who had been acting as chief controller in his absence.

581 LCol Lapeyre attached his remarks to the report on June 25, 1992. He concurred with the findings but omitted the finding that MCpl Wheeler was at fault for failing to stand up. He directed Battalion Standing Orders be amended according to the recommendations. He agreed with the findings that the Enemy Force Controller and the APC driver had been negligent, and with the recommendation that no disciplinary action be taken. He noted that administrative action had been ordered against them, a reproof to the Enemy Force Controller, and a Recorded Warning to the APC driver.

4.2 Analysis of the Initial Investigations

4.2.1 The 2002 Petawawa Training Accident

582 The investigation into MCpl Wheeler's death took place more than a decade ago, and the intervening years have seen a number of changes to the way in which the CF investigates such incidents. As result, the Ombudsman's team studied the way in which the CF would have investigated a similar incident today. To that end, the team examined what happened in the aftermath of the tragic death of a Canadian Forces private on September 23, 2002, during a training accident at CFB Petawawa. She was killed when the Light Armoured Vehicle (LAV) III, in which she was an occupant, overturned during a training exercise.

583 The section below sets out the principles of good investigations. It goes on to examine whether the investigations into MCpl Wheeler's death followed these principles and compares them to the process by which the 2002 Petawawa death was investigated.

4.2.2 Integrity of Initial Investigations

584 To be credible, investigations must be, and must be perceived to be, independent, transparent, objective and thorough. These principles are especially important in cases involving a death.

585 The investigation of fatalities usually has five components that reflect the principles of good investigations. They are as follows:

586 1. The investigators must be experienced and independent.

587 2. All potentially relevant issues must be identified and pursued.

588 3. All physical evidence must be preserved, collected and examined as necessary.

589 4. All relevant witnesses must be identified, segregated where practical, and interviewed.

590 5. All relevant documentation and records must be secured and reviewed.

591 There are significant differences in focus between criminal and administrative investigations; however, in my view, the general principles outlined above apply to both, albeit to different extents. This section analyses whether the CF had these components in place in MCpl Wheeler's case, in both the criminal and administrative investigations, and discusses what would happen if a similar accident occurred today.

4.2.2.1 The Investigators Must Be Experienced and Independent

592 Investigative agencies usually assign their most competent and experienced investigators to oversee investigations of deaths, whether they are caused by a traffic accident, an industrial misadventure or a possible homicide. In addition to experience, investigators must be independent.

593 The RCMP and the MP investigators met the independence test in that they were both independent of the unit involved in this incident. I have no mandate to comment on the quality of the RCMP investigation. However, there is no doubt that the MP investigation was not as thorough as it could have been.

594 At the time, the MP investigator assigned to the case had no experience in investigating sudden deaths, other than having attended several suicides at a previous posting. He stated to my investigators that he did little investigation in those cases. He also stated that MCpl Wheeler's was the first autopsy he had attended. He had received very little training on scene-preservation techniques and no detailed training on how to investigate fatalities.

595 I want to emphasize that this is in no way a criticism of the MP corporal. It was not his fault that he had not been trained how to investigate unnatural deaths. Furthermore, his work was supervised by a senior Non-Commissioned Officer at CFB Suffield, and was approved without comment by NDHQ without any red flags having been raised.

596 The SI met neither the experience nor independence test. The SI investigator was a junior officer who had graduated from military college in 1990. He had joined 2 PPCLI the same year and been appointed Assistant Adjutant in

January 1992. He told my investigators that, during his time at military college, he had received some instruction about the overall process the CF used to investigate incidents but had received no instruction that he could recall about how to actually conduct an investigation.

597 The SI investigator stated that his experience of conducting SIs at the time of MCpl Wheeler's death was limited to relatively minor issues, such as investigating the loss of equipment, such as a lost bayonet, or less serious injuries, such as a soldier who had tripped on ice. He had not conducted any investigation involving a serious injury.

598 The SI investigator had never investigated a fatality of any kind. To his credit, he brought his concerns to the attention of his chain of command. As he told my investigator:

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> I know that at some point in time I expressed the observation or concern that [the investigation] perhaps belonged to somebody more senior to myself at that point in time. It was a fairly significant incident. It had, potentially, a huge impact, and they were appointing it to myself.

600 He made similar remarks at the 1997 BOI.

601 One of the SI investigator's tasks was to ascribe blame. Ultimately, he found fault with the Enemy Force Controller, the APC driver, and MCpl Wheeler. Ascribing blame is a very powerful tool, particularly when a death has occurred. Both the Enemy Force Controller and the APC driver stated that they are still living with the consequences, which went far beyond the administrative measures taken against them.

602 The SI investigator also ascribed some blame to MCpl Wheeler. That conclusion was not supported by the evidence. This finding caused tremendous pain for the Wheeler family, notwithstanding the results of 1997 BOI, which made it plain that a serious mistake had been made in that respect. The SI investigator subsequently acknowledged, both at the BOI and to my investigators that, in retrospect, he was wrong to come to that conclusion. The chain of command at 2 PPCLI, 1 Canadian Brigade Group, and Land Force Western Area allowed this finding to remain in the completed report.

603 The SI investigator cannot be considered an independent investigator. He was a junior officer who directly reported to those who were ultimately responsible for the training exercise. His superiors could potentially have been found directly or indirectly responsible for MCpl Wheeler's death, depending on the results of the investigation. Although the SI investigator is adamant that there was no interference in his investigation from any quarter, he was clearly placed in a very difficult position. His investigation could have unearthed evidence that might have implicated officers senior to him in the unit or cast the unit in a poor light. Certainly, he was concerned about investigating a peer — the Enemy Force Controller. If the investigation had explored all the issues that it should have, he would have had to interview his superiors, including his CO.

604 The Administrative Review Board (ARB) noted:

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> those appointed to conduct an investigation must be at arms-length from the immediate chain of command or other influencing factors, to ensure they feel sufficiently secure to make findings on merit alone without fear of any kind of retribution or without regard to the power and influence of persons involved in the process or of those who give effect to the decision.

606 I fully concur. The former 2 PPCLI Adjutant told my investigators that, with the wisdom of hindsight:

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> Probably, in the sort of circumstances as this, it may even be beneficial to appoint someone from outside the unit by the Brigade [to ensure that the investigation is done] … by somebody external to the unit with a good background and experience to complete the investigation.

608 Two soldiers directly involved in the investigation commented on the need for independence when conducting serious administrative investigations. One 2 PPCLI member told my investigators:

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> There should be an outside party getting involved in the investigation first of all. They should have had the RCMP in there or the OPP. There should have been a team coming down from Ottawa ASAP. It should have happened not five years down the road, not ten years down the road, but as soon as the accident happened.

610 Major-General (MGen) Leslie, who recently completed a tour of duty as the Deputy Commander of the International Security Assistance Force (ISAF) in Kabul, Afghanistan, was a staff officer at Land Force Western Area who played a role in the review of the SI in 1992. When asked by my investigator what could have happened better in 1992, he stated that:

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> [N]ever have a complex investigation done by somebody within the unit, ever. And that became the rule. Why? Not because the investigating officer has a lack of moral fibre or an ethical sense of trying to get to the truth, but if you are too close to the issue sometimes your perception is skewed and you can't see the bigger picture.

612 Has the situation improved since MCpl Wheeler died? My investigators reviewed some of the Canadian Forces National Investigation Service (CFNIS) report into their investigation of the 2002 Petawawa training accident. Overall, the CFNIS response demonstrates much improvement since 1992. The response was fast, sufficiently resourced and included qualified, experienced and trained investigators and forensic technicians.

613 The Petawawa MP detachment was first on the scene. It contacted the CFNIS 54 minutes after the incident occurred, and informed the CFNIS that rain was forecast and they were covering the scene. The private who was killed in the accident had been moved away from the vehicle so that first aid could be administered, but none of the vehicles had been touched.

614 The CFNIS took immediate carriage of the investigation. A team of investigators was dispatched to the scene, arriving within a few hours. A qualified accident reconstructionist, with special training in analysing motor vehicle accidents, was also dispatched to CFB Petawawa. In total, five investigators were assigned to the case.

615 Before their arrival at CFB Petawawa, the CFNIS investigators were told that some of the witnesses had been prescribed medication. To ensure a fresh account of the events, the CFNIS investigators asked the unit Adjutant to have the witnesses write out their recollections of the day's events. Then, when the CFNIS investigators arrived, they interviewed all five of the surviving occupants of the two LAV III's that had participated in the training exercise. They also interviewed witnesses who arrived on the scene immediately after the accident, and the training instructor.

616 The investigators made sure the site was photographed. Since the vehicles had not been moved, the investigators were able to determine the exact routes taken from the markings on the ground. They also documented the state of the terrain in detail. The coroner was then called, and the body of the deceased was taken to the hospital for an autopsy.

617 The investigation also considered whether anyone involved had been impaired (it was determined they had not) and other possible causes, including human error and technical failure. Investigators reviewed the unit's personnel records and the training histories of the five survivors, as well as training technical directives and driver training course materials for the LAV III.

618 The vehicle and information about the scene were sent to the CF's Quality Engineering Test Establishment (QETE). QETE provides a broad range of engineering and applied science services to the Department of National Defence (DND) and the CF. These services encompass investigative, advisory, reference laboratory and management support, with performance and evaluation components.

619 With the information provided by the CFNIS, the engineers at QETE were able to recreate the route of the LAV III and the accident. They also conducted an extensive technical examination of the vehicle. The investigators were subsequently able to establish the approximate speed of the vehicle; the physical movement of the vehicle at, during and after impact; and the sight-lines the driver would have had immediately prior to and at the time of impact; along with other information. Furthermore, they conducted a re-enactment at the scene using a LAV III fitted with information-gathering instruments, which also furnished valuable evidence.

620 A BOI was convened to conduct the administrative investigation into the death. The President of the BOI came from outside of 2 Combat Engineer Regiment (CER), the unit involved in the training exercise.

4.2.2.2 All Potentially Relevant Issues Must Be Identified and Pursued

621 In criminal investigations, the goal of the investigating agency is to ascertain whether or not an offence has been committed. In many cases, offences are not readily apparent, and thorough investigation is required to ascertain whether there is evidence to support or refute any conclusion about criminal culpability. In the context of a motor vehicle incident involving death, a wide range of offences could be found to have occurred, depending on circumstances such as the driver's intention and his or her conduct leading up to the incident.

622 Investigators are responsible for determining what facts exist to prove or disprove the essential elements of any potential charge. For example, a key element in determining criminal negligence is wanton and reckless action on the part of the potential accused. Accordingly, it is crucial to ascertain just what individuals involved in the incident did or said before, during, and after the incident. Investigators will also look at a broader range of issues that may have a bearing on whether or not an offence has been committed, including training; instructions to or by the individual; and compliance with rules, regulations and/or standard operating procedures. Investigators will normally focus their attention on individuals in a position to provide such information.

623 For example, in the case of MCpl Wheeler, the Enemy Force Controller obviously had relevant information about the movement of the APC and could have shed light on the APC driver's statement that he was "not instructed to follow any route." The Enemy Force Controller may have also shed light on the genesis of the modifications to the APC and the reason why there was no crew commander in the vehicle. Yet he was not identified as a potential witness by the police investigators.

624 It is clear that other issues, which later became central in establishing what had occurred and why, were never explored by either the RCMP or the MP investigation. Their findings appear to have been based on a determination that the death was simply the result of a tragic accident for which no one was

responsible. Relevant issues included the role and responsibility of the chain of command, including who was acting as Chief Controller during the exercise, as well as whether 2 PPCLI had actually received OTPD 107 on or before April 7, 1992.

625 Obviously, it is crucial to identify and determine the facts surrounding all potentially relevant issues as quickly as possible. It is far easier to investigate an issue at the time, when memories are fresh, than years later: documents are not lost or destroyed; perishable physical evidence may still be available. In my view, a thorough, professional and objective investigation that identified and explored all the issues immediately after the incident occurred could have prevented much heartache, suspicion and expense over the past 12 years.

626 I am pleased to report that there has been significant improvement in the CF's approach to examining all potentially relevant issues since 1992. Our review of the investigation into the 2002 death of a CF member in a training accident at CFB Petawawa confirmed that the CFNIS investigation was far more extensive. For example, they investigated whether potential manufacturing or design faults in the LAV III may have contributed to the accident. To that end, we understand that the investigators arranged for detailed testing on the vehicle, interviewed representatives of the manufacturer and looked at the design process.

627 It is also important for administrative investigations to identify and explore all issues that may be relevant. Clearly, the SI did not identify all issues, even with the benefit of the review at 1 Canadian Brigade Group in late May 1992. The SI took no steps to address issues that later became so contentious, such as who was the Chief Controller and whether he held any responsibility for what had occurred. Most importantly, the SI failed to rigorously explore the events immediately preceding MCpl Wheeler's death, including what instructions were given to whom, by whom, and where individuals were located.

4.2.2.3 All Physical Evidence Should Be Preserved, Collected and Examined As Necessary

628 One of the keys to effective investigation is the ability to have experts collect and document evidence at the scene as quickly as possible after an event occurs. This ensures that all available physical evidence is collected and forensically examined, if necessary, to assist the investigative team in determining what happened. Physical evidence generally means anything tangible that may be related to the event, such as, in this case, the APC, MCpl Wheeler's clothing, marks on the ground, and so on. Scene protection means that no-one is allowed into (or, in some cases, out of) a scene until the arrival of the investigative team, except to preserve life or prevent further injury.

629 The facts of this case illustrate how failure to preserve and protect evidence at a scene can impede a thorough investigation. The scene was rich in potential evidence and should have been frozen immediately after MCpl Wheeler was evacuated. Nothing should be brought into or taken away from a scene, nor should anything be moved or disturbed within it. Immediately after the accident, the APC was where the APC driver had stopped it: it may have left marks on the ground; other evidence on the ground, such as bodily fluid, may have indicated the point of impact; and there may have been trace evidence on the APC itself. It may also have been possible to determine the driver's field of vision.

630 The APC itself should have been examined to determine if mechanical failure or malfunction contributed to the incident. Footprints or other marks on the ground could have proved relevant. A qualified accident reconstructionist may have been able to determine the speed of the APC at the time of impact. Briefing notes or other documents at the scene may have been available to shed some light on what occurred, particularly with respect to who was to do what action at what point during the counterattack. In short, there was a significant possibility that very important evidence would have been found on the scene.

631 Unfortunately, the scene was not preserved and in fact was irrevocably disturbed by the re-enactment. The decision to re-enact the events, while undoubtedly made with the best of intentions, permanently destroyed the original accident scene. Not only was the APC moved, the original participants had an opportunity to hear, and possibly be influenced by the recollection of other witnesses.

632 The re-enactment ultimately provided little useful investigative information. Experienced investigators would have recognized that a re-enactment at the scene was of limited value, since such accidents are notoriously difficult to recreate in a way that produces useful evidence. An experienced investigator would also have recognized that it is more important to preserve the scene so that original evidence can be noted, recorded and seized, and to immediately identify, separate and interview key witnesses so that their fresh, independent and untainted recollections can be recorded. If a re-enactment was necessary, it could have waited until after the scene was preserved and documented.

633 This should certainly not be interpreted as a criticism of the major who had been put in charge of the accident scene, or his decision to re-enact the accident. The Canadian Forces Administrative Order (CFAO) that governs the investigation of deaths or serious injuries makes no mention of the need to preserve a scene. It is unreasonable to expect a CF member not trained in investigations to be aware of proper procedure to investigate a serious or fatal accident.

634 The photographs taken during the re-enactment provide us with the best available pictorial evidence of what went on. Neither the RCMP nor the MP attended the scene immediately after the incident, and there was no professional forensic examination of the scene. There is also no record of any attempt to analyse equipment, for example, by examining the APC or testing the radios to ensure they were transmitting properly.

635 In contrast, the investigative procedures followed by the CF today appear to be much improved and more thorough. After the 2002 training accident at CFB Petawawa, the scene was preserved by the local MP section pending the arrival of the CFNIS investigating team. The investigators were able to make their observations and ensure that all relevant physical evidence was collected. The scene was photographed prior to anything being moved,

thereby providing a permanent record. The body remained at the scene until the completion of the forensic identification process. I understand that measurements were taken. The investigators made arrangements for the LAV III to be moved to the QETE facility for expert examination.

636 This type of response would have made a difference had it been employed in the Wheeler case. Investigators would have been able to determine if there was a deficiency in the equipment; it may have been possible to estimate the speed and route of the APC; experts could have determined sight-lines and the impact of the modifications to the APC, and so on.

4.2.2.4 All Relevant Witnesses Must Be Identified, Segregated Where Practical, and Interviewed

637 A thorough investigation requires that investigators identify, segregate and interview witnesses or potential witnesses as quickly as is practical. In the case of MCpl Wheeler, there were approximately 80 individuals at or near the scene at the time the incident occurred. This figure includes the Friendly Force as well as the Enemy Force. Even individuals who may not have seen the incident, but who arrived within a few minutes may have overheard utterances by those who were present. Other potential witnesses in this case certainly include the chain of command directly responsible for the conduct of the exercise and could also have included those responsible for the creation of safety rules and regulations.

638 It is unclear how many individuals were asked to make handwritten statements. It was certainly more than the five who were formally interviewed by the RCMP and the MP. The list of people interviewed did not include Capt Kaduck, Maj Semianiw and LCol Lapeyre, who should have been interviewed given their positions and responsibilities in relation to the conduct of the training exercise.

639 In the course of this investigation, we interviewed a number of individuals who expressed surprise that they were never interviewed, either for the police investigation or for the SI. These individuals were at or near the scene, or had background information such as information on the organization of the exercise. Both the RCMP and the MP investigators appear to have

selected their witnesses from the list supplied by the major in charge of the accident scene. There was no effort that we are aware of to ascertain if other individuals had any other information that may have had a bearing on the death.

640 Once witnesses are identified, it is very important that they are segregated so that their evidence cannot be tainted — inadvertently or otherwise — by what they hear others say about an incident. There is a natural and understandable tendency to discuss extraordinary events with others who have been through the same experience. Once that process begins, witnesses' own recollections can become tainted by the accounts of others. While sharing information may be valuable from a therapeutic perspective, it is not a good investigative practice.

641 Segregating witnesses can be problematic in a few cases — sometimes, it is simply not practical to separate large numbers of individuals for long periods of time until investigators arrive. In such cases, it is very important that potential witnesses are instructed not to discuss the events with any other party until they are interviewed.

642 In the case of MCpl Wheeler, there is no evidence that any witness was segregated, although one person present recalls being instructed not to talk about what happened prior to leaving the scene. However, his understanding was that he was instructed not to talk about the incident with anyone outside the unit, rather than with other witnesses.

643 The failure to segregate witnesses may have affected the accuracy of witness statements in this case. Several witnesses advised my investigators that they discussed what had happened with other witnesses in the hours and days after the incident. For example, during the SI, one key witness wrote, in response to a question about instructions given to the APC driver, "From what I understood from talk after the accident, I thought the track was to …"

644 While there is absolutely no evidence that there was any attempt to deliberately taint witness accounts in this case, I am troubled by the fact that witnesses were permitted to discuss the case prior to being formally interviewed.

645 In fact, a debriefing held on the evening of April 7, 1992 involved many of the approximately 80 participants who had been present and who were potential witnesses. The primary purpose of the debriefing appears to have been to deal with critical incident stress, an admirable goal, which I fully support. However, such debriefings could adversely affect the integrity of an investigation if care is not taken. I have dealt with similar situations during my tenure as Director of Ontario's Special Investigations Unit, an independent agency that investigates incidents in which police officers are involved in deaths and serious injuries. In those cases, we received assurances from the debriefers that the facts of the incident would not be discussed. It is important that such assurances are sought and received in all cases.

646 Obviously, the sooner statements are taken, the fresher the evidence. That is why investigators interview witnesses as soon as they can. However, in this case, only one witness (Capt Kaduck's driver) was interviewed the day the incident occurred. The remaining four witnesses were not interviewed until later the following day. I am not clear as to why, and it is an issue that would be difficult to explore some 12 years after the event, particularly since the interviews were conducted primarily by the RCMP.

647 In my view, the interview process did not meet the requirements of an investigation into a fatality, either during the police investigations or during the SI. The interviews during the SI were not sufficiently thorough or detailed; for example, the Enemy Force Controller was asked only eight questions in his initial interview. Other interviews with key witnesses were equally brief. Key areas — such as issues relating to who was in charge of safety or who was instructed to do what by whom — were either not addressed or explored in insufficient detail.

648 Furthermore, the written question-and-answer format used in the SI is not an ideal vehicle to adduce detailed information. It is cumbersome, time-consuming and, as the SI interviews amply demonstrate, raises more questions than it answers. Face-to-face, tape- or video- recorded interviews provide investigators with more information about a witness' state of mind, determined by listening to the person's voice and observing his or her demeanour and body language, none of which are present in handwritten responses to questions. Face-to-face, recorded interviews also permit

investigators to explore key areas in a sensitive fashion, put a witness at ease and allow the interviewer to tailor his or her questions to the interviewee's response. The overall goal is to ensure that the investigation gets at the truth.

649 In the investigation into the 2002 training accident at CFB Petawawa, key witnesses were instructed to complete detailed written statements prior to going off duty on the day of the incident. According to the investigators' notes, the CFNIS investigators made arrangements to interview members who had been present at the scene or in the LAV III when the incident occurred, prior to going off duty that day. In fact, all the major interviews of witnesses to the incident were completed within a day or so of the incident. Witnesses were also taken back to the scene by the investigators (after it had been frozen and documented) to better demonstrate what had occurred.

4.2.2.5 All Relevant Documentation and Records Must Be Secured and Reviewed

650 Investigations into serious incidents in which negligence or wrongdoing may have been a factor must look for any documents detailing SOPs, safety standards, protocols, etc. These documents set out what conduct is expected in the situation and provide a standard by which one can measure what actually happened. For example, in a shooting incident involving a police officer, investigators would look at what the police officer has been trained to do in the circumstances that led to the shooting. To do so, the investigators must obtain and review such documents as training course curricula, the officer's training record, national and local standards, and so on.

651 The ARB reached a similar conclusion. It noted that its investigation was hampered by the fact that the 2PPCLI correspondence logs and other documentation from early 1992 had not been preserved. It recommended that:

652

> The Army should develop a methodology to "freeze" all applicable rules, regulations, directives, orders and guidance when an incident occurs, to ensure their availability for future investigators. Unit historical reports are not sufficient, and the lack of complete information seriously compromises investigators' ability to assess the regulatory framework as part of the overall context surrounding an incident.

653 I fully support this recommendation.

654 In the investigation of the 2002 Petawawa incident, investigators obtained documentation relating to the LAV III, including vehicle history, technical directives and maintenance records, within hours of the incident occurring. They obtained the LAV III driver course instructions, as well as the training records and Unit Employment Records of all members involved in the incident. This material was potentially relevant to the investigation, given the broad range of possible underlying causes of the accident, which could include driver error, inadequate training and/or mechanical defects, among many others.

4.2.3 Discussion and Recommendations

655 Insp Grabb, an experienced RCMP investigator on secondment to the CFNIS in 2000, conducted the most recent criminal investigation related to this case. He completed an extensive review of the entire file. In an interview with my investigators he stated that "[The Wheeler case] is a quintessential example of the CF not getting it when it comes to the proper investigation of deaths and serious incidents …" I agree. Since 1992, there have been some significant improvements in the way the DND/CF conducts investigations. However, as discussed below, aspects of the way in which the DND/CF investigates deaths and serious injuries can be improved to ensure that investigations are as fair and thorough as possible.

4.2.3.1 Criminal Investigations

656 Based on our analysis of the criminal investigation into the 2002 death at CFB Petawawa, I am pleased to report that much has changed in the way the CF investigates deaths and serious injuries since the death of MCpl Wheeler, at least from a policing aspect.

657 One of the most positive developments has been the creation of the CF National Investigation Service (CFNIS) in September 1997. The CFNIS has a mandate to investigate serious criminal and service offences throughout the DND/CF. It currently has a complement of some 120 investigators in various detachments across Canada. It has introduced a training program that gives CFNIS investigators access to advanced investigative training at civilian

police colleges; it has an 'in-house' forensic investigation team; and it has access to technical expertise, including accident reconstructionists. According to the Deputy Provost Marshal in charge of CFNIS, it can and does respond quickly and has sufficient resources to process a scene, identify and interview witnesses, and collect physical and documentary evidence.

658 I understand that the CFNIS is now almost always called to investigate instances in which a member dies unnaturally within CF jurisdiction. It also monitors investigations by other agencies in cases where a member dies outside of CF jurisdiction. However, in at least one case, there has been some resistance to the CFNIS' role in investigating an unnatural death. One senior MP stated that, on occasion, there is "a lack of understanding as to why fatalities must be the subject of a police investigation, in addition to other technical investigations."

659 Unfortunately, CFAO 24-6, which governs how the CF deals with the investigation of deaths and serious injuries, has yet to be made explicit enough to ensure that all members of the chain of command are fully aware that the CFNIS should be called to investigate unnatural deaths. More, importantly, it does not make it *mandatory* for the CFNIS to participate, at least initially, in any investigation of such an incident.

660 CFAO 24-6 was issued on February 1975. While it is sound and relevant in many respects, in my view the CFAO requires revamping to deal with the investigative deficiencies that the case of MCpl Wheeler has so painfully exposed — in particular, with regard to the preservation of evidence.

661 First, it is my view that it should be mandatory for the CFNIS to be called in to conduct an initial assessment of all deaths of CF members who are on duty, or which may have some connection with CF duties, *regardless of the apparent circumstances of the death.* The CFNIS may then conduct a full investigation if it deems it appropriate after an initial assessment of the circumstances. The initial call to CFNIS should be made by the chain of command as soon as a fatality is apparent or if, in the case of a serious injury, there is a possibility the person may succumb to his or her injuries. The reason for this is obvious: nobody can be really sure about what happened and who may be responsible until and unless the circumstances of a death are looked at by trained professionals. Furthermore, the chain of command responsible for the unit within which the fatality occurs should not make the

decision whether a police investigation is warranted or not. There is too much potential for a conflict of interest, and the unit's chain of command is too close to the situation for a truly objective and independent assessment of all the circumstances. As mentioned above, much heartache would have been avoided had a thorough and objective investigation been conducted into MCpl Wheeler's death when it happened.

662 I appreciate that there are circumstances in which a local MP investigation will be more than adequate. However, in many cases, issues that appear to be cut-and-dried may be more complicated than is readily apparent to local authorities. These may well be evident to those with greater expertise or those with an outside perspective.

663 Similarly, there may be circumstances in which it might be appropriate to decide a coroner's, a medical examiner's or a local civilian police investigation will suffice; however, that decision should not be made without the benefit of an initial review by the CFNIS. This view is in keeping with CFNIS's mandate to conduct investigations into serious and sensitive matters.

664 The recommendations which follow deal with unexpected deaths, which are or may be related to duty. "Unexpected" includes accidental deaths, as well as suicides, but does not include death from illnesses. Such deaths are clearly related to duty when they occur while the member is on duty (such as in the cases of MCpl Wheeler and the 2002 training accident at CFB Petawawa), but there may be duty-related deaths which do not occur when the member is on-duty; for this reason, I think it would be valuable for the CFNIS to evaluate all unexpected deaths, to determine if there is a connection to duty.

665 **I therefore recommend that:**

666 **1. CFAO 24-6 be amended to provide that CFNIS shall be notified immediately of an unexpected death or serious injury of a member. Upon such notification, the CFNIS will conduct an assessment of the circumstances to determine whether a CFNIS investigation is warranted.**

667 As noted earlier, we provided the CF with an Interim Report and invited them to comment on our recommendations prior to this report being finalised. The CF did so in a document entitled "Response to Ombudsman's Interim Report", which is appended to this report.

668 The CF "agreed in principle" with this recommendation and undertook to incorporate the requirement to notify CFNIS in such cases in one of a series of DAODs that are being developed by the CF to deal with casualty reporting and administration.

669 The CFAO also needs to be updated to reflect the realities of 21st century investigative techniques and processes, in particular the need to protect and preserve evidence in the immediate aftermath of an incident involving death or serious injury of a member. Although the system worked as it should in that regard in the investigation of the 2002 training fatality at CFB Petawawa, senior individuals within the military justice system advised my investigators that there is still a need to make the obligations of the chain of command crystal clear in such situations. In fact, it is only fair to the chain of command to do so. As noted above, it is unreasonable to expect commanders in the field to be experts in — or, indeed, cognizant of the need for — scene preservation and witness sequestration, without providing them with some guidance.

670 **I therefore recommend that:**

671 **2. CFAO 24-6 specifically indicate that, in the event of an unexpected death or serious injury of a member, the following steps shall be taken by the chain of command immediately upon notifying the CFNIS:**

672 • **the scene shall be secured once all measures necessary are taken to preserve life or prevent any further danger to individuals;**

673 • **all potential witnesses shall be instructed not to speak about the incident to any other person until they have met with investigators;**

674 • **witnesses shall be segregated wherever there is a concern that they may discuss their evidence or at the request of the CFNIS; and**

675 • **no investigative steps should be taken without express permission from the CFNIS, unless necessary to preserve perishable evidence. In such cases, the CFNIS shall be advised of all steps taken.**

676 The CF agreed in principle with this recommendation, subject to the following exception:

677 > In respect of instruction of witnesses not to speak about an incident, care must be taken to avoid violation of Charter rights such as the right to remain silent or freedom of expression, as well as the contrasting obligations of CF members to report wrongdoing or wastage under QR & O Chapters 4 & 5.

678 These reservations are in my view without merit. First, the "right to remain silent" is just that. It is a right to remain silent, not a right *to* speak. There is no way that a direction to remain silent can contravene the right to remain silent. It is a direction to act consistently with a *Charter* right. Moreover, the right to remain silent is a right which arises when dealing with a demand of suspects for information from persons in authority. A direction to *all* witnesses not to speak, including among themselves, does not raise "right to remain silent" issues.

679 Freedom of expression does not, in my opinion, pose an impediment to this recommendation. I acknowledge that the scope of this *Charter* right is broad. Any attempt to prevent persons from communicating information (other than information that incites violence) has been considered by courts to be a *prima facie* violation of freedom of expression. A moment's reflection, however, should reveal that there are innumerable restrictions on this right which have been recognized in our society. In other words, there are a multitude of reasonable limitations on freedom of expression which have been accepted as justified under s. 1 of the Charter by our courts. Without question, the goal here - – to avoid witness tainting - is one that any court or tribunal would agree is pressing and substantial. A good investigator advises witnesses not to speak to one another so that their versions will not become influenced or confused. Good lawyers give the same advice to their witnesses. Courts routinely make witness exclusion orders that prohibit the discussion of their evidence. Clearly a rule within an organization designed to prevent witness contamination on matters as serious as deaths is pressing and substantial.

680 This directive would also meet the proportionality requirements of the *Charter*, meaning that the nature of the limitation on the right is directly related to the goal of fostering effective investigations of deaths, and is not overly intrusive. A temporary ban on the discussion of evidence is a rational way of attaining the objective of preventing witness tainting. The directive does not provide for a permanent or even long term muzzle. It is a temporary direction, lasting only until the witnesses have met with investigators. They are not prevented from discussing incidents – they are simply told not to do so until their untainted versions can be recorded.

681 The final issue in determining whether a limitation on rights is justified under the *Charter* is to determine whether the benefits of the measure outweigh its downside. There is in my view no apparent downside and the benefits are obvious. Freedom of expression furnishes no impediment to this rule anymore than it could strike down an order in an institution not to divulge trade secrets, or in a profession like law not to divulge confidences. This rule is an important adjunct to an effective investigation. It would be a mistake to blunt it out of inapplicable concerns relating to *Charter* rights.

682 With respect to the CF's concerns about duties to report wrongdoing or wastage under the *Queen's Regulations and Orders*, it strikes me that there is no opposition between the spirit of the QR & O and this recommendation. The

QR & O is apparently intended to encourage reporting. This rule contemplates having witnesses speak to "investigators" who will invariably be officials within DND/CF. Even if the QR & O identifies who the report should be made to (ie, someone other than an investigator), if a member is impeded by this order in "reporting" as required by QR & O Chapter 4 and 5, he can immediately speak to an investigator and then immediately report. In the end, a QR & O should not be used to impede an important initiative. If it stands in the way, this internal order should be modified to enable that important initiative.

683 I was impressed by the degree to which CF has embraced the recommendations made in this Report. Frankly, this response is out of keeping with that spirit. I encourage the CF to reconsider their response and strive to adopt a "can do" problem solving approach, as opposed yo focusing on needless reservations.

4.3 Summary Investigations

4.3.1 Applicable Regulations for Investigating Non-Combat

684 The rules and regulations relating to the investigation of non-combat deaths are set out in *Queen's Regulations and* Orders (QR&O) Chapter 21. QR&O 21.46 provides that either a BOI *or* an SI *must* be held when a member "dies otherwise than as a result of wounds received in action." The QR&Os are silent on which form of investigation is appropriate in any given set of circumstances.

685 CFAO 21-9, which amplified the QR&O by setting out general instructions for BOIs and SIs, was in effect in 1992. It provided no instruction as to which form of investigation was to be used. It appears that the decision was entirely at the discretion of "the officer empowered to order" either an SI or a BOI.

686 While the QR&Os provide that a BOI may be called "on any matter," it is clear that CF practice was — and is — to call BOIs on matters that are deemed to be more serious or complex. However, the threshold does not appear to be particularly high: BOIs are sometimes convened to investigate what could be

considered relatively trivial matters. As an illustration, an appendix to CFAO 21-9 provided a template for a "model terms of reference" for a hypothetical BOI. In the model, the BOI has been convened to "investigate the loss of a parachute." While the loss of a parachute can have serious consequences or highlight serious deficiencies, it is not on its own merits on the same level as a training death. Training deaths are by definition unnecessary and require a proper investigation, not only to determine the cause of the accident and the death, but also to recommend improvements needed to prevent recurrences. The investigation must have the rigour required to give the recommendations legitimacy.

687 The DAOD 7002 series replaced CFAO 21-9 in February 2002. DAOD 7002-1 provides some direction on when a BOI should be convened. It states that a BOI is normally ordered:

688 • to investigate and report on matters of unusual significance or complexity;

689 • when specifically required by QR&Os, CFAOs, DAODs or other orders; or

690 • when directed by a higher authority.

691 DAOD 7002-2 sets out when an SI is normally ordered, in particular, "to investigate and report on matters of a minor, straightforward and uncomplicated nature."

692 The DAOD confirms that a BOI may be called "on any matter," and again the threshold does not appear to be particularly high. In this instance, the appendix in the DAOD provides a "model terms of reference" to "investigate the loss of a missing military vehicle."

693 In fact, it is not unusual for BOIs to be convened on relatively minor matters, and they do in fact occur fairly frequently. One of my Special Advisors, the former CO of CFB Winnipeg advised that several dozen BOIs were conducted each year at the Base during his tenure in the mid-1990s, including inquiries into lost sports equipment. BOIs have also been convened to investigate instances of sexual harassment or injuries sustained by members as a result of sports training. A BOI is held whenever there is a change of command within the Land Force. A recent BOI dealt with the release of a member who failed to pass a qualification test.

694 A BOI possesses far greater powers than does a person conducting an SI. A BOI has the power to subpoena witnesses, including civilians, and to receive evidence under oath. A BOI can instruct witnesses to bring documents and other items in their possession to the BOI, if they are necessary "for the full investigation and consideration" of the matter before the Board. An SI investigator is not empowered to take evidence under oath. In cases in which witnesses are reluctant to take part in an investigation, for whatever reason, the increased powers of a BOI go a long way to ensure cooperation.

695 QR&O 21.08 sets out quite clearly that members of a BOI should not have "a connection with or … a personal interest in the investigation." The President should be of a rank equivalent to "any officer whose reputation may be affected as a result of the investigation." In addition, the BOI's power to compel the attendance of witnesses and production of documents ensures that, even if the witnesses outrank the President and members of the BOI, they are required to cooperate with the Board.

696 In practice, a BOI into serious cases is usually made up of officers who are not directly associated with the unit being investigated. There is also the possibility of appointing non-commissioned members and civilians, including retired members, in exceptional circumstances. This gives the convening authority the flexibility to ensure that the BOI members are sufficiently independent, and that the Board has the expertise it needs to conduct a thorough investigation.

697 The QR&O is silent on who should conduct an SI. CFAO 21-9 (in effect in 1992) stated only that a warrant officer should not be appointed as the investigating officer "if the investigation may affect the reputation of an officer or a man of equivalent or higher rank." The DAOD that replaced CFAO 21-9 states: "Conflict of interest and the appearance of conflict of interest must be considered prior to appointing an investigator."

4.3.1.1.1 CFAO 24-6

698 The investigation of deaths and injuries to CF members is also governed by CFAO 24-6, issued on February 28, 1975. It is designed to amplify the provisions of the QR&O. It has not been updated since (although it makes reference to certain provisions in other orders that have been updated), and

was in effect when MCpl Wheeler died. This CFAO provides that a "BOI should be convened if the circumstances surrounding the injury or death are such that a detailed and formal investigation is warranted."

699 In the case of a death, an SI must be conducted if a BOI is not convened. The CFAO is silent on the qualifications and experience of BOI members or SI investigators.

700 In summary, there was not in 1992 — nor is there today — a mandatory requirement for a BOI to be convened when a member dies on duty, but not from wounds sustained in action.

4.3.1.1.2 The Decision in MCpl Wheeler's Case

701 As noted above, LCol Lapeyre stated that, upon his return to battalion headquarters on April 8, 1992, he asked his Adjutant to contact the JAG in Winnipeg to seek advice on what his options were as the CO. In an interview with my investigators, the Adjutant advised that he did not recall being asked to contact the JAG by LCol Lapeyre. He confirmed that, to the best of his knowledge, no member of 2 PPCLI sought legal advice with respect to the decision to call an SI. He told my investigators, the JAG was consulted after the draft SI Report had been prepared so that it could be reviewed with regard to findings of responsibility and the administrative or disciplinary consequences recommended.

702 The 2 PPCLI Adjutant stated that he spoke with the Chief Clerk at 2 PPCLI, who he said had experience in dealing with at least one death involving a member. They discussed a case in which a member had died off-duty in a motorcycle accident, which had been dealt with by way of an SI. In his statement to my investigators, the Adjutant said that, after his conversation with the Chief Clerk, he concluded that "summary investigations were a completely viable option for investigating the death of a serviceman" and relayed that advice back to LCol Lapeyre, recommending that an SI be ordered. He stated that:

> **703** the primary focus was simply to confirm the member was on duty at the time of the accident, attributable to military service, therefore all of the benefits would be extended. That was the primary focus of the investigation. We thought the Summary Investigation would be an appropriate tool for the Commanding Officer given the form of the events …

704 In an interview with my investigators in 2003, the former Chief Clerk of 2 PPCLI said he could not recollect a death investigation in the unit after he arrived in 1989 until April 1992. He stated that "this might have been the first one" that he had dealt with.

705 The Adjutant also stated that, when formulating his advice, he considered the fact that LCol Lapeyre was present at the scene very shortly after the incident occurred. He made the assumption that, if LCol Lapeyre had any misgivings about calling an SI based on his own observations at the scene, then he would have indicated that he wanted a BOI.

706 The Adjutant also told my investigators that both he and the Chief Clerk had "liaised informally" with Brigade Headquarters, who "were aware of the situation and explained that a SI was about to be initiated." According to the Adjutant, LCol Lapeyre had called the Commander of Land Force Western Area within an hour of the incident to advise him what had occurred, and had briefed the staff officer for Operations Plans and Training, since the Commander was not available. In addition, a draft of the SI's terms of reference was sent to 1 Canadian Brigade Group Headquarters.

707 The Chief Clerk told my investigator that he has no specific recollection of having contacted Brigade Headquarters, but does recall discussing with the Adjutant and possibly LCol Lapeyre whether an SI or a BOI should be called. He stated that the prevailing view at that time, based on all the information available from CFB Suffield, indicated that the incident was a straightforward accident. The Chief Clerk could not recall specific reasons why an SI was chosen, stating "To this day I couldn't tell you why we settled for an SI." He also noted that, in retrospect, "I can't think of a good reason why [a BOI] couldn't have been done."

708 Other factors may have come into play in the decision. The Chief Clerk pointed out that there was some urgency to notify MCpl Wheeler's next of kin, out of a concern they would soon learn of the accident through media reports. He felt the unit's overriding concern for the family might have affected the time and effort spent researching the appropriate form of investigation.

709 LCol (retd) Lapeyre, who ordered the SI into the death of MCpl Wheeler, was — until this year — under the impression that his Adjutant had, in fact, consulted the JAG. He stated to my investigators that he based his decision on the following factors:

710 - The incident, while tragic, did not appear to him to raise any immediately apparent issues that required the more rigorous BOI process.

711 - The SI could be halted and a BOI convened in its place should information emerge that warranted such a step.

712 - He was relinquishing command of 2 PPCLI within 60 days and had a major exercise starting within 15 days. He believed that an SI would be conducted more quickly than a BOI could.

713 The Adjutant and Assistant Adjutant drafted terms of reference for the SI on April 8, the day after the incident. The Assistant Adjutant was appointed as the investigating officer at that time.

714 The terms of reference read as follows:

715 1. [SIN deleted] [the SI investigator] shall conduct a Summary Investigation into the circumstances surrounding the death of [SIN deleted] MCpl Wheeler R.A.

716 2. The Summary Investigation shall be conducted in accordance with the provisions of QR and O Chapters 21, 33 and 38, CFAO 24-2, 24-6, 21-9 and 210-29, and other relevant orders.

717 3. The Summary Investigation shall include as annexes the Terms of Reference, a copy of the CF 98 [*Report on Injuries or Immediate Death*], statements from all available witnesses, a copy of the autopsy report and/or findings of any inquest if applicable, a

statement from a competent medical authority, and a police report submitted with but separate from the investigation. In particular, it shall determine and make reference in the findings as to:

a. how the death occurred so that the Canadian Pension Commission may determine pension entitlement if necessary;
b. the cause of death;
c. responsibility for the death; and
d. disciplinary or other administrative action taken, or required.

4. Findings shall be made as to:

a. the cause of death;
b. whether the deceased man was on duty at the time of injury;
c. whether the deceased man or any other person was to blame for the death; and
d. whether the death was attributable to military duty as such.

5. Where the death was caused by the fault of another person, the Summary Investigation shall record whether the individual or personal representative has:

a. received;
b. been offered; or
c. claimed or intends to claim compensation from the persons at fault.

6. Recommendations shall be made as appropriate:

a. on any findings;
b. corrective measures to prevent recurrence;
c. on any safety changes required to any unit procedure or operations; and
d. any disciplinary action deemed necessary.

7. In accordance with the direction of the Commander 1 CBG, the investigating officer is to consider this investigation as his primary duty until such time as it is satisfactorily completed.

8. This investigation shall be classified as PROTECTED A.

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> 9. The Summary Investigation shall be delivered in one copy to the Adjutant by 16 April 1992. Should it be impossible to complete the investigation within that time, a written explanation shall be submitted before the due date.
>
> [Signed] J.M. Lapeyre, Lieutenant-Colonel, Commanding Officer

739 The wording of the terms of reference incorporated certain areas of required investigation under QR&O 21.47 for a BOI or an SI into a death or serious injury.

4.3.2 Analysis of the Decision to Call a Summary Investigation

740 The initial decision to call an SI was flawed, although there is no evidence it was made in bad faith. Rather, the decision was based on an assumption — that this incident was a straightforward training fatality with no collateral issues — that proved to be erroneous. As LCol (retd) Lapeyre told my investigator, he felt that there was nothing

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> … that would cause me to believe it was anything more than a vehicle accident. There was no other outside influence that I knew of at the time that may have been a contributing factor that would require an in-depth, more deliberate, longer, independent investigation.

742 Unfortunately, he was mistaken. In my view, there were enough warning signs available in the immediate aftermath of the incident to raise serious concerns about exactly what had happened. Certainly, by the time the SI was under way, it was, or should have been, readily apparent there would be an issue over exactly what the APC driver had been told to do and by whom. Furthermore, it was clear that there was no crew commander in the APC and that the APC itself had been modified. It was clearly foreseeable that safety policy, along with command and control of the exercise, would likely be a central issue in any investigation. In fact, it appears that LCol Lapeyre sent a package of material related to the conduct of the exercise to 1 Canadian Brigade Group within days of the incident. All of this information was available before the SI was completed, and while it was still possible to halt the SI and request that a BOI be convened. It is difficult to understand how what had occurred could be interpreted as a straightforward accident.

743 A BOI would likely have dealt with many of the issues that should have been apparent in 1992 and became increasingly apparent in the following years — especially if the BOI were conducted by members from outside the unit, with broad terms of reference and with the full range of evidence-gathering tools at its disposal. A BOI held in the immediate aftermath of the incident would have gathered information while it was still relatively fresh in the minds of witnesses. It would likely have located, reviewed and preserved documents and photographs that have since been lost. It may have provided answers to many of the Wheeler family's questions sooner rather than later, in an open and transparent way that might have brought a greater degree of closure to the family and assured other soldiers that training accidents are not considered routine nor are they acceptable.

744 The ARB came to a similar conclusion, finding that "the choice of investigative means was inappropriate" in this case. The ARB noted that, had a BOI been convened in 1992, it "would have ensured a more thorough and credible examination of the circumstances of the accident when the evidence was still fresh and the facts could be firmly established." In 1997, the former Adjutant of 2 PPCLI himself recognized, in hindsight, that a BOI should be called in cases involving training fatalities. In his evidence to the BOI, he stated that "investigations relating to training accidents probably should be referred to a BOI because they are potentially complex and very high profile and sensitive."

745 How then can we ensure that all deaths are examined thoroughly and credibly? As a starting premise, it is difficult to imagine a set of circumstances in which the death of a CF member who is on duty cannot be not construed as potentially a "matter of unusual significance or complexity," as one of the criteria for convening a BOI within the meaning of the DAOD.

746 In my experience, every death investigation is of "unusual significance" and is invariably complex. Investigations into unexpected deaths are complicated by any number of factors, not least the fact that a key witness to what happened — the deceased — cannot give evidence. Furthermore, family members of the deceased have very high expectations of the investigation process. They expect — and deserve — a full, fair, objective and transparent investigation into the death of their loved one. The Wheeler family put their

trust in the CF to furnish them with the facts. This case, and the events that have flowed from it, is a prime example of what can happen when a thorough and rigorous investigation is not conducted as soon as possible after a death occurs.

747 In addition to the responsibility to the family, the CF has a responsibility to other CF members in the wake of a training accident. It is important to reassure members of the CF that training accidents are not taken lightly, that all available resources will be used to determine the cause and that all reasonable steps will be taken to prevent a similar occurrence in the future. These objectives can only be accomplished by a thorough and rigorous investigation using the most effective tools available.

748 My investigators have been advised that the system has changed considerably since 1992. They have been told repeatedly during the course of this investigation that it is now unlikely, although not impossible, that any unexpected death potentially related to duty would be the subject of an SI. However, during the course of this investigation we came across local directives that imply that SIs are not ruled out in the case of a death. For example, Land Forces Command Order (LFCO) 11-16 (*Service Investigations Administrative Guidance*) discusses the various types of investigations, including CF 98 (*Reports on Injuries*), SIs and BOIs, that might be appropriate for various incidents. Annex A to LFCO 11-16 (Chief of Staff Administration Guidance), under the heading "Injuries/Death," reads:

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> With the exception of minor cuts or bruises, injuries and deaths must be investigated and reported upon by CF 98 or summary investigation/BOI. Convening authorities must establish a CF 98 monitoring system to ensure serious cases are promptly addressed — this must be done notwithstanding the fact that the medical authority may not have determined the disability is permanent.

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> All CF 98s and SIs must contain specific details and documentation to substantiate findings of "on duty" or "Attributable to service", if such is the case. Final decisions are made by the Canadian Pension Commission.

751 I am aware of a case as late as 2002, in which a CF member committed suicide. Although it was not a training death, it should have been investigated by a BOI. My office has learned that the member's parent unit

had not even considered holding an SI into the death, let alone a BOI. We have been advised by the Director of Casualty Support and Administration (DCSA) that he intervened in that case. After reviewing the SI findings, DCSA recommended to the Assistant Deputy Minister (Human Resources—Military) (ADM HR-Mil) that a BOI be convened because of "glaring questions" that arose from the SI. I am aware of another accidental death in 2000 of an officer cadet on a Canadian Forces base; it was initially investigated by Summary Investigation, and a BOI was later convened to investigate matters not addressed by the SI.

752 The fundamental premise that a death connected to duty should automatically result in a BOI being convened is still not set out unambiguously in the QR&O, DAODs, CFAOs or other orders and directives. In my view, it should be. This case is an excellent illustration of the dangers of not making it absolutely clear that a BOI must be held when an unexpected death related to duty occurs. A CO made a wrong decision, albeit in good faith, because he had the discretion to interpret the rules as he saw fit. As described above, LCol Lapeyre understood that, when an SI was sufficient to meet the needs, it was preferred to a BOI as a more efficient method of investigation.

753 The decision to hold an SI was not taken in a vacuum. It was at least tacitly endorsed by the chain of command, which had been informed of MCpl Wheeler's death in a Significant Incident Report sent shortly after the incident. On April 8, 1992, NDHQ sent a message to Land Force Western Area instructing:

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> The death of Master Corporal Wheeler shall be investigated and the minutes of the BOI or the Report of the Summary Investigation shall be forwarded thru CHQ [(Army) Command Headquarters] to NDHQ for approval on behalf of the CDS.

755 In this case, it is abundantly clear the discretion to choose an SI over a BOI did not yield the appropriate result. The process for the investigation of deaths should be written down in a comprehensive and crystal-clear fashion in the appropriate CF-wide regulations — in this case, QR&O 21, DAOD 7002 and/or the revamped CFAO 24-6. It should make clear that a BOI is mandatory in such cases.

756 I understand that the JAG is currently working on changes to the DAOD 7002 series that would make a BOI the default position for investigating deaths. I welcome this development and look forward to reviewing the amended DAOD. However, I do have some concerns: the JAG apparently considers that there may be circumstances in which an SI should not be ruled out in the death of a CF member since, according to a senior JAG lawyer, an SI is less resource intensive and can be accomplished more quickly than a BOI.

757 There is some, albeit very limited, merit in this argument. There may be circumstances in which an SI is an appropriate tool to investigate the unexpected death of a CF member but only, in my view, in situations when there is absolutely no alleged or apparent connection with duty. One example may be in a case in which a member is killed in a motor vehicle accident while on vacation. In instances like these, unexpected deaths of members not engaged in CF duty will likely be investigated by civilian police forces. If the CFNIS are called in to review all unexpected CF deaths, as recommended above, I am confident that their initial inquiries will quickly determine whether or not there is any connection between the death and CF duty. Often this will be done by contacting the police force and the coroner / medical examiner investigating the death. In such instances, where it is clearly shown that there is no nexus between the death and duty, an SI is an appropriate tool to ensure next of kin are advised of all the benefits to which they are entitled and to deal with other administrative issues arising from the death.

758 Conversely, if any credible evidence emerges that may connect the death with the CF, such as, for example, a fatal vehicle accident involving a member driving from a CF establishment to his or her home, then a BOI is the appropriate vehicle to investigate the death.

759 Convening a BOI in these circumstances should not be too onerous on the system in terms of resources. BOIs do not necessarily have to be lengthy or resource-intensive. They can be tailored according to the circumstances. Furthermore, we understand that, thankfully, deaths on duty are relatively infrequent occurrences.

4.3.3 Review of the Summary Investigation

760 QR&O paragraph 21.15(3) states: "The convening authority and any other authority through whom the minutes [of the SI or BOI] are transmitted shall record on the minutes his concurrence in or opinion of the report, findings or recommendations." Further direction on the responsibility of review authorities requires them to point out any errors, omissions or shortcomings in the investigation.

761 In May 1992, the staff officer for Administration and Personnel of 1 Canadian Brigade Group Headquarters offered suggestions as to issues the SI should highlight or investigate. The completed SI was then forwarded to LCol Lapeyre, who approved the SI Report in substance on June 25, 1992. While LCol Lapeyre added other comments regarding safety policies and the administrative action he had taken, he was silent regarding the SI investigator's finding that MCpl Wheeler was responsible for his own death.

762 LCol Lapeyre's comments were then forwarded to 1 CBG, where the Commander, BGen Ashton, concurred with the comments and recommendations made by LCol Lapeyre. In turn, these comments were forwarded on to the Commander of Land Force Western Area, MGen deFaye. MGen deFaye approved the SI Report, yet he expressed concern that MCpl Wheeler did not react to the approaching APC, stating "the weather and visibility were good, although I note his hearing category was H3." He recommended that final disposition of the SI await the autopsy report, which was to be forwarded upon receipt. On August 26, 1992, the file arrived at the Directorate of Personnel Legal Services and, on July 14, 1993, the SI was approved on behalf of the CDS.

763 MGen deFaye explained to my investigators that he believes the review process ensures an SI is conducted properly. He stated that the system of "checks and balances" allows a young, inexperienced officer to conduct such investigations, since experienced officers then oversee and approve them. MGen deFaye also explained that each review level is responsible for implementing the recommendations within its authority.

764 Based on our review of the SI and the approval process, it appears that substantive shortcomings in the investigation were overlooked. The "checks and balances" to which MGen deFaye referred, in fact, failed. Instead of

"experienced officers" catching the errors of an inexperienced officer, a faulty SI travelled from investigating officer to Commanding Officer, to Brigade, to Area Commander, and to DPLS, at which time it was approved. No real questions appear to have been asked, let alone answered.

765 Our investigation into the review and approval process revealed the following areas of concern:

766 • the request of the staff officer for Administration and Personnel of 1 CGB Headquarters for further information on the Enemy Force Controller's location, prior to the SI's completion, was ignored;

767 • LCol Lapeyre's summary of the SI Report he approved omitted the finding that MCpl Wheeler was partly responsible for his own death, but LCol Lapeyre did not explain this difference, nor did any subsequent reviewers comment on it;

768 • BGen Ashton, Commander of 1 Canadian Brigade Group, concurred with the SI's comments and recommendations, but did not refer to the finding that MCpl Wheeler bore partial responsibility;

769 • while MGen deFaye, Commander of Land Force Western Area, commented on deficiencies in exercise planning and supervision, no further investigation examined this issue;

770 • MGen deFaye's concerns about MCpl Wheeler's lack of reaction, despite clear conditions, also went unheeded;

771 • some of the recommendations were not implemented at the levels at which they could have been implemented;

772 • none of the review authorities questioned the appropriateness of the choice to investigate the death by way of an SI;

773 • none of the review authorities raised any concerns about the potential conflict of interest resulting from the investigation being done in-unit;

774 • none of the review authorities dealt with the possibility that the SI investigator may have felt constrained by investigating a peer, or considered the possibility that he might have limited the investigation into the activities and involvement of superior officers; and

775 • none of the review authorities caught the error in interpreting the regulations that led to the erroneous finding of responsibility against MCpl Wheeler.

776 As part of the process in place today, all deaths of CF members are reported to the Director, Casualty Support Administration (DCSA), who is also responsible for reviewing all SIs and BOIs into deaths and serious injuries. As previously mentioned, in one case of which I am aware where the parent unit did not intend to conduct an SI, DCSA ordered one. When, on review, the SI appeared to inadequately address the issues raised, the Assistant Deputy Minister (Human Resources – Military) convened a BOI on the recommendation of DCSA. The widow of the deceased CF member in that case informed my investigators that, after seeing a summary of the SI report, which she felt left questions unanswered, she also urged the CF to better investigate her husband's death. In another case, an accidental death originally investigated by SI was reinvestigated by a BOI convened by the Vice Chief of the Defence Staff, but only after the Chief of the Defence Staff was contacted by a lawyer hired by the parents of the deceased.

777 Only one of the two re-convened investigations – the BOI convened by the Vice Chief of the Defence Staff – had been completed at the time of writing this report. I was able to review both the Summary Investigation and the Board of Inquiry into the incident in question. Based on a preliminary review of the two investigations, I am able to say that the BOI explored a number of issues that were not considered by the SI.

4.3.4 Other Militaries

778 We looked at how other militaries investigate fatalities that occur on duty. In particular, we examined how the Australian, the British and the Dutch armed forces deal with such issues.

Australia

779 The Australian Defence Force (ADF) provided an interesting example for a number of reasons. The ADF is roughly comparable to the CF in terms of size and structure; both have their roots in the British military system; both have participated in peacekeeping and peacemaking operations; and both have recently engaged in combat operations.

780 The Australian Parliament recently reported on military justice procedures in the ADF,[1] and a departmental inquiry (the Burchett Inquiry) reported on the same subject.[2] A third inquiry was recently launched in the Senate, into the effectiveness of Australia's military justice system, including the ability of the military justice system to produce impartial, rigorous and fair results; its capacity to be open, transparent and publicly accountable; and the way in which the ADF conducts "inquiries into the reasons for peacetime deaths in the ADF (whether occurring by suicide or accident), including the quality of investigations, the process for their investigation, and implementation of findings."[3]

781 The Parliamentary report was authored by the Joint Standing Committee on Foreign Affairs, Defence and Trade as a result of concerns expressed in Parliament over the military investigations process, particularly when loss of life is involved. A significant proportion of the report touched on the investigation of accidental deaths of ADF members in peacetime situations. The Parliamentary Committee heard 30 witnesses and received submissions from over 80 individuals and organizations. The Committee made 59 recommendations, 45 of which were related to the conduct of military inquiries. The government supported all but two of the recommendations, in whole or in part, and committed to implementing 46 of the 59 recommendations.[4]

782 The Committee's most dramatic recommendation with respect to military inquiries was the suggestion that, during peacetime, the Minister of Defence should be required to convene a General Court of Inquiry (GCI) — a body wholly independent of the Minister and the ADF — to inquire into the accidental death of an ADF member participating in an ADF activity. That recommendation was not supported by the government.

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[1] Australia, the Joint Standing Committee on Foreign Affairs, Defence and Trade, *Military Justice Procedures in the Australian Defence Force*, tabled 21 June 1999. (Chapter 3 of the report deals with Military Inquiries.)

[2] Australia, *Report of an Inquiry into Military Justice in the Australian Defence Force*, submitted to Chief of the Defence Force Admiral Barrie, 12 July 2001 (the Burchett Inquiry).

[3] Australia, *Terms of Reference for the Foreign Affairs, Defence and Trade References Committee of the Senate*, Reference Number 114, Journals of the Senate, 30 October 2003.

[4] Australia, *Government Response To the Report on Military Justice Procedures in the Australian Defence Force by the Joint Standing Committee on Foreign Affairs, Defence and Trade*, March 2001.

783 Both in the Committee's Report and the government's response, it was noted that the Minister of Defence already has the discretion to appoint a GCI to inquire into matters affecting the ADF. The government felt it was important to retain the flexibility to permit internal investigations when warranted. It noted that, in addition to military investigations, local (state and territorial) coroners investigate peacetime deaths of ADF members. The government felt that a concurrent coroner's investigation ensures the military investigation is sufficiently rigorous and independent. The government did, however, commit to implementing some parts of the Committee's recommendations aimed at strengthening the role of local coroners with respect to the investigation of service deaths.

784 The Burchett Inquiry focused on the criminal side of military justice, but also dealt with related administrative issues. Some recommendations applied to administrative as well as criminal justice and focused on the need for greater transparency, not only in investigations, but also in the hearing process and in terms of the outcome of any procedures. The inquiry commented on the need for a mechanism to ensure that complainants and victims have standing at both administrative and criminal hearings in which they have an interest, and for providing them with information about "the true career effects" of administrative or criminal sanctions.

785 The inquiry was also specifically charged with determining the role of a new Military Inspector-General; it recommended that his or her functions should include overseeing administrative inquiries to ensure they comply with relevant guidelines, and to create and maintain a register of personnel qualified to carry out various types of inquiries.

786 In its response to both reports, the Australian government undertook to appoint a Military Inspector-General with the power to advise the Chief of the Defence Force on internal investigations and to initiate own-motion investigations into ADF activities. It also suggested that the Chief of the Defence Force or of any of the military branches advise the Minister of Defence on when a GCI is appropriate to investigate a service death. Ultimately, the government wanted the Minister to retain this discretion, but suggested the following criteria for when a GCI should be used instead of a BOI:

787 a. the presence of a serious national interest in the matters to be the subject of the inquiry; and

788 b. the likelihood that an inquiry by the Defence Force may be perceived to be biased because of the involvement, in the matters to be the subject of the inquiry, of the most senior officers of the Australian Defence Force.

789 Under Australian law, the local coroner must be informed of all accidental service deaths in Australia. The Committee recommended a more structured relationship between ADF investigators and local coroners, including requirements that coroners be called in immediately after a death; that they continue to be involved in what it termed "coronial deaths"; and that they be assigned a military liaison officer to assist with investigations. The government supported all of these recommendations.

790 The Committee also recommended that coroners not be prevented from conducting investigations on military land or property. The government agreed that coroners should be able to investigate military deaths occurring inside Australia during peacetime, and undertook to change certain regulations (which do not appear to have been commonly used) that allowed the military to bypass the coronial system. The Committee recommended that coroners be encouraged to determine whether there is the potential for criminal charges and to attribute degrees of responsibility for the incident. The government did not support this recommendation. It noted that coroners already have the authority to assign degrees of responsibility and did not wish to grant them powers with regard to military deaths that they did not have generally.

791 In addition to making recommendations, the two reports outlined the reasons for some of the changes suggested. The Burchett Inquiry discussed the fact that:

792 … some long running complaints against the ADF are likely to have been contributed to by an administrative failure to explain sufficiently, or at all, the nature of action taken.

793 The Parliamentary Committee commented on the need for thorough and independent investigation of military deaths. It made a number of valuable points, which I feel are relevant to this case as well. It noted the high costs associated with the need to re-investigate an incident that was not properly

investigated in the first place, and the fact that incomplete investigations almost inevitably led surviving family members to believe that the military was covering something up, possibly to protect senior officers involved in the incident or its investigation. In its response to the Committee's report, the government mentioned this mistrust — on the part of family members and the public — as a factor that should be taken into account in the Minister's decision to call for a GCI.

794 The Senate's inquiry was ongoing at the time of writing, but some of the presentations made before the committee have highlighted the current features of military inquiries in the ADF. General Cosgrove,[5] the Chief of the Defence Force, noted that detailed procedures were in place to guide the reporting and investigation of deaths, as well as notification and support to next of kin. According to Gen Cosgrove, suicides of ADF members are deemed to be related to duty, and are investigated accordingly. He reported that the army established a Directorate of Personnel Operations, whose responsibilities include managing the response to "all sudden deaths" and educating commanders about administrative investigations. Gen Cosgrove also pointed to examples of BOIs in which a conscious effort was made to be more open and transparent by appointing civilian BOI members, by opening the proceedings to the public, and by extensive public release of the BOI's reports.

795 The DND/CF investigations into the death of MCpl Wheeler perfectly illustrate the points raised by the Australian Parliamentary Committee. A cursory investigation immediately following the accident led MCpl Wheeler's family to believe that the military was covering something up. As a result, a BOI was called five years later, and some 12 years after the accident, the case was still being subjected to extensive internal reviews, with much distress to those directly involved including the Wheeler family.

[5] General P.J. Cosgrove, Submission to the Senate Foreign Affairs, Defence and Trade References Committee Inquiry into the Effectiveness of Australia's Military Justice System, 23 February 2004.

United Kingdom

796 The *Queens Regulations* (QR) (Army) that govern the United Kingdom's (UK's) Land Forces provides that:

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> A BOI is to be held following every unnatural death of, or serious injury to a Serviceman (or dependant or other associated person) occurring on Service property or in a service context, in the United Kingdom or abroad, unless, by exception, there is no need for such an investigation, for example after a straightforward traffic accident. (Queen's Regulations, Annex to Chapter 5, paragraph 15)

798 The QR provides that the BOI must start as soon as possible after a death. It also sets out a process by which the decision to call a BOI is made. The first step is for the Commanding Officer to determine if any disciplinary action is necessary. The CO then makes recommendations to a more senior officer as to whether a BOI should be held. This senior officer forwards recommendations to the Ministry of Defence, which makes the final determination. The Ministry must consider a number of factors before exercising discretion not to call a BOI, including:

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- Was the death or serious injury linked to any likely procedural or equipment faults or any other military failings that may require rectification to avoid a recurrence?

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- Does the MP report contain sufficient information for the chain of command to take all appropriate follow-up action?

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- Is any other form of inquiry being held (e.g., Land Accident Prevention and Investigation Team)?

802
- What other interests may be involved?

803 Clearly, the norm is to hold a BOI when a death occurs, with the onus on the decision maker to demonstrate reasons why a BOI has not been convened. We were advised that holding a BOI into a training death is almost automatic.

804 One of the most interesting developments has been the UK Army's creation of a Land Accident Prevention and Investigation Team (LAIT).

805 LAIT has a mandate to:

806 a. Investigate and report at the earliest opportunity the circumstances and causes of all fatal accidents and those which are potentially life threatening or have caused serious injury, as directed by Chief LAIT on behalf of Chairman Standing Committee on Training Safety.

807 b. Record and investigate as appropriate all other accidents which result in injury to military or civilian personnel on duty, members of the general public or which result in serious damage to equipment as a consequence of, or when traveling to or returning from, any military activity including Physical or Adventurous Training.

808 c. Scrutinize the Findings of Boards of Inquiry, Regimental Inquiries and Subject Matter Experts reports for all accidents, including vehicle accidents, to ensure that the right lessons have been drawn and acted upon.

809 d. Identify measures to prevent accidents and to make the appropriate and timely recommendations to the Chain of Command, through the Standing Committee on Training Safety.

810 The Chief of LAIT reports to the Chief of Staff at the Land Command, who is of Major-General rank and is also the Chair of the Standing Committee on Training Safety (SCOTS).

811 LAIT was stood up in 1995 after a series of British army training deaths at CFB Suffield. It is, according to team members, unique, insofar that they believe no other military has a similar system. LAIT has conducted approximately 1,100 investigations to date.

812 LAIT is staffed by retired senior army officers and has very broad mandate to look at an incident. According to its terms of reference, LAIT does not ascribe blame: its primary goal is to make recommendations to minimize recurrence; it is not involved in any criminal or internal discipline aspects of an investigation.

813 According to different estimates, the British army suffers between 100 and 140 non-combat deaths per year, of which approximately 10 involve training incidents. LAIT is called to all fatalities involving a member in a training

context; it is not called to suicides or off-duty private motor vehicle deaths. It works in tandem with coroners, Health and Safety Executive officials, and civilian police, Ministry of Defence (MOD) Police and Royal Military Police (RMP).

814 LAIT staff are on call 24 hours a day. LAIT's stated goal is to respond anywhere in the world within 24 hours, and anywhere within Europe within 12 hours. LAIT investigators advise that a scene is frozen until they arrive. They have access to Subject Matter Experts from both within and outside the military, as required.

815 However, LAIT investigators do not take formal statements and they use informal investigative techniques. They state that they are allowed complete access to all military and civilian police statements, and have sat in on some civilian police and RMP interviews. They have a mandate to report within four weeks of an incident, although the report will not be released without the consent of the criminal investigative agency if a criminal investigation is ongoing. They also meet with families of the deceased and explain their findings.

816 LAIT also plays a central role in the BOI process. Its reports are provided to BOIs and their investigators will give evidence at BOIs, as required. They report directly to SCOTS on whether their recommendations have been addressed and on "what progress has been made towards the holding of a BOI, where appropriate." LAIT members advised us that a BOI would certainly have been called into the circumstances of MCpl Wheeler's death, had that scenario occurred in the British army.

817 The chain of command views LAIT as a way of dealing with the increasing number of claims against the army as a result of accidents, in the belief that ensuring all the facts are brought out enables better assessment of the merits of any given claim. Accordingly, LAIT's terms of reference were widened in 2001 to permit the team to review less serious accidents. In the words of Major-General Viggers, the Chairman of SCOTS, this was necessary

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> [t]o provide information in support of and to refute the multitude of claims for compensation which are beginning to arise as we move into an ever-increasing litigious society …

819 On this point, I believe one reason the DND/CF must carefully review its processes for investigating fatalities and accidents causing serious injuries is to eliminate the need for families to have to resort to litigation to get the answers they need and deserve.

820 It is clear that the investigators investigating the 2002 training accident at CFB Petawawa identified and dealt with training issues that arose from the incident, and that the investigative process is much improved since 1992. Furthermore, the number of training fatalities sustained by the CF may not justify the creation of a new agency. That said, LAIT brings an element of independence and expertise to the investigation of serious training incidents. I believe it may be worthwhile to explore if there are other ways of achieving the same goal. To that end, I invite the Chief of the Defence Staff to review the LAIT process to explore instituting a similar process or adopting elements of the process here.

The Netherlands

821 Two developments have arisen in the investigation of military-related fatalities by the Dutch. The first concerns an investigation conducted by the Royal Netherlands Army (RNA) into a training fatality that occurred in Bosnia in 2001. The second involves the Dutch government's initiative to add civilian oversight to the investigation of fatalities in the Netherlands Armed Forces, which is currently before the Dutch Parliament.

822 On May 8, 2001, a Dutch soldier on a crowd-control training exercise at Bugojno, Bosnia was run over and fatally injured by an RNA Armoured Recovery Vehicle. Three other soldiers were injured. In accordance with the policy in place at that time, a BOI was conducted under the auspices of the RNA's Occupational Health and Safety Service.

823 The BOI did not attend the scene until 21 days after the incident. It interviewed key witnesses 22 and 35 days after the incident. Other interviews did not take place until 42 days after the incident. The BOI reported in April 2002. There appear to have been some concerns raised over the report and the way that the family of the deceased had been treated. There was media coverage of the case.

824 The Secretary of Defence asked the Inspector-General of the Netherlands Armed Forces to conduct "a more detailed, independent investigation" to determine whether "the defence organization had acted adequately and, in regards to the family, appropriately in all respects." The investigation covered a wide range of issues related to the accident, including the instruction and training of those concerned, the accident itself and the process by which the accident had been investigated.

825 The Inspector-General also investigated how the family of the deceased had been treated by the chain of command, with particular attention to the accuracy of information provided to the family. The Inspector-General's report, in June 2003, was critical of the way the BOI was conducted. It noted that the BOI had not attended the scene as soon as possible, that BOI members made no records of their interviews with witnesses and that there were delays in finalizing the report. The report made a number of recommendations, including:

826 • that a BOI travel to the scene sooner than was done in this case;

827 • that local commanders instruct witnesses to prepare statements as soon as possible after the incident;

828 • that a BOI should make detailed records of all interviews; and

829 • that a BOI should issue informal interim reports, presuming that the final report will take a long time to complete.

830 The Dutch Parliament is in the process of setting up a Safety Investigation Board (SIB) to investigate major accidents in both the public and private sectors, including, but not exclusively, military accidents. I am advised that it is anticipated the SIB will be functioning in the near future. It will report directly to Parliament and receive its budget from the Ministry of the Interior and Kingdom Relations.[6] It will report annually to the Chairpersons of both Houses of Parliament. Its mandate includes the investigation of major accidents in both the public and private sector, including the investigation of fatal accidents that occur in the Netherlands Armed Forces. For example, the

[6] The information concerning the SIB is taken from a document entitled "Main Points Memorandum, Independent Accident Investigation," by the Independent Disaster and Accident Investigation Project, September 14, 2001.

SIB anticipates investigating accidents involving military aircraft. It can investigate on its own initiative or when requested, but retains discretion to decline to investigate.

831 The SIB will be governed by a Board made up of five "qualified civilians," recruited "amongst persons including professors, high-ranking experts from the public administration, authoritative representatives from the private sector and legal professionals." They will serve a four-year term, renewable once. The SIB will have its own staff of permanent investigators and on-call experts. It will collect data and look for trends.

832 Under the proposed legislation, the SIB must be notified of major accidents immediately; failure to do so will be an offence. An Order in Council is being created to designate those responsible for making the notification. The SIB will have powers to subpoena witnesses and to take evidence under oath. It will have a right of entry into premises, other than private dwellings; the right to records and documents; and the power to collect samples.

833 The SIB will conduct a parallel investigation but will not interfere with criminal or disciplinary investigations. It is not clear how it will co-exist with existing Netherlands Armed Forces investigation and review mechanisms, but from conversations with the Netherlands Armed Forces Inspector-General, I understand that the SIB is expected to have precedence in any investigation in which it becomes involved. Indeed, the intent seems to be that the SIB will conduct exclusive investigations involving the Netherlands Armed Forces. The document referred to above notes that any existing or new Netherlands Armed Forces investigating mechanisms "will refrain from an investigation to learn from any occurrence under investigation by the Board." However, the SIB indicates it intends to use experts from the Netherlands Armed Forces to assist in the investigation of accidents involving military members.

834 At the conclusion of an investigation, the SIB will make recommendations to the appropriate person or authority since the SIB will not investigate only military accidents, other Ministers may be involved, such as the Transportation Minister for a civilian airplane accident. The Minister for the

relevant sector will report on implementation of the recommendations to the Lower House of Parliament. The Act will stipulate the period of time that parties have to respond to the recommendations and require written reasons why any recommendations have not been adopted.

4.3.5 Discussion and Recommendation

835 Studying these models can be helpful, even when the needs and means of meeting them may be different in the context of the CF. These models represent the best practices for investigating unexpected deaths and other incidents. I believe the DND/CF should study them, with a view to identifying features which will work well in the Canadian Forces, and learning from the experiences of other militaries.

836 As the former Officer Commanding, CFNIS Sensitive Investigations Detachment told my investigators, "it should never be the case that [DND] relies on a summary investigation only for fact finding [in a death]." My investigators were repeatedly assured that, today, an accident such as the one that killed MCpl Wheeler would be investigated by the CFNIS and a BOI. However, whatever the practice may be, there is no formal order or directive that makes this mandatory. In fact, there is nothing in the regulations now in place to prevent an accidental death from being the subject of an SI or to require anyone other than the Base MP detachment to be notified; neither is there any formal mechanism to prevent an officer who may be implicated in an incident from participating in its investigation.

837 As noted earlier, the SI into MCpl Wheeler's death was not independent. Convening a BOI made up of senior officers from outside the unit may do much to allay any suspicions family members may have that the process is anything other than fair. Even an ostensibly straightforward death of a CF member may have widespread ramifications that may not become apparent until the full facts are brought out into the open. I feel requiring a BOI to investigate unexpected, duty-related deaths is justified due to the gravity of any death of a CF member. A BOI is the most efficient tool that CF has at its disposal to maximize the chances of the full facts being brought into the open. Surely, if it is a suitable mechanism to investigate the loss of a parachute, a BOI should be the only option in the unexpected death of a CF member while pursuing his/her duties.

838 **I therefore recommend that:**

839 **3. The CF amend the applicable rules and/or regulations to provide that it is mandatory to convene a BOI to investigate unexpected non-combat deaths.**

840 I am pleased to report that the CF has accepted this important recommendation and will be amending regulations and directives accordingly.

5 Investigative Training

841 More precisely though, had I received any formal training in the conduct of the board? No. One is expected to be self-taught, I would say is probably the best way of putting it. The regulations are all there. They are accessible. I was provided a legal advisor to interpret the regulations, but that would be the extent of it.

— Col J.J. Selbie, President, BOI, 1997

842 The ARB found significant defects in both the SI and the BOI, as did my Office's investigation. These defects included: flaws in the conduct of the BOI; failure to call relevant witnesses; a lack of procedural fairness in failing to allow LCol Lapeyre to fully participate in the inquiry; and conclusions that were not supported by the evidence.

843 The ARB focused on the training of investigators as a remedy. It noted that the DAOD 7002 series provides guidance on the basics of procedural fairness for investigators, but emphasized the need for training in the fundamentals of procedure and investigations.

844 The ARB recommended that:

845 The Army should consider the provision of further training in the conduct of investigations.

846 I am fully in agreement with this recommendation.

847 The CLS accepted this recommendation and, in his covering letter submitting the ARB to the CDS, noted that a pilot Administrative Investigator Qualification course had been conducted in March 2003. We are advised that the course began to be offered on a permanent basis in the fall of 2003.

848 I have reviewed a draft of a training plan that was developed by Land Force Doctrine and Training System (LFDTS) Headquarters / Directorate of Army Training (DAT) to instruct CF members in how to conduct administrative investigations.[7] I understand this training plan is being used in the Administrative Investigator Qualification course.

[7] Training Plan, Administrative Investigator Qualification, 20 February 2003.

849 The training plan's stated aim is to "prepare Army personnel to perform the duties of an administrative investigator and properly review any type of administrative investigation as an administrative authority and/or a convening authority." Candidates for the course must be officers or NCMs of the rank of sergeant or above (this reflects the qualifications for the composition of a BOI, under QR&O 21.08), and their attendance must be recommended by their CO. The training plan includes segments on:

850 • how to conduct investigations;

851 • how to organize investigations;

852 • how to process evidence;

853 • how to analyse evidence; and

854 • how to finalize investigations.

855 The course content includes instruction on different types of administrative investigations, including investigations into allegations of harassment, SIs and BOIs. It discusses the principle of procedural fairness, and covers drafting terms of reference; preparing and planning questions; interview techniques; and obtaining documentation, as well as other investigative steps.

856 It has been decided that the course, originally planned to take between five and ten days, will be five days long. It can accommodate a maximum of 16 students in four "syndicates" (study groups), although the preferred number of students is 12. The senior instructor will be of the rank of major or captain, while the syndicate instructors will be of the rank of sergeant or captain.

857 Successful completion of the course is noted as a qualification on a member's file, which facilitates selection of appropriately trained investigators. However, no guidance has yet been put in place instructing convening authorities to ensure that members appointed to a BOI have successfully completed the Administrative Investigator Qualification course.

858 Australia in particular has recognized the need to train members of its armed forces to conduct investigations, partly as a result of public outcry over a series of incidents in 1997 and 1998, in which it was alleged that recruits were assaulted under the guise of informal disciplinary measures.

859 The report of the inquiry into military justice in the ADF (the Burchett Inquiry) noted that:

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> This Inquiry found that a pivotal factor in many of the submissions alleging unfair treatment [in administrative inquiries and investigations], which it received, was the poor quality of some report undertaken by an Investigation Officer. A complaint about the outcome of an Inquiry was often the result of an inappropriate choice of investigative vehicle or an inappropriate choice of investigator. Too often the investigator lacked experience or could be seen to be affected by an actual or potential conflict of interest.

861 The report's recommendations focused on the summary trial process, which is disciplinary in nature. However, it also emphasized the need to educate officers of all ranks about the principle of procedural fairness, through such means as annual awareness training on military justice issues. These principles are applied not only to disciplinary hearings, but also to BOIs and other administrative investigations in which a person stands to be adversely affected by decisions based on the findings of an investigation.

862 In 1998, the Australian Commonwealth Defence Force Ombudsman, at the request of the Chief of the Defence Force, conducted an extensive investigation into how the ADF responded to allegations of serious incidents and offences.[8] In reviewing the training of investigators, the report noted that:

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> The lack of experienced investigators and the inadequacy of training in investigations means that investigators do not always grasp the real issues … There is a need to provide better training to officers …

864 The Ombudsman identified a number of serious flaws in administrative investigations, including: inadequate planning; failure to interview all relevant witnesses; pursuing irrelevant issues; failure to record evidence appropriately; and failure to conduct an objective analysis of the evidence. The Ombudsman recommended:

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[8] *Own motion investigation into how the Australian Defence Force responds to allegations of serious incidents and offences: Review of Practices and Procedures*, Report of the Commonwealth Defence Force Ombudsman pursuant to section 35A of the Ombudsman Act 1976, January 1998.

> **865** the ADF develops a training strategy for officers who conduct investigations under the DIRs [Defence Inquiry Regulations] …
>
> **866** that officers should not be appointed to conduct investigations under the DIRs unless they have received training, or they have other experience or expertise which makes them suitably qualified to do so [and] …
>
> **867** substantial changes to the guidance on the investigation of serious offences and incidents. Because of the difficulties experienced … in the past five years, I am also recommending that the guidance on such investigations be revised to provide advice to Commanding Officers and Investigating Officers on how to plan and conduct investigations.

868 The Ombudsman also noted that the Royal Australian Air Force was "moving toward a centrally controlled and specially trained group of investigators to deal with both disciplinary and administrative investigations."

869 In response to these recommendations, the ADF contracted with a university to conduct a three-week training course to train investigating officers.

870 The Parliamentary report by the Joint Standing Committee also reviewed the question of military inquiries. It looked at a wide range of issues, including the training of BOI members. It suggested that the selection of an investigator in serious and/or sensitive cases should depend, not only on training, but also on experience, noting that officers should not be appointed in such cases "unless they possess a level of experience appropriate to the type of investigation to be conducted." The Parliamentary Committee also noted that officers involved in BOIs were not receiving adequate training, but acknowledged that "prior to the commencement of proceedings it is normal for a BOI to have a long period of instruction from legal officers."

871 The current (at the time of writing) Senate inquiry into the effectiveness of Australia's military justice system was also examining inquiries into peacetimes deaths in the ADF, and how they are investigated.

5.1 Analysis

872 The CF's Administrative Investigator Qualification course provides an excellent introduction to the basics of investigations and will prove effective in training CF personnel how to investigate relatively minor issues. It is a positive step that demonstrates the CF's determination to improve the quality of investigations.

873 However, I am not convinced that the course can be anything more than a part of the solution to preventing a recurrence of the errors made in the 1997 BOI. The course provides only the basics of the investigative process and procedural fairness; it is extremely short, especially when considering the amount of material covered, and it appears to be geared toward junior officers and senior non-commissioned members. Moreover, it does not focus directly on procedural fairness and issues that almost inevitably arise in high-profile, serious and/or complex BOIs. For example, the segment of the course devoted to "Procedures and Methods Applicable to Administrative Investigation" (which includes SIs, BOIs and investigations into allegations of harassment) comprises two 40-minute lessons.

874 It is important to remember that the purpose of procedural fairness is to ensure that those potentially affected by the findings of an inquiry have a meaningful opportunity to participate — the more complex and more serious the issues, the higher the degree of procedural fairness that should be afforded. Denying an individual basic fairness can make the whole exercise appear unfair and flawed, tainting even the most justified of conclusions.

875 When former Chief Justice Antonio Lamer conducted his review of the amendments to the *National Defence Act*,[9] he examined the type of training that would be appropriate for Assisting Officers for summary trials. His report recommended a general training course, followed by an exam and delivery of materials that could be reviewed to refresh the AO's memory. In my view, a similar approach is warranted for BOI training.

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[9] *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 Acts, as required under section 96 of Statutes of Canada 1998, c.35*, submitted to the Minister of National Defence 3 September 2003.

876 I would suggest that one way to approach this training would be to conduct it much the same as is done to qualify summary trial Presiding Officers at present. Articles 101.09 and 108.10 require that all superior officers, COs and delegated officers in the CF must be trained in the administration of the *Code of Service Discipline*, and certified by the JAG as qualified to perform these duties.

877 To attain this qualification, officers must complete a 20-hour self-study package available on the JAG Web site, and then take a threshold knowledge test, again available on-line. They are then required to attend a two-day Presiding Officer Qualification Course, taught by qualified legal officers and conducted at various locations and times across the country. Qualification is valid for four years, at which point a re-qualification is required. The re-qualification process is also fairly simple: officers can either take the Presiding Officer Re-Certification Test, available on the JAG Web site, or attend the two-day Presiding Officer Training Course again. I believe that developing a similar package for training BOI presidents and members, based on the classroom basic / self-administered refresher model, would not be that difficult. The basic course already exists, and can be modified to better address the needs of more senior officers, who are more likely to be involved in investigating deaths. It can also be modified to include more information on procedural fairness. The refresher course can be available on a web site, but should be delivered by an expert to members of a BOI before they undertake an investigation into a death. The package could also contain refresher material and updates on such topics as investigative principles, procedures and lessons learned from other BOIs.

878 Ideally, the president and all members of the BOI would have successfully completed the basic course, prior to being appointed to a BOI, particularly one into a death. If this is not possible at a minimum at least one of the members should have completed this course. As I have noted in a previous report dealing with Boards of Inquiry[10], the BOI process is a complex and important undertaking, which can have significant impact on members of the Canadian Forces. There is no reason to believe that the gains that make education programs worthwhile in other instances, such as summary trials and harassment investigations, would not also accrue in the case of BOIs. In

[10] *Special Report: Ministerial Directed Investigation: Review of Board of Inquiry Examining Serious Injury* (submitted to the Minister of National Defence on August 23, 2004)

that previous report, I recommended that the CDS issue a directive that absent exceptional circumstances, each Board of Inquiry must include at least one member who has completed approved training, and that where this is not possible, the reasons why and the steps taken to include a trained member must be furnished by the convening authority. I acknowledged that this may pose logistical challenges and additional cost. I noted however, that what cannot be overlooked in any cost/benefit analysis of such a recommendation is the cost to the reputation of the Canadian Forces for arguing that the expense of training is not worth paying, for routinely using untrained members to conduct BOI's, or for defending the system on the grounds that Boards of Inquiry are ordinary decision-making exercises calling for ordinary levels of skill that require no training. In the case of a BOI dealing with a death, in my view the significance and gravity of the subject matter warrant taking my recommendation with respect to training further, to ensure that – at a minimum – one board member has always received formal training, and that all board members receive at least some training in the form of the refresher package immediately before the BOI.

879 Once the BOI is convened, the president and all of the members would review the refresher training package under the guidance of a legal or investigative advisor. It may even be possible to tailor the refresher package to deal with specific issues which are likely to arise in the upcoming investigation. The refresher package would ensure that all BOI members, including those who may not have received the full training, will at least have a basic sound understanding of the principles of procedural fairness and of the investigative process fresh in their minds as they being their work.

880 I appreciate that there will be some instances in which a BOI is required to begin its investigation so urgently that it is impossible to deliver the refresher package prior to the BOI commencing. In those, undoubtedly very rare, cases, the refresher package should be provided as soon as possible, and it should be made clear to Board members that their overall investigation will be held to the standards detailed in the package.

881 I realize that creating and delivering a training package will require time and resources. I believe this is a worthwhile and cost-effective investment for three reasons. First, as this case demonstrates, significant resources will be saved by making sure the inquiry is done properly and fairly the first time. Second, cases such as these are very serious, and have potentially very

serious consequences for the individuals and family members involved. Third, a properly conducted BOI is more likely to identify systemic shortcomings and make recommendations to prevent a recurrence of similar incidents in the future.

882 **I therefore recommend that:**

883 **4. CF regulations and orders concerning SIs and BOIs be amended to require at least one member of any BOI convened to investigate a death to have completed a training course in investigative techniques and procedural fairness.**

884 **Prior to the start of a BOI convened to investigate a death, the president and all members of the BOI receive a refresher training package, which should focus on procedural fairness and investigative principles.**

885 The CF agreed, in its response to this recommendation, that those conducting BOIs "must have the competency to do so." The CF stated that it "intends to go further" by conducting a major review of the entire BOI system "with a view to improving the effectiveness and efficiency of the BOI process." I applaud this initiative and look forward to reviewing the results.

5.2 Provision of Specialist Investigative Advice to BOIs

886 I believe that, in addition to the training recommended above, BOIs involving a fatality or serious injury require specialist investigative expertise to guide them. By specialist investigative advice, I mean a member of or advisor to the Board, who can guide members on the proper conduct of investigations.

887 Clearly, both the MP investigation and the SI into the accident that claimed MCpl Wheeler's life were flawed, because they did not follow basic investigative principles. Many of the problems with the BOI may have been avoided had the BOI members had the guidance and assistance of a person with significant investigative experience, such as a senior police officer with a background in major criminal investigations. Such a person could have provided Board members with advice and guidance on investigative issues throughout the inquiry process. He or she could have ensured that all investigative avenues were fully explored and all potential witnesses were

given an opportunity to give an account of what happened. He or she could have also assisted the Board with regard to investigative techniques, evidence gathering and evidence processing, scene visits, investigative aids and a number of other areas likely unfamiliar to Board members.

888 The Land Accident Prevention and Investigation Team (LAIT), which investigates training deaths and serious injuries that occur in the British army, has an investigator from the Special Investigations Branch of the Royal Military Police (RMP) permanently attached to it. This person is an officer. His or her role is set out in LAIT's terms of reference as follows:

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> The principle function of the SIB is to advise the members of LAIT on all matters regarding evidence handling and protection. The post holder is also required to provide the interface between LAIT and RMP, the Home Department and MOD [Ministry of Defence] Police, Health and Safety Executive and any other investigative agencies.

890 The Special Investigations Branch officer deploys with the LAIT investigators and provides advice and guidance, not only to the LAIT investigators, but also to the Royal Military Police officers responsible for the criminal investigation.

891 In my view, for the purposes of the CF, specialist investigative assistance to the BOI could be from within or outside the DND/CF. A civilian specialist would be a sign that the DND/CF truly embraces openness and transparency, and would be in keeping with the growing trend to add a civilian element to military investigations, as is the practice in the Netherlands and to an extent in the UK. Outside expertise may also increase the confidence of family members that the process is objective and neutral, and ultimately lead to fewer allegations of "cover-ups" and less recourse to expensive litigation.

892 The circumstances of each case would determine whether or not the investigative specialist would sit as a member of the Board, although I anticipate that would only occur in truly exceptional circumstances.

893 **I therefore recommend that:**

894 **5. When there has been a death, the convening authority appoint a person with expertise in the conduct of complex investigations of serious incidents to assist the BOI members.**

895 The CF has agreed with this recommendation and it will be included in the CF review of the entire BOI system.

Families of CF Members Who Die On Duty

6 Treatment of the Wheeler Family

6.1 Notification of Mrs. Wheeler

896 Mrs. Wheeler complained about the way in which she was notified of her husband's death. While she understands that there were mitigating factors, she believes the Canadian Forces (CF) could have handled the situation more sensitively and compassionately.

897 Master Corporal (MCpl) Wheeler was pronounced dead at 10:53 a.m. Mountain Standard Time on April 7, 1992. Lieutenant-Colonel (LCol) Lapeyre, the Battalion Commanding Officer (CO), contacted his Adjutant in Winnipeg. He informed him of the accident, and directed that MCpl Wheeler's next of kin be notified. LCol Lapeyre did not return to Winnipeg until April 8, and was therefore unable to inform Mrs. Wheeler in person. However, on his return to Winnipeg, he visited Mrs. Wheeler and expressed his condolences.

898 The Adjutant told my investigators:

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> As the Adjutant on that particular exercise that occurred in Suffield, I was on rear party back in Winnipeg. Immediately thereafter, I became engaged. In fact, I got a call from the Commanding Officer, Lieutenant Colonel Lapeyre, explaining the situation and the gravity of the situation in terms of the seriousness and given immediate instructions to ensure that the next of kin was notified. I called in the Padre [chaplain] to assist in that matter.

900 Every member of the CF is required to complete a Personal Emergency Notification (PEN) form upon enrolment and it is then their responsibility to update it as their personal circumstances change. Its purpose is to ensure that, when a member dies, is injured, becomes seriously ill or is missing, the

appropriate person is notified. This form normally identifies two people, referred to as the primary and secondary next of kin. The member then indicates which of the two to contact in case of an emergency. Although there is provision to identify a third person as the emergency contact, the majority of members identify a primary and secondary next of kin, and the primary next of kin is usually their emergency contact. A copy of the PEN form is kept in the Unit Personnel Record, located in the unit headquarters, and in the Unit Employment Record, which is the responsibility of the employee's immediate supervisor.

901 My investigators were unable to obtain a copy of MCpl Wheeler's PEN form from 2 PPCLI. Therefore, I cannot confirm who was listed as his primary and secondary next of kin or his emergency contact.

902 The Adjutant told my investigators that, on retrieving MCpl Wheeler's Unit Personnel Record, which contained a copy of his PEN form, he discovered that Mrs. Wheeler was not listed as the primary next of kin. He stated

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> … we had some difficulties finding out where the next of kin was. The first thing that we had to do after calling in the Padre was trying to find the next of kin form which we normally keep on the inside of our personnel files. So we brought that down and unfortunately she was not listed as the next of kin at the time.

904 However, the Adjutant made the decision to contact Mrs. Wheeler based on his belief that she was the proper person to be notified. Time was also a consideration, since the accident had been reported in the media in Alberta and it was believed the media in Winnipeg would pick up the story fairly quickly. In attempting to find a current number for Mrs. Wheeler, the Adjutant contacted her place of employment, hoping that they could provide a current number for Mrs. Wheeler. He told my investigators:

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> But through a number of contacts, we were able to find out, I think, in some other correspondence where she had worked ... so we had some problems. We did happen to track down where she had worked, the place of employment. So I got engaged because it was already in the media out in the west and Colonel Lapeyre said we absolutely — it had to just be a matter of minutes or hours before the story hit Manitoba, and we wanted to make sure that they were called.

906 Upon reaching Mrs. Wheeler's office by phone, the Adjutant was connected directly to her office, notwithstanding that he had not requested to speak to her. She answered the phone.

907 Mrs. Wheeler recalled the phone call for my investigators:

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> I was at work that day and I got a phone call. It was [the Adjutant] who phoned me. My understanding is that he was supposed to have been speaking with my boss to — rather than speak to me directly, to have me put into an office or, you know, sort of taken out of the work environment. They were to be notified so that they could wait for the Padre to come and sort of keep it from me until they had to.

909 Although he had not expected to speak directly with Mrs. Wheeler, the Adjutant identified himself, and advised her that there had been an accident involving her husband and that a chaplain had been dispatched to talk to her:

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> [My conversation with Mrs. Wheeler was] very brief. She asked me why I was calling and I said well it is a serious matter and the Padre I guess will be coming around. If you have been in the military for a while, you know that this is not good news. She wouldn't have known at that time whether it had been a death, an injury or something else. All she would know is something bad had happened to her husband.

911 Mrs. Wheeler, a military spouse of some seven years, knew that, whatever the chaplain was going to tell her, it was not going to be good. She told my investigators that she had asked the Adjutant for more information, which he declined to provide.

912 At that point, according to Mrs. Wheeler, one of her co-workers took the phone. The co-worker was also married to a CF member and understood the implications of Mrs. Wheeler being contacted. The co-worker identified herself to the Adjutant and tried to get further details. According to Mrs. Wheeler, the Adjutant would say nothing other than there had been an accident and a chaplain was on the way. Having confirmed Mrs. Wheeler's address, the Adjutant dispatched the chaplain to advise her of the accident. She indicated that waiting for the chaplain to arrive was excruciating and that the uncertainty only added to the anxiety. In her words,

913 > ... it seemed to take forever for the Padre to arrive. That whole — I could have done without that length of time from the phone call to the waiting, because everything imaginable and then some went through my mind.

914 Mrs. Wheeler estimated it was 45 minutes from the time she received the phone call to the arrival of the chaplain. When the chaplain did arrive, he informed Mrs. Wheeler of her husband's death and left shortly afterwards. Mrs. Wheeler stated that she could not remember the chaplain providing any significant support during his brief visit. She describes herself as very disappointed with his conduct.

915 The chaplain was apparently not accompanied by anyone from her husband's battalion, although Mrs. Wheeler did recall he may have had a driver with him. The only other individual Mrs. Wheeler could remember being present was her co-worker's husband, a sergeant serving with 2 PPCLI at the time, who arrived directly from work at about the same time as the chaplain. She had no recollection of the presence of a senior officer, or anyone else for that matter, from her husband's chain of command.

916 The Adjutant cannot recall sending anyone with the chaplain:

917 > I did not go. The Padre went and I am just wondering if we sent someone else, and I can't recall if we did or not. Normally, we like to do that, though, to give assistance to the Padre.

918 Mrs. Wheeler remembers little from that point until approximately 10:00 p.m. She cannot recall having had any contact from the military after the chaplain left her place of employment at approximately 3:45 p.m. until that time the assigned Assisting Officer (AO), arrived at her residence.

6.2 Analysis and Recommendation: Notification of Mrs. Wheeler

919 I understand that, in this case, notification of the next of kin was complicated by a number of factors. The accident occurred while most of the battalion was off Base, having left only a small rear party in Winnipeg. It was this small rear party that had to handle the notification. MCpl Wheeler's PEN form was not up to date, which meant that the Adjutant had to locate Mrs. Wheeler.

Finally, during his attempts to locate Mrs. Wheeler, the Adjutant was unwittingly connected directly to her on the phone and therefore found himself in a situation in which he had to give her some explanation as to why he was trying to contact her.

920 Even though he was removed from the situation due to the battalion's deployment to Canadian Forces Base (CFB) Suffield, LCol Lapeyre's initial response was correct as required by Canadian Forces Administrative Order (CFAO) 24-1. This regulation governs the procedure for notification of a member's next of kin in the event of his or her death or serious injury.

921 Paragraph 15 provides that "…a member's commanding officer is responsible for notifying the PEN contact in the quickest and most appropriate manner."

922 Paragraph 16 provides that:

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> … the main objective in reporting a casualty is the prompt and sympathetic notification of the PEN contact, avoiding morbid details but including sufficient information to assure the PEN contact that they are not deprived of significant details.

924 LCol Lapeyre instructed his Adjutant to inform MCpl Wheeler's next of kin, as designated by his PEN form, of the accident.

925 Based on his knowledge of MCpl Wheeler's personal circumstances, however, the Adjutant knew that the information on the PEN form was out of date and, exercising his discretion, made the decision to locate Mrs Wheeler, since he believed she was the correct person to be informed.

926 Had the PEN form been up to date, it would have identified Mrs. Wheeler as the emergency contact and provided the required information on how to contact her, both at her residence and place of employment. This would have enabled the Adjutant to immediately dispatch the chaplain to her place of employment, ensuring she was informed quickly and in person.

927 Paragraph 18 of CFAO 24-1 provides:

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> The initial notification to the PEN contact shall be made in person and should be conveyed by a Chaplain or Clergyperson of the appropriate faith.

929 However, the Adjutant first had to locate Mrs. Wheeler: this introduced an unneeded delay in the process, and left Mrs. Wheeler with the feeling that the system had failed her when she needed it most. When he contacted Mrs. Wheeler's last known place of employment, he was unfortunately connected directly with her. As a result of this unforeseen circumstance, the Adjutant was then put in the position of again having to make a difficult decision, either to advise her over the phone of what had happened or to tell her that a chaplain was being dispatched. CFAO 24-1 provides guidance in this area as well.

930 Paragraph 19 provides:

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> If the PEN contact or NOK [next of kin] inquires about the status of a member before official notification can be made, the CO or the CO's representative should inform the PEN contact or NOK of the member's condition during the course of the conversation. Notification should be made as compassionately as possible and the PEN contact or NOK should be told official notification will follow.

932 Advising someone of the death of a spouse by phone is not the preferred course of action in most cases. In this case, the Adjutant decided that it was more important that Mrs. Wheeler hear about her husband's death face-to-face rather than over the phone. As a result, he informed her that a chaplain was on the way to see her, which took approximately 45 minutes.

933 I understand that, as operational tempo has accelerated, the Departure Assistance Group system for all major out-of-country deployments has also evolved, and stresses the requirement for all members to review their PEN forms prior to deployment. Of course, the Departure Assistance Group process applies only to members being deployed "on a mission to an area of operations," and does not apply to routine training or exercises. However, given the nature of military training and exercises, I believe the need to keep PEN forms updated should be stressed at all times.

934 CFAO 26-18, which took effect in 1978, provides that the PEN be completed on enrolment by a CF member and kept up to date as circumstances dictate. It also states that, twice yearly, an entry shall be made in unit routine orders "to ensure members are made aware of this requirement."

935 Although this regulation makes it the member's responsibility to ensure their PEN forms are kept up to date, it also assigns some responsibility to the member's unit to ensure they do so.

936 While I agree that a member must be responsible for keeping the PEN form current, this responsibility should be shared with the unit. After all, the unit is ultimately responsible for proper notification in the event of an accident and will need this information readily available. Updating the forms should be viewed as part of the unit's obligation: the importance of ensuring correct and up-to-date information is available for timely and sensitive notification cannot be over-estimated. Timely and sensitive notification of the family in a time of crisis is certainly worth the additional time and resources required. In some circumstances, a quick check of forms could be done electronically, either on an annual basis or routinely, whenever a member notifies the CF of a change in family status, such as when they get married or divorced. The notification of family members in a time of crisis will set the tone for their relationship with the CF as they deal with their grief and, later, when they have to deal with administrative issues. If done impersonally or insensitively, this notification not only can aggravate an already painful and shattering experience, but it can also irreparably damage the relationship between the family members and the CF, and turn what should be a supportive relationship into an adversarial one.

937 I believe the unit must take every step possible to ensure the direction in CFAO 26-18 is followed. I encourage all units to ensure that PEN forms for each member are up to date prior to any major training activity or lengthy out of area deployment. In addition, units should routinely ensure that their members review their PEN forms on a yearly basis. This is not an activity that people normally like to think about or engage in. It is normal to expect that a regular reminder or impetus would be in order. Should the unspeakable happen, the importance to the surviving family is clearly evident to all and is worth the extra minutes such a regular check and update might take. In order to minimize logistical efforts and expense the yearly review of PEN forms could easily be coordinated with other regular yearly activities such as the annual Personnel Evaluation Report – this would not add significantly to such processes. I do not believe that most members would be opposed to this, and would readily acknowledge and accept the importance of such an exercise.

938 **I therefore recommend that:**

939 **6. Each unit ensure that all members review their PEN forms on a yearly basis, and prior to any major training activity or lengthy out-of-area deployment.**

940 In the departmental response to the Interim Report, the CDS agreed with this recommendation, stating: "This is currently common practice. Members are also reminded, on a regular basis, of the importance of updating PEN forms via Routine Orders. Moreover, an annual reminder will be included in members' pay statements."

941 While an annual reminder in members' pay statements is a good start, I do not see how this will improve the situation. As noted there is already a requirement to remind members of the need to ensure PEN forms are updated in routine orders. However, it is clear that routine reminders do not work. Routine reminders are easy to ignore. Even members who heed the reminder and determine to review their PEN forms are likely to assign a low priority to the task, and can easily forget their plan to review the form.

942 For these reasons, I believe that there should be a periodic, formal occasion when members are presented with their PEN forms, and asked to either confirm that the information is current, or make the necessary changes. I had suggested that the annual PER would be an opportune time for this process, but department officials maintain that this would detract from the purpose of the PER. As a result, I am not recommending a specific occasion for the PEN form review, but I do believe that, whenever it occurs, it should be a formal review during which the member is presented with his or her current PEN form and asked to confirm its accuracy or update the information.

6.2.1 Chaplain Support

943 It is difficult to know exactly what transpired between the chaplain and Mrs Wheeler, as my investigators were unable to either identify or locate him. They could find no record of who he was; neither could the Adjutant or Mrs. Wheeler recall his name.

944 However, Mrs. Wheeler has a clear recollection that the chaplain was not supportive. She was upset with the perfunctory way she feels he dealt with her and it is this memory that remains with her.

945 The chaplain's lack of familiarity with the unit may have influenced the quality of the interaction between himself and Christina Wheeler. Had he been the unit chaplain, or even been given some background on MCpl Wheeler and his family by the Adjutant, he might have been better prepared to provide support to Mrs. Wheeler.

946 I am pleased to note that the CF has developed training to assist chaplains in the delicate task of notifying next of kin of a death. My investigators interviewed a former CF Chaplain General, who advised that notification of next of kin is a very important part of the training now conducted as part of CF Chaplain training at CFB Borden.

947 The parents of the private killed in the 2002 training accident at CFB Petawawa stated that the chaplain who notified them of their daughter's death was, in their words "outstanding" and showed exceptional compassion, honesty and helpfulness. As they told my investigators:

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> We had just moved to Halifax, we didn't know anybody. The Padre stayed with us until eleven o'clock that evening [the evening they were notified] and he took over making all of the arrangements to get us flights to Ottawa, trying to get information from the Commanding Officer of 2 CER [Combat Engineer Regiment] at the same time … Eleven o'clock that night, he left. He wanted reassurance that we were fit to be alone, you know, with the knowledge that we didn't have any family or close friends near by.

949 I applaud the initiative to train chaplains to deal with sudden deaths and hope it will continue. It is important that any chaplain assigned the task of notifying a member's next of kin of their death be as prepared as possible to provide more personal and meaningful support to the family.

950 While I fully appreciate that time is of the essence when unexpected deaths occur, the chaplain should be from the same unit as the deceased member or, if that is not possible, have as much background information on the member as is practical in the circumstances.

951 It would greatly help family members to have someone with whom they can identify, if only by the uniform he or she wears, during their time of grief. A chaplain from the unit in which the deceased member served will know, or should be able to find out, at the very least, basic information about the family (such as children, ages, special needs, basic information on the circumstances of the death and religious considerations) and will also be aware of any support mechanisms available in the local community and from the unit. This familiarity is needed to begin a supportive relationship, since the chaplain attached to the unit will likely continue to remain a source of support throughout the funeral and afterwards, as family members deal with returning to their daily lives. If the chaplain is not from the unit, he or she should have, at a minimum, some personal information about the member, as well as information about support services.

952 If the chaplain dispatched to inform Mrs. Wheeler of her husband's death had had this type of information, he might not have seemed to her to be so indifferent, and may have been able to make a world of difference to a bereaved family trying to deal with shock and grief.

953 **I therefore recommend that:**

954 **7. The CF put in place direction to ensure that, when notifying a CF member's next of kin of a death, the assigned chaplain is from the deceased member's unit or, if that is not possible, is given as much background information as is available about the member.**

955 In their response, the CF agreed with this recommendation, noting that it will revise regulations to specify that the chaplain come from the deceased's unit, whenever possible.

956 I am also very pleased to note that the CF has created a Working Group to review the entire casualty administration process. I understand that the Working Group will be drafting a CF-wide policy on casualty administration, with a view to improving the treatment of the families of deceased CF members. I am hopeful that this review and the resulting policy will address many of the recommendations set out in this section of my Office's report.

6.2.1.1 Use of Appropriate Personnel to Notify Family of Death

957 Based upon statements to my investigators from both Mrs. Wheeler and the Adjutant, no one from MCpl Wheeler's chain of command accompanied the chaplain when he visited Mrs. Wheeler to inform her of the accident. The only other individual present was the husband of a co-worker who, although a member of 2 PPCLI, was there as a result of a phone call from his wife, rather than officially representing the battalion. Someone from MCpl Wheeler's chain of command, preferably a senior officer, should have accompanied the chaplain, to not only express condolences but, more importantly, to indicate to Mrs. Wheeler that her husband had been an important part of his unit.

958 The Adjutant discussed the notification with my investigators. He stated that:

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> … it is quite regrettable and that is something that we did not handle the way that we would normally like to handle these things … normally, particularly if the Commanding Officer would be in town, we would find out where they are working and a senior representative, usually the Commanding Officer, if available, with a padre, would go set up an appropriate time, an appropriate venue to visit to break the news.

960 I cannot emphasize strongly enough the significance of the presence of a senior officer to a member's primary next of kin when they are notified of a member's death. Although some may perceive this to be mere "window dressing," in my view, the presence of a senior officer sends a very important message — that the deceased was a valued part of the CF whose sacrifice has not gone unnoticed. The lack of one sends exactly the opposite message.

961 The CFAOs are silent as to the rank of person who notifies the next of kin of a death. There is no requirement for an officer, senior or otherwise, to accompany the chaplain when such notification is to be made. Lack of direction in this regard may create anomalies, whereby next of kin are treated differently depending on different circumstances.

962 For example, when four soldiers were killed in Afghanistan in 2002, the CF ensured that the next of kin were personally informed of the deaths by senior officers, including in at least two instances by General Officers. The CF is to

be applauded for the way it handled this incident: having senior officers make personal notifications is a tangible sign of respect to both the families and the deceased.

963 However, I am concerned that notifications are done on an *ad hoc* basis and that any formal orders appear to be limited to specific operations. For example, Section 205, paragraph 10 of the Standing Orders for the Task Force deployed to Bosnia-Herzegovina states:

> **964** ***Notification of Next of Kin:*** Initial notification of NOK [next of kin] should be conveyed personally by the OC [Officer Commanding] of the unit rear party accompanied by a chaplain or clergyman. Assistance from the CF unit/base nearest the PEN contact should be requested when necessary. Units shall advise all addressees as soon as possible after NOK have been notified, if not already indicated in the initial casualty message.

965 Maritime Forces Atlantic (MARLANT) has recently issued a detailed directive to deal with notification of next of kin when members are killed in action. These guidelines provide that:

> **966** On receiving notification of death to a member [killed in action], the following tasks shall be completed:
>
> **967** a. Comd [Commander] MARLANT [a rear-admiral] will personally inform the next of kin of the death of a family member. The Comd will be accompanied by a Chaplain and, if possible, a friend of the family;
>
> **968** b. an Assisting Officer will be assigned immediately to be responsible for the administrative details. The Assisting Officer shall receive a briefing from MCS [MARLANT Customer Services Officer] or MARLANT SSO PERS POL [Senior Staff Officer Personnel Policy] on their duties and responsibilities;
>
> **969** c. Chaplain of the appropriate religious denomination will ascertain the wishes of the NOK concerning religious services. The Assisting Officer will ensure that arrangements are completed for a military funeral, subject to the concurrence of the NOK to be coordinated by the Base Chief; and

970 d. the family will be afforded complete support of the Formations Helping Professionals, including but not limited to the MFRC [Military Family Resource Centre], Chaplains, Social Workers, SISIP [Service Income Security Insurance Plan], VAC [Veterans Affairs Canada] Counsellors.

971 While the MARLANT directive is excellent, it is limited to combat casualties in a theatre of operations. A death has a profound impact on the next of kin, regardless of the circumstances, and this should be reflected in policies that ensure that, regardless of the cause of the death, the next of kin are treated with the same respect and sensitivity.

972 I appreciate it may not always be possible to have a General Officer immediately available. I also understand the importance of informing the next of kin before they hear of a death through the media, which might override other concerns. Furthermore, the next of kin might live in a different part of the country, making it impractical for someone from the member's unit to inform them of the death. But, wherever possible, the most senior officer available should make the notification.

973 **I therefore recommend that:**

974 **8. The most senior CF officer available, accompanied by a chaplain, personally inform the next of kin of the death of a member who has died unexpectedly.**

975 The departmental response was to agree with this recommendation, noting that "CF policy is that the deceased member's Commanding Officer shall accompany the chaplain to inform the NOK. In instances where it is not practical or possible for the Commanding Officer to advise the family, the chaplain shall be accompanied by the most senior officer available." I am pleased that this response reflects the essence of what I am recommending, however, it does not deal with the fact that I have been unable to find – and the department has not pointed me towards – a CF-wide directive or order which makes this mandatory. I believe the policy must be put in a Forces-wide order or directive of sufficient prominence that it would be one of the first sources of information accessed by someone in charge of notifying the next of kin. Until this happens, unfortunately it may still be possible for some families to slip through the cracks.

6.2.2 Immediate Support after Notification

976 On April 7, 1992, Mrs. Wheeler was left on her own by the CF from approximately 3:45 p.m. to 10:00 p.m., when the Assisting Officer and a second chaplain arrived at her residence. It is unclear how Mrs. Wheeler got from her place of work to her home after being informed of MCpl Wheeler's death. No one from the CF, that I am aware of, offered to assist her in those first few hours. Mrs. Wheeler had two small children at home, whom she had to tell about their father's death. She also had other family members to deal with. She needed assistance then and there. It was not forthcoming. In fact, she was abandoned by the CF for several crucial hours.

977 In my view, the CF should make every effort to ensure that the next of kin receive tangible support in the immediate aftermath of being notified of a death or serious injury. Unlike many civilian families, a significant number of military families do not live in close proximity to relatives and therefore cannot rely on their immediate support in these circumstances. Therefore, that responsibility falls to the CF. In many cases, the Assisting Officer provides this support; however, in some instances, such as this one, the Assisting Officer is unable to reach the family immediately. In such circumstances, the CF should coordinate and, where necessary, provide interim assistance to the next of kin. This assistance could involve dealing with transportation, assistance with meal preparation, coordinating child care and so on.

978 The next of kin should not be abandoned or left to fend for themselves. There is a need for written guidelines that will ensure any immediate needs are met when required, and that the CF takes measures to deal with the immediate concerns of the next of kin, prior to an Assisting Officer taking charge.

979 **I therefore recommend that:**

980 **9. The CF put in place direction and guidelines that ensure that the next of kin of deceased members are given whatever immediate assistance they may require after notification.**

981 The CF agreed with this recommendation and is working on a guide designed to aid Assisting Officers. This guide will clearly set out that next of kin will be provided with whatever immediate assistance they may require after being notified of the death.

6.3 Notification of and Support to MCpl Wheeler's Father

982 In his letter to the Minister of National Defence dated May 5, 1992, Mr. Wheeler made two complaints about the way he had been treated in the aftermath of his son's death. They were:

983 • the military had failed to notify him of his son's death; and

984 • that he was ignored by the military in the days after the death, in particular as far as funeral arrangements were concerned.

985 In his letter, Mr. Wheeler complained that it was his daughter-in-law who informed him of the death of his son, not the military:

986 > Apparently I was on my son's information sheets to be contacted. However, I recently moved and he didn't change my address on the forms. We were advised the military was unable to find us which is totally unacceptable. Therefore, they called my daughter-in-law four hours later and asked her to call me, which she did. So, as you can see, there was a total lack of concern for myself or my daughter-in-law at that time. I don't have to tell you she could hardly speak let alone inform me of the details.

987 CFAO 26-18 requires that every member of the CF complete a PEN form identifying their next of kin and providing for an "emergency contact" they want contacted in case of accident or death. CFAO 24-1 gives guidance on the notification of any secondary next of kin. My investigators were unable to obtain the latest unit copy of MCpl Wheeler's PEN form, and I cannot therefore identify exactly who was listed as his primary and secondary next of kin, or his emergency notification contact. However, on the PEN form retained at headquarters, MCpl Wheeler had indicated his father as the secondary next of kin, and he appears to have been treated as the secondary next of kin by 2 PPCLI and the DND/CF.

988 Paragraph 22 of CFAO 24-1 provides:

989 > Notification to other than the PEN contact shall not be made through military channels unless, in the opinion of the CO, such action is warranted. Factors to be considered are:
>
> **990** a. the difficulty in locating the PEN contact;
> **991** b. the benefits to be derived by the casualty;
> **992** c. a recommendation by a Chaplain or a medical, welfare or legal officer; or
> **993** d. a request by the PEN contact.

994 Mrs. Wheeler told my investigators that, on the day of the accident, she indicated that she wished to contact her father-in-law personally to advise him what had happened, which she did, and she accepts responsibility for having made that decision.

995 I understand that, after Mrs. Wheeler had broken the news, the Assisting Officer called Mr. Wheeler to advise him of funeral arrangements. Mr. Wheeler advises that he received no further direct contact from 2 PPCLI after that. In the immediate aftermath of his son's death, he received no official expression of sympathy from anyone in the CF. Since then, any information he received about his son's death was in response to his efforts or as the result of his daughter-in-law's requests that he be included.

6.3.1 Analysis and Recommendations

996 The CF followed Mrs. Wheeler's express wish as the primary next of kin by allowing her to be the one to inform her father-in-law of his son's death. The PEN form allows a member to designate primary and secondary next of kin, as a back-up. Both are usually close relatives, and there is an argument to be made that the CF should treat them in the same manner; they deserve the same respect and consideration.

997 It may not be practical to treat all secondary next of kin in the same manner in every case. Much depends on the family of the deceased, geographical location, availability of resources and other factors, including family circumstances. For example, in the Wheeler case, I believe it would have been both practical and desirable to have had someone from the CF make a personal visit to Mr. Wheeler to express condolences on behalf of the CF.

Although geography would have made it impractical for that person to have been from 2 PPCLI, I do not believe that it would have been unreasonable for a significantly senior officer from the nearest CF Base to have made that visit. Wherever possible, secondary next of kin should be shown the same respect as the primary next of kin.

998 Earlier, I recommended that the most senior officer available, accompanied by a chaplain, be the one to personally notify the primary next of kin of the death of a CF member. I believe this practice should be followed as far as practical for secondary next of kin as well. If it is not practical for someone from the member's unit to visit the secondary next of kin, a senior officer should be dispatched from the nearest CF establishment to express condolences on behalf of the CF and the country. Personal notification in such circumstances would not require significant resources, as service deaths are relatively rare.

999 The same arguments that apply to providing personal support for the primary next of kin can also be made for the secondary next of kin. An impersonal or insensitive first contact, or lack of contact entirely, can set the stage for an ongoing adversarial relationship because family members feel they have been treated poorly. In the time immediately after a death, personal support and assistance is a sign of respect to the deceased and provides a sense that the CF supports family members in their time of most need. A clear procedure for notifying secondary next of kin and providing them with support, if warranted, would also take some of the responsibility and pressure from the primary next of kin, who are often overwhelmed. In assessing whether personal notification of the secondary next of kin is necessary, the CO should take into account the wishes of the primary next of kin. In situations in which the CF does not personally make the notification of secondary next of kin, however, an officer of appropriate rank should make a follow-up visit immediately after notification to offer condolences, support and assistance. This should be done by a senior officer from the member's unit, if practical, or by a senior officer from the nearest CF establishment, as soon as possible after the death.

1000 **I therefore recommend that:**

1001 **10. CF policy be amended to require the commanding officer of the deceased member's unit to assess whether or not secondary next of kin should be notified personally by a senior officer. This assessment should be made in consultation with the primary next of kin where practical.**

1002 The CF agreed "in principle" with this recommendation, noting that the CF "must follow the member's wishes as specified on the PEN form." The CF also agreed that notification of secondary next of kin should be discussed with primary next of kin at the time of notification, and agreed to amend its casualty administration directive accordingly. The CF Working Group on Casualty Administration will also review the PEN form to make sure that it specifies that secondary next of kin are informed if primary next of kin are not immediately available.

6.4 Liaison with Mr. Wheeler

1003 Mr. Wheeler complained that he was not allowed any significant input into funeral arrangements for his son. He stated in his letter to the Minister of National Defence:

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> During the entire week the only concerns shown on the part of the military was for Christina, and they hardly acknowledged Rick had brothers or a mother and father in Nova Scotia. Every time we voiced an opinion on decisions or arrangements we were told Christina was their only concern and because she was not capable of making decisions, they were being made for her.

1005 The Assisting Officer told my investigators that his primary responsibility was to respect and follow the wishes of Mrs. Wheeler as the primary next of kin, with regard to the funeral of her husband. He tried to accomplish this task while attempting to respond to the questions and concerns of MCpl Wheeler's father.

1006 Mrs. Wheeler told my investigators that there was some miscommunication:

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> There were some mistakes made in communication and with the wishes of his parents out in Nova Scotia, and part of that, you know, I have to accept responsibility for that, because I let my friend do a lot of talking for me, and everybody wanted to protect me from any more than I had to deal with, and so they made some assumptions.

1008 The Assisting Officer advised my investigators that:

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> [Mr. Wheeler stated] that I was not compassionate towards the family. That I had made decisions, circumvented his authority as the father, i.e., stopping the movement of the remains of his son, not allowing the casket until he physically signed for the additional monies for the casket, the open casket, and there were a number of other incidents in which he had recalled. Those were the big ones. Those were the ones that he came out with both barrels, basically saying that I was not professional and did not take into consideration the family. Whereas, I explained to him on more than one occasion, as much as I sympathized with Mr. Wheeler, he was not the next of kin and the decision was that of Christina Wheeler and Christina Wheeler only. If he had a problem with the decisions he should discuss them with Christina and not me. They were her decisions. I only enforced her decisions.

1010 Mr. Wheeler's letter resulted in a Ministerial Inquiry, which I understand exonerated the Assisting Officer of any wrongdoing.

6.4.1 Analysis and Recommendation

1011 I recognize that using a term like "family" when discussing issues related to casualty support requires more in the way of explanation, since one cannot assume that a CF member will always be part of an intact, traditional nuclear family. In MCpl Wheeler's case, "family" included MCpl Wheeler's wife and daughters, his father and step-mother, and his mother. Since then, there have been other cases in which the CF has had to decide who is to be considered family for the purposes of casualty administration. This was one of the issues that arose after the incident in Afghanistan that resulted in the death of four soldiers from friendly fire; the Tarnak Farm Board of Inquiry (BOI) recommended that the CF undertake to define "family" in light of evolving

concepts of family. I understand that Director, Quality of Life is working on implementing the recommendation, which is being tracked by the Vice Chief of the Defence Staff. I believe this is a worthwhile enterprise and look forward to reviewing the results.

1012 The Assisting Officer's responsibilities were to ensure that the funeral was conducted according to the widow's wishes, and he accomplished this task. I believe that the problems perceived by Mr. Wheeler were the result of a number of factors: the physical distance between Christina Wheeler and Bill Wheeler; the natural shock and grief both were suffering, which may have led to breakdowns in communication; the Assisting Officer's attempt to balance the conflicting demands of the interested parties; and misunderstandings about the Assisting Officer's role.

1013 Many of these problems could have been pre-empted if Mr. Wheeler had had access to a contact whose primary role was to explain to him what was happening. Such a person could have facilitated communication between the CF and Mr. Wheeler on any number of issues that arose, including funeral protocol and the responsibility of the CF to the primary next of kin. In addition, this person could have dealt with any concerns that arose, including liaising with the Assisting Officer. This step would have left the Assisting Officer free to focus on assisting Mrs. Wheeler with the necessary arrangements.

1014 My investigators asked the Assisting Officer about the wisdom of having a person deal directly with close next of kin in these circumstances:

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> Hindsight being 20/20, that would have been of tremendous value. Somebody to explain the military situation to Mr. Wheeler and to explain to Mr. Wheeler that he was not in fact, in the driver's seat on this one. Also to provide a degree of compassion from the military because my dealings with him on both was from thousands and thousands of miles away. He would normally call me after the fact and he was very upset. It is difficult to deal with somebody who is in an emotional state. They lost their son, and not really truly understanding why decisions are being made.

1016 The experience in the case of the 2002 training death at CFB Petawawa shows that the CF has made significant process in assisting and supporting families in the aftermath of an unexpected death of a member. In that case, both

primary next of kin (mother and family) and secondary next of kin (father and family) were assigned an Assisting Officer. A total of four officers were tasked. Their main responsibility was to provide information and respond to the questions and concerns of the next of kin. My investigators interviewed both primary and secondary next of kin of the soldier killed at CFB Petawawa in 2002. Both families felt that this initiative worked very well, in spite of a few glitches at the beginning.

1017 One of the key lessons learned from the case of MCpl Wheeler is the importance of liaising with close family members other than the primary next of kin, in this day and age when the concept and makeup of family is diverse. Failure to do so may lead to friction between various parties who all feel a close connection with the deceased, and to a sense of resentment toward the CF if they feel ignored. The extent of family members who are to be provided with assistance should be governed by family dynamics and common sense, on a case-by-case basis. This approach appears to have worked well in the case of the 2002 training accident at CFB Petawawa.

1018 **I therefore recommend that:**

1019 **11. CF policy be amended to require that a Liaison Officer be assigned to provide support and assistance to extended family members in the event of the death of a CF member, up to or shortly after the funeral of that member.**

1020 I am pleased to report that the CF has agreed with the recommendation, and has undertaken that its guide for Assisting Officers will specify that as many Assisting Officers as necessary will be assigned, to provide support and assistance to extended family.

7 The Flow of Information between the CF and Christina Wheeler

7.1 Immediately after the Accident

1021 In an interview with my investigators, Mrs. Wheeler's Assisting Officer explained that:

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> … a widower or a widow is assigned an officer by the Canadian Forces to assist with the funeral, the movement of the remains, if there is a military honour guard and all of the financial aspects of having been killed in the line of duty — what are her entitlements in the system and those sorts of things.

1023 The Assisting Officer first attended the residence of Christina Wheeler at approximately 10:00 p.m. on April 7, and discussed the funeral service and burial arrangements with her. She described the information she was given immediately following her husband's death as sketchy:

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> It was — they basically drew a map with sort of two intersecting lines and just said that the APC was coming around a corner and they weren't able to see properly and that Rick had been in the way and that he had been run over. But no — you know, no more detail than that, and really that was essentially it.

1025 On the evening of April 8, upon his return to Winnipeg, LCol Lapeyre visited Mrs. Wheeler to offer his support and condolences. Christina Wheeler did not recall a great deal about his visit, but she told my investigators that he might have been the person who provided her with the rough sketch of the accident site. She recalled that LCol Lapeyre's wife also visited to sit with her and provide some support.

1026 Mrs. Wheeler told my investigators that, in May and June of 1992, as the Summary Investigation (SI) was being conducted, she "kept asking questions" but "kept getting really nothing back." She was under the impression that the accident was a case of her husband being "in the wrong place at the wrong time," but stated there were suggestions from non-official channels that indicated to her it might not have been as simple as that. Mrs. Wheeler did not provide specific details with regard to this informal

information, merely stating that "somebody would come and say that so-and-so had some information and, if I felt up to it, they wanted to talk to me about it." However, she said no one came forward with anything other than the offer of information at that time, and very few people visited her at all unless they were on official business.

1027 Mrs. Wheeler commented that she had found the silence very bewildering. She believed that, if the death had been the result of an accident, there should have been nothing to fear:

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> Those were the first stirrings of my starting to question the military and what they were telling me, and the non-information that I was getting … complete absence of anybody other than official representatives of the military come to do their business and then gone again, a complete absence of information other than "It was just a terrible accident" … That is all I knew for the longest time until, I think, 18 months later … — that is all I knew about the accident.

1029 The lack of any official policy about how to pass information on to the surviving family contributed to Mrs. Wheeler's suspicions. Her Assisting Officer focused his efforts on providing her with the practical information she needed after her husband's death. During his attempts to get information about the accident for her, he was told to wait until the investigation was completed and approved. The Assisting Officer told my investigators that, on more than one occasion, he brought Mrs. Wheeler's concerns to the attention of his CO, who responded that he was not withholding the information and that it would be released as soon as it was available. Without information from official sources, Mrs. Wheeler relied on rumours.

7.2 Summer 1992 to Fall 1997

1030 Mrs. Wheeler did not receive the MP investigation report until September 1, 1998, when BGen Ross sent it to her. The report included photographs of the accident site and statements by several of the witnesses. There was also a delay in getting the medical examiner's report, which was provided to her at the same time as the MP investigation; the medical examiner is a provincial official, and the request had to be made under Alberta access to information legislation, not through the CF.

7.2.1 ***The Summary Investigation***

1031 The Assisting Officer told my investigators that Mrs. Wheeler was aware that the SI was under way. However, he could not confirm whether she was ever officially informed of the process, since he was not directly involved in the SI. Mrs. Wheeler told my investigators that she had assumed that there was some kind of investigation being conducted, but she did not know what an SI was or what it entailed.

1032 Mrs. Wheeler was anxious to learn of the circumstances surrounding her husband's death. She stated that she frequently expressed her concerns to her Assisting Officer about the length of time it was taking to get any further information. She felt increasingly abandoned by the CF, and the fact she was receiving little or no concrete information from the CF fed into that perception.

1033 The SI into the death of MCpl Wheeler was completed at unit level on June 24, 1992. Mrs. Wheeler informally requested a copy of the SI Report. By this time, her Assisting Officer had been deployed overseas, and a new Assisting Officer had been assigned to Mrs. Wheeler. The second Assisting Officer informed her that the SI report was at the review stage and was shortly to be forwarded to National Defence Headquarters (NDHQ), at which time it would be released. He offered his assistance in making a formal request for the information to the Department of National Defence (DND), writing in a letter of July 27, 1992, "I can assist you in this area should you require it." Despite his offer of assistance, Mrs. Wheeler never received any information about the SI from anyone who was involved in the investigation. She was not briefed on the process or informed of the results.

7.2.1.1 The Résumé of the Summary Investigation

1034 On August 6, 1992, not having received any further information, Mrs. Wheeler made a formal request to DND under the *Privacy Act* for a copy of the SI Report. She was sent acknowledgement of her request on September 17, 1992 by the Deputy Privacy Coordinator at NDHQ, who advised her that her request could take four to six weeks to fulfil.

1035 In a letter to Mrs. Wheeler dated January 12, 1993, the Deputy Privacy Coordinator explained that the Privacy Act only permitted disclosure of personal information about individuals who had been dead less than 20 years to the executor or administrator of the estate for the sole purpose of settling the estate. The letter did not comment on the fact that Mrs. Wheeler was not the executor of her husband's estate but explained that ministerial discretion allowed for the provision of a résumé of the requested information to the deceased member's next of kin. The résumé, which was under three pages long, sketched out the purpose of the SI and gave a brief description of the training exercise and the accident. The SI Report is over 50 pages long, including appendices; it was not provided to her.

1036 The résumé provided to Mrs. Wheeler stated that the SI was conducted by 2 PPCLI. It briefly explained that the SI's terms of reference were to determine the cause of MCpl Wheeler's death, his duty status, whether anyone was to blame for his death and if his death was attributable to military service. It summarized the training exercise scenario and noted that MCpl Wheeler was acting as Enemy Force Commander. It explained that, prior to the attack, the Enemy Force was briefed on its battle plan, including the information that the Armoured Personnel Carrier (APC) would "move out of its hide in the river bed and stop at a pre-assigned position outside the village" and that the driver was supposed to fire his weapon and feign death. It described the battle developing "as planned" until the APC entered the village at 20 kilometres per hour, made a sharp left turn and ran over MCpl Wheeler:

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> The left track of the vehicle ran over Rick who had feigned death and was lying in the road. The driver never saw him. Medical attention was immediate and your husband was evacuated by helicopter to Medicine Hat Regional Hospital where he was pronounced dead by the attending physician.

1038 The résumé described the SI findings about factors that contributed to the accident. These included: "some confusion in the instructions given to the driver"; the lack of a crew commander, which was "contrary to Force Mobile Command Orders" and for which the Enemy Force Controller attempted to compensate by acting as a ground guide; the possibility that the speed of the APC and the reduced visibility afforded by the periscope was not appropriate, given the proximity to dismounted troops; and, finally, given

that all of the participants had been warned to stand up if they were in danger from an armoured vehicle, the possibility that MCpl Wheeler's hearing "may have contributed to Rick's failure to react" to the APC.

1039 The findings of the SI were summarized as follows:

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> The Summary Investigation concluded that your husband's death occurred as a result of the injuries he sustained when an Armoured Personnel Carrier drove over him. Your husband was found to be on duty at the time of the accident and his death was found to be attributable to military service. The investigation also concluded that responsibility for your husband's death could be attributed to negligence by Canadian Forces personnel, including your husband, for failing to adhere to established safety and training procedures.

1041 Aside from MCpl Wheeler, none of the people involved in the accident or the training exercise were named in the résumé. The résumé noted that the Commander, 1 Canadian Brigade Group had directed that safety standards be enforced and training only be conducted with adequate and qualified safety control staff. The Deputy Privacy Commissioner ended the résumé by expressing condolences and the hope that the explanation helped Mrs. Wheeler.

1042 Mrs. Wheeler told my investigators that she was appalled and shocked by the résumé. She was particularly distressed by the conclusion that her husband was partly to blame for his own death.

1043 The résumé also mentioned that MCpl Wheeler had been assigned a hearing category of H3 in 1986, which was the minimum acceptable category for his trade, and suggested that this may have contributed to his failure to react to the approaching vehicle. Mrs. Wheeler told my investigators that her husband had had a cold at the time, and she believed he had been wearing a helmet; as a result, she was concerned that he would not have been able to hear anything at all. She expressed to my investigators the anger and indignation she had felt at the notion that he could be held at all responsible:

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> And the fact that they attributed part of it to him — that really set me off. I was not happy with that at all. I wasn't going to accept that. I thought, if nothing else, I mean, I am going to get to the bottom of that and clear his name. I can't see how you could blame somebody for not stepping out of the way given the circumstances of this. It

> would be like saying, "You know, you shouldn't have stepped off the curb when that bus hit you, buddy, because you should have known that it was coming." It is ridiculous. That was the beginning of my attempt. It took me six years to get my official letter that said that he had been removed from blame.

1045 On March 8, 1993, the second Assisting Officer wrote to Mrs. Wheeler to inform her that there was still no news about the release of the actual SI Report. He apologized for not having contacted her sooner, explaining that he had been busy with preparations for his departure to the former Yugoslavia. He said that he had not received any further information regarding the SI, and assumed that it was still "tied up in Ottawa." He advised her to contact the Officer Commanding (OC) 2 PPCLI rear party or the rear party Adjutant if she needed any further assistance. Mrs. Wheeler told my investigators that she neither knew nor heard from either of the persons referred to by the second Assisting Officer.

1046 The second Assisting Officer's explanation about the SI still being "tied up in Ottawa" appears to have been correct. MGen deFaye, Commander of Land Force Western Area, had approved the SI Report on August 15, 1992; it was then sent to the next review level — NDHQ — on August 18, where the DPLS reviewed it on behalf of the Chief of the Defence Staff (CDS). This review continued until July 14, 1993, when it received final approval and was sent to Land Force Western Area for distribution to 1 Canadian Brigade Group and 2 PPCLI.

1047 On July 29, 1993, an edited copy of the SI Report was sent to Christina Wheeler. This was almost 16 months after the death of MCpl Wheeler, but two weeks after the SI Report was approved by the CDS. The report was accompanied by a very brief letter from the Coordinator of Access to Information and Privacy at NDHQ, who pointed out that both personal information and information received by DND in confidence had been withheld. Mrs. Wheeler described how frustrating it was to finally receive a copy of the report, only to find it had large sections removed, or severed:

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> It answered some questions, but it actually generated a whole other set of questions because of the information that was severed. It just made me question even more what was going on and why this

> information was severed and what it was that they were hiding, and why would they delete portions of it if they weren't hiding information.

1049 Mrs. Wheeler provided my investigators with a copy of the severed SI Report. Significant portions had been deleted, including the names of the APC driver and the Enemy Force Controller, and information about the administrative measures that had been taken against them.

1050 Mrs. Wheeler's first Assisting Officer told my investigators that he could not recall whether anyone had explained the investigative process or any of the findings to Mrs. Wheeler at any time prior to her receiving her copy of the report, or if anybody had guided her through the document when she finally received it. He said that Mrs. Wheeler had contacted him in an extremely emotional state after she had received the three-page résumé of the SI in January 1993, which suggests that it is unlikely that she had received any form of preparation.

1051 The first Assisting Officer was aware that the SI Report had been accompanied by a letter, but he felt that the letter was not sufficiently detailed to enable a reader to follow the report. He described the version of the report that Mrs. Wheeler received as follows:

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> I saw a copy that had been blacked-out so badly that it could not be read. It was not legible at all. That was the copy that was given to Christina … I have told her and other people have repeatedly told her, "don't worry, the investigation is coming. The report will answer all of your questions." Then you get it and you can't read it. It doesn't answer any of the questions or it doesn't answer all of the questions. This is what you have been led to believe will be the Holy Grail at the end, and it isn't.

7.3 Events Leading up to the BOI

1053 Despite problems getting information from official sources, Mrs. Wheeler continued to press the CF for information.

1054 Mrs. Wheeler told my investigators that, sometime in 1994, she received an unsolicited letter from an anonymous source: "It just came up in my mailbox. No return address, but somebody took a risk, I think, copying it for me and

sending it." The letter contained information related to the finding that her husband was partially responsible for his own death and cited CFAO 24-6 (Investigation of Injuries or Death), paragraph 29 (Blame). It informed Mrs. Wheeler that it was contrary to CF policy to find a CF member responsible for his or her own death or injuries, "unless they resulted from wilful disobedience of orders, wilful self-inflicted wounding, or vicious or criminal conduct." Mrs. Wheeler stated the information renewed her desire to clear her husband's name:

1055 > I just thought that if I had that kind of information I would be able to address the issue of his being blamed for the incident … So I used this little piece of paper, along with my request for his name to be cleared. I think it's pretty clear. He didn't wilfully do anything.

1056 Then, in October 1996, an article in the Calgary Herald, written by investigative reporter Bob Bergen, caught Christina Wheeler's attention. The article dealt with the death of a CF member at CFB Suffield during a live-fire exercise in 1995. His death was originally attributed to a grenade explosion. The investigation was re-opened and it was established that the soldier had been accidentally shot in the head before the grenade exploded. His CO was eventually convicted of two counts of negligence at a court martial and was demoted. It was largely due to Mr. Bergen's efforts that the truth came out and the accident was reinvestigated.

1057 The article encouraged Mrs. Wheeler to resume her search for answers to her questions; it also reinforced her suspicions about a cover-up in her husband's death. She contacted Mr. Bergen in November, 1996 to ask for his assistance. In her letter, she wrote:

1058 > Right from the beginning it has been difficult getting information about what really happened that day. Initially, it took the Attorney General's Office of Alberta five months to complete the autopsy reports and the official investigation report from the military took 16 months to reach me. Until the time the report was in my possession, I had only received some unsatisfactory verbal explanations and a summary letter.

1059 On February 23, 1997, the first in a series of articles about MCpl Wheeler by Mr. Bergen was published. It dealt with the accident itself and with Mrs. Wheeler's unsuccessful attempts to obtain a full

explanation of what had happened and why. Mrs. Wheeler told my investigators that, until that time, it had been extremely difficult to get anyone to listen to her who would "not write me off as somebody who was bitter and twisted by what had happened …" "The first person to not write me off was Bob Bergen … In fact, he was quite instrumental in my getting as far as the BOI," she said.

1060 On March 23, 1997, Mrs. Wheeler spoke to a former colleague of her husband's. The two had been put in contact by a colleague and friend of Rick Wheeler's. This former colleague had participated in the 1992 training exercise at CFB Suffield and had been narrowly missed by the APC seconds before it struck MCpl Wheeler. Mrs. Wheeler described their conversation to my investigators as follows:

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> His account to me of what happened that day was quite an eye opener, and I asked him to send me something in writing — as much as he felt that he could do without getting himself into trouble, you know, with his own job. And he sent me these maps, and this is the documentation that I used to send in my official request to hold a new investigation, based on his testimony.

1062 Mrs. Wheeler received the maps on April 3, together with a new diagram indicating the placement of people and equipment at the time of the accident. The diagram was drawn by a former colleague of MCpl Wheeler in 1997, based on his recollection of the day of the accident. It showed one of the exercise participants —the Enemy Force Controller — in a different position from the one he assumed during the re-enactment of the accident, which reinforced Mrs. Wheeler's suspicions of a cover-up.

1063 By 1997, Mrs. Wheeler had the following information about the circumstances surrounding her husband's death: a rough sketch of the accident site; a three-page résumé of the SI; a heavily edited copy of the SI Report; and communication from unofficial sources, including anonymous sources. This information was obtained as a result of either her own efforts (access to information requests) or the efforts of former colleagues of MCpl Wheeler. The scarcity of information communicated to Mrs. Wheeler through official channels led her to conclude that information was being withheld or manipulated.

1064 On April 1, 1997, Mrs. Wheeler was contacted by Maj Kaduck, who had been a captain in 2 PPCLI, the Officer Commanding Combat Support Company and the Friendly Force Controller during the training exercise in 1992. In 1997, he was the staff officer for Operations Plans and Training, reporting to the Commander of 1 Canadian Mechanized Brigade Group, BGen Meating.

1065 Maj (now LCol) Kaduck told my investigators that, after reading the *Calgary Herald* articles, BGen Meating had asked him to contact Mrs. Wheeler to find out "if she was actually unhappy and what she was unhappy about." Maj Kaduck had been given Mrs. Wheeler's number by her first Assisting Officer, with her permission. LCol Kaduck told my investigators that he believed BGen Meating had asked him because he knew he had been present on the day of the accident.

1066 With regard to the contact initiated by the CF, Mrs. Wheeler told my investigators:

1067 > That is the very first time that anybody from the military had sought me out for any reason, other than the initial first couple of weeks, and they wanted to talk to me. I guess they didn't like the press that was going out. They wanted to know what the problem was and what they could do for me.

1068 Mrs. Wheeler explained the stated reason for Maj Kaduck's call as follows: "He said the military had realized that they had not been as forthcoming as they should have been and what questions did I have." Accordingly, she identified a number of her concerns, including the following:

1069 - No one had been held accountable for the death of her husband.

1070 - There were what she described as "screaming contradictions" in the SI Report regarding, for example, the location of the Enemy Force Controller during the exercise and whether he was acting as a ground guide.

1071 - Her husband had been held partly responsible for his own death.

1072 • She was unable to obtain a copy of her husband's medical records.

1073 • Large sections of the SI Report that she received had been removed, which, as she told my investigators, made her wonder whether something was being hidden.

1074 Maj Kaduck told Mrs. Wheeler that the issue of the severed report was one of the things he had been asked to look at. He said that the CF had recently changed their way of "doing business," primarily as a result of the 1995 training death at CFB Suffield, and that there was no reason why she could not see the complete document.

1075 Mrs. Wheeler not only wanted her questions answered, but also requested an inquiry into the entire investigation and that people be held accountable. She informed Maj Kaduck that she knew of someone who could confirm what she believed to be the Enemy Force Controller's true location at the time of the accident. Maj Kaduck responded that, if she had the name of a witness who had new information that might be grounds for re-opening the investigation; he however did not ask Mrs. Wheeler for the name of the person who had given her the new information.

1076 Maj Kaduck told Mrs. Wheeler that her husband's medical records could probably be tracked down and it would be possible to let Mrs. Wheeler read an unedited copy of the SI Report. With respect to Mrs. Wheeler's request for "due process," he said he would have to look into the matter. He arranged to call her within a few days to report on the progress he had made.

1077 Meanwhile, Mrs. Wheeler believed that her concerns were not being taken seriously and so continued to seek information from her husband's colleagues. On April 20, 1997, at the suggestion of the former colleague of MCpl Wheeler who had recently contacted her, she spoke with the exercise photographer, who was still a serving CF member. He told her that the Enemy Force had been severely understaffed on the day of the exercise.

1078 The next time she contacted him, Mrs. Wheeler was informed by the exercise photographer that his unit's Adjutant had instructed him to put all her queries through the chain of command, which led Mrs. Wheeler to further suspect that information was being withheld and that the exercise photographer feared losing his job. However, he told my investigators that he was not concerned for his job when he spoke to Mrs. Wheeler in 1997. In addition, the exercise photographer's notes documenting his contact with Mrs. Wheeler indicate that going through official channels was consistent with standard practice.

1079 Mrs. Wheeler said that, on May 27, 1997, almost two months after their April 1 telephone conversation, she called Maj Kaduck. He explained that he had not contacted her earlier since he had been called away to Winnipeg on short notice and had therefore been unable to accomplish a great deal. As BGen Meating told my investigators, those two months were devoted entirely to disaster relief for severe flooding in Manitoba: "This is why this might not have moved as quickly [as it could have] in April, May and June of 1997."

1080 With regard to the medical records, Maj Kaduck explained that it normally took a long time for such records to come to their "final resting place" but thought they should be able to locate them at NDHQ.

1081 With respect to re-opening the investigation, Maj Kaduck explained that the response from NDHQ was that this could only be done if significant new evidence had come to light. When Mrs. Wheeler reiterated the point she had made previously concerning new evidence, Maj Kaduck advised her to write a letter to BGen Meating to inform him of the new information and to formally request the investigation be re-opened.

1082 Mrs. Wheeler told my investigators that, during their conversation, Maj Kaduck informed her of his belief that she already had the entire SI Report in her possession. She responded that several pages appeared to be missing from her copy, and that information had been severed from the pages that she did have. She commented, "When I challenged him on the severed portions, he felt that the rulings in the *Privacy Act* had changed, but that he would check into it. So he was just sort of dancing around the issues."

1083 Maj (now LCol) Kaduck confirmed to my investigators that, after speaking with Mrs. Wheeler on May 27, he inquired with the Judge Advocate General (JAG) about obtaining an un-severed copy of the SI Report for Mrs. Wheeler. He also forwarded Mrs. Wheeler's request that her husband be absolved of all blame. The response he received on June 10 was that, because the SI Report had been approved on behalf of the CDS, only the CDS had the authority to either re-open the investigation or to absolve MCpl Wheeler of blame.

1084 Maj Kaduck also contacted the Land Force Western Area's staff officer for Administration and Personnel, who informed him that if 1 Canadian Mechanized Brigade Group received a letter from Mrs. Wheeler, it should take her letter as a point of departure, conduct a detailed critique of the SI and forward that to Land Force Western Area.

1085 Mrs. Wheeler wrote to BGen Meating on May 28, 1997, requesting that the investigation into her husband's death be re-opened. She reiterated the concerns that she had expressed to Maj Kaduck on April 1. She also referred to her husband's impaired hearing and questioned why, if it was referred to in the SI Report, there was no follow-up: "How can you acknowledge a medical problem, attribute it to the reason Rick didn't react to the oncoming APC, turn around and blame him for not reacting, and not follow up on the medical report?"

1086 Mrs. Wheeler also informed BGen Meating that, according to the map of the accident site provided to her by the former colleague of MCpl Wheeler's, a copy of which she enclosed with her letter, there was a contradiction in the reported position of one of the exercise participants (the Enemy Force Controller).

1087 In an interview with my investigator, BGen Meating described Mrs. Wheeler's letter as "a plea, a cry in the wilderness." He stated: "I also show support for Mrs. Wheeler, a person who lost her husband on an exercise. She might have received an apology, although I don't recall that having been offered. She hardly ever received any information from anybody until she put this letter forward."

1088 Mrs. Wheeler also wrote to MGen Jeffries, Commander of Land Force Western Area, requesting that action be taken and the investigation be re-opened.

1089 LCol Kaduck told my investigators he had informed Mrs. Wheeler on June 9 that, if she made a request under the *Access to Information Act*, she would be able to obtain an un-severed copy of the original SI Report and a copy of her husband's medical records. He also told Mrs. Wheeler that her letter to BGen Meating had been received and was being staffed.

1090 Mrs. Wheeler told my investigators that on July 7, having already written to BGen Meating and MGen Jeffries, she decided to "triple [her] assault" by writing to then-Minister of National Defence, Arthur Eggleton. She explained to him her difficulties in obtaining information and expressed her disappointment in the edited copy of the SI Report she had received. In her closing comments, she appealed to Mr. Eggleton to see that justice prevailed and requested a Ministerial Inquiry.

1091 In a Victim Impact Statement written during the course of the CFNIS investigation, Mrs. Wheeler stated that, on July 17, Maj Kaduck had telephoned to inform her that, on July 10, a letter had been sent from BGen Meating to MGen Jeffries and BGen Ross (who was replacing MGen Jeffries as Commander of Land Force Western Area). The letter recommended that the investigation be re-opened and that MCpl Wheeler be absolved of all blame. Mrs. Wheeler was provided with a copy of the letter.

1092 BGen Meating told my investigator that, once he had started gathering information on MCpl Wheeler's case and putting it all into chronological order, he realized that he was faced with what he considered to be a flawed SI. He stated that he had MGen Jeffries' full support as he continued his inquiries. In July 1997, BGen Meating wrote to MGen Jeffries asking him to have the case re-opened.

1093 According to his letter, although BGen Meating was of the opinion that there had been no deliberate attempt to hide the truth, he was concerned that the SI appeared "insufficiently rigorous in its logic and findings." With regard to provision of information, he noted that his legal advisor had informed him that Mrs. Wheeler should now be able to obtain an un-severed version of the SI Report through an *Access to Information* request. He also expressed doubts that the administrative

action taken was appropriate or adequate. He commented that, although under the statute of limitations it was too late to take disciplinary action, there were "significant unanswered questions which cast a poor light on the administration of military staff procedures — questions that may warrant reopening the investigation." BGen Meating felt that it might be of some comfort to Mrs. Wheeler to see the matter "finally investigated in all of its aspects."

1094 In a letter to Mrs. Wheeler dated August 6, 1997, BGen Ross, who had just assumed his duties as Commander of Land Force Western Area, informed her that he had convened a BOI into the death of her husband. The BOI was to report by the end of October; BGen Ross undertook to meet with Mrs. Wheeler by November 30 at the latest, and review with her a copy of the completed report. He advised Mrs. Wheeler that he would probably be compelled by the *Privacy Act* to have personal information about some individuals severed. However, he added, that would not affect their ability "to discuss findings and recommendations in reasonably specific terms." The letter confirmed what he had communicated to Mrs. Wheeler by telephone earlier that day. In her Victim Impact Statement, Mrs. Wheeler wrote that, during the telephone conversation, BGen Ross had informed her that her husband should not be blamed for the accident and that the military had never properly investigated the incident.

1095 In a letter dated August 23, 1997, Mrs. Wheeler thanked BGen Ross for his prompt response and expressed her immense relief that someone was finally listening. She wrote: "You have lessened the weight of the burden I have carried alone during this time and I now have hope that justice will prevail." BGen Ross responded to this letter on September 5, 1997, enclosing a copy of the terms of reference for the BOI.

1096 On September 19, Mrs. Wheeler received a response to the letter she had sent to the Minister of National Defence, informing her that BGen Ross had ordered a BOI and would inform Mrs. Wheeler of the findings once the investigation was complete. The letter noted that the BOI was to submit its report by October 31, 1997.

1097 With regard to his undertaking to meet with Mrs. Wheeler by November 30, BGen Ross told my investigators that it was his intention right from the start to provide answers to the family:

1098 Not only do we have questions about our own safety procedures here, but also we owe the truth to Christina Wheeler and to [MCpl Wheeler's] parents. So that was clear right up front and it wasn't a problem. General Leach did his job in making sure that I had clearance in the public interest to disclose all the information. Nothing would drive the family more crazy than to see that we were doing an investigation and we're not telling them. We had to have a clear understanding that we actually would be able to provide them with the information that we had.

1099 According to Mrs. Wheeler's Victim Impact Statement, she sent a letter to BGen Ross on October 8, 1997, requesting a firm date for a meeting in November, because her father-in-law would be attending and he needed to make travel arrangements. Mr. Bill Wheeler told my investigators that he was not actually invited by BGen Ross to attend the meeting and that it was his daughter-in-law's request that he be there, since she did not wish to be alone when she received the BOI Report.

1100 In her Victim Impact Statement, Mrs. Wheeler wrote that BGen Ross had confirmed he would meet with her on November 28, even if the report itself was not complete at that point, and that he would visit Mrs. Wheeler and go through what he did have with her. She also wrote that, when she mentioned the obstacles in her efforts to obtain access to DND information, he said that he would try to obtain an un-severed copy of the SI Report, along with copies of her husband's medical records.

1101 In an article that appeared in the *Calgary Herald* on October 17, 1997, MCpl Wheeler's death and the 1995 training death at CFB Suffield were both linked to allegedly questionable safety standards. Christina Wheeler was quoted in it as saying:

1102 My main goal was to clear Rick's name and get justice. Now I'm looking at why did this get past everyone without raising an eyelash. The senior chain of command in Ottawa let it slide and go through the whole justice system itself.

1103 BGen Ross called Mrs. Wheeler two weeks later, on October 30, with regard to the access to information issue. In response to her repeated plea that she not be denied information related to the death of her own husband, BGen Ross advised her that information could be disclosed if it were in the public

interest, and that he would approach the Information Commissioner with regard to getting a reduction in the number of severances in Mrs. Wheeler's copy of the SI Report.

7.4 The BOI (1997)

1104 On October 31, 1997, Col Selbie sent a letter to BGen Ross, enclosing the findings of the BOI. The most notable finding for the Wheeler family was that MCpl Wheeler was not in any manner to blame for his own death. In a letter to the Chief of the Land Staff (CLS), LGen Leach, dated November 19, BGen Ross commented on the findings and recommendations of the BOI. He concurred with the findings and informed the CLS that he had directed that a memorial cairn be erected at the site of the accident and that the unit conduct a dedication ceremony.

1105 The documents enclosed with BGen Ross' letter included a 39-page narrative setting out the events of April 7, 1992 and summarizing the Board's findings. In a fax sent to the Director Land Personnel (DLP) on November 12, 1997, Land Force Western Area requested the narrative be sent to the JAG for review to determine if it could be disclosed to Mrs. Wheeler by BGen Ross.

1106 Several sections were severed from the 39-page summary that was ultimately given to Mrs. Wheeler by BGen Ross, on the advice of the then-Director, Access to Information and Privacy. The sections withheld from Mrs. Wheeler included references to the emotional and psychological impact of the death of MCpl Wheeler on the Enemy Force Controller and the APC driver; the Enemy Force Controller's criticism of the APC driver's "reckless" driving habits; the Enemy Force Controller's admission to the BOI that he did not have positive control of the APC driver and that he stopped ground-guiding the APC before it had come to a complete stop where he (the Enemy Force Controller) had intended it to stop; and an observation by the Enemy Force Controller that it was possible that his directions to the APC driver with regard to the route the APC was to take during the exercise had been misinterpreted.

1107 From what my investigators have been able to gather, the Enemy Force Controller and the APC driver, whose personal information was withheld, were never asked by anyone at the Directorate, Access to Information and

Privacy for their permission to release that information to Mrs. Wheeler. We met with the Director, Access to Information and Privacy in 2004, who said that permission to release personal information is rarely sought. She indicated that, for a number of reasons, including the difficulty in tracking down all of the people involved, it would not be feasible to ask for permission to release personal information in all cases.

1108 According to Mrs. Wheeler's Victim Impact Statement, BGen Ross called her on November 20, 1997, one week before their scheduled meeting, to inform her that he could not meet with her as arranged, because the Office of the Minister of National Defence had not yet been briefed on the findings. BGen Ross told my investigators that, in retrospect, the date he had set for the meeting with Mrs. Wheeler was unrealistic, given that LGen Leach had yet to decide what action was to be taken with respect to the two senior officers: "I can't take that decision in terms of Lapeyre and Semianiw, so it had to go to Leach, and then they had to think about it and they had to talk about it and say: 'What are we going to do, how are we going to do it and when are we going to do it.' So that pushed the date."

1109 According to an article that appeared in the *Calgary Herald* on November 24, 1997, Mrs. Wheeler described the impact on her of the delay as "another kick in the teeth." Although she acknowledged BGen Ross as the "first soldier to honour commitments to her following her husband's death", she was critical of top-level defence officials in Ottawa for adding to her emotional distress.

1110 She told my investigators that she made some important career decisions based on the original November meeting date. She abandoned a part-time degree course she was taking because the matter of her husband's death had not been resolved: "I had spent two years taking courses at this college towards getting a degree, and now it was all — it was gone. And I had to make the decision to drop it because I didn't know what was going to happen, and this [the meeting with BGen Ross] was more important at that time." In the *Herald*, BGen Ross explained the need to get input from the CDS and the Minister of National Defence, and said: "We still hope to do it before Christmas so [Mrs. Wheeler] can get closure as completely and as soon as possible."

1111 Mrs. Wheeler was unhappy with the delays. She expressed her disappointment and frustration over the postponed meeting in a series of letters to recipients as diverse as her Member of Parliament, the Minister of National Defence and an investigative reporter at CTV. She also made a statement at a public hearing of the Parliamentary Standing Committee on National Defence and Veterans Affairs, in which she said: "My children and I have been treated as non-entities since the beginning. We have no status, no access to people or information. I was given a pension and swept under the rug — no answers, no accountability, no closure."

1112 Meanwhile, internal correspondence between DND/CF officials indicates a concern about releasing sensitive details about the BOI's findings to Mrs. Wheeler, particularly before the review process was completed.

1113 In an article on March 4, 1998, the *Calgary Herald* reported that the Minister of National Defence had said that the size and complexity of the investigation made it impossible to say when the results would be released to Christina Wheeler.

1114 On March 5, 1998, LGen Leach, in a letter to the CDS, Gen Baril, accepted the BOI findings and most of the recommendations of BGen Ross. He did not agree that LCol Lapeyre's and Maj Semianiw's failure to fulfil their supervisory duties amounted to indirect responsibility for the death of MCpl Wheeler. General Baril signed LGen Leach's review, indicating his approval of the report and all the comments and amendments to it. He also approved releasing the information to Mrs. Wheeler, as being in the public interest.

1115 On March 18, 1998, LGen Leach wrote to BGen Ross, advising him of the final status of the BOI. He asked BGen Ross to convey his apologies to Mrs. Wheeler for the length of time it had taken for the review to be completed and explained that, to ensure fair and appropriate closure of the Board, it was critical to receive the input of the various staffs at NDHQ. With regard to disclosure of the BOI results to Mrs. Wheeler, he wrote that the CDS intended to grant authority to provide full disclosure to Mrs. Wheeler once he had discussed the results with the Minister and with the JAG, and after the Director Access to Information and Privacy had completed the appropriate severances.

7.4.1 The BOI in the Media

1116 Also in March 1998, the CF began to develop a media communications plan in anticipation of the BOI being finalized, along with an action plan for briefing Mrs. Wheeler. On March 19, the CF prepared a media response on the BOI findings that was not to be used "until personally authorized by CLS following MND [Minister of National Defence] approval." The media response contained a formal apology to Christina Wheeler for "taking so long to finally conclude that her husband had no responsibility whatsoever for his death." It commented, "She has suffered for an unnecessarily long time and we want to acknowledge that her position in that regard was right all along. Mrs. Wheeler is to be commended for her perseverance and patience."

1117 After being informed of the findings against him, LCol (retd) Lapeyre requested a copy of the BOI report, and that the CF postpone publicizing the report until he had time to review and respond to it. In response to LCol (retd) Lapeyre's request, LGen Leach wrote, in a letter dated March 31, 1998: "This incident has been a source of heartache to Mrs. Wheeler and of concern to the Canadian public for over five years. It is now time to make this incident public, learn from and be accountable for our mistakes." LCol (retd) Lapeyre was given access to the BOI report, as he had requested.

1118 On April 1, 1998, the Coordinator of Access to Information and Privacy at NDHQ prepared to release the BOI information under s. 8 (2) (m) (i) of the *Privacy Act*, which allows the release of personal information in the public interest. It was also DND's intent to provide to Mrs. Wheeler the personal information contained in the follow-on correspondence of the Board, citing the public interest in releasing details concerning the failures that amounted to indirect responsibility for MCpl Wheeler's death with the hope that disclosing such information would assist Mrs. Wheeler to achieve closure by helping her to understand what had occurred.

1119 The documents provided to Mrs. Wheeler were a severed copy of the BOI Report, BGen Ross's letter of November 19, 1997, LGen Leach's letter to the CDS (Gen Baril) of March 5, 1998, and LGen Leach's letter of March 18, 1998 to BGen Ross.

1120 On April 3, 1998, BGen Ross visited Mrs. Wheeler and her children at their home to make a formal apology. He provided her with a 265-page summary of the 2,165-page BOI Report and a copy of LGen Leach's letter of March 5, as endorsed by Gen Baril. The full 2,165-page version included, in addition to the information provided to Mrs. Wheeler, appendices with transcripts of all witness testimony and a second edited version of the SI Report.

1121 On April 6, 1998, the Minister of National Defence telephoned Mrs. Wheeler at her home. Mrs. Wheeler told my investigator that she does not remember exactly what they discussed.

1122 On April 7, an article in the *Calgary Herald* published some of the findings of the BOI and reported Mrs. Wheeler as declaring that her fear of a cover-up had been confirmed by the Board's conclusion that her husband was in no way responsible for his own death. LCol (retd) Lapeyre and Col Semianiw were named in the article, which reported that they had been found to have failed in their supervisory duties. According to the *Herald*, Mrs. Wheeler commented that the BOI Report was everything she had thought "and more and worse" and added that, although she had now achieved closure, she had not achieved justice.

1123 In a letter to BGen Ross dated April 7, Mrs. Wheeler expressed her gratitude for the role he and BGen Meating had played in her having achieved some measure of closure: "I think you know how important it was for us to have the truth and to clear Rick's name, and you have done that for us." In a letter to BGen Meating, she wrote: "I understand that it was a difficult position for you to be in but I appreciate the fact that you were willing to step forward and initiate the proceedings to re-open the 1992 investigation." In his response on June 1, 1998, BGen Meating wrote:

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> Your husband can rest in peace due to your efforts; I thank you for having the conviction of character and resolve in bringing the situation to my attention when you did. The decision to have the 1992 investigation reopened was not difficult; I was very comfortable that it was the right and only possible course of action.

1125 Bob Bergen wrote in the *Calgary Herald* on April 11, that Mrs. Wheeler was concerned that the information concerning the senior officers whom the BOI found to have erred in their supervisory responsibilities had been withheld for so many years. Her view was that the BOI Report revealed that the military had covered up a "litany of errors."

1126 On April 22, 1998, the Minister of National Defence, following up on the call he had made to Mrs. Wheeler on April 6, wrote to her to confirm that all levels of the chain of command agreed that MCpl Wheeler was in no way to blame for his own death. He said he hoped that the BOI findings would finally bring closure to her concerns surrounding the circumstances of her husband's death.

1127 On May 5, 1998, at the request of BGen Ross, Mrs. Wheeler was provided with a photograph of the accident site, and promised additional photographs of an APC in both a clean configuration and modified, as it would have been on the day of the accident. In September 1998 Mrs. Wheeler received the original (1992) MP report.

7.5 After the BOI

1128 The memorial service for MCpl Wheeler, held at CFB Suffield on May 23, 1998, gave Mrs. Wheeler and her daughters some satisfaction that MCpl Wheeler had been accorded the respect he deserved. BGen Ross told my investigators that:

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> [Mrs. Wheeler] had closure to some degree. She had all the facts. There were no other facts. It was 100 per cent. Finally, the Battalion was seen to have done the right thing.

1130 Members of 2 PPCLI had built a cairn, prominently located on the main road leading to the training ground, to serve both as a memorial to MCpl Wheeler and as a reminder of the training fatality. At the service, the organizer presented Mrs. Wheeler with a photograph album as a memento of the ceremony on behalf of all ranks of 2 PPCLI. In his accompanying letter, he wrote:

> I hope you share with me the belief that in dedicating this monument, Rick has received the honour and recognition that he has so long deserved. His death, while a tragedy, has ultimately served to promote a better and safer place for those of us who carry on the best traditions of the regiment that Rick represented.

1131 Mrs. Wheeler wrote to the CF members who had built the cairn to express her appreciation for their care and attention: "When I remember that day I will also remember that you camped beside the memorial to protect it until our arrival. In doing so you showed that honouring Rick's memory was as important to the men of 2 PPCLI as it was to his family."

1132 Even as Mrs. Wheeler was being provided with information from the BOI, a whole new chain of events was beginning at NDHQ. These developments included allegations that the BOI was flawed, new evidence coming to light and a CFNIS investigation into alleged perjury. They culminated in an Administrative Review Board (ARB). Other than contact with the lead investigator in the CFNIS, Mrs. Wheeler received no information from any CF party about what was happening until November 20, 2003, when she was presented with a severed copy of the ARB Report by the Commander, Land Force Western Area.

1133 Significant events began almost immediately after LGen Leach wrote to Col Semianiw and LCol (retd) Lapeyre on March 18, 1998. Both immediately and vigorously challenged LGen Leach's decision that they had erred in their supervisory duties. They wrote separately to the highest levels in the chain of command, complaining about a number of issues. They both felt they had been treated unfairly and that the BOI had made erroneous findings. Among other issues, they focused on the BOI's finding that a replacement Chief Controller had not been appointed. They submitted information they claimed cast doubt on the BOI's findings, including evidence from potential witnesses who had not been called by the BOI. They also individually raised other issues, including alleged comments by BGen Ross that the initial investigation into the death was, in his view, a "unit cover-up."

1134 Their complaints resulted in a number of developments at NDHQ, including a review of the accuracy of the letters from the CLS to LCol (retd) Lapeyre and Col Semianiw, in light of the arguments and information they presented.

1135 There was a voluminous exchange of information between LCol (retd) Lapeyre and CLS staff about which regulations had been in effect in April 1992 and what was required in terms of a safety staff for the type of exercise in question. In July 1998, Col Selbie, the President of the BOI, was asked to clarify the BOI's Report and findings in light of these challenges. He provided a detailed response. On October 30, 1998, the DLP recommended that the CLS remove Col Semianiw's letter of displeasure from his personnel file.

1136 On December 7, 1998, the CLS wrote to both Col Semianiw and LCol (retd) Lapeyre, providing them with Col Selbie's response, from which only the comments of the BOI's legal advisors were severed. He advised them that the letters he had sent in March were "informative," and not intended to be "an administrative or a pseudo-disciplinary" measure. On March 9, 1999, LCol (retd) Lapeyre wrote to the CLS again, raising concerns about how the BOI was conducted, alleging that it was "procedurally unfair." He had already raised issues related to the fact that the BOI Report was completed within hours of when he completed his testimony.

1137 No information about any of these developments was shared with Mrs. Wheeler. In March 1999, a desk officer at DLP prepared a memorandum recommending that a letter be sent to Mrs. Wheeler to provide her with information about the new developments. This was never done. He also raised concerns about the way that Col Semianiw and LCol (retd) Lapeyre had been treated, in particular in the media.

1138 In addition, by March 1999, DLP was in possession of a signed letter from LCol Kaduck, stating that he now recalled replacing Maj Semianiw as the exercise Chief Controller, an extremely significant development that clearly brought into question a crucial finding of the BOI. The DLP officer responsible for handling this case recommended further investigation noting, "It is never too late to get things right and set the record straight."

1139 Other significant events relating to the case occurred in this time period, including the following:

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- Land Force Western Area issued instructions to 1 Canadian Mechanized Brigade Group units to destroy their copies of the BOI Report, since new information had come to light since its release;

1141 • In a subsequent message, 1 Canadian Mechanized Brigade Group confirmed that all recipients of the BOI Report had destroyed their copies;

1142 • LCol (retd) Lapeyre made a harassment complaint to the CF Provost Marshal against senior officers;

1143 • LCol (retd) Lapeyre made a complaint to the Land Force Command Inspector (LFCI);

1144 • Col Semianiw raised a concern with the Executive Assistant to the CLS that the letter of displeasure had been placed on his "merit" or personnel evaluation report file (the file kept at NDHQ, used for career management purposes) when he had been told that it would only be kept on his unit personnel file;

1145 • The CLS asked the Director General, Military Careers to ensure the letter was removed from Col Semianiw's merit file, as "it was not meant to serve as an administrative or pseudo-disciplinary measure against him."

1146 Mrs. Wheeler was not advised of any of these developments.

7.5.1 The CFNIS Investigation (2000) and Afterwards

1147 In a letter dated July 7, 1999, the Provost Marshal informed the CLS that she had directed the CFNIS Sensitive Investigation Section to conduct an investigative review of MCpl Wheeler's case. She assigned Russ Grabb, an RCMP Inspector seconded to the CFNIS, to conduct an independent investigative assessment into a possible perjury charge against LCol Kaduck and into possible criminal charges arising from the original incident.

1148 Inspector (Insp) Grabb contacted Mrs. Wheeler when he began his investigation. He maintained frequent telephone contact with her throughout his investigation and visited her two or three times. He spoke with her on at least four occasions between February 28 and March 31, 2000, updating her on his investigation and making arrangements to visit her home.

1149 Insp Grabb travelled to Victoria on April 4, 2000 to brief Mrs. Wheeler on his plans for re-evaluating the circumstances of the case. According to Insp Grabb's notes, he also discussed with Mrs. Wheeler the relevant law and procedure in a death investigation. In addition, he reviewed the documents that she had collected over the years and allowed her to read the first 25 pages of the time-line he was creating, which summarized all the steps that had been taken in relation to the death of her husband. He noted in his casebook that it was clear to him that no one had ever fully briefed Mrs. Wheeler on the facts of the case.

1150 Insp Grabb called Mrs. Wheeler at least twice a month and occasionally once a week from April to September 2000, when he completed his investigation. On September 4, Insp Grabb made arrangements to visit Mrs. Wheeler again and suggested that her daughters be present, if she wished. He met with her on September 13, to notify her of the outcome of his investigation. He also informed her that the Assistant Chief Crown Prosecutor in Medicine Hat, Alberta, had assessed the case and concluded that the facts did not support laying of any charges under the *Criminal Code.*

1151 On September 26, Insp Grabb travelled to Nova Scotia to brief Mr. Bill Wheeler on the outcome of the investigation.

1152 The contact with Insp Grabb was the first that Mrs. Wheeler had had with anyone in authority in the CF since May 1998. It was also the first time that she had been advised that LCol Kaduck was the subject of a perjury investigation. According to the documentation made available to my investigators, Mrs. Wheeler had not, until then, been informed by the CF that LCol Kaduck had changed his testimony. The CFNIS investigation established that then-Capt Kaduck had been the Chief Controller in Suffield on April 7, 1992, which contradicted the BOI finding that Maj Semianiw had left CFB Suffield without appointing a Chief Controller in his place, leaving a "supervisory vacuum."

1153 Insp Grabb told my investigators that he was uncomfortable with the way Mrs. Wheeler had been treated by the CF in some respects, noting that, "All she wanted and had been looking for [was] two things: fair treatment from the CF and a comfort level that this would never happen again." He added that:

1154 It is no wonder that Christina Wheeler feels the way she does because it is consistent with the many things that she described over the eight-year period as having happened to her. If you didn't have these type of experiences, you could dismiss her as being an overly sensitive widow who just can't move on and who is trying to criticize the department because she can't come to terms with her grief. But I think if you look into it, you will find that there are probably situations where she wasn't treated the way I would like my wife to be treated if I was killed in that setting, in that situation.

1155 With regard to the flow of information to Mrs. Wheeler from the military authorities, Insp Grabb told my investigators that he did not believe that she had received an adequate level of support:

1156 Whether it is the OPP or the RCMP, if there is a car accident on the 401, at the end of the day, someone, some Constable or somebody comes out to the widow and sits down over coffee and says, "Here are the results of our investigation," or there is a coroner's inquest, always some sort of instrument for the family to know what happened and have a comfort level that it was properly investigated. I was the first person to tell her what the coroner had concluded …

1157 In addition to keeping the Wheeler family informed of the progress of his investigation, Insp Grabb also addressed the issue of their emotional welfare, particularly Mrs. Wheeler's. He attempted to find out about a CFNIS Victim Assistance Programme that endeavoured to mirror the type of program used in civilian policing. In an e-mail to the Provost Marshal on April 11, 2000, enquiring about the status of the program, he wrote: "For eight years Christina Wheeler has been fighting tooth and nail to … obtain even the most basic information about her husband's death." He also asked the Provost Marshal how he could obtain a copy of the new CF policy that precluded an SI from being conducted by the unit under investigation. He said that he had promised Mrs. Wheeler that he would "try to obtain a copy of this policy in order to provide her further comfort under the circumstances."

1158 Mrs. Wheeler made several unsuccessful (and frustrating) attempts to obtain the actual CFNIS investigation report, through the Director, Access to Information and Privacy. She made official requests, beginning on September 28, 2000, under the *Privacy Act* and the *Access to Information Act*, and lodged a formal complaint with the Information Commissioner of Canada. It was not until May 14, 2001 that she received the report. My investigators did not see

the version of the report that Mrs. Wheeler was provided, but she informed them that she remembers it was severed, to the extent that it had been rendered difficult to follow.

8 Bill Wheeler and the DND/CF

1159 MCpl Wheeler's father, Mr. Bill Wheeler, was extremely disappointed at the failure on the part of the military to provide any answers to his questions. In a letter to his local newspaper on April 29, 1998, Mr. Wheeler wrote: "Families going through the grieving process should not have to bear the burden of getting to the true facts in these cases."

1160 Mr. Wheeler and his wife told my investigators that, nine months after the accident, Mrs. Wheeler had sent them a copy of the three-page résumé of the SI Report she had received. They said that no information had been sent to them by the military and that they were never briefed about the accident. They stated that initially they did not believe that there had been any suspicious circumstances surrounding the death of MCpl Wheeler. According to Mrs. Wheeler: "Like I said, even to this day Bill and I still truly believe it was just an accident. We just wanted the answers for sure and we thought … Rick deserved a little more respect than that."

1161 Their understanding was that the CF had not been forthcoming with information because they were expecting a lawsuit from either Christina or Bill Wheeler, when all that the Wheelers wanted was information: "If they had come to grips with that and realized that that's all we want is answers to what happened, whether good or bad, and we could have put it behind us, we'd never have gone through the years of misery like we did, never."

1162 Mr. Wheeler said that only receiving intermittent snippets of information from his daughter-in-law made it very difficult to put the whole matter to rest. Each telephone call from her would get him thinking again: "Things kept playing on your mind all the time. It never went away … You were always thinking about it." Mr. Wheeler said that he did put in a formal request for information but was told that his request would take some time to fulfil. However, he expressed satisfaction at the fact that he received a prompt response and was at least warned that the process would be slow.

1163 On April 21, 1998, BGen Ross wrote to Mr. Wheeler, commenting on the BOI findings. (Mr. Wheeler had been unable to attend the meeting at which BGen Ross handed over the findings to Christina Wheeler.) BGen Ross also offered Mr. Wheeler his apologies for the time it had taken "to conduct the appropriate investigation and to provide full disclosure of the facts." Mr. Wheeler told my investigators that BGen Ross also sent him a copy of the BOI Report.

1164 In his letter to the editor of April 29, 1998, Mr. Wheeler had also described the struggles that he and his daughter-in-law had endured since his son's death. One of the concerns he expressed was that no one had been held accountable for the accident. He wrote: "Thanks to Brig General Robert Meating and Brig General Dan Ross, we now have an official apology and my son has been cleared of any blame into his own death. Six years of waiting and still no real accountability makes it hard to forgive." Nevertheless, Mr. Wheeler told my investigators that he was extremely satisfied with the way he was treated at the memorial service for his son in May 1998. He received a leather-bound book of photographs of the event from the military, a gesture that he very much appreciated.

1165 Mr. Wheeler wrote to Bob Bergen on June 2, 1998. His letter, which appeared in the *Calgary Herald* on June 7, 1998, announced Mr. Wheeler's intention to go on a hunger strike to bring attention to the pain and suffering that he and his family had been put through and to force the military to overhaul the justice system. It appeared that Mr. Wheeler had become convinced that there had been a cover-up, based on events such as the Somalia affair, the 1995 training death at CFB Suffield, and several alleged assault and rape cases that he felt were not taken seriously. He also cited what he considered to be the flaws in the SI and the BOI.

1166 Part of Mr. Wheeler's anger and indignation was based on his erroneous belief that the statute of limitations, which prevents disciplinary action under the *Code of Service Discipline*, expired after five years; he therefore concluded that the five years that had elapsed between the SI in 1992 and the re-opening of the investigation in 1997 was due to the CF's desire to avoid legal charges against any of the members involved. However, the relevant section of the *National Defence Act* that was in effect at the time required that a service trial commence within *three* years of commission of an offence.

1167 I fully understand how Mr. Wheeler could draw the conclusions he did, considering the lack of information provided to both him and his daughter-in-law after the death of his son. My investigators could find no evidence that the delay was a deliberate effort to avoid charges being laid under the *Code of Service Discipline*.

1168 In a letter dated June 12, 1998, the Commander, Land Forces Atlantic Area (Mr. Wheeler lived in Nova Scotia) offered his condolences to Mr. Wheeler on the death of his son and assured him that changes to the *National Defence Act* and to the CF's investigative procedures would improve transparency, accountability and impartiality. He enclosed information on the action that had already been taken in this regard. In his closing, he expressed his willingness to meet with Mr. Wheeler at any time, at the location of his choice.

1169 An article that appeared in the *Calgary Herald* on October 7, 1998 reported that Mr. Wheeler had called off his hunger strike after I assured him that my Office would give priority to his case if it fell within my mandate. At that time, this Office was not yet operational and its mandate was still under discussion.

9 The Need for an Institutional Approach to Getting Information to Families

1170 On April 4, 2000, Christina Wheeler made a Victim Impact Statement. Describing the emotional impact of the accident that claimed her husband's life, she wrote: "I was isolated by the military and received only filtered information through my liaison officer. Even through my grief I became aware of the hedging and side-stepping." In an e-mail to the Provost Marshal, on April 11, Insp Grabb of the CFNIS described Mrs. Wheeler as follows:

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> Although some may dismiss her as a grieving widow who simply cannot get on with her life, my impression is that she is an entirely reasonable person who has been left to speculate and draw often inaccurate conclusions about what happened. All she is looking for is: credible information [and] a sense that everything that can be done has been done.

1172 It became evident during the course of this investigation that a great deal of the suffering Christina Wheeler and her family experienced was attributable to a lack of consistent, reliable information from official CF sources. The scarcity of official information also led Mrs. Wheeler to rely a great deal on the limited amount of sometimes unreliable information from unofficial sources. The lack of official information and her reliance on rumours led Mrs. Wheeler to conclude that information was being purposely withheld and the military was covering something up. Our investigation did not turn up any evidence of a cover-up, but given the consistent and appalling refusal to provide her with information, I believe it was entirely reasonable for Mrs. Wheeler to conclude that someone was trying to hide something.

1173 During this investigation, and over the course of the more than 12 years since her husband's death, Christina Wheeler has related to my investigators and others the devastating effects of the lack of information on her and her family. To obtain answers, she was forced to devote a great deal of time and attention to battling the DND/CF bureaucracy, to the detriment of her personal and professional life. MCpl Wheeler's daughters and father also suffered from the lack of information; Bill Wheeler even considered going on a hunger strike to bring attention to the lack of information from the military.

1174 The need to provide surviving family members with information is crucial, as is reflected in the CF's improved response to recent tragic deaths. The Australian Parliamentary Committee report, described earlier, highlighted lack of information to families of casualties as a fundamental issue that contributes to mistrust on the part of families and the public at large, and affects morale. In its report, the Committee stated:

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> The most frequent experience among next of kin … was a feeling of alienation from the system following an investigation into the death of a loved one. This feeling of alienation has the potential to prolong the suffering of the victims' families by reducing their willingness to accept the death.

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> Where an incident involving fatalities has occurred, the price of not involving families in the inquiry process is high, regardless of the reasons for doing so. It impedes the grieving process, and in many instances creates long-term problems for family members who refuse to accept the outcome of a military inquiry. In contrast, the cost of involving bereaved families much earlier is often lower, particularly in terms of reducing the suffering of the next of kin.

1177 The Committee noted that, when relatives were kept fully informed or allowed to attend inquiries, they were more accepting of the inquiry process. That is not to say that they will necessarily be satisfied with the recommendations or with the actions taken as a result. However, the Committee noted that there was compelling evidence that involvement in the inquiry process was of distinct benefit to next of kin.

1178 The Australian Defence Force (ADF) departmental inquiry (the Burchett Inquiry), also described above, looked at more specific problems associated with lack of information about the career consequences of criminal and administrative sanctions. It recommended that "steps should be taken to improve the dissemination of information upon the true career effects of convictions … and of various administrative sanctions." The Burchett Inquiry also noted:

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> at least some of the long-running complaints which have plagued the Australian Defence Force for years might have been avoided had the complainant, as a victim, been fully enlightened about the action

> taken and the reasons for it at an earlier stage … Both victims and other persons with a legitimate interest should often be informed if an inquiry is to clear the air fully and effectively.

1180 In response to the many inquiries into the military justice system in Australia, a number of initiatives have been implemented to increase the openness and transparency of the military justice system, both criminal and administrative. General Cosgrove, the Chief of the Defence Force, recently outlined some of these initiatives. With regard to the investigation of accidental military deaths, Gen Cosgrove cited numerous examples of next of kin being allowed to participate in the BOI process, being provided with information and being given legal assistance during BOIs and even coroners' inquests (which have no relation to the military). He noted that the army provides next of kin with the opportunity to be involved in the drafting of terms of reference for a BOI, and has also implemented a program with a policy of "zero tolerance of unacceptable behaviour," which includes "visible accountability" for those whose behaviour has been found to be unacceptable. All of these initiatives respond to the families' need for information about the death of a loved one.

1181 In the days immediately following the news of a death, the surviving spouse or other family members require specific information about practical matters, such as how to arrange for a funeral, how to apply for benefits, etc. They also may need emotional support to know exactly what happened to their loved one, particularly in operational and training deaths, since they are unexpected. They may have other questions not specifically related to the accident, but which are equally important to them. It is crucial that these needs are appreciated and respected.

1182 The CF's initial response will colour the relationship between the military and survivors: allowing a survivor to feel ignored or unimportant may cause that person to never again trust any information from the CF.

1183 I am pleased to report that the DND/CF has made some progress in terms of greater sensitivity to the needs of families for information, particularly during the criminal investigative stage. The general trend, in Canada and in other countries like Australia and the Netherlands, appears to be a recognition of the need to be more open with families to prevent the kind of mistrust that was apparent in the relationship between Mrs. Wheeler and the CF. Recent examples include the

sensitive treatment and openness accorded the families of CF members killed in the friendly-fire training incident at Tarnak Farm in Afghanistan, and of the CF member who was killed in a training accident at CFB Petawawa in 2002.

1184 My investigators met with several officers from 2 Combat Engineer Regiment (CER), the unit of the soldier who was killed in the 2002 training accident at CFB Petawawa, to get a better idea of how training accidents are handled today. They were told that from the outset, the Commanding Officer of 2 CER encouraged a policy of openness with respect to providing information to family members. His instructions were that, when the family members arrived for the funeral, they were to be given whatever they wanted, including a visit to the accident site. The family chose to visit the site and also requested to speak with the crew of the vehicle involved in the accident, which the regiment arranged.

1185 The 2 CER Adjutant at the time of the accident was responsible for making all the administrative arrangements. She told my investigators that the crew offered their full cooperation, although they found it extremely difficult to meet with family members. The mother of the deceased maintained contact with one crew member for some time after the incident.

1186 The members of the deceased soldier's family told my investigators that they experienced excellent cooperation from the unit; however, information on the investigations into their daughter's death was not always forthcoming. Nonetheless, they had nothing but praise for the actions of the 2 CER chain of command immediately after the accident. They were given full access to the accident site, allowed to talk to unit members and escorted to the city morgue to view their daughter's body. The soldier's mother and stepfather are very appreciative of the way they were treated by the unit, particularly from the time they were notified of the death until the funeral. They found the information and access they were given was a great comfort at a very trying time.

1187 It is not clear whether Christina Wheeler would have opted to visit the accident site at CFB Suffield or meet with soldiers who had witnessed the accident. However, a greater willingness to discuss the details of her

husband's death and at least the offer to accompany her to the site or to arrange a meeting with some of his colleagues might have helped to quell her suspicions that information was not forthcoming because the CF had something to hide.

1188 I commend the CO of 2 CER and his unit for providing family members with an opportunity to have their questions addressed right from the start. Clearly, an overview of events at an early stage can play a significant role in helping the bereaved to accept the death of a family member. It can also contribute to a positive relationship between the survivors and the CF.

1189 I would hope that this openness applies in all deaths investigated by the military. However, it appears that the degree of openness often depends on the personalities involved, their personal commitment to the family and even the degree of public interest in the incident being investigated. The DLP noted that the expression of this new policy of openness is not yet entrenched in regulations and orders. I believe it should be, as quickly as possible.

1190 The ARB also addressed the issue of the flow of information to the family of a deceased member. Although its mandate was to advise the CLS on the relevancy, thoroughness and accuracy of the findings and recommendations of the 1997 BOI, the ARB was also instructed to provide any related recommendations. One such recommendation was that the army chain of command must "recognize and support the requirement that units have an ongoing and essential responsibility to properly support the family of any soldier killed or injured while a member of that regiment." I support this recommendation, and concur with the ARB's observation that "the concerns and best interests of the Wheeler family do not appear to have been properly served through their ongoing contact with the army."

1191 Taking care of a family is not confined to financial affairs, housing or other practical matters. According to the ARB, the family of a deceased CF member must be provided with all information concerning the circumstances that led to the death of their loved one as it becomes available. In the case of the four friendly fire casualties in Afghanistan, it was not deemed necessary to wait

until the full circumstances had been determined. An interim report was made available to the families and the public. The President of the Tarnak Farm BOI, Gen (retd) Baril, gave a briefing to the families while the investigation was still under way.

1192 I concur with the ARB's position that there must be an institutional response to the needs of the family; that is, families should not have to rely on individual efforts to receive information. The Adjutant of 2 CER at CFB Petawawa in 2002, commented that it was her Commanding Officer's personal belief that maintaining open lines of communication with the family was simply "the right thing to do." The section head of the Family Policy Team, at the CF's Directorate of Quality of Life — a retired Commander with considerable experience in casualty administration — confirmed to my investigators that the nature of the interaction between the CF and the family of a deceased CF member is very much "personality-driven."

1193 This approach results in uneven treatment of different families and can also result in patchy communication with different members of the same family. Even when cooperation and communication are initially good, information imparted on what I would describe as a piecemeal, informal basis increases the risk of conflicting information. As many have pointed out, inconsistent information can lead to a breakdown of trust and suspicion that information is being withheld or manipulated. In turn, this suspicion can colour the public's perception of the CF and affect the morale of CF members; it can also impede the implementation of recommendations, which can be forgotten without someone to push for their implementation.

1194 An institutional response to the needs of families could be translated into concrete form by including direction for the provision of information to the family of a deceased CF member in the terms of reference of an inquiry into a death. Such a provision would demonstrate the CF's commitment to supporting the survivors and would compel the investigative body to anticipate the concerns of family members, respond to their needs and respect their rights to receive information promptly and on a regular basis. As the Deputy Provost Marshal for the CFNIS explained to my investigators, this function is served by the CFNIS' Victim Assistance Programme. The person assigned to liaise with the family works in tandem with the Assisting Officer, without usurping his or her role. The same relationship should be established with respect to an administrative investigation.

1195 To ensure uniformity, I believe it is important to clearly set out the approach to be taken with regard to the release of information to the family of a deceased member. This approach should be guided by the principle that it is in everyone's interest to be as open as possible with the family of a deceased member; this not only allows the family to understand and come to terms with a death, it is also in the organization's interest. As a rule, information should only be withheld for valid operational security reasons or to protect an ongoing investigation, in which case, the information should be made available as soon as possible after the investigation is completed.

1196 Family members seeking information about a deceased CF member are in a special class. The information they seek is of intimate significance to them, and this should be acknowledged in the way they are treated. As a result, I believe that CF directives for casualty administration should direct that as much information as is legally possible should be made available to the family immediately after a death. Family members should not have to deal unnecessarily with bureaucratic procedures, and every effort should be made to process their requests for information quickly and with sensitivity to their need for the information.

1197 The new PEN form contains a section allowing the designation of an individual who can receive a member's personal information in the event of death or serious injury. This is an important tool for allowing a CF member to determine, during his or her lifetime, who should be given access to personal information. I understand that the Director, Access to Information and Privacy accepts the new PEN form – if completed – as a means to allow greater leeway in the information which can be released after a member dies. This is an important development, however, I do not agree with the interpretation that the family of a member who filled out an older PEN form without the designation, should not be entitled to any of the member's personal information.

1198 Even where a person has been named as the recipient of the member's personal information on the new PEN form, procedures can be clarified. I believe it would be helpful for the new PEN form's implications with regard to the passing of information to be described in CF directives for casualty administration. This would provide guidance to the CF members and DND or VAC officials who are dealing directly with the deceased member's family, which could streamline the process for

providing information to the family. The directives should specify what information can be released to the person named on the PEN form, and who is responsible for passing on that information.

1199 Certain types of information and access should routinely be made available to the family members of deceased CF members, including, where applicable: access to the accident scene; photographs; diagrams and maps which could help them understand the accident; names and contact information of witnesses or other involved parties who are available and willing to provide information about the incident; copies of all investigation reports related to the incident that led to the death; and any actions taken as a result of the incident or investigation.

1200 CF policies should explicitly address the matter of allowing the family access to the site of the incident and should encourage all CF members to answer the family's questions candidly. I recognize that the nature of an investigation may require CF members to be circumspect about discussing what they witnessed. That is one reason I stress the importance of investigations taking place expeditiously. I also understand that it may not be possible or advisable for the family to have access to witnesses in the immediate aftermath of an incident; however, I believe it is the duty of the CF to provide as much information as possible, as soon as possible.

1201 Obviously, the degree of openness will vary, depending on the location of the accident and the requirements of any ongoing investigation. Furthermore, surviving family members might have different needs for information, varying capacities to deal with potentially painful information and differing abilities to recall what they have been told or shown. In addition, some family members who initially may not want information might reconsider after the passage of time.

1202 **I therefore recommend that:**

1203 **12. The CDS issue a CF-wide directive that the families of CF members who die in circumstances related to duty be provided with all information relevant to the death, the circumstances surrounding the death, copies of all investigations into those circumstances and any subsequent developments, on a priority basis and as soon as such information is available.**

1204 The departmental response to this recommendation reads:

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> Agree in principle. The CF recognizes the need to be open and transparent in these matters and will provide all of the information available as expeditiously as possible, in accordance with its statutory obligations to all parties. The Working Group will examine the possibility of developing a family information package template responding to the questions who, what, when, where and why

1206 I do not feel that this response adequately addresses the recommendation. I also emphasize that there is nothing in this recommendation inconsistent with DND/CF's obligations under access to information and privacy legislation. The department's reassurances fall short of a commitment to issuing a CF-wide directive dealing with the passing of information to the family. Further, I am not convinced that a family information package template would be more likely to inspire trust on the part of family members than some of the current practices. I believe that what families require from the CF after the death of a member is to feel that they can discuss the death and its circumstances with the people who have first-hand knowledge of the incident. This includes the members' colleagues, chain of command, and the people involved in investigating the death.

9.1 Support and Information during Criminal Investigations

1207 Mrs. Wheeler indicated that she was not contacted at any time by the MP or the RCMP during their investigation immediately after MCpl Wheeler's death. They did not provide her with specific information about the investigation conducted in 1992. She did not receive a copy of the MP report until 1998, when BGen Ross sent it to her. The report included photographs of the accident scene and statements by several of the witnesses. When my investigators asked the MP investigator why the report had not been shared with Mrs. Wheeler, he replied that he did not know, since, as a corporal, he would not have been responsible for the distribution of the report.

1208 Services for victims in the CF have improved considerably since 1992. My investigators met with the Deputy Provost Marshal for the CFNIS, who explained that the CFNIS is committed to working closely with family members at all stages of an investigation. This is borne out by Mrs. Wheeler's

treatment during the CFNIS investigation in 1999 and 2000. Insp Grabb appears to have been the first person from the DND/CF who, in an official capacity of keeping Mrs. Wheeler informed, actually made an effort to ensure that she knew what was going on. He seems to have been appalled by the way in which she had been treated until then.

1209 The family of the soldier killed in the 2002 training accident at CFB Petawawa also seems to have been kept reasonably well-informed about the progress of the CFNIS investigation into the death. The soldier's mother informed my investigators that, while the CFNIS investigators did not always initiate contact with her, they responded to her questions and she was able to keep apprised of the investigation. There were some problems in getting the actual CFNIS report once the investigation was concluded, but it appears that the system worked fairly well when it came to providing information to the family during the investigation.

1210 Chapter 22 of the *Military Police Policies*[11] deals with victims' rights. It defines a "victim" as "an individual who has suffered physical or psychological injury, mental anguish, material loss, or a substantial violation of their rights." Under this policy, the MP is required to inform victims about the disposition of their case and, during lengthy investigations, provide at least one oral progress report.

1211 In addition to the policies governing how the MP works, the Provost Marshal maintains a Victim Assistance Program, which was implemented in response to the recommendations in my report, *Provision of Compensation and Counselling Services to Sexual Assault Victims*. The Victim Assistance Program is described in the *Police Policy Bulletin 13/2000 — Military Police Operations,* which was distributed to all CF bases in October 2000.

1212 The Victim Assistance Program is a sanctioned and appropriate way for the CF to pass information on to next of kin, which serves a very important end. Giving Mrs. Wheeler the kind of attention that is now accorded those who are victims of crimes, particularly with respect to updates and reports, would have been invaluable in 1992.

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[11] *DND/CF Security Orders*, Vol. 4 A-SJ-100-004/AG-001.

9.2 Assistance in Dealing with Provincial Authorities

1213 The autopsy on MCpl Wheeler was conducted at the Medicine Hat hospital by an Alberta Medical Examiner. CF members who die in Canada will normally be autopsied by provincial officials, even if their deaths are investigated within the CF. This can be confusing for family members, since provincial officials operate under different legislative frameworks, and there are different rules and policies about how family members can get information about the autopsy or answers to other inquiries.

1214 The SI Report noted that there was a delay in getting documentation from the Alberta Medical Examiner. The autopsy report had to be forwarded separately, after the SI Report was sent to review authorities. It is not unusual for pathologists to take a considerable period of time to finalize an autopsy report, for legitimate reasons such as the need to examine specimens or wait for the results of laboratory tests. While the DND/CF cannot be held accountable for delays in getting information from provincial authorities, an experienced investigator would have been aware of the reasons for the delay and would have been able to explain the process to Mrs. Wheeler or may have known how to expedite the process. Mrs. Wheeler's Assisting Officers did make efforts on her behalf, for which they are to be commended.

1215 We interviewed officials at the CFNIS and at the Office of the Coroner for the Province of Ontario. They indicated that there are no formal policies for passing information to the family about an autopsy report or the findings of a coroner's inquest, in the case of the unexpected death of a CF member. Dr. Jim Cairns, the Deputy Chief Coroner of Ontario, told my investigators that autopsy reports are provided to family members as a matter of course, usually on request, or automatically if there is an inquest.

1216 The investigation of a CF member's death can involve a number of different officials from municipal, provincial, federal and DND/CF bodies. Knowing the roles that these officials play in an investigation, what information is held by whom and how to go about getting that

information is complex and confusing. I believe an approach is needed that would make it easier for families to get all the information they need, seamlessly from a single source, regardless of who has that information.

1217 The information contained in the autopsy is a factual, scientific account of the cause of death and other medical information about the state of the deceased at the time of his or her death. This information can be invaluable to surviving family members. According to the Ontario Coroner's Web site:

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> The autopsy report provides a factual basis for counselling the relatives of the deceased, particularly in cases where there is anxiety around the circumstances of the death or other issues that may arise some time after the death, such as those related to insurance claims.[12]

1219 Dr. Cairns has been a coroner since 1978; he has dealt with the families of some 100,000 individuals who have died in his jurisdiction and has presided over hundreds of inquests. He notes that it is extremely important the next of kin receive as much information about a death, as quickly as possible.

1220 Dr. Cairns said that, typically, the grieving process evolves from disbelief to anger and blame before a person can reach acceptance and a degree of resolution. In his experience, failure to provide as much information about a death as possible in a timely fashion often means that surviving family members are stuck in the anger and blame stage. Frequently, family members will equate a lack of information with an attempt to "cover-up" the death. Once they arrive at that conclusion, it can be very difficult for them to regain trust in the process.

[12] *http://www.mpss.jus.gov.on.ca/english/pub_safety/office_coroner/coroner_why.html*

1221 In situations where the family of the deceased distrusts the information provided by the CF, the independence of the coroner or medical examiner (who is a provincial official) can help the family come to terms with the circumstances of the death. In such cases, the family can compare the report to the information received from official CF sources to gauge the accuracy of official CF information.

1222 **I therefore recommend that:**

1223 **13. CF directives on casualty administration and CFNIS operating procedures be amended to direct that assistance be provided to families of deceased members, and that best efforts be made to ensure they are able to obtain information from provincial authorities, including autopsy and coroner's reports and medical files, as soon as possible after the member's death.**

1224 The department agreed to implement this recommendation, noting:

1225 > recognizing that we cannot bind provincial authorities nor avoid the application of the *Privacy Act*. In the case of a member's serious illness/injury or death, a medical assisting officer (military medical officer or civilian physician from the CF Health Services Group (CFHSG)) shall be identified where practicable to ensure that the next of kin are kept apprised in a timely fashion wrt the member's medical circumstances. The Assisting Medical Officer (MO) will provide liaison with civilian health care providers and be the source of up to date, accurate info for the family. The Assisting MO will also be the medical adviser for the chain of command on the support the family should receive. The Assisting Officer, with assistance from the CFHSG, will ensure liaison for the family with other government authorities to expedite the release of information.

1226 I am pleased that the CF have made this commitment. Although I recognize that DND/CF cannot bind provincial authorities, I am certain that its assistance will be invaluable in facilitating families' access to information about the circumstances of the death of a CF member, which is held by other government agencies. I am also confident that such assistance can be provided in a manner which is not inconsistent with the *Privacy Act* and which will still ensure that all relevant information is available.

9.3 Providing Information to Families and the Application of the *Access to Information* and *Privacy Acts*

1227 More than a year after her husband's death, the only documents Mrs. Wheeler had from the CF were the summary of the SI Report and an extensively severed copy of the SI Report itself. The documents were mailed to her by a directorate within the DND that had not been involved in the investigation and would not have been able to answer any questions beyond those related to access to information or privacy issues. There was no one she could talk to about the investigation and its results. She was still trying to obtain copies of other documents, such as MCpl Wheeler's medical file, without success.

9.3.1 Access to Information and Privacy Legislation

1228 The federal *Access to Information Act* and *Privacy Act* govern the release to the public of information held by the government. The *Privacy Act* gives individuals the right to request personal information about themselves held by government institutions, subject to specific and limited exemptions. The *Access to Information Act* gives individuals access to information held by government institutions, subject to specific and limited exemptions, such as personal information about identifiable individuals. Once a request is responded to, the information is no longer under the control of the government institution. Information released under the *Access to Information Act* enters the public domain and information released under the *Privacy Act* comes under the control of the requestor, as his or her personal information.

1229 The *Privacy Act* defines "personal information" in section 3. Under the Act, personal information can only be released to the person to whom it relates, unless it falls under one of the exceptions in section 8. The exceptions allow the disclosure of personal information, even without the consent of the person concerned, in certain circumstances.

1230 The *Access to Information Act* also contains a number of exemptions to the general rule that access should be granted, in sections 13 to 26. Some are mandatory, and others are discretionary. Section 19 of the Act requires the

head of a government institution to refuse to disclose personal information unless the individual to whom it relates consents to the disclosure, the information is publicly available or the disclosure is in accordance with section 8 of the *Privacy Act*.

1231 Section 8 of the *Privacy Act*, contains exceptions, allowing the disclosure of personal information in certain circumstances, including: disclosure for the purpose for which it was collected, or for a use consistent with the purpose for which it was collected (s. 8 (2) (a)); or if in the opinion of the head of the institution, the public interest in disclosure clearly outweighs any invasion of privacy that could result from the disclosure, or disclosure would clearly benefit the individual to whom the information relates (s. 8 (2) (m)).

1232 When the personal information sought relates to someone who has died, there are often difficulties for surviving family members attempting to obtain personal information about the deceased. The deceased person's information will be excluded as personal information under the Act, and the executor or administrator of his or her estate has only a limited right to request information required for the administration of the estate. However, it is not impossible for a government institution to release this information; the laws provide a number of possibilities.

1233 Section 8 (2) (m) of the *Privacy Act* contains an important reason for exemption (the public interest in disclosure) that permits the release of personal information under both Acts. I believe that assisting families to come to terms with the death of a family member by providing them with all possible information about the death serves a very important public interest.

1234 Recent changes to the Personal Emergency Notification form also facilitate the passing of information to a deceased member's family. On the new PEN form, section 4 allows CF members to designate someone to receive their personal information in case they die or are seriously injured. A note on the back of the form explains that if the member does not designate someone in section 4, the member's family will be unable to access his or her personal information until 20 years after the death, and will have no special rights of access. The new PEN form is an important document, which will allow those responsible for deciding what information can be released to the family of a deceased CF member to be confident that they are respecting the wishes of the deceased, and the letter of the law.

9.3.2 DND's Approach to Access and Privacy

1235 For the purposes of both the *Access to Information Act* and the *Privacy Act*, the "head" of a government institution is the minister responsible for that institution. Ministers normally appoint someone to carry out their responsibilities for the access to information and privacy legislation. This person will exercise the discretion given in the legislation to the department "head." Within the DND/CF, the Director, Access to Information and Privacy is the Minister's delegate under the *Access to Information Act* and the *Privacy Act*.

1236 Certain kinds of information, including the personnel and medical files of CF members, are routinely sent to Library and Archives Canada under an agreement between the two Departments. Once responsibility for the information is transferred, requests no longer go through Director, Access to Information and Privacy, but through the Archives. Library and Archives Canada does not have the information required to exercise discretion in applying most exceptions allowing the release of personal information (other than information required for the administration of an estate), and does not consult with the DND/CF about such matters. As a result, its response to a request for documents that contain personal information will usually entail waiting until 20 years have passed since the person's death, after which information is no longer considered "personal information" under the *Privacy Act*. This was the impasse Mrs. Wheeler met when trying to obtain her husband's CF medical file.

1237 In addition to the formal process for requesting information under the two Acts, government departments are encouraged to create informal methods through which citizens can request information. Within the DND/CF, this policy is reflected in DAOD 1001-2 (*Informal Requests for Access to Departmental Information*), which states: **"**It is DND and CF policy to allow access, on an informal basis, to the records under its control which do not qualify for an exemption or an exclusion under the *Access to Information Act* (*AIA*)." It is also reflected in other procedures, such as those which allow CF members to access their personal information.

1238 According to correspondence between the Director, Access to Information and Privacy and Mrs. Wheeler, when the relative of a deceased CF member is seeking information from the CF, there is some ministerial discretion to

provide information about the death. The letter accompanying the three-page résumé of the SI Report explained that the information was being provided to Mrs. Wheeler on that basis.

1239 Aside from the limited application of this discretion and the provision for the estate administrator in the *Privacy Act*, a family member seeking information about a deceased CF member is treated in the same way as a member of the public. For any other information, the family must apply under the *Access to Information Act*, which requires the personal information to be severed. This creates a conundrum: the family is unable to get specific information about the circumstances of the member's death because the only person to whom the information can be released is dead.

1240 In other jurisdictions, this problem has been addressed through legislation. For example, in the UK, the *Access to Health Records Act* gives patients the right to apply for a copy of all or part of their health records. It gives the same right to someone authorized in writing by the patient, the parents of minor patients, a person appointed by the court to manage the affairs of a patient judged incapable of managing his or her own affairs, or, "where the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death." Some of these rights are included in the rights granted to the estate administrator under the Canadian *Privacy Act*, but the UK legislation goes farther, since it does not restrict access to those records related to administration of the estate.

1241 The DND/CF has taken the first step in addressing this problem with the new PEN form, which in effect allows members to consent to the release of their personal information to a person (or people) of their choice. I applaud this initiative; however, as mentioned earlier, there are concerns about how diligent members will be in completing these forms and in keeping them current. In addition, I believe there needs to be clear policy specifying what information should be provided and who is responsible for providing it.

9.3.3 Facilitating the Process for Families

1242 I do not believe that families of deceased CF members should have to fight to obtain information about their loved ones. Mrs. Wheeler's experiences are not isolated occurrences. Many of the improvements since 1992 appear to have been limited to high-profile incidents, and families still face problems obtaining information through the *Access to Information Act* and *Privacy Act*.

1243 The mother of the soldier killed in the 2002 training accident at CFB Petawawa complained to my investigators about delays in obtaining the information she had requested through DAIP. She found the process extremely frustrating. She had been promised an Assisting Officer to help her navigate the process to make a request for the full CFNIS report under the *Access to Information Act*. She states that this did not happen, and that she found the request form and filled it out and sent it into Director, Access to Information and Privacy by herself. The Director, Access to Information and Privacy confirmed receipt of the request and then informed her that the information would have to be reviewed under the *Privacy Act*, since it contained a great deal of personal information, and General Motors would have to be consulted, as the manufacturer of the Light Armoured Vehicle (LAV) her daughter was in at the time of her death. They estimated the review would take four to six weeks. The soldier's mother was under the impression that the report was sent to a different office, one responsible for the *Privacy Act*, for this review.

1244 The mother of the soldier killed in the 2002 training accident at CFB Petawawa told my investigators that, toward the end of the four- to six-week period, she telephoned the person she had been dealing with and was told the review was going slowly but was on track. She said she was informed that General Motors was refusing to agree to the release of any information about the LAV. The soldier's mother said that the next time she called the same access to information and privacy officer, she got an answering machine message informing her that the person was on parental leave, resulting in

further delays. Her description of her experiences dealing with Director, Access to Information and Privacy leaves no doubt that she was extremely frustrated and did not know what to do next. She told my investigators:

1245 > So that is where we are at with the Access people. We are no further ahead than we started back in May, absolutely no further. Actually, we are probably further behind now because when [the first officer] was working on the account, at least it was going in some direction. Now that she is gone on a year's maternity leave, he [her supervisor] has pulled it, given it to somebody brand new and said go through it. Do I have to wait another 10 weeks to get this same information? This is ridiculous.

1246 The soldier's mother and step-father expressed the belief that the department was "running interference" on the file, because they did not want the information to get out. This shows their attempts to get information about the death have resulted in a great deal of frustration and created distrust.

1247 Ten years after MCpl Wheeler's death, the experience of the family of the solider who was killed in the 2002 training accident at CFB Petawawa with the administration of the *Access to Information Act* mirrors Mrs. Wheeler's. The CF should have provided Mrs. Wheeler with some assistance in navigating and understanding the system, rather than leaving her to fill out and send in the requests on her own. She was also left to her own devices to decipher what was sent to her. The information missing from the copy of the report that Mrs. Wheeler received had been severed in accordance with privacy legislation; however, a bereaved family member cannot be expected to be aware of the individual circumstances and the complex and confusing nature of the legislation. If she had been given some preparation before receiving the document and had had someone to guide her through it, some of the frustration she experienced upon receiving her heavily blacked-out copy could have been avoided. Furthermore, her belief that information was being concealed or manipulated would not have been reinforced.

1248 I believe that the CF has a positive duty to tangibly assist family members in navigating the complexities of the *Access to Information Act* and *Privacy Act* and, if necessary, to act as an advocate to ensure that as much information as possible is released to the family. This can be done through the criminal and/or administrative investigative body (the CFNIS and/or the BOI) or coordinated through the Assisting Officer. The person assigned to assist

should be knowledgeable about the legislation; liaise with the Director, Access to Information and Privacy, the Privacy Commissioner and the Information Commissioner as required; explain any severances; and last, but not least, ensure that any fees are waived.

1249 Recent experiences with the Tarnak Farm BOI demonstrate the benefits of openness, not only to the family but also to the Canadian public in general. The terms of reference for that BOI were released publicly and the report was made available on the Internet, with limited severances that appear to relate to operational information. There was no downside to this practice, and I believe that it fostered a greater confidence in the military on the part of family members and the public.

1250 There is a pressing need to accelerate the cultural change that is creating a more open and transparent CF. BGen Ross, speaking of how the Wheeler family should have been treated and the requirement not to hide behind a veil of "operational security," told my investigators:

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> Families have a right to know within — I mean, these people weren't flying Stealth bombers to destroy nuclear power plants in Iraq that you aren't going to tell the rest of the world about. This was a training exercise, for God's sake, in the prairies in Suffield, Alberta. There is no security classification issue here whatsoever. You may have an investigation where you have a security issue. Even then, I find that's a bit soft. Legitimately, there may be those cases. This wasn't one of those cases. There was nothing here that we couldn't have spoken to them about.

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> … [Otherwise] people feel frustrated and hurt and damaged, and that is exacerbated by time. The longer the time that has passed, the more that damage is and the harder it is to repair. Then, at some point, it is not repairable at all. It is just long-term permanent damage.

1253 I believe the same requirements apply with respect to all investigations the DND/CF conducts in relation to the unexpected non-combat death of a member. The DND/CF has a duty to do everything the law permits to be as open and transparent with the family of the deceased as possible. This duty stems from the DND/CF's responsibility to the member and the member's family. When a CF member dies on duty, families need information to help get them through the grieving process, to achieve closure and to enable them to move on with their lives.

1254 It is true that the access to information and privacy legislation, when interpreted narrowly and restrictively, seems to preclude the provision of full information to the family. I do not believe that is the intent of the legislation, which, after all, allows a great deal of discretion in the way it is interpreted. I believe that in such cases, it is incumbent on the DND analyst to apply the legislation as liberally as possible, in order to provide the family with the most information possible. Not to do so frustrates family members and contributes to the feeling that information is being withheld or covered up.

1255 No family should have to wait months, only to get a stack of papers in the mail with significant portions blacked out and little or no explanation, or opportunity to talk to someone from the CF about it. I realize it will take additional resources, but I believe that requests from families for information about deceased CF members should be processed on a priority basis wherever possible. Furthermore, the information should be provided to the family, in a personal meeting where possible, which would allow someone with knowledge of both the file and the legislation to explain why information has been withheld.

1256 Finally, in some cases it is fair to say that preventing the family of a deceased CF member from obtaining the member's personal information is contrary to the member's wishes. Where the PEN form has been filled out to give the CF the authority to release personal information, it indicates the member's clear intention to have that information released to a specific person. When we spoke with the Director, Access to Information and Privacy in 2004, she informed us that when this is the case, DAIP considers that the information can be released under section 19 (2) (a) of the *Access to Information Act*, which allows the release of personal information with the consent of the person it is about. I believe that this practice should be followed, not only immediately after a death, but with regard to all of the subsequent information generated in criminal and administrative investigations, and their consequences.

1257 The Director, Access to Information and Privacy informed my investigators that her directorate does not require formal access to information requests on the part of family members seeking information on a deceased CF member. Rather, she pointed out, much of the work is done informally on a priority basis, understanding the importance of providing grieving families with information. She said that, although there is no formal policy about these matters,

1258 DAIP [the Director, Access to Information and Privacy] has taken the position that as much information as possible is provided to grieving families to assist in obtaining closure. When requestors ask, either the Director, Deputy Director, or the analyst who worked on the file speaks with whoever asks to explain severances. Compassion and as much openness as possible is used at all times. Most of the analysts at DAIP are well experienced; those who are not work under the tutelage of those who are.

1259 She also noted that the high volume of requests received and filled every year means that even priority cases can encounter delays. In addition, she identified the major impediments to providing families with information. According to the Director, Access to Information and Privacy, before the introduction of the new PEN forms, it was very difficult to supply families with information about a deceased CF member, but the new PEN form provides for the required consent. The remaining impediments are operational security and the personal information of other people involved. It is possible to release other people's personal information with their consent, but it is unusual for a DND analyst to seek that consent, she said. The Director, Access to Information and Privacy mentioned that it is always possible for the person making the request (the requestor) to get the consent of people he or she knows were involved and to include those releases with the access request. She indicated that some requestors know about this option, and that it greatly facilitates processing when an access request is accompanied by consent forms.

1260 However, there is no mechanism for informing requestors of the benefits of getting consent from people involved or that this is an option available to them. As a result, it requires the requestor to be informed about access to information law, about the DND's procedures, and about the identities of people whose consent might be required. It also puts the onus on the requestor to find those people and ask them for their consent. Assuming the requestor even knows to ask for these consents, it does not follow that he or she will know the identities of everyone involved; staff of the Director, Access to Information and Privacy, however, will have a copy of the document, which will include the names of everyone involved. In addition, while in some cases it may be relatively easy for the requestor to get the consent of a friend or neighbour, he or she will not always be in a better position than Director, Access to Information and Privacy staff to ask for consent. Finally,

in cases of accidental death, in which emotions might understandably be high, it might be more prudent and productive for the request for consent to come from a disinterested party.

1261 I appreciate the approach taken by the Director, Access to Information and Privacy and the constraints under which that directorate operates. However, I am concerned that the lack of information about Director, Access to Information and Privacy's procedures and the lack of information about how a requestor can facilitate the process may be unfair to requestors.

1262 **I therefore recommend that:**

1263 **14. Regulations and policies be amended to allow the person designated on the Personal Emergency Notification (PEN) form as the recipient of the deceased member's personal information to have the same rights of access as the CF member would during his or her lifetime, whether under the *Privacy Act* or as a result of departmental regulations or policies.**

1264 **CF directives for casualty administration and directives relating to access to information and privacy be amended to direct that, whenever a request is made to provide information to the family of a deceased member, such requests will be processed so that:**

1265 • **they are handled on a priority basis by experts in the subject matter and analysts;**

1266 • **a compassionate, open and transparent approach to administering access to information and privacy legislation is taken;**

1267 • **special consideration is given to the liberal application of the discretionary exceptions in the legislation, including obtaining consents for the release of third parties' personal information;**

1268 • **the assigned analyst maintains communication with the family or the Assisting Officer; and**

1269 • **when the information requested is ready for release, the assigned analyst and any subject matter expert who prepared the information make themselves available to explain to the family how the request was prepared, what information was included and the reasons for any exclusions and/or severances, and to discuss any questions.**

1270 The department agreed with this recommendation, noting:

1271 > Agree. Moreover, this is already being done as Section 4 was recently added to the PEN form in order for the member to grant permission for the release of his/her personal information, should he/she choose to do so. Unless the member places restrictions on that access (by annotating the comments section), the designated individual has the same right of access as the deceased. This is in accordance with the *Privacy Act*. The Working Group will prepare a transitional recommendation for dealing with situations where the revised PEN form has not been used.

1272 > … Rules and regulations pertaining to the provision of information are well defined and the CF will accommodate the family within the limits of applicable legislation.

1273 > The Assisting Officer will work in conjunction with DAIP to press for the quick release of information and to provide the family with clear explanations wrt ATI/Privacy procedures.

1274 I think this is a good start. I am concerned, however, that the intended approach, as set out in the response, does not appear to take into account the point which I believe underpins all of the recommendations in this section, namely that families of deceased CF members have a peculiar status, and should be treated differently by virtue of that status.

1275 The problems that family members experience while attempting to obtain information from the DND/CF and the Archives are not related to the fact that these institutions must comply with the applicable laws and regulations. The problems stem from the fact that they are treated like any other citizen attempting to access any other kind of information held by the government. This approach fosters frustration, suspicion, and even acrimony on the part of the family members, and I believe that we can and should do better. We owe

as much to the families who have lost a member in the service of our country, who are unable to move on with their lives without a basic understanding of what happened, and who can only get the information they need for that from the DND/CF.

1276 There are examples in the DND/CF of when the families were treated according to the principles discussed above: the Tarnak Farm BOI stands out as one example, as well as some other highly publicized deaths. I have not been provided with any convincing arguments as to why someone who has lost a family member in an incident which has less public resonance should not be treated with the same consideration and sensitivity.

9.4 Participation of Families in the BOI Process

1277 Mrs. Wheeler's experience with the SI and the BOI into her husband's death appears to be typical of the way the CF regards the role of family members in the BOI process. The CF instinctively shies away from including family members; if they are informed, it is usually a case of too little, too late. Families rarely have input into the inquiry's line of investigation, and by the time they get the report, a good deal of information is withheld.

1278 In the case of the soldier killed in the 2002 training accident at CFB Petawawa, a BOI was convened to conduct the administrative investigation. It was determined that the Board would only begin the investigation once the CFNIS concluded its investigation. According to the family, they were not informed about any of this. The soldier's mother and stepfather are both CF members, so they anticipated that there would be a BOI. As a result, they say they knew to ask, and they were eventually told that one had been convened. The soldier's stepfather told my investigators: "My expectation was that there would be a BOI. If I was Joe Civilian, pizza delivery guy, I wouldn't have had a schmik of what was going to take place."

1279 The family of the soldier killed in the 2002 training accident at CFB Petawawa was contacted by the BOI in the early fall of 2003. The BOI met with the family on November 7, 2003, discussed its findings to date and asked for the family's input into those findings. The family was very pleased that the BOI had taken this step.

1280 This approach is not the only route available to the CF. Gen (retd) Baril, the President of the Tarnak Farm BOI, in a letter which accompanied the final report, stressed the need for "open and transparent communication with the affected families, the men and women of the Department of National Defence and the CF, and the greater Canadian public."

1281 One objective of such an approach, Gen (retd) Baril explained, was to "balance the need of the families to understand what befell their loved ones with the desire of the wider public for information on this important national issue, in the most compassionate yet pragmatic manner." Accordingly, an interim report was released as well as the final report, not only to family members, but also to the general public over the Internet.

1282 The executive summary of the final report notes that the President of the BOI met individually with all of the victims' next of kin, following through on his personal pledge to relay information on the progress of the Board to them in as timely a manner as possible.

1283 Under the regulations governing the CF, the convening authority may direct that a BOI be open to the public (*Queen's Regulations and Orders* (QR&O) article 21.12). Even when a BOI is closed to the public, QR&O article 21.12 (c) allows "a person whose attendance is required by the president" to be present. QR&O article 21.10 (4) permits the BOI President to allow the attendance of a person at the inquiry if the evidence "appears likely to adversely affect" him or her.

1284 The Australian Parliamentary Committee report on the military justice system recommended that inquiries into the deaths of ADF members be open to next of kin and other immediate family members; that the requirement to keep the families informed be written into inquiries' terms of reference; and that investigative bodies appoint a liaison officer to communicate with the

family. The Committee also recommended that the next of kin be allowed to represent the interests of the deceased person and be entitled to legal representation at the government's expense if the deceased member's reputation is likely to be affected by the BOI.

1285 The Burchett Inquiry recommended that the ADF study ways of achieving "fair and effective transparency" in criminal and administrative hearings and of ensuring proper information is provided to "victims and other persons with a legitimate interest." The most recent inquiry is looking into other ways of ensuring openness toward the families of deceased ADF members. In the interim, a number of initiatives have already been implemented, which were explained to me in meetings with Gen Cosgrove (Australia's Chief of the Defence Force) and other senior ADF members, including members of the legal community, that the ADF's investigation of duty-related deaths is geared to include next of kin. They advised that next of kin "would be invited to participate in the process, regardless of the circumstances."

1286 In his 2004 submission to the Australian Senate Foreign Affairs, Defence and Trade References Committee, Gen Cosgrove pointed to a number of recent ADF inquiries in which families were given an opportunity to participate. He noted that the BOI into a fire on the Royal Australian Navy ship *Westralia* released Volume I of its report publicly, and released all volumes to the next of kin, with some privacy deletions. He also mentioned another case in which a leading seaman went missing and was presumed dead, the Royal Australian Navy provided legal counsel for the deceased and for nine navy members who were determined to be "affected persons." In the latter case, after a review, the BOI was directed to rewrite the executive summary of the report to make it accessible to readers with no knowledge of the navy and to allow the public release of the narrative of the event without the need for deletions. Gen Cosgrove also referred to an army BOI the results of which were provided to the family of the deceased member and noted "the Army continues to assist the [family's] understanding of the report." He also described a Royal Australian Air Force BOI into the suicide of a cadet; he said the Air Force was aware of the cadet's mother's concerns and, as a result, she "was provided with a full and uncensored copy of the final report of the inquiry and with various forms of support." He also noted that she was consulted on some of the proposed policy changes and that one of her ideas was incorporated into the new cadets' policy.

1287 In Canada, there are many examples of legal mechanisms that provide for families to participate in official inquiries into the death of a family member. All provinces require coroner's inquiries into fatal accidents to be open to the public, with some exceptions depending on the matters being investigated. In six provinces, the relevant legislation allows coroners to grant standing or allow the participation of families or other interested parties at coroners' inquests. A seventh province (Newfoundland and Labrador) requires reports be sent to the next of kin, the executor and other interested parties.

1288 While coroners' inquests are not completely analogous to BOIs, the two procedures serve similar functions. Neither procedure is a criminal investigation and neither has the primary goal of determining culpability; rather, they complement the criminal investigation of a death by searching for explanations for unexpected deaths and recommending changes aimed at preventing similar deaths in the future. As a result of their similar functions, coroners' inquests and military BOIs uncover similar information of interest to families of the deceased, which may not be available from other sources such as criminal investigations. For these reasons, we looked to the way coroners interact with family members and other interested parties for examples of useful practices.

1289 Under Section 41(1) of the *Ontario Coroner's Act*, anyone may apply for standing at a coroner's inquest, and "the coroner shall designate the person as a person with standing at the inquest if the coroner finds that the person is substantially and directly interested in the inquest." Someone who has been granted such standing may be represented by counsel or an agent, and has the right to call and examine witnesses, to present arguments and submissions, and to cross-examine other witnesses in relation to the person's interest in the proceedings. In addition, section 26 (1) of the Act allows members of the deceased's immediate family or the deceased's personal representative to apply to the coroner to hold an inquest, if the coroner has determined that there will not be an inquest.

1290 Dr. Jim Cairns, Ontario's Deputy Chief Coroner, indicated that the family of a deceased person would automatically be granted standing at an inquest on applying. He pointed out the importance of the family's direct involvement in all stages of the process.

1291 I believe that allowing the involvement of interested parties would make the CF's BOI process more open and transparent and would actually contribute to the rigour of the Board's findings, since participants often have information that would otherwise not come before the Board. I have made similar recommendations in another report based on a complaint to my Office. In that case, a BOI was held to inquire into very serious injuries sustained by an officer cadet during an official athletic competition. His injuries were related to a rare medical condition that he claimed was exacerbated by the rigours of training and the pressure to perform. Since the injury meant he could no longer remain in the CF, the inquiry had serious consequences for his eligibility for benefits and disability allowances. Nonetheless, he did not qualify for attendance at the proceedings under QR&O 21.10.

1292 In that report, I recommended the CF expand the provisions for attendance at BOIs to include anyone with a direct and substantial interest in the proceedings, whether or not they are likely to be adversely affected by the findings. The current regulations restrict the people who may be given standing at a BOI to CF members likely to be adversely affected by the evidence. Former members or non-CF family members cannot request permission to attend, examine witnesses or call evidence. Also, others with a direct and substantial interest in the outcome may not qualify for participation under the narrow definition of adverse effects. Examples include Mrs. Wheeler, in this investigation, and the officer cadet in the investigation described above. These parties are not currently allowed standing by the regulations, although they can be profoundly affected by the decisions of the BOI, which can make determinations with regard to benefits or other issues that directly affect them.

1293 The participation of family members of deceased CF members, or others with a direct and substantial interest in the proceedings, is just as relevant to a BOI as the attendance of people likely to be adversely affected by the evidence. Allowing them to bring forward their concerns, to cross-examine witnesses, present evidence and make statements would contribute just as much to the fact-finding mandate of a BOI. In the officer cadet's case, I found that granting him standing may have allowed him to question some of the medical evidence considered by the BOI, and therefore may have led the Board to a more complete and thorough examination of the facts.

1294 Granting family members standing at a BOI inquiring into the death of a deceased CF member would serve a number of purposes: it would be the best way to ensure the family's questions are answered first-hand; allowing them to hear the same testimony and evidence as the BOI members would be a quick, uncomplicated way to ensure they get all the information they need; and it would go a long way toward acknowledging that a family member is more than just another witness or an outside party with nothing to contribute to the process. Including family members in a BOI would demonstrate sensitivity to their needs to receive information and to be included in the process, and would contribute to the thoroughness of the findings of the BOI. It should also increase family members' trust that information is not being withheld and thus increase their confidence in the results of the BOI.

1295 Finally, granting family members standing allows them to raise relevant issues and questions the BOI might otherwise not address, which facilitates the search for truth — the goal of a BOI. This goal is especially important when an inquiry concerns the death of a CF member, the investigation of which I believe should be as thorough as possible.

1296 During this investigation (and several others), we were told about concerns over the type of information that can be heard at BOIs. I am aware that QR&O 21.12 allows the convening authority to order that BOI meetings be open to the public. I am not recommending that all BOIs be open to the public, because of the possibility that sensitive information might be discussed at these inquiries. I also recognize that the Board may hear evidence related to military operations, which it might legitimately wish to keep secret. However, I do not believe these reasons should be used as excuses to bar family members from the entire inquiry. Rather, the rules and regulations should clearly state the kind of information that would provide cause for excluding family members, while ensuring that they are present for as much of the inquiry as possible.

1297 Other concerns relate to the possible effect on the proceedings of attendance by family members, whether by outright disruption, by creating an atmosphere in which witnesses might feel they cannot be completely candid or by rendering the process an adversarial one. I do not believe that these are necessary consequences of granting standing to family members. Disruptions

and confrontational attitudes can be managed by BOI members, who can be trained to control the process; an Assisting Officer can also explain the limits of their participation to family members and provide guidance on appropriate ways for them to raise concerns.

1298 It is true that BOIs, like coroners' inquests, are not adversarial in nature; they aim at finding the truth. However, having people with conflicting interests present to ask different questions can help to uncover the truth; it does not necessarily mean that the process will become adversarial.

1299 Neither should the presence of family members unduly affect witnesses. After all, witnesses are under oath to tell the truth, which is not something that should be influenced by who is in the room with them. Family members of victims are allowed to be present at criminal trials, and witnesses are able to give frank testimony in their presence. In fact, one would hope that the presence of the deceased's family at a BOI would serve to remind witnesses of the serious nature of the proceedings and motivate them to be frank and forthright out of respect.

1300 Family members of CF members who have died unexpectedly have a compelling interest in the investigation pursued by a BOI into the circumstances of the death. I believe that, as in the coroner's system in Ontario, they should be considered to have a prima facie right to full standing. This would include notice of the decision to convene a board of inquiry and being provided with a copy of the terms of reference and an opportunity to have input into them. The family as part of their right of standing should be provided with an assisting officer to guide them through the proceedings and have the opportunity to be represented by this officer or a representative of their choice, including counsel. During the proceedings, they should be entitled to be present, hear evidence, question witnesses, present evidence and make submissions. They should also receive a full copy of the board's report at the end of the process.

1301 **I therefore recommend that:**

1302 **15. CF regulations be amended to direct that where a Board of Inquiry is convened for the purpose of investigating the unexpected death of a CF member, the family of the deceased member shall be notified of the decision to convene the Board and provided with a prima facie right to full standing in the proceedings.**

1303 The DND/CF agreed in part with this recommendation and has undertaken to amend Defence Administrative Orders and Directives with respect to Boards of Inquiry to give the President of a Board of Inquiry the discretion to allow the attendance of family members of a seriously injured or deceased CF member at the meetings of a BOI. I agree that this is an excellent first step. It also reflects a practice which has been adopted informally by some recent Boards of Inquiry, including that examining the death of Lt (N) Saunders aboard the HMCS Chicoutimi.

1304 The DND/CF has noted that standing is a more complex issue which must be assessed in light of the effects that it would have Boards of Inquiry as internal administrative fact findings mechanisms. During my Office's meetings with ADM (HR-Mil) and Judge Advocate General officials concerns were expressed that according standing to families -- including the right of representation, which in some cases might involve lawyers from outside of the JAG in the process -- would unduly complicate and delay the proceedings. My investigators encouraged the CF and members of Judge Advocate General who will be involved in the CF's review of the Board of Inquiry Process to closely study the provincial coroner's system as an example of how such concerns can be effectively managed. The coroner's system is also an excellent example of the value which is achieved by affording families a voice in the process. In my view the advantages associated with including families and allowing them a voice in the process far outweigh the challenges cited by DND/CF officials about potential disruption to the proceedings. Families can bring important information, and even a fresh perspective to the proceedings, which assists in the search for truth and aids the Board of Inquiry in their fact finding mission. This impact is lost if their status is limited to that of observers present at the discretion of

the BOI president. Finally, allowing families a voice in the process, as I have previously noted, will help instil a greater degree of confidence not only in the fairness of Board of Inquiry proceedings but also in the ultimate conclusions and recommendations of the Board.

9.4.1 Liaison and Information to Families after a BOI

1305 Mrs. Wheeler's persistence over the years was motivated in part by a desire to know if the changes to safety procedures recommended by the SI were ever implemented. She frequently commented on how important it was to her to ensure that lessons learned from her husband's death prevent similar accidents in the future. Despite numerous attempts to obtain this information, she met with no success.

1306 She was also unsuccessful in getting specific information about the administrative or disciplinary actions taken against the individuals found responsible by the BOI. When briefed by BGen Ross and provided with information about the BOI, she was given copies of the letters sent to Col Semianiw and LCol (retd) Lapeyre. It appears that she was assured that the letters would have serious career consequences.

1307 However, she was not kept informed of subsequent developments: she was not told that the chain of command's approach to the letters was changing; that the two officers had been told that the letters were primarily informative, not disciplinary; or that the letter had been ordered to be removed from Col Semianiw's merit file. Nor had she been told that the two officers involved had made substantive submissions to the chain of command, alleging that the BOI was fundamentally flawed.

1308 In addition, Mrs. Wheeler could never have known to ask about new information — in particular, the reviews being conducted as a result of challenges to the BOI by Col Semianiw and LCol (retd) Lapeyre and, later, LCol Kaduck's statement that he remembered being appointed Chief Controller.

1309 Mrs. Wheeler was eventually informed of the new information from LCol Kaduck by the CFNIS investigator, Insp Grabb, who also took it upon himself to inform her of other developments. I find Insp Grabb's

commitment to keeping Mrs. Wheeler informed of the progress of the case laudable. As noted earlier, I also commend the initiative of the Provost Marshal in stressing the importance of such updates.

1310 I find, however, that there is a distinct lack of a similar commitment in other parts of the CF. If not for the CFNIS investigation into possible perjury charges against LCol Kaduck, no other mechanism was in place to inform Mrs. Wheeler about LCol Kaduck's change in testimony.

1311 Furthermore, since the completion of the CFNIS investigation, Mrs. Wheeler had no contact with anyone from the DND/CF, with the exception of my Office, until recently. In the intervening time, the CLS convened the ARB to look into the BOI. Mrs. Wheeler was informed of this development by my Office, at the request of CF officials concerned about the prospect of approaching her without prior warning.

1312 LGen Jeffery, the CLS who convened the ARB, told my investigators that he had discussed with LCdr Sylvain Allard, the DLP desk officer for this case and Secretary of the ARB, their responsibility with respect to keeping Mrs. Wheeler informed of the most recent developments. He reported his position on this issue as follows:

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> I felt strongly that there was no need to bombard her with information or to raise issues with her that were not of any substantive nature in terms of the overall case because she had been through enough … On the other hand, if we don't do anything or decisions were going to result in substantive changes of findings and direction, then we had a moral responsibility to tell her that.

1314 LGen Jeffery did not think that Mrs. Wheeler was aware that an ARB was being conducted; he told my investigators that the ARB's terms of reference did not include the way the CF treated the Wheeler family because it was not an issue that had been explicitly raised with him at any stage.

1315 On November 20, 2003, the Commander of Land Force Western Area met with Mrs. Wheeler and her daughters to brief them on the ARB, and provide them with a copy of the report. The Commander, Land Force Western Area had not been involved in the BOI or the ARB and was not in a position to answer Mrs. Wheeler's questions about any of the issues they examined.

1316 The copy of the report Mrs. Wheeler was given was extensively severed. Much of the missing information was the personal information of LCol (retd) Lapeyre. We asked LCol (retd) Lapeyre if he would allow Mrs. Wheeler to see the version of the ARB Report he was given, which still contained some severances, but which included his personal information. He agreed, commenting that he would have given his permission to release his personal information to Mrs. Wheeler but was not asked to do so. This chain of events indicates that efforts to provide Mrs. Wheeler with information were not as thorough as they could have been.

1317 Overall, I find that, with the exception of the CFNIS perjury investigation, once the BOI was completed and Mrs. Wheeler informed of the results, she was treated as a non-entity. No efforts were made to keep her informed of any developments stemming from the actions taken as a direct result of her efforts. It is impossible to have a connection to this case and not be aware of its importance to Mrs. Wheeler and her insistence on having complete and thorough information.

1318 Families have an interest, not only in the information about the circumstances of a death, but in the information generated as a result of the death. They should be entitled to know about any action taken as a result of the death, in terms of determination of responsibility, disciplinary action, changes to policies and procedures, and the outcome of any other recommendations. They are also entitled to know if any initial issue has been revisited, if anyone has appealed actions or challenged findings, and if any new information has come to light.

1319 In this case, one senior DLP officer who reviewed LCol (retd) Lapeyre's complaints noted that the Wheeler family had an interest in the complaints and other developments since the BOI, and recommended that they be kept informed. However, the Wheeler family was told nothing about the events unfolding until the CFNIS investigation in 1999 and 2000, and when they were provided with a severed copy of the completed ARB report in 2003. There is no evidence that the failure to provide information to the Wheeler family was done maliciously. Rather, it appears to stem from the fact that no one was directly tasked with keeping the family informed of significant developments as the case progressed.

1320 Families also need to make an effort to keep in touch with the CF through the officer assigned to them, if they wish to receive information. There must, however, be a stable point of contact to inform the family of any new developments, should they wish to receive this information.

1321 **I therefore recommend that:**

1322 **16. After the conclusion of all formal processes with respect to the unexpected death of a CF member, including the BOI, a CF contact person be designated to maintain contact with the surviving family, if they wish, and to inform the family of any significant developments, including the implementation of any recommendations made by the BOI and any subsequent reviews or appeals related to its findings and conclusions.**

1323 The CF agreed with this recommendation, noting that the casualty administration review will determine how to best implement it.

10 Ongoing Support to Mrs. Wheeler

10.1 Complaint

1324 Mrs. Wheeler complained that she and her daughters received insufficient support from the CF in the aftermath of her husband's death and that she felt increasingly abandoned by the CF as time went on. She made several specific complaints about the way she was treated, including:

1325 • her first Assisting Officer's lack of experience;

1326 • lack of continuity of Assisting Officers;

1327 • her husband's personal effects were withheld from her until all her husband's equipment was accounted for;

1328 • failure to assist her in accessing counselling in a timely fashion; and

1329 • her husband did not receive sufficient recognition from the CF in the aftermath of his death.

10.2 Sequence of Events

1330 The CO of 2 PPCLI assigned an Assisting Officer to Mrs. Wheeler immediately after the death of her husband. That individual then became responsible for liaison between Mrs. Wheeler and the CF. Mrs. Wheeler's Assisting Officer was a rifle platoon commander, a second lieutenant in his mid-twenties at the time.

1331 This member had not previously acted as an Assisting Officer to a bereaved family. He believes he was selected because he had some fairly recent personal experience of losing a family member, his mother having passed away in 1989 and his mother-in-law, in 1990.

1332 The Assisting Officer told my investigators the CF had not provided him with any formal training to prepare him for this duty or any guidelines about what was required of an Assisting Officer in these circumstances. He said that he had:

1333 No idea [of what the duties were], until I was told I was the Assisting Officer and basically, was given my terms of reference at that time and started opening up books to find out what I was expected to do. I think there was some document there that sketched out what I was responsible for. No, I had no idea.

1334 Mrs. Wheeler first met with her Assisting Officer at approximately 10:00 p.m. on the evening of the accident, when he arrived at her house with a chaplain (not the same chaplain who had notified her of her husband's death earlier that day).

1335 Mrs. Wheeler believes that, although the Assisting Officer was young and inexperienced with regard to his role, he did an excellent job in arranging her husband's funeral. On June 16, 1992, she wrote to LCol Lapeyre, complimenting her Assisting Officer on his overall conduct, including his assistance with the funeral:

1336 From the minute he first stepped into my home [the Assisting Officer] has been nothing but considerate and concerned for myself and my daughters. He complied with my wishes for my husband's escort as well as his honour guard even though it was not "regulation," he knew without asking how upset I would have been had these men not been allowed to do as I had asked. Although officially his job is done [he] continues to call and help in any way he can.

1337 During the weeks immediately following the accident, the Assisting Officer visited Mrs. Wheeler regularly, providing her with information about her benefits. A rapport developed between the two, and they kept in contact for several years after he relinquished his formal duties as her Assisting Officer.

1338 However, in the year after her husband's death, Mrs. Wheeler had to deal with three different Assisting Officers. Her first Assisting Officer carried out this task until July 1992. A second Assisting Officer then assumed this responsibility until the spring of 1993. Both had to relinquish their duty as a result of being deployed overseas.

1339 Mrs. Wheeler still had many unanswered questions when her first Assisting Officer handed over his duties: she had not been notified of the details of the SI; she was still dealing with pension issues; and she was awaiting a copy of her husband's death certificate. At that point, she started to believe the CF

was, in her words, "getting tired of me." In July 1992, she wrote to 2 PPCLI complaining about the lack of assistance.

1340 In March 1993, prior to deploying overseas, the second Assisting Officer wrote Mrs. Wheeler, advising her that an unnamed Rear Party Adjutant had taken over his duties as Assisting Officer. Mrs. Wheeler told my investigators that she never heard from the third Assisting Officer:

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> This is his [the second Assisting Officer's] letter from 8 March 1993 apologizing for not contacting me sooner because he has been busy with his preparations for Yugoslavia: "I hope you are in contact with the 3PPCLI Rear Party Adjutant and he is providing you with whatever assistance you require. If not, please write to [the] Officer Commanding 2PPCLI Rear Party." Neither one of these people I had heard from or knew who they were. If they had walked through the door, I wouldn't have had a clue who they were. So I don't recollect being contacted ever by the Rear Party Adjutant, although it doesn't really say who he is. It just gives his title.

1342 She became so frustrated that she had little to do with 2 PPCLI or the CF from that point on.

1343 One issue that upset Mrs. Wheeler, and remains most vivid in her memory, was the way in which she was asked to return some of her husband's army equipment that he had kept at home. Her understanding was that, until she returned specific items, she would not be given the personal effects that MCpl Wheeler had kept at the battalion:

1344

> One thing that stands out that I still find very upsetting to this day is a couple of days after he was killed, they came to me, the liaison officer came to me and said that he had Rick's personal effects, but that he wasn't able to give them to me until I returned all the military effects back to them. I was just stunned. I didn't know what he was talking about … And in particular what they were looking for was a flak vest, because he did not have that out in the field with him with his gear, and they had this itemized list of what gear they were expecting back to the military. Essentially what it was, was that until I gave that vest to them, they were not going to give me his personal effects.

1345 The flak vest was returned and her husband's personal effects were returned to her.

1346 Mrs. Wheeler stated that she was never offered grief counselling and, in fact, had to ask for help when she realized both she and her daughters would benefit from some professional counselling. Even then, she found it was difficult to keep appointments at CFB Winnipeg because she no longer held a recognized Base identification card. She had to have authorization from someone to permit entry, which she found cumbersome and frustrating. She also found it difficult to meet with the counsellor in military surroundings and would have preferred the counselling sessions be held off-Base. Mrs. Wheeler also states that she received little information about possible services or resources that might have been available to her, including services provided by Military Family Resource Centres (MFRCs).

1347 In May 1998, 2 PPCLI erected a cairn in MCpl Wheeler's honour at CFB Suffield. Mrs. Wheeler, who was present at the dedication of the cairn, was later presented with a photograph album of the ceremony. She is extremely disappointed it took the CF six years to recognize the more than 10 years of service her husband had given his country prior to his death:

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> My husband died serving this country in peacetime. My children and I deal with that every day, but we also have to deal with the knowledge that his death was so insignificant that it was deemed a minor incident. I do not understand how a man's death can be so insignificant to so many. It was as if he never existed, his contributions to the military never recognized.

10.3 Analysis and Recommendations

1349

> [T]hey tell you there is the "military family" and they are there for you and they will always support you in this and that and take care of you, and that is not true. It's a joke. The minute that there is — the minute the service member is deceased or injured or basically out of commission and out of work, you are done. The door is shut, the key is turned, and you are done.
>
> — Christina Wheeler, April 2002

1350 Mrs. Wheeler feels that she never had the depth and consistency of support that she required from the CF, although she acknowledges that her first Assisting Officer treated her with kindness and respect, and did the best job he could in the circumstances. Nevertheless, to a significant extent she was left to handle a number of complex issues on her own, in addition to her struggle to obtain information about her husband's death, which went on for more than a decade. She felt abandoned and betrayed by the military family of which she had been a part for many years. Over the course of time she became increasingly disillusioned and frustrated with the CF.

10.3.1 Guidelines for Appointing Assisting Officers

1351 An Assisting Officer assigned to a bereaved family should ideally be both experienced and knowledgeable. As the contact point between the CF and the family, his or her conduct will form the foundation of how the family

perceives it has been treated. In this case, the first Assisting Officer assigned to Mrs. Wheeler was a very junior officer with little formal knowledge of the bureaucracy surrounding death benefits and no training or experience in dealing with the family of a CF member who had suddenly died. He was given a very difficult task, without the tools required to do it thoroughly. Nevertheless, and to his great credit, he performed many aspects of his task admirably.

1352 To ensure families receive the best possible support from the assigned Assisting Officer, a CO should consider a number of factors prior to selecting an Assisting Officer. They include, but are not limited to:

1353 • age;

1354 • training and experience, in particular in dealing with sudden deaths;

1355 • knowledge of CF and Veterans Affairs Canada (VAC) assistance mechanisms available to bereaved families;

1356 • communication skills; and

1357 • availability in both the short and long term.

1358 At present, there are no written CF-wide guidelines setting out the factors a CO should consider in deciding whom to appoint as an Assisting Officer to the next of kin of a deceased CF member. While I am sure that most COs are aware of the crucial role of the Assisting Officer in such circumstances, I feel it is important to articulate that message clearly in writing, so there can be no confusion. To meet that need, I believe there is a requirement for CF-wide guidelines setting out the criteria that COs should use to assign qualified personnel to the task.

1359 **I therefore recommend that:**

1360 **17. The CF develop guidelines for Commanding Officers on the selection of Assisting Officers for next of kin of CF members who have died unexpectedly.**

1361 The CF agreed with this recommendation, noting that these guidelines will be incorporated into the Assisting Officers Guide.

10.3.2 Training for Assisting Officers

1362 Mrs. Wheeler's first Assisting Officer told my investigators that he had received no training in preparation for his duties as an Assisting Officer to the family of a deceased CF member. When he was appointed, he had no idea what his responsibilities were, learning "on the job," which, in my view, is far from ideal. I am advised that this is not an unusual situation, and that the majority of Assisting Officers for families of CF members killed on duty are line officers with little or no previous experience in the responsibilities or duties that come with this task. We found no evidence of any type of training — either formal or otherwise — that would directly prepare an officer for this responsibility.

1363 I recognize that, with limited training resources, time and budgets, it would be both impractical and impossible to conduct in-depth training for all officers assigned as Assisting Officers.

1364 However, I also believe that, because of the important role an Assisting Officer plays in providing support to families, some form of training module outlining the basic role and requirements of the Assisting Officer's duties should be introduced into the curriculum of Basic Officer Training. The aim of this module should be to provide officers with an outline of the duties of an Assisting Officer, as well as an overview of the resources available to them, such as MFRCs and the Employee Assistance Program, services available through the Director of Casualty Support and Administration and Personnel Specialist Officers.

1365 The investment of additional time and resources in training Assisting Officers is well justified considering the important role Assisting Officers assume. An Assisting Officer who has been given a basic understanding of his or her duties and has been sensitized to the needs of next of kin will surely provide knowledgeable, sound and compassionate advice and support to families. This would go a long way to improving families' perceptions of how they are treated by the CF.

1366 My investigators discussed this recommendation with a senior Director, Quality of Life staff member who has experience as an Assisting Officer and in providing support to Assisting Officers, as well as a former CF Chaplain

General and found it received their full support; they believe that it is both practical and beneficial.

1367 **I therefore recommend that:**

1368 **18. The CF develop a training module to introduce officers to the role and responsibilities of Assisting Officers to the families of deceased CF members, including the special needs of families in such situations.**

1369 The CF agreed with this recommendation. The casualty administration review will examine how to best implement it.

10.3.3 Guidance and Support for Assisting Officers

1370 The introduction of a formal training module into existing officer training is only the first step to ensuring that any officer selected as an Assisting Officer is properly prepared. Step two would entail development of a formal, written guide for Assisting Officers, covering a variety of subjects.

1371 The training and the guide would complement each other: while the training is intended to sensitize officers to the issues and special needs of family members in such situations, a written guide would provide details on how to carry out the role of an Assisting Officer if and when called upon to do so.

1372 As noted above, Mrs. Wheeler's first Assisting Officer essentially educated himself about his responsibilities as an Assisting Officer for the Wheeler family. Other than a briefing from a financial officer, he appears to have been left to his own devices to deal with the panoply of issues that inevitably arise following an unexpected death. My investigators could find no evidence of any formal guidance, other than that contained in CFAO 24-5, paragraph 5, which focuses mainly on assisting the family with funeral arrangements — it contains virtually no direction for providing ongoing support.

1373 I understand the CF has made significant efforts to support Assisting Officers since 1992, and a number of information packages have been created at the Formation, Base/Wing and unit levels. However, there is no CF-wide information package, which can result in inconsistent treatment of next of kin.

1374 My investigators have reviewed two local packages, specifically the ones for Maritime Forces Atlantic (Marlant) and Canadian Forces Support Unit (Ottawa) (CFSU(O)). Although they are both excellent guidelines, and there are similarities between the two, in my opinion both have strengths and weaknesses. For instance, the Marlant package includes advice on the "Reactions of People to Grief" as well as "Tips for Helping Those in Crisis," while there is little or no mention of this crucial subject in the CFSU(O) package. On the other hand, the package prepared by CFSU(O) lists the available assisting agencies, their functions, phone numbers and how they could help, while Marlant's merely states, "the family will be afforded complete support of the Formation's Helping Professionals, including but not limited to the MFRC, Chaplains, Social Workers, Service Income Security Insurance Plan (SISIP), VAC Counsellors." Clearly, the information contained in such packages must be of the highest standard and must be consistent across the CF. A comprehensive, national standard is required.

1375 I am pleased to note the CF is making an effort to address this shortcoming. The DCSA is now immediately notified of all deaths and serious injuries of CF members and within 48 hours directly contacts the Assisting Officer to offer assistance. My investigators were advised that DCSA has drafted a *Guideline for Assisting Officers*, which is now being circulated to various Subject Matter Experts for review. When approved, it will become the CF-wide standard and will deal specifically with deaths and serious injuries to CF members. This is a very positive and timely initiative that should be implemented as quickly as possible.

1376 I also believe it would be worthwhile to offer two or three families who have recently experienced the loss of a family member the opportunity to comment on the draft guide. My investigators found the interviews with the families of MCpl Wheeler and of the soldier killed in the 2002 training accident at CFB

Petawawa contributed a wealth of knowledge, and they valued their input. After all, families know their needs best; their experience could help ensure the guide addresses the real, practical concerns and questions facing Assisting Officers.

1377 My investigators also reviewed casualty support documentation used by some other militaries, specifically the Australian Defence Force[13], and United States Air Force Instructions.[14]

1378 The US Air Force Instructions provide excellent guidance on virtually every aspect of support to next of kin and appear to be applicable to the way the CF supports next of kin at present. The general US Air Force Instruction describes procedures for the Casualty Services Program for all levels of command and all Air Force organizations. It provides very specific direction and guidance on such things as:

1379 • notification of next of kin, including secondary next of kin;

1380 • general support;

1381 • the requirement for the Family Liaison Officer to introduce the next of kin to the regional Veterans Services Officer who will be handling their benefits issues;

1382 • the requirement for the Family Liaison Officer to assist the next of kin in obtaining any documents related to any ongoing investigation into the member's death;

1383 • the amount of time that contact is to be maintained with the next of kin; and

1384 • examples of condolence letters to be sent by various individuals in the chain of command.

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[13] *ADF Instruction DI(G) PERS 42-6*

[14] *US Air Force Instructions 36-3002 and 34-1101.*

1385 There is also a more detailed instruction, which is intended for use by the member's Wing/unit. It provides guidance and checklists for individuals, from the Wing/unit commander to the Family Liaison Officer. I recommend the CF review both these documents for background on what should be contained in the guide for Assisting Officers.[15]

1386 **I therefore recommend that:**

1387 **19. The CF create and distribute to all Formations, Bases, Wings and units, a standard guide for Assisting Officers containing information to assist them in providing advice and support to families of deceased CF members, including a list of available resources.**

1388 The CF agreed with this recommendation, noting that work had already begun implementing it.

1389 It is also clear that an Assisting Officer in these circumstances needs as much support as possible. It is unreasonable to expect that every Assisting Officer will have specific knowledge of, or expertise in, all areas in which next of kin will undoubtedly have questions or concerns. These areas could include potentially complex financial and insurance issues, return of equipment and clothing, dealings with Veterans Affairs Canada or access to counselling — indeed, many of the issues about which Mrs. Wheeler complained. It is difficult for Assisting Officers to deal with all these issues on their own, particularly in the immediate aftermath of a death. Furthermore, even the most experienced Assisting Officer can find dealing with a bereaved family, particularly if it includes many close next of kin, very stressful. As Mrs. Wheeler's first Assisting Officer told my investigators, the task is: "Horrific. It is just horrific for one individual to try and do."

[15] Online at http://afpubs.hq.af.mil.

1390 When my investigators asked him if he could think of anything that might have improved the assistance provided to both himself and Christina Wheeler, he proposed an interesting solution:

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> I think a team has to be formed. I mean whether you want to call it crisis management team or whatever. Whether it be the Assisting Officer is a part of that team or the Assisting Officer is the head of that team. I had a lot of people putting stuff together for me but it was on an as required basis, whereas I think that if a small team had been put together to help the family deal with things and help the Assisting Officer deal with things … There is a lot of different things that you don't know. You can pull out all the references and pull out all the guides to certain things. Having a team together, that team may consist of a social worker, a padre, someone from the financial side of the house … I had a finance officer that I could call on to put certain things together for me and the supply officer but it was when I went to them to ask about things. They weren't a part of an integral team to deal with this. It also would have made it a lot easier for me to have people that I could have talked to about what is going on, because it was basically me and Christina Wheeler and the kids.

1392 I agree. A team approach makes sense. The CF has made gigantic strides in providing various mechanisms of support for CF members and their families since 1992, whether the support is needed as the result of a death, or when a CF member retires. Yet there appears to be no formal procedure for pulling these mechanisms together as a team to assist next of kin as soon as the CF becomes aware of a death.

1393 My investigators consulted various senior staff officers who have extensive experience as Assisting Officers or in providing support to Assisting Officers. They confirmed that Assisting Officers consult Subject Matter Experts in various fields in the wake of a death. For instance, chaplains are responsible for providing spiritual support; personnel and pay specialists are involved in providing advice on financial benefits; and Base/Wing Chief Petty/Warrant Officers support funeral arrangements. Social workers and mental health professionals may provide counselling or other assistance, while supply specialists may deal with any issues concerning return of clothing and equipment. Each group has likely acquired significant expertise in a particular aspect of dealing with bereavement.

1394 However, as Mrs. Wheeler's first Assisting Officer stated and my investigators confirmed in conversations with various CF agencies, Assisting Officers tend to approach each of these specialists as the need arises. There is no overall, formalized coordination. These specialists rarely, if ever, formally get together as a team to pool their expertise and to discuss which issues have been addressed and which require additional resources. This lack of coordination, in my view, represents a wasted opportunity to deal with emerging issues quickly and thoroughly.

1395 Responsibility for ensuring such a team is put in place should reside with the CO of the deceased CF member's parent unit. Although members of the team would likely be drawn from the unit's supporting Base/Wing or Formation, it should be the unit CO's responsibility to ensure it is put in place and is available to advise the Assisting Officer.

1396 Confirmation that the support team has been established, along with details of its composition, would then be reported to DCSA, which would track its progress. I believe DCSA is the proper monitoring agency, since it is already responsible for contacting and providing assistance to Assisting Officers as required. This team should be formed as soon as the CF becomes aware of a death and should work together until its services are no longer required by either the Assisting Officer or the next of kin.

1397 When this idea was discussed with them, senior officials at Director, Quality of Life fully supported it as both practical and beneficial. They recommended that the Assisting Officer or chaplain, because of their familiarity with the family, should always be the lead. I agree — it is important that next of kin have a constant central point of contact with the CF if there is a requirement to introduce other members of the team to the family.

1398 **Accordingly, I recommend that:**

1399 **20. The CF create a formal mechanism that would provide Assisting Officers with the support of a team of specialists.**

1400 In their response to my Office's interim report DND/CF has indicated that they accept this recommendation and that it will be implemented by including the mechanism for specialist support and a list of specialist resource contacts in the Assisting Officer's Guide that is being developed. It is my hope that the mechanism for implementing this recommendation will

ensure that assisting officers receive support from an actual team of experts that can provide them with the necessary expertise and assistance to best serve the family they are assigned to.

10.3.4 Continuity of Support to Families

1401 Mrs. Wheeler's faith in the CF was not enhanced by the fact that she was assigned three Assisting Officers in less than a year. By the time her second Assisting Officer handed over his duties in early 1993, Mrs. Wheeler was so disillusioned that she concluded, "I was pretty much done with them and their liaison, you know, because I wasn't getting anywhere and they weren't being helpful whatsoever."

1402 It makes sense to have one person act as the Assisting Officer for as long as possible. Most often, Assisting Officers become the trusted military representative in which the next of kin develop confidence. Breaking that link can lead to problems. However, I am fully aware that this may not be possible in all circumstances — most Assisting Officers come from the unit to which the deceased CF member belonged but, in most cases, these units are operational units, which means that the Assisting Officer may be deployed regularly for training, operations or postings. If the relationship between the next of kin and the original Assisting Officer is broken, through no fault of the Assisting Officer, it can be very difficult to re-establish trust, particularly if the family is not familiar with the new Assisting Officer.

1403 In looking for solutions, I wish to make it clear that I fully support appointing the Assisting Officer from the deceased member's unit. I believe that, in most cases, familiarity with the deceased and knowledge of the member's way of life when on duty helps nurture the special trust that should develop between the Assisting Officer and the next of kin. As noted above, however, it is a fact of military life that at some point an Assisting Officer may be deployed or transferred.

1404 I do not suggest that those assigned as Assisting Officers be exempt from being deployed out of area for a specific period. What I am recommending is that the chain of command weigh any decision to post or deploy an Assisting Officer very carefully, particularly in the immediate aftermath of a death or when there are still unresolved issues. If there is an overriding reason for that posting or deployment, then the CO must ensure that the circumstances are

fully explained to the family, and that the replacement Assisting Officer has been properly briefed and introduced to the family by the original Assisting Officer. There should be as long a hand-over period as possible, including meetings with the next of kin. Doing it by letter, as occurred in Mrs. Wheeler's case, does not work.

1405 According to conversations my investigators had with both Mrs. Wheeler and the family of the soldier killed in the 2002 training accident at CFB Petawawa, even if every effort is made to ensure that a new Assisting Officer is introduced to the family as compassionately as possible, losing the known and trusted point of contact is a traumatic experience for next of kin. Each time a new Assisting Officer is assigned, there is an adjustment period for all involved: family members must adjust to a new personality, and the Assisting Officer must strive to establish a level of trust with that family as quickly as possible. Until family members feel they can trust and confide in the new Assisting Officer, they will likely question whether he or she fully understands the case, comprehends their needs or appreciates what has already transpired. No matter how well prepared the Assisting Officer is, or how hard he or she tries, until trust is re-established, family members are likely to feel that they are not being cared for as well as before.

1406 Maintaining continuity is, I believe, the key to resolving this issue. For the reasons already outlined, I fully support appointing the Assisting Officer from the member's parent unit, but I also understand that in today's military it is quite possible for an Assisting Officer or even a complete unit to be deployed prior to resolution of all issues. The key to trusting an Assisting Officer appears to be the ability to confide in them and also knowing that they understand the family's concerns.

1407 To ensure the next of kin will always have an individual who is familiar with them to provide them with assistance, I recommend that the CO of the member's unit, in consultation with the unit's support base, appoint a second officer from the Base, to be brought into the picture shortly after the incident. The second appointed officer should be introduced to the family as soon as practical, and should monitor the file and all developments, so that he or she can maintain services to the family in the event a change-over is required.

1408 At first glance, this may seem to be a duplication of already scarce resources, but I believe it is one that is warranted. This individual would be introduced to the next of kin relatively early in the process and would then become part of the team approach, working with the Assisting Officer and acting as back-up in the event the Assisting Officer was not immediately available, thus providing a measure of continuity.

1409 The second Assisting Officer would be available for as long as required to answer any ongoing questions the next of kin may have and to assist if there are unresolved issues such as a BOI that is held a considerable period after the death.

1410 **Therefore, I recommend that:**

1411 **21. CF directives with respect to casualty support be amended to direct that the Commanding Officer of a unit, when appointing an Assisting Officer to the family of a deceased CF member, arrange for a second officer to act as back-up should the original Assisting Officer become unavailable for any reason.**

1412 The CF agreed with this recommendation and is examining how it can best be implemented.

10.3.5 The Return of Personal Property

1413 Mrs. Wheeler told my investigators that she considered it totally inappropriate that she was asked to return a flak jacket that her husband had kept at home before she could receive the personal effects he had kept at his place of employment. While she had no objection to returning the flak jacket and other items, she was astounded that the return of her husband's personal effects was contingent on her providing the flak jacket.

1414 The return of property of a deceased member is governed by CFAO 25-1, paragraph 5, which provides that, when a member dies, the CO shall:

1415 a. ensure that all personal effects, cash, public clothing and material in the possession of the deceased, i.e., found on his person, in quarters, or otherwise in the care of custody of the Canadian Forces, are collected and safeguarded, however, such action shall

> not be taken in respect of any personal effects or cash located in married or civilian quarters or in the care or custody of the next of kin unless, in the opinion of the Director of Estates, the circumstances make such action necessary for their safekeeping;
>
> b. appoint a committee of adjustment not later than 48 hours after the death;

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1417 This means that any items issued to MCpl Wheeler during his CF career, which he would not have been entitled to keep at the time of his release, had to be recovered and accounted for.

1418 Part of a Committee of Adjustment's responsibility is to gather all available information on amounts owed to the member, such as pay, outstanding monies from claims and the value of any unused leave. It is also responsible for determining if the member owed the Crown any money as a result of outstanding advances on claims, pay, debt for rations or quarters, and any public equipment the member possessed that was unaccounted for at the time of death. These two separate values or sums are then entered into the minutes of the Committee of Adjustment and forwarded to the Director of Estates to be used in determining the member's service estate. Had MCpl Wheeler's flak jacket not been returned, its value would have been deducted from his service estate, decreasing the value of the estate. Of course, that was not the issue for Mrs. Wheeler. Her perception was that her husband's personal effects were being held hostage pending return of the flak jacket.

1419 It would appear that not a lot has changed since 1992. When interviewed by my investigators, the family of the soldier killed in the 2002 training accident at CFB Petawawa stated that, after her death, they had asked if they might have her beret. They say that they were advised that this was not possible until after the Committee of Adjustment had finished their work. According to them, it was almost 60 days before they received the beret.

1420 Given the circumstances in cases involving death, I believe it is reasonable to build some discretion into the adjustment process. In my view, CFAO 25-1, paragraph 5, is administrative in nature; it is meant to address financial issues and ensure a balancing of accounts between the member and the CF. This administrative order was not intended to, and should not be used to, place a hold or lien on the personal property of a member that obviously has important value to the member's family. Settling of financial accounts and

monies and equipment owed should be dealt with separately from the return of personal effects. If there are outstanding monies owed or property to be returned, there are surely more appropriate means to recover them than giving families the impression that personal items are being withheld until the Committee of Adjustment has completed its report.

1421 In cases involving death, all personal effects should be returned to the next of kin as soon as possible, regardless of any property that has not been returned to the CF. However, I appreciate that, in very rare circumstances, such as when the effects are required as evidence in ongoing criminal investigations, this may not be possible. In such cases, the exceptional circumstances must be fully explained to families.

1422 **I therefore recommend that:**

1423 **22. CFAO 25-1 be amended to provide for the return of all personal effects to the next of kin as soon as possible, save in exceptional circumstances. The return of personal effects should not be contingent on the return of any outstanding public property by the next of kin, or the conclusion of a Committee of Adjustment.**

1424 The CF agreed with this recommendation, noting that "the return of personal effects should not be contingent upon the return of any outstanding public property." The Assisting Officers Guide will make this abundantly clear.

10.3.6 Availability of Counselling Services for Families

1425 My investigators could find no evidence that Christina Wheeler was ever offered professional grief counselling services by anyone in the CF. When she finally, on her own initiative, asked for some assistance, she found that the impediments outweighed the benefits. She was referred to a counsellor who initially visited her at her residence but after only a few appointments changed the location of their meetings to CFB Winnipeg. Since her military identification card had been returned after her husband's death, Mrs. Wheeler had difficulties getting onto the Base. Once there, she found being in a military environment too difficult to deal with. She outlined her frustration in a letter written to the Official Opposition critic for Veterans Affairs, dated May 19, 1998:

1426 I was offered the service of a social worker for grief counselling after asking and this person came to my house for the first couple of visits, which was fine. After that I was required to go to the Base for any further sessions, and I had to be "checked in" at the gate. As someone had neglected to tell the MP's [Military Police] that I was expected for an appointment I was grilled as to who I was there to see and why. After getting past the gate to the proper building, I found I could not talk to this person because I was on the Base and he was in uniform.

1427 Mrs. Wheeler and her family should have been offered professional counselling immediately. She should have had the opportunity to retain a civilian counsellor if she so chose, and meet with that person off the Base if she wished.

1428 There has been some improvement since 1992. From an interview my investigators conducted with a former CF Chaplain General, I understand that today the Chaplain General has the responsibility of ensuring family members receive counselling if they so wish. However, it appears that the next of kin are still not automatically offered that counselling. The mother of the soldier killed in the 2002 training accident at CFB Petawawa told my investigators that she only began receiving professional help after her personal physician referred her to counselling.

1429 It is understandable if family members do not wish to undertake counselling immediately after their loss, considering the many issues they must deal with at that stage; however, they should be given the opportunity to seek professional help if they so wish, either at initial contact or thereafter. To the best of my knowledge, it is not mandated anywhere in writing that the next of kin be offered counselling; my investigators could find no CF order or directive that formally addresses this very important issue. To ensure that families do receive the assistance they require, I believe the CF not only must mandate an agency to officially assume responsibility for this very important support, but must also allocate the funds required for it. This proposal is supported by senior staff at the Directorate, Quality of Life

1430 As Mrs. Wheeler explained, she found it very difficult to attend counselling sessions at CFB Winnipeg because of the memories evoked when she entered the Base. It is entirely possible that other next of kin will experience the same

feelings. I therefore also recommend that families be given the option of seeing either a CF caregiver or a civilian caregiver with whom they may feel more comfortable.

1431 **I therefore recommend that:**

1432 **23. CF directives assign responsibility and the CF provide funding to a specific agency to ensure that families of deceased CF members are offered the opportunity to receive counselling with either a CF or civilian caregiver if they so desire. This agency should work directly with the Assisting Officer to ensure that counselling services are offered and available.**

1433 DND/CF has agreed in principle with this recommendation and provided a list of the agencies and services which exist to meet the needs of families of deceased members. The DND/CF response also indicates that the lead agency for the provision of counselling services to family members will be determined in the course of the Casualty Administration policy review. I am hopeful that the lead agency identified by this review will take the necessary steps to ensure that family members' needs for counseling and professional support are identified and met immediately in a format which is acceptable to the individual with the costs of care being covered by the CF.

10.3.7 Military Family Resource Centres' Support to Families

1434 At no time was Mrs. Wheeler advised of a number of resources that might have helped her and her daughters deal with the tragedy of her husband's death. She was not made aware of the existence of the Winnipeg Military Family Resource Centre (MFRC), which had been set up in 1991. She told my investigators:

1435 > But I certainly didn't know what I could or couldn't have or what, if anything, was available or not available. So I just really felt that I had been put out into the cold and that was that, you know, just cut off.

1436 Since that time the MFRCs have become an essential part of the military community: their mandate states they are "to offer programs and services that promote healthy living for all who share the unique experience of military life." As such, they should be included as one of the resources made available to immediate surviving family members. All MFRCs (except those in Newfoundland and Labrador) have on staff Prevention and Intervention Coordinators (trained social workers), a Spousal Employment Coordinator who can assist with job-hunting and an Information Referral Coordinator who can provide information on many issues, including resources available in local communities.

1437 I envision MFRCs as an integral part of the team formed to support Assisting Officers. It is therefore important that Assisting Officers liaise closely with local MFRCs, subject to the wishes of the next of kin. Furthermore, MFRCs should be informed of deaths and provided with contact information for the next of kin. The packages developed by Marlant and CFSU(O), mentioned above, refer to MFRCs as a possible resource available to families; however, neither package makes it mandatory to give families contact numbers for MFRCs, nor do they give direction to ensure MFRC staff members are advised of a family's possible need for their services. The guide for Assisting Officers, which is now under development, should include that information.

1438 It is unrealistic to expect an Assisting Officer or the CF to indefinitely assume day-to-day support for the next of kin of a deceased member. MFRCs have a role to play in that respect: they have the expertise to assist the next of kin with services such as counselling, employment assistance and information resources; as part of the military community, the staff understand the military system and as a result are probably in a better position to help next of kin navigate through the military bureaucracy than those without such knowledge.

1439 I am not suggesting that using MFRCs lessens the responsibility of the member's unit/Base to provide front-line support to next of kin for as long as is reasonable. However, MFRCs could continue to assist next of kin after a certain point in time. For that reason alone, it is important that MFRCs are a part of the team that supports the next of kin from the outset. The Director of Military Family Services, who is responsible for the administration of the MFRCs, advised my investigators that it was practical for MFRCs to provide this service, although some additional funding may be necessary.

1440 **I recommend that:**

1441 **24. CF directives on casualty administration be amended to direct that Assisting Officers ensure that families of CF members who die unexpectedly are made aware of the services available to them through local MFRCs and are provided with information on how to contact them, and that local MFRCs are advised of the death of a CF member as soon as possible so they are aware of the potential need for services.**

1442 The CF agreed with this recommendation, noting that the requirement to notify the MFRC of a death will be included in the Assisting Officers Guide.

10.3.8 Access to CF Facilities for Families

1443 That no one ensured Mrs. Wheeler was cleared to enter CFB Winnipeg to see the social worker is, in my opinion, symptomatic of the lack of continuity of Assisting Officers she had throughout this period. That her military identification had been taken from her compounded the problem.

1444 There will be instances when the immediate family of a deceased member may wish to have access to military facilities, whether to see a social worker, visit friends or even to use the Base's Canex. At present, to do these things they must either be signed onto the Base or have some type of valid recognizable identification. Not having proper identification can result in the kind of difficulties Mrs. Wheeler encountered getting onto the Base. Indeed, in today's world of heightened security, such difficulties are even more likely than in 1992.

1445 With the introduction of the Military Family Identification Card in 2000, I believe the issue of very recognizable identification for immediate next of kin of a deceased CF member is easy to address. At present, this identification card is issued by the local MFRC only at the request of a member and their family; in other words, not all next of kin have one.

1446 To ensure that no other family experiences the same difficulties as Mrs. Wheeler, I believe that all immediate next of kin of members killed while on duty should be offered the opportunity to receive a Military Family Identification Card. A reasonable and appropriate expiry date, determined

through discussions with the families, should be indicated. The Assisting Officer, acting as a liaison with the local MFRC, should assume responsibility to ensure the paperwork is completed and the card issued.

1447 **Accordingly, I recommend:**

1448 **25. That the immediate family members of any CF member who dies unexpectedly related to duty be offered and issued a Military Family Identification Card if they so desire, allowing them access to DND facilities. The Assisting Officer should ensure this is done.**

1449 The CF has agreed to implement this recommendation.

10.3.9 Memorial and Recognition

1450 MCpl Wheeler died on April 7, 1992, but not until May 23, 1998 was a cairn erected in his honour at CFB Suffield, only after the BOI in 1997.

1451 The cairn and the presentation of a memorial album of the ceremony enabled Mrs. Wheeler and her family to finally achieve a degree of closure, albeit six years after his death. It is clear that the efforts made to recognize her husband helped restore her faith in the CF, at least as far as 2 PPCLI was concerned. In a letter to the then-CO of 2 PPCLI, dated July 19, 1998, Mrs. Wheeler stated:

1452

> I have received the photo album of the memorial ceremony conducted in Suffield. I wanted to send you a letter to let you know how much I appreciate what you did for us with the dedication ceremony of the memorial cairn. Your kindness and respect towards myself and my family has gone a long way to healing old wounds.

1453 I am pleased to see that, since 1992, the CF has improved in its recognition of members who die on duty, at least in some cases. Shortly after her death, a cairn was dedicated to the memory of the soldier killed in the 2002 training accident at CFB Petawawa. Her parents were deeply touched. In addition they were presented with a memorial book depicting the deceased's time in the CF; this initiative was undertaken by her regiment, which absorbed the full cost of the book out of regimental funds.

1454 Recognition and acknowledgement of CF members who die on duty and presentation of a memento to the next of kin appears to be current practice, but it is being done at the discretion of the member's unit. My investigators could find no CF-wide direction or policy stating that a proper memento be presented to the family of a member killed while on duty.

1455 Such a policy would not only ensure that this practice is formalized and standardized, but also that no case falls through the cracks. A direction could be crafted in such a way as to allow discretion to the member's unit as to the most appropriate form of recognition, given all of the circumstances, including the wishes of the family. At present, the member's unit absorbs the cost of these mementos, as was the case with the soldier killed in the 2002 training accident at CFB Petawawa. I believe, however, that since this is a CF-wide issue, the costs should be provided from central funds at NDHQ, not from individual units. Based on the numbers obtained by my investigators during this investigation, I do not believe that these costs would be excessive. I would recommend that DCSA become the controlling directorate for such funds, since it is the agency already dealing directly with Assisting Officers and the member's unit. Having a CF-wide policy with the funds controlled by a directorate in NDHQ would also ensure that a national standard is established and followed.

1456 **I therefore recommend that:**

1457 **26. CF directives for casualty administration be amended to direct that a tangible, formal recognition of the service of a CF member killed on duty be provided to the member's family, within a reasonable time after the member's death, and that appropriate funding be made available through the Director of Casualty Support and Administration. The form of this recognition should be determined by the member's unit, taking into account the circumstances of the member's service and the wishes of the family.**

1458 The CF agreed with this recommendation, and will be examining the process for providing tangible recognition for families of deceased members in the casualty administration review.

1459 A report entitled *An Overview of Support Strategies for Australian Defence Force Bereaved Families*[16] was commissioned by the Australian Defence Force (ADF) to review the issue of support to families of members killed on duty. It makes a number of specific recommendations under "Memorial and Recognition." One of the report's recommendations deals with the production of a Memorial Certificate, signed by the Prime Minister, which recognizes the ADF member's service, to be presented to the next of kin.

1460 The recent introduction of the "Depart with Dignity" initiative by the CF ensures that virtually all CF members who have served their country honourably are recognized for that service. It seems reasonable to me that this recognition be extended to those who have died for their country, and that a token of that recognition be presented to their next of kin. I believe the cost of producing such a certificate, signed by the Prime Minister, would be minimal, but would have immeasurable value for the member's family. At a minimum, this certificate should be presented to the primary next of kin by the member's CO.

1461 The ADF report also recommended that consideration be given to the presentation of a lapel pin by the unit CO to all next of kin of those lost while serving the ADF, regardless of the cause of death, as a standard procedure in post-death administration; families who lost members in recent years should also be retrospectively presented with a pin.

1462 In Canada, currently, the mothers of CF members killed in action receive the Silver Cross. There is, however, no provision for recognizing any other next of kin, or for recognizing members killed as a result of any other type of mishap. I believe it would be appropriate for the CF to design and produce a memorial lapel pin, which would be presented to all next of kin, both primary and secondary, thus giving families something to signify their loss. Again, I do not believe the cost would be prohibitive.

1463 The report to the ADF also recommended that the ADF "[e]stablish a system at Service HQ Level whereby families are automatically sent a condolence letter at the one year anniversary of the death." I believe a letter of condolence would also be a very worthwhile initiative that would mean a great deal to families. DCSA already records the date of death of any CF

[16] *Online at* www.churchilltrust.com.au

member, and I do not believe that it would be difficult for them to advise the appropriate unit CO of the impending anniversary, so that a letter could be sent to the family signifying that their loved one's sacrifice has not been forgotten. The US Air Force Instructions, discussed earlier, contain examples of this type of letter.

1464 These are just a few examples of how members' deaths can be honoured. The families of deceased CF members appreciate tangible expressions of the value of the member's service and sacrifice. I strongly encourage the CF to review the Australian study, with a view to implementing similar measures in Canada.

10.3.10 Information Resources for Families

1465 To assess how other militaries address issues of support to next of kin, my investigators reviewed the Web sites of six different armed services to determine how much information was publicly accessible. They were looking for reference and guidance to next of kin in the following areas: general information; referral information; bereavement support; pension information; and any other relevant information that might help a family member.

1466 The sites reviewed were:

1467 • the (UK) Royal Navy (*http://www.royal-navy.mod.uk/*);
1468 • the (UK) Royal Air Force (*http://www.rafcom.co.uk/index.cfm*);
1469 • the Royal Australian Navy (*http://www.navy.gov.au*);
1470 • the Royal Australian Air Force (*http://www.defence.gov.au/raaf/*);
1471 • the Royal New Zealand Navy (*http://www.navy.mil.nz/*); and
1472 • the Royal New Zealand Air Force *http://www.airforce.mil.nz/home/main.htm*).

1473 Of the six sites, only the Royal Navy and Royal Air Force sites contained any significant information, although all contained a link to the appropriate Veterans Affairs department.

1474 My investigators then examined two CF Web sites for the same type of information: the site for the Centre for the Support of Injured and Retired Members and Their Families ("The Centre") (*http://www.dnd.ca/hr/thecentre/*), administered by DCSA; and the site for "Families", administered by the Assistant Deputy Minister (Human Resources—Military) (ADM (HR-Mil)) (*http://www.dnd.ca/hr/engraph/families_e.asp*).

1475 The CF "Families" site contains no information that might help a family member of a deceased CF member looking for assistance, while "The Centre" site has a link to the VAC site and a toll-free telephone help line. However, nothing on either site provides information on pensions, benefits, bereavement assistance, MFRCs or any other information and resources for next of kin.

1476 In comparison, the Royal Navy site contains a complete section on family support, including information on such topics as family news, welfare support, community information and other material important to naval families. Although it is not overly detailed, it does provide information on such topics as: the Naval Personal and Family Service, including how to contact that agency for bereavement counselling; the Naval Chaplaincy, complete with how to contact a chaplain; and an explanation of how emergency notification is coordinated and handled.

1477 The Royal Air Force site is by far the most comprehensive. It includes extensive information about general issues of importance to families, as well as a specific section on how to access bereavement and counselling assistance. It includes a comprehensive bereavement information package and video, as well as links to organizations that provide professional grief counselling. The site also contains links to the equivalent of Veterans Affairs, and to resources and assisting organizations for pension and benefits, including the Royal Air Force Widows Association.

1478 The type of information contained on the Royal Air Force site must be invaluable to next of kin of deceased members. It not only seems to be extremely comprehensive, but also has the added advantage of being accessible to next of kin as they need information on a variety of issues. It is the type of Web site I would encourage the CF to develop and put in place. Such a Web site would provide the type of information next of kin are looking for and make it accessible to virtually all, regardless of their location

or circumstances. It should contain information on BOIs, the grieving process and where to find counselling; information on entitlements with links to VAC; and information and links to local MFRC Web sites, to name but a few of the possibilities for such a site.

1479 **Accordingly I recommend that:**

1480 **27. The CF develop and put in place a Web site to provide information and resources to families of deceased CF members.**

1481 The CF agreed with this recommendation and will include the information on the DCSA / The Centre for the Support of Injured and Retired Members and Their Families website.

10.3.11 A Place to Turn for Families

1482 Mrs. Wheeler told my investigators that she believes the next of kin of CF members who have died need someone outside the CF to act as an advocate for them. This person would actively assist next of kin to deal with the CF in all areas that affect them, including the areas discussed elsewhere in this report.

1483 My investigators interviewed an officer in the Personnel Policy section, at Directorate of Land Personnel about an initiative to establish a support network or program for the families of CF members killed on duty, which the Chief of the Land Staff is exploring. This initiative was suggested by the widow of one of the four soldiers killed by friendly fire in the training incident at Tarnak Farm in Afghanistan in April 2002.

1484 CLS staff realize that such a program should be CF-wide. At present, they are discussing with other agencies the best way to develop and implement such a program across the CF.

1485 This investigation found that the CF treated the Wheeler family poorly after the death of MCpl Wheeler. My investigators interviewed a number of senior officers who stated they would not like to see their families treated the same

way if they were injured or killed while on duty. MCpl Wheeler's surviving family members were not provided with information, were alienated and isolated, were not apprised of important developments and were not afforded proper support.

1486 More recent experiences have shown that the CF has improved the way families of CF members who die unexpectedly are treated, but there is still much work to be done. I have made extensive recommendations in this report to improve the system so that military families receive the highest degree of compassion and service when their loved one is killed in a service-related incident. The Ombudsman's Office continues to offer a source of advice, information and referral, and to address the complaints of such family members when they feel they are not being fairly treated, not receiving information or not getting full support. I intend to review the progress the CF has made in implementing the systemic recommendations in this report to ensure that the Wheeler family's experience has served as an impetus for real change and results in further improvements to the way such families are treated.

10.4 Requirement for a National Policy on Support to next of kin

1487 It is not hard to see why Mrs. Wheeler became so frustrated with the CF after the death of her husband. She had three different Assisting Officers. She received no offer of grief counselling and had to deal with VAC on her own. At the same time, she was trying to deal with her own grief, as well as trying to explain to her two young daughters what had happened to their father.

1488 Families of deceased CF members need to be helped through the bureaucratic maze from start to finish. From the time the Assisting Officer steps into their house and establishes rapport, families should be able to rely on help for everything, from arranging the funeral, pension and benefits, to return of personal items, to an introduction to their VAC caseworker. The assistance should be seamless. The whole issue of continuity of support depends entirely on contact being maintained with the family and ensuring all their needs are being addressed.

1489 My recommendations up to this point have dealt with very specific issues that, if implemented, will most surely enhance the level of support the CF provides compared to the perceptible lack of support Mrs. Wheeler experienced. To take the matter one step further, however, one must look at the need for an *overall* approach to support.

1490 At present, various agencies are responsible for different types of support, but there is no overall central direction or control. For instance, the member's home unit is responsible for providing an Assisting Officer whose responsibilities include funeral arrangements, pensions and benefits, and other matters; chaplains are responsible for initial notification and providing counselling if required; a financial officer is responsible for preparing and briefing the Assisting Officer on pensions and benefits; DCSA notifies VAC of the death; and VAC is responsible for processing pension forms.

1491 Each of these responsibilities is outlined separately in QR&Os, CFAOs or DAODs. However, nowhere is there a national policy defining specific responsibilities for each area of support and ensuring these agencies work together. Nor is there any specific policy ensuring that each agency has fulfilled its specific responsibility, or that contact with the family is maintained for a specific period of time.

1492 I believe the CF must develop a national policy that binds together the various existing support steps and responsibilities, expands on areas where required and indicates exactly who is responsible for what. In addition to the requirements already contained in various regulations and orders, this policy should address the issues raised in this report, to ensure the Wheeler case is learned from.

1493 Having such a national policy would ensure a consistent national standard for provision of support to families of deceased CF members, as well as help ensure continuity of support for as long as it is needed.

1494 **I therefore recommend that:**

1495 **28. The CF develop and implement a national policy for support to families of deceased CF members, which ensures all needs are covered and defines specific responsibilities for each area of support.**

1496 The CF agreed with this recommendation, noting that Director Quality of Life is developing a national policy.

1497 The establishment of a national policy on provision of support to next of kin is, I believe, only part of the solution to ensuring that families are properly supported. During this investigation, a constant complaint has been disappointment and frustration with the lack of continuity of information and support from the CF. I do not believe that this failure is because the CF does not care; rather, I believe it is attributable to the lack of a national policy, combined with the lack of a consistent point of control for monitoring that support.

1498 The majority of agencies involved in providing support are doing what they are mandated to do. However, I believe that, without the presence of a coordinating agency to ensure various support organizations are engaged as required, and remain involved as long as required, there can be no guarantee that support to families will be consistent.

1499 I believe rectifying this issue is a two-step process: the first, as I have already recommended, is to create a national policy on support to next of kin that would help ensure a constant and standard approach; the second is to establish some form of a monitoring or tracking mechanism to oversee the coordination of that support.

1500 The documents we reviewed from the United States Air Force and the Australian Defence Force indicate that both use a "Case Management" approach. At first glance, the establishment of such a system may appear to be both resource- and labour-intensive. However, based on my information, the number of cases that would require monitoring amount to approximately 50 to 60 cases each year; therefore I believe the CF would be able to adopt and implement a Case Management approach fairly easily.

1501 DCSA is already responsible for monitoring and providing support to families of deceased CF members in a limited way. They are informed of all deaths, and are the primary source of information and contact for Assisting Officers. I believe that it would be a simple matter to expand DCSA's mandate to include a role for monitoring support to next of kin. A Case Officer responsible for monitoring and tracking the support process provided to each family would be assigned whenever there is a death of a CF member. I do not envision this Case Officer doing actual case work, but rather acting

as a coordinator to the various people and agencies responsible for providing support. Along with the establishment of a well-defined national policy, Case Management under a central coordinating authority would ensure the proper people and agencies have been engaged and remain involved as required. From the assignment of the Assisting Officer through each step of the support process, the Case Officer would monitor progress to ensure that the support afforded to next of kin is of the highest standard and is consistent across the CF.

1502 **I therefore recommend that:**

1503 **29. The CF develop and implement a Case Management system to coordinate, monitor and track the support provided to next of kin.**

1504 The CF agreed with this recommendation. DCSA will review how best to implement it.

10.5 Compensation to Mrs. Wheeler

1505 I have found that Christina Wheeler was not treated fairly by the system during her long struggle to obtain the truth about the death of her husband. Except for the willingness of some individuals to try to provide her with information at specific times, the support the CF provided over the past twelve years has been virtually non-existent. She was left to deal not only with her own grief but also with the grief of her children, while at the same time trying to answer their questions about why MCpl Wheeler died. Any corrective measures taken to improve the investigations into a death of a CF member as a result of the recommendations in this report will do little to remedy the anguish that Christina Wheeler and the Wheeler have gone through. In my view, she and her family are entitled to some acknowledgement by the CF for the unfair treatment they received during the investigation into MCpl Wheeler's death. An attempt should be made to redress the stress, anxiety and frustration they have suffered as a result of injustices revealed by my Office's investigation. I only have the power to make recommendations, and I am not a court of law. I cannot order the chain of command to do anything, however, I would strongly encourage the CDS

to acknowledge the injustices and stress suffered by the Wheeler family. Given the length of time that has elapsed, I would suggest that such an appropriate redress could only be attained by way of adequate and reasonable compensation.

1506 **I therefore recommend that:**

1507 **30. The Chief of the Defence Staff take action to acknowledge the unfair treatment that the immediate family of MCpl Wheeler received during the investigation of MCpl Wheeler's death, and ensure that appropriate measures are taken to ensure redress so that adequate closure can be obtained by the family.**

1508 The department's response to this recommendation reads:

1509 Agree in principle. A family visit to the site of the accident and the erection of the memorial cairn, was greatly appreciated by Mrs Wheeler. LFWA continues to maintain contact through a Liaison Officer.

1510 The DND/CF recognizes the trials that Mrs. Wheeler has endured during the entire process. The departmental OPI [office of primary interest] for compensation claims, DND/CFLA CCL [Department of National Defence / Canadian Forces Legal Advisor Claims and Civil Litigation], has no authority, however, to settle this matter without first receiving a claim from Mrs. Wheeler. Were such a claim to be received by CCL from Mrs. Wheeler, it would receive the sympathetic consideration that any meritorious claim against the Crown would receive.

1511 Although the DND/CF response appears to indicate that legal advisors for the military would be amenable to making some offer of compensation to Mrs. Wheeler in response to a legal claim submitted by her, this does not in my view go far enough to recognize the harm which she and her daughters have suffered. I note that in accordance with the DND/CF response above Mrs. Wheeler has documented the extent of the impact of these events on her and her children and also provided statements from her daughters as to how they have been affected. This has been done at great emotional expense on all of their parts. It is manifestly unfair however, to place the onus on Mrs. Wheeler to jump through additional bureaucratic hurdles to make a case for

compensation, especially given the findings contained in my Office's report. The ordeal which she has suffered is well documented and the impact on her and her immediate family should speak for itself. It is also deserving of an acknowledgement at the highest level. I am calling upon the Chief of the Defence Staff to formally acknowledge the impact on Mrs. Wheeler and to instruct military legal advisors to ensure not just that her claim receives "*sympathetic consideratio*n" but that she receive adequate and just compensation on a expeditious basis, so that she and her family can put closure to this lengthy saga.

Treatment of LCol (retd) Lapeyre

11 LCol (retd) Lapeyre's Complaints

11.1 Introduction and Summary of Complaints

1512 Lieutenant-Colonel (LCol) retired (retd) Lapeyre complained to my Office that he had been unfairly treated following the death of MCpl Wheeler. He alleged that this unfair treatment has caused significant prejudice to him, including harm to his reputation, personal stress and anguish, the effect magnified by continuing close contact with CF officers in his civilian employment. He feels the 1997 Board of Inquiry scapegoated him and unfairly allocated responsibility to him for the death of MCpl Wheeler. In his extensive correspondence with the Canadian Forces and in his discussions with this Office, LCol (retd) Lapeyre has attempted to express his complaints as objectively as possible. It is clear to me that he has spent a great deal of time, effort and resources to clear his reputation over the years.

1513 LCol (retd) Lapeyre approached my Office in March 1999. After the Minister of National Defence authorized this Office to investigate his and Mrs. Wheeler's complaints, the SORT Investigators assigned to this file interviewed LCol (retd) Lapeyre. During this interview and in subsequent correspondence, he identified a number of major complaints and many other specific sub-issues about how the DND/CF had treated him with respect to the investigation of MCpl Wheeler's death.

1514 We have broken down LCol (retd) Lapeyre's complaints for analysis, as follows:

1515 1. Comments by the DND/CF officials with respect to LCol (retd) Lapeyre's involvement in the circumstances leading to MCpl Wheeler's death, which he feels resulted in his being treated unfairly by the BOI;

1516 2. The fairness of the BOI process;

1517 3. The lack of supporting evidence for the BOI's finding that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death;

1518 4. The inadequacy of the review of the BOI's findings by the chain of command;

1519 5. Privacy issues arising from the release of the BOI's results;

1520 6. The DND/CF response to requests for a review of the BOI;

1521 7. CFNIS investigation following LCol (retd) Lapeyre's complaint to the Provost Marshal; and

1522 8. Allegations of abuse of authority.

11.1.1 Overall Treatment of LCol (retd) Lapeyre by the DND/CF

1523 My Office's role is to assess whether or not the system treated LCol (retd) Lapeyre fairly, based on a review of the processes followed after MCpl Wheeler's death. The Ombudsman's role is not the same as that of an appeal court or adjudicator, in that I do not purport to pronounce on the guilt or innocence of individuals. It is also beyond my role to substitute my opinion or judgement for the chain of command's assessment of the issues. Rather, my role is to determine whether the system treated LCol (retd) Lapeyre fairly. I have found that it did not. This section analyses how LCol (retd) Lapeyre was treated, in an attempt to discover what went wrong, and discusses how the system could work better in the future. Finally, I offer my recommendations regarding how the DND/CF could attempt to address the injustice LCol (retd) Lapeyre suffered personally as a result of his lengthy ordeal.

11.2 The DND/CF Investigation of LCol (retd) Lapeyre's Complaints

1524 Mrs. Wheeler had never accepted the findings of the SI into her husband's death in 1992. For years, she pushed for the investigation to be re-opened until, in 1997, a BOI was convened as a result of her efforts. LCol (retd) Lapeyre was asked to testify at the BOI, which he did, but he was not warned of the possibility that he might be held responsible for MCpl Wheeler's death.

1525 The BOI found LCol (retd) Lapeyre to be indirectly responsible for MCpl Wheeler's death, due to failure to adequately promote safety during the exercise. The Board's allocation of indirect responsibility was based on its findings that LCol (retd) Lapeyre had not sufficiently emphasized the importance of following safety procedures in the exercise instructions and had not included reference to certain directives, which the Board found had been in effect at the time. The BOI also faulted LCol (retd) Lapeyre for not ensuring that adequate supervision was in place when Maj Semianiw left Canadian Forces Base (CFB) Suffield before the end of Exercise Surging Rage to go on an approved house-hunting trip. The BOI found that Maj Semianiw left without clear direction about who was to act as exercise Chief Controller in his absence, creating a supervisory vacuum. LCol (retd) Lapeyre was given a letter of displeasure, in which the Chief of the Land Staff (CLS) commented on the Board's findings against him.

1526 When he was given his letter, LCol (retd) Lapeyre was advised that information on the BOI's findings was going to be released to Mrs. Wheeler and the media. LCol (retd) Lapeyre took issue with the letter he received; he asked for a copy of the BOI Report for review and for the release of the report to be delayed until he had time to study it. He was allowed to see the report, but the request for a delay was not approved. Land Force Western Area prepared a news release about the BOI, which did not contain the names of anyone involved. The results of the BOI were also shared with Mrs. Wheeler in an official briefing. The subsequent media reports quoted the Land Force Western Area news release, but also named the individuals against whom findings were made and action was taken. The letter sent to LCol (retd) Lapeyre was explained as the only sanction available against him, since he had retired from the military.

1527 LCol (retd) Lapeyre felt the media reports left the impression that he was somehow to blame for MCpl Wheeler's death. He wrote to the CLS, complaining about this, as well as about some of the Board's findings, the composition of the Board and the way he had been treated by the Board, including the fact that he had not been given a chance to respond to the findings that attributed MCpl Wheeler's death to failures on his part. LCol (retd) Lapeyre raised counter-arguments, particularly with regard to which

orders were in effect at the time and to what kind of activities they applied, which he said he would have presented to the BOI had he known the Board was considering them in making its determinations.

1528 LCol (retd) Lapeyre entered into a lengthy correspondence with CLS staff, in which he raised these issues and pushed for reconsideration of the BOI's results. However, instead of re-opening the investigation or convening a new one, the CLS referred the questions and the new information raised by LCol (retd) Lapeyre to Col Selbie, the Board's President, in an *ad hoc* procedure the CLS staff called a "Commander's Inquiry." Col Selbie's response was to essentially defend the Board's findings.

1529 By March 1999, LCol (retd) Lapeyre felt his efforts to get the CLS staff to re-open the BOI were not producing the desired response. He contacted my Office to ask for assistance in re-opening the investigation. In March 1999, LCol (retd) Lapeyre provided the CLS with a signed letter from Capt (now LCol) Kaduck, who stated that he now remembered acting in Maj Semianiw's place on April 7, 1992. LCol Kaduck had originally stated (to the BOI in 1997) that he did not recall a hand-over brief and did not believe that he was acting as the exercise Chief Controller in Maj Semianiw's stead. Based on this and other testimony, the BOI found there had been a supervisory vacuum and that, consequently, LCol (retd) Lapeyre and Col Semianiw were indirectly responsible for MCpl Wheeler's death. The new information from LCol Kaduck brought the BOI's finding of indirect responsibility into question.

1530 The letter was the basis of a CFNIS investigation into possible perjury charges against LCol Kaduck, since its effect was to revise testimony he had given under oath to the BOI. The CFNIS investigation also looked into other matters related to the accident that killed MCpl Wheeler. The CFNIS investigation found no evidence that Capt Kaduck intentionally gave false evidence, but it did confirm that then Capt Kaduck had been acting as the exercise Chief Controller.

1531 Based on his contact with my Office, I decided that LCol (retd) Lapeyre's complaint raised important issues and asked the Minister of National Defence to approve a pre-mandate investigation. In March 2001, the CLS informed LCol (retd) Lapeyre, Col Semianiw and LCol Kaduck that he was going to direct a final review of the case. On May 25, 2001, I called LGen Jeffery, the CLS, to discuss the Wheeler/Lapeyre case and offered at that time

to investigate the case should he make the request. The CLS first attempted to reach a settlement with LCol (retd) Lapeyre and Col Semianiw. LCol (retd) Lapeyre, citing his mistrust for the DND/CF by that time, insisted on a formal investigation by my Office. In March 2002, I formally advised the CLS that my investigation had started and sought his cooperation. He responded in April 2002, supporting my investigation and indicating his intention to convene an ARB. On May 3, 2002, LGen Jeffery convened the ARB, appointing BGen Greg Mitchell, Commander of Land Forces Atlantic Area, as President, and Col William Brough and Col William Peters as members. The secretary of the ARB was Lieutenant-Commander (LCdr) Sylvain Allard, the DLP staff officer with carriage of the Wheeler file. The ARB also had the benefit of a legal advisor. The ARB's terms of reference instructed it to:

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> … examine the concerns raised by LCol (retd) Lapeyre pertaining to the conduct of the 97 BOI (ref A) which investigated the circumstances surrounding MCpl Wheeler's death. The ARB is also mandated to advise the CLS on the relevancy, thoroughness, and accuracy of the findings and recommendations of the 97 BOI and subsequent actions.

1533 The ARB reported to the CLS on January 28, 2003. My investigators were provided with a copy of the ARB Report in July 2003. The ARB Report and my investigation complement each other in a number of areas. Briefly, while the ARB did not support all of LCol (retd) Lapeyre's complaints, the ARB found that he had been treated unfairly by the BOI, which did not adhere to the procedural safeguards set out in *Queen's Regulations and Orders* (QR&O) 21.10(4), and that the BOI did not thoroughly examine all of the issues or call all witnesses with relevant information. The ARB also acknowledged the CF's actions after the BOI negatively affected LCol (retd) Lapeyre's reputation.

1534 While some felt that two investigations (the ARB's and my Office's) constituted an unnecessary duplication of effort, I do not agree. As I understand it, the ARB was necessary to allow changes to the findings and sanctions that flowed from the 1997 BOI, which had been approved at the Chief of the Defence Staff (CDS) level. Its terms of reference limited the ARB to examining the BOI and its consequences. My Office looked into a much broader range of issues as a result of both LCol (retd) Lapeyre's and Mrs. Wheeler's complaints. Each investigation also used different methods: the ARB was limited to examining documentary evidence, whereas my investigators interviewed numerous witnesses. I have had good cooperation

with the DLP, and the advantage of having read the ARB's Report. Indeed, I agree with most of the ARB's extensive findings and recommendations, as described below.

11.3 Analysis of LCol (retd) Lapeyre's Treatment by the DND/CF

11.3.1 Comments by DND/CF Officials about LCol (retd) Lapeyre

1535 Following the original SI into MCpl Wheeler's death in 1992 and prior to the convening of the BOI in 1997, DND/CF officials made several statements with respect to the circumstances leading to MCpl Wheeler's death, the adequacy of the SI and LCol (retd) Lapeyre's degree of responsibility as the CO of the Second Battalion, Princess Patricia's Canadian Light Infantry (2 PPCLI). LCol (retd) Lapeyre complained to my Office that a number of these statements were inaccurate and generally unfair, and that they were prejudicial to him.

11.3.1.1 BGen Meating's Letter to Mrs. Wheeler and Media Coverage (August 1997)

1536 In 1997, MGen Jeffries, Commander of Land Force Western Area, asked BGen Meating, Commander 1 Canadian Mechanized Brigade Group, to contact Mrs. Wheeler to determine the reasons for her dissatisfaction with the results of the SI into her husband's death. As a result of the questions that she raised, BGen Meating called for a review of the SI. In a letter to MGen Jeffries dated July 10, 1997, he recommended that the investigation into MCpl Wheeler's death be re-opened; that MCpl Wheeler be absolved of any blame for his death; and that the administrative actions taken against those found responsible for MCpl Wheeler's death be reviewed to confirm they had been adequately enforced.

1537 To keep Mrs. Wheeler informed, a copy of BGen Meating's letter was sent to her. Subsequently, in a series of newspaper articles published in early August 1997, the following passages from BGen Meating's letter were quoted:

1538 … I am not suggesting there was a deliberate attempt to hide the truth, but it does not appear the investigation was pursued with rigor.

1539 … In a case where a soldier's life was lost as a result, even partially, of safety violations, it would in my view have been appropriate to raise charges and evaluate issues of responsibility by means of a court martial.

1540 Media comments included the following excerpts:

1541 … Meating said the investigation into how Master Cpl. Rick Wheeler was run over by an armoured personnel carrier in 1992 at CFB Suffield was superficial and incomplete. The investigation improperly blamed Wheeler for his own death and shifted blame from safety personnel, Meating said.

1542 … Brig.-Gen Bob Meating, the former commander of the 1 Canadian Mechanized Brigade Group, which includes the unit involved in the accident, has asked his superiors to re-open the investigation into the death because the previous probe was "insufficiently rigorous." He said it's too late for a court martial now, because the statute of limitations is passed, but he urged that the investigation be re-opened, and that Wheeler be absolved of blame for his own death.

1543 LCol (retd) Lapeyre complained that the newspaper articles left people outside the DND/CF with an unfair impression about the SI and the responsibility of the 2 PPCLI chain of command with respect to MCpl Wheeler's death. In 2003, the ARB's review of the BOI found that the SI was an inappropriate means to investigate MCpl Wheeler's death. It noted that LCol (retd) Lapeyre misjudged the seriousness of the accident and the potential consequences, and that he placed himself in a conflict of interest by ordering the SI and endorsing its report. This conflict, the Board noted, raised suspicion about the accuracy of the SI's findings. After reviewing the SI, I have to agree; a number of subsequent investigations have clearly demonstrated that the original SI was inadequate.

1544 In 1992, the SI had been reviewed by BGen Ashton, the Commander 1 Canadian Brigade Group, who approved its results and forwarded it to MGen deFaye, Commander of Land Force Western Area. MGen deFaye found that the SI had failed to identify deficiencies in the planning, conduct

and supervision of specific training serials. However, despite MGen deFaye's identification of problems, the SI was approved by National Defence Headquarters (NDHQ) without further comment. It is unfortunate that no action was taken by the chain of command to deal with identified inadequacies in the SI until Christina Wheeler was finally successful in drawing attention to the fact that the original investigation was less than thorough. Her efforts, which prompted BGen Meating to write to her to acknowledge her concerns, and her ongoing struggle to ensure that her husband's death was fully investigated, prompted the media coverage about which LCol (retd) Lapeyre complained.

1545 There is no evidence that the letter authored by BGen Meating was intended to specifically prejudice LCol (retd) Lapeyre or cause any harm to his reputation. Rather, its purpose was to acknowledge the validity of some of Mrs. Wheeler's concerns, to keep her apprised of developments in the case and to explain the rationale behind the decision to convene a BOI into MCpl Wheeler's death. I note that LCol (retd) Lapeyre was not named in the newspaper articles that referred to BGen Meating's letter, nor was he referred to by rank or position. The articles do, however, clearly leave the impression that the original SI was not thorough and that more serious actions might have been warranted. This general impression about the inadequacy of the SI has been confirmed by the BOI, the ARB and my investigation. Therefore, I cannot say that the letter was unfair.

11.3.1.2 Briefing Note from DLP (August 1997)

1546 In early August 1997, DLP staff prepared a briefing note for the Minister of National Defence. The note was prepared following the article by Bob Bergen in the *Calgary Herald*, which referred to BGen Meating's letter to Mrs. Wheeler. It indicated that BGen Meating's letter implied that the 1992 SI was not done properly.

1547 The note indicated that the investigating officer had attributed MCpl Wheeler's death to negligence of a minor character on the part of the Enemy Force Controller, the APC driver and MCpl Wheeler himself. The briefing note also described the levels of review for the 1992 SI as follows: LCol

Lapeyre, the CO of 2 PPCLI, concurred with the SI findings, as did BGen Ashton, Commander 1 Canadian Brigade Group. MGen deFaye, Commander of Land Force Western Area, concurred in part, but expressed some concerns, and questioned MCpl Wheeler's failure to act and his hearing level.

1548 The note indicated that MCpl Wheeler's hearing level (H3) was within the limits established for full, unrestricted employment as an infantryman, but that this was not raised as an issue during the SI except in MGen deFaye's comments.

1549 The note also addressed the concern as to why no disciplinary action had been taken, pointing out that the CO had exclusive jurisdiction to determine whether action was required. It noted the CO had accepted the SI's recommendation that no disciplinary action be taken and had opted instead to take administrative measures against the APC driver and the Enemy Force Controller.

1550 The briefing note concluded with three matters: first, no disciplinary action could be taken against any members because the three-year limitation period under the *Code of Service Discipline* had expired; second, Mrs. Wheeler was pursuing the matter at various levels; and finally, the new Commander of Land Force Western Area had issued terms of reference to convene a BOI into the matter.

11.3.1.2.1 Analysis

1551 The August 1997 DLP briefing note was a factual account of the existing situation. Much of the background was copied directly from a previous briefing note prepared for the Minister on March 4, 1997, following a *Calgary Herald* article indicating that Mrs. Wheeler had forwarded her concerns to the Special Advisory Group on Military Justice and Military Police Investigation Services.

1552 Input to the March 1997 DLP briefing note was provided by Assistant Deputy Minister, Personnel (ADM Per) staff, in a separate briefing note on the same subject. The author of the ADM Per briefing note included his personal comments on apparent shortcomings of the SI into MCpl Wheeler's death. His concerns pertained to his belief that the circumstances surrounding the death of MCpl Wheeler had not been fully explored by the SI and deserved closer examination. In hindsight, he was correct in that respect, as borne out

by the subsequent BOI, the ARB and my Office's investigation. A number of the shortcomings he raised were evident based on an examination of the SI Report, and it does not seem unreasonable that he felt obliged to point them out. There is no indication that his comments were aimed at LCol (retd) Lapeyre personally, or that they were intended to cause him any harm. There is also no indication that the comments reached the Minister or that the members of the subsequent BOI had access to the personal opinion on the briefing note.

1553 While the August DLP briefing note makes reference to BGen Meating's letter, as I have previously stated, there is no evidence that BGen Meating's letter intended to specifically prejudice LCol (retd) Lapeyre or cause harm to his reputation.

11.3.1.3 Comments by BGen Ross to Land Force Western Area Seminar (September 1997)

1554 LCol (retd) Lapeyre complained that BGen Ross, the convening authority for the BOI, referred to him as the commander of 2 PPCLI and used MCpl Wheeler's death as an example of poor leadership and supervision in the conduct of a training exercise. He said the comments were made during a seminar of Land Force Western Area commanders and commanding officers (COs) on the weekend of September 5 to 7, 1997. A retired lieutenant colonel who had been a participant in this seminar related the following to LCol (retd) Lapeyre by letter in April 1999:

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> During his opening address BGen Ross sited [sic] a number of examples where, in his estimation, poor or inadequate leadership displayed by Commanding Officers was found to be the fundamental cause of sequential problems. He specifically referred to an incident that occurred during the period you were Commanding officer 2 PPCLI and a soldier under your command was injured during field training. During the remarks made by BGen Ross he specifically mentioned you by name and his inference was that as Commanding Officer you did not exercise due diligence in ensuring a responsible chain of command was in place and that the field training conducted was not supervised adequately.

1556 LCol (retd) Lapeyre also alleged that Col Selbie was present when BGen Ross made the remarks, and was influenced by them. The seminar took place after the terms of reference for the BOI, naming Col Selbie as President, had been drawn up.

1557 LCol (retd) Lapeyre complained several times to the CLS and his staff about this matter; however, there is no indication that he received any response to his complaints. He also included this issue in a complaint he made to the Privacy Commissioner in March 2000. The Privacy Commissioner responded to LCol Lapeyre's complaint in a letter dated May 9, 2001, which indicated that a copy of the letter by the retired lieutenant colonel who had been present at the leadership seminar had been shown to BGen Ross. BGen Ross is said to have recalled the seminar and to have indicated that the purpose of his remarks was to impress upon those present that the actions of COs have a lasting effect on the professional development of junior leaders coming up in the ranks. The Privacy Commissioner's letter noted that BGen Ross did not recall having mentioned LCol (retd) Lapeyre by name, but that he acknowledged that he likely referred to the 1992 accident at CFB Suffield. He also acknowledged that, even had LCol (retd) Lapeyre's name not been mentioned, many of those present would have known LCol Lapeyre was the CO of 2PPCLI at the time in question.

1558 The Privacy Commissioner was unable to find there had been any violation of the *Privacy Act*. He found that, even if BGen Ross had made the comments as alleged, they would have amounted to an expression of his individual opinion. The Privacy Commissioner indicated that it was not within his mandate to decide whether such statements were in keeping with military form, and referred LCol (retd) Lapeyre to the Department of National Defence to address the substance of BGen Ross' remarks.

1559 When my investigators interviewed BGen Ross, he indicated that the seminar in question was part of an indoctrination program for new COs, that he always addressed the group, and that one of his points was to emphasize accountability and the need to always be conscious of the circumstances within which an accident could occur. He indicated:

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> I didn't give any specific example, nor did I mention Jay Lapeyre by name or by appointment. I just said, "We have had accidents. We have had deaths and this is what I want you to … this is the state of mind that I expect."

1561 BGen Ross was provided with a copy of the Privacy Commissioner's letter to LCol (retd) Lapeyre and was asked whether the incident that resulted in MCpl Wheeler's death might have been one of the examples he used in relation to accountability of COs. He replied:

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> I don't know. I don't know. I don't think so. I certainly never would have mentioned any CO by name, particularly with Colonel Semianiw still serving. I may have said, an example being: A CO will not do their own investigation as 2 PPCLI did in the Wheeler death. It's a fact. It's not a question; it's a fact. You will not do yours as this Battalion did. I had no idea whether or not Colonel Selbie would find Jay Lapeyre indirectly responsible or have comments about his professional abilities or anything else at that time because I had no idea what Colonel Selbie was going to tell me. So it's kind of hard to believe that I had, you know, made such extensive comments at the seminar.

1563 My investigators asked BGen Ross if he felt his comments at the seminar could have influenced Col Selbie, the BOI President, in any way. He replied that Col Selbie, as a Base Commander, was responsible for safety on his base. He acknowledged that his comments could have influenced Col Selbie during the BOI; however, BGen Ross did not feel that any undue pressure had been put on Col Selbie. He told my investigators:

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> No. I never gave any specific direction for Col Selbie to look at the accountability of the CO. I said, "you know what the terms of reference of the BOI were, and that is what you got." I knew he would do a good job. He didn't need me to baby-sit him or to give him any advice on how to do a BOI.

1565 BGen Ross was steadfast in his beliefs about the responsibilities of COs and referred to these repeatedly during his interview with my investigators. He indicated:

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> As the Commanding Officer, I organized my own training. I was responsible for my own safety, command and control, umpires, everything. No one else does that for the Commanding Officer and the Commanding Officer always has some degree of responsibility if there is an accident and particularly one that involves a serious injury or death.

1567 BGen Ross also expressed concern about the regimental culture of keeping things in-house that had existed within the CF and expressed a sincere desire to ensure that the full story was made available to MCpl Wheeler's family. Referring to the 2 PPCLI SI, he stated:

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> I don't think they had any intention of doing an investigation with a view to providing answers to the family, whereas I did have that intention right from the beginning with General Leach's support. Right from the beginning, I said not only do we have questions about our own safety procedures here, but we owe the truth to Christina Wheeler and to his parents. So that was clear right up front and it wasn't a problem.

1569 Col Selbie indicated to Ombudsman investigators that he did not specifically recollect the September 1997 seminar, but acknowledged he would likely have been present. Col Selbie also stated that he did not recall hearing any reference to the 1992 incident at a seminar. He did point out, however, that he was aware that BGen Ross, throughout his time in command, had a particular concern about training safety. Col Selbie stated that, even had BGen Ross made reference to the incident at CFB Suffield, he did not believe it would have influenced his own thinking. He told my investigators that he did not feel any pressure, as President of the BOI, to reach any specific findings.

1570 The ARB could not conclude for certain that BGen Ross made statements prejudicial to LCol (retd) Lapeyre while the 1997 BOI was being conducted.

11.3.1.3.1 Analysis

1571 Having considered the letter of the retired lieutenant colonel who had been present at the 1997 leadership seminar and the acknowledgements by BGen Ross indicated in the Privacy Commissioner's report, as well as his acknowledgements to my investigators, I conclude it is likely that BGen Ross did refer to MCpl Wheeler's death in the 2 PPCLI training accident during the September 1997 seminar. Although there is no record of what was said, it is reasonable to conclude that — in the context of pointing out past problems related to duties and responsibilities of COs, and to instil a sense of responsibility and accountability in new leaders — BGen Ross' comments were indirectly critical of the leadership of 2 PPCLI and, at a minimum,

inferentially critical of LCol (retd) Lapeyre. At least one person at the seminar (the retired lieutenant colonel) formed the impression that LCol (retd) Lapeyre's handling of the incident had been used as an example of poor leadership.

1572 Fostering responsibility and accountability, and encouraging leaders to benefit from lessons learned, are clearly laudable objectives. BGen Ross' comments should be understood in that context. There is no evidence that he intended any deliberate harm or prejudice to LCol (retd) Lapeyre's reputation.

1573 That said, by that time it was clear that the question of who was responsible in MCpl Wheeler's death and the responsibility of various levels of the 2 PPCLI chain of command was a live issue. It would therefore have been prudent for BGen Ross to have refrained from commenting on the 2 PPCLI training accident at CFB Suffield, at least until the BOI had been concluded and the results finalized. Upon learning of these comments, LCol (retd) Lapeyre, not unreasonably, formed the perception that the senior chain of command within the DND/CF had already reached conclusions about his responsibility in the death of MCpl Wheeler. This perception contributed to his lack of faith in the BOI.

1574 I also conclude that Col Selbie, who had been appointed President of the BOI, was present at the September 1997 seminar when the remarks in question were made. As a commander within Land Force Western Area, he would have attended the seminar. I cannot conclude, however, that he was directly influenced by BGen Ross' remarks, or that the remarks played any role in the major flaws my Office uncovered with respect to the subsequent BOI. That said, it is understandable how knowledge of Col Selbie's presence at the seminar would have affected LCol (retd) Lapeyre's perception of the fairness of the BOI. It was not unreasonable for LCol (retd) Lapeyre to have had concerns about the BOI process, Col Selbie's conclusions and the review by BGen Ross, after having learned about the comments.

11.3.1.4 Comments by BGen Ross to MGen Crabbe

1575 In June 1998, Col Semianiw wrote to LCol (retd) Lapeyre, to recount a meeting he had had with MGen Ray Crabbe, Commander of 1 Canadian Division, in Kingston in late August or early September 1997. According to

Col Semianiw, MGen Crabbe had asked him about the death of MCpl Wheeler, saying that BGen Ross had recently called him and voiced the opinion that the Wheeler case was another example of a unit cover-up, like the case of the other CF member killed in a training accident at CFB Suffield in 1995.

1576 An Ombudsman's investigator asked now-LGen (retd) Crabbe if he recalled the discussion Col Semianiw described. LGen (retd) Crabbe replied that he did not remember the circumstances, but that he did remember a comment BGen Ross had made:

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> I think it was about the time this was being re-investigated or the Board had been put together … I couldn't say when it was, but that could very well be because the comment that he made to me was something to the effect that the Regiment, referring to the PPCLI, was in bad shape or words to that effect. I can't recall exactly what he said, but the implication was that there were a lot of problems with the Patricias and there had been some — this was one incident of several that I think were ongoing at the time that the PPCLI had been involved with … It was his view, as I recall, that the Regiment was not in very good shape, wasn't very well led and that these incidents had not been properly handled. I think that was kind of the gist of what Ross told me … he had mentioned something about cleaning up some of the things that had been left that he inherited as the Area Commander.

1578 LGen (retd) Crabbe did not recall whether the term "cover-up" had been used but indicated it could have been. He did recall BGen Ross talking about other incidents that also needed to be cleaned up because they weren't properly handled and thought that "clean-up" was the wording BGen Ross had used.

11.3.1.4.1 Analysis

1579 The ARB concluded that LCol (retd) Lapeyre had not provided enough reliable evidence to support his allegation that BGen Ross had made comments to the effect that there had been a cover-up in MCpl Wheeler's death. In the absence of more reliable evidence, the Board determined that the allegation was unfounded.

1580 BGen Ross' exact words to MGen Crabbe are unknown. However, regardless of what words were used, it is clear that a conversation took place between BGen Ross and MGen Crabbe about BGen Ross' concerns regarding the state of the regiment, including its leadership, and certain events, including MCpl Wheeler's death. Such comments would not have been inconsistent with the statements made at the 1997 September seminar, or with the statements BGen Ross made to my investigators.

1581 Nonetheless, there is no evidence that BGen Ross' comments to MGen Crabbe had any direct impact on LCol (retd) Lapeyre or on the results of the BOI. MGen Crabbe was not involved in the BOI process, nor was he in a position to have any direct influence over the BOI, its results, or any subsequent actions or decisions. I am also not satisfied that BGen Ross' comments were made with any deliberate intent to prejudice LCol (retd) Lapeyre. His comments to MGen Crabbe, as for his previous comments noted above, reflected his desire to ensure that the chain of command accepted responsibility with respect to MCpl Wheeler's death if warranted and that those responsible were held accountable.

11.3.2 Fairness of the BOI Process

1582 The 1997 BOI found that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death insofar as he failed to promote adequate safety and control of the exercise. In 2003, the ARB's review of the BOI found that the Board had not extended to LCol (retd) Lapeyre the procedural safeguards required by applicable regulations, that the Board's fact-gathering and analysis were deficient and that the BOI focused inordinately on blaming senior officers. The ARB also found that LCol (retd) Lapeyre was negatively affected by the BOI and the subsequent actions of the DND/CF, and recommended (an unspecified) settlement that reflected those effects.

1583 LCol (retd) Lapeyre complained about the way he was treated by the BOI. He said that the composition of the Board — particularly the lack of a member with experience commanding a mechanized battalion — led to improper analysis of some of the issues and testimony. He also complained that he was never warned of the possibility of adverse findings, and never given the chance to refute — or even know — the evidence against him. He stated that, when he asked for time to prepare himself for the BOI's questions, the Board

denied his request, citing its reporting deadline. LCol (retd) Lapeyre also felt that the timing of the BOI Report, which was completed the day after his testimony, indicated that Board members had made up their minds about him before he even testified.

1584 In this section, I will review LCol (retd) Lapeyre's general complaints about the process followed by the BOI. The purpose of this review is not to find fault or assign blame to individuals, but rather to determine whether flaws in the 1997 BOI were specific to MCpl Wheeler's case or whether they are systemic in nature and, if so, to make recommendations to prevent similar injustices in the future.

11.3.2.1 Expertise of BOI Members

1585 BGen Ross, Commander of Land Force Western Area, convened the BOI. He approved the terms of reference on August 15, 1997. Originally, he appointed Col Selbie as the President, and Maj Johnson and a major with infantry experience as Board members. Col Selbie and Maj Johnson were both artillery officers; neither had served in the infantry. The infantry major was not available for the whole BOI, and was replaced by Capt Price, who had limited mechanized infantry experience. According to the terms of reference, Maj Johnson was to act as the safety expert, advising the Board on questions of training safety.

1586 The two artillery officers were under BGen Ross' chain of command. LCol (retd) Lapeyre felt that their connection to the convening authority contravened the principles of independent investigations that BGen Ross articulated during his review of the BOI Report. LCol (retd) Lapeyre believed that BGen Ross had stated that one should not task subordinate officers of one's own organization with serious investigations and that only those with no direct links to the convening authority should be assigned to such investigations.

1587 BGen Ross's comments on the BOI results, dated November 19, 1997, indicated:

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> In the cases of serious training accidents or deaths, I have directed that only officers of the appropriate rank and experience be assigned as the investigating officer. Further, to avoid conflict of interest by

> unit commanding officers, investigating officers will be assigned from outside the unit. This is not intended to limit independent and responsible investigation to only accidents causing serious injury or death. Where commanders or commanding officers believe that safety violations have the potential to result in injury or death, they are to conduct the appropriate investigation.

1589 BGen Ross stated to my investigators that he specifically chose Col Selbie as President of the BOI, but he believes the other Board members were proposed by his Chief of Staff and discussed with Col Selbie. BGen Ross stated that his primary criterion for selecting the Board members was the members' independence from the PPCLI and from the accident itself. In that regard, he pointed out that Col Selbie had never served in western Canada prior to going to Shilo as Base Commander and was not a member of the infantry. Finally, he pointed out that Col Selbie had no prior knowledge of the accident whatsoever.

1590 BGen Ross told my investigators that he believed that his Chief of Staff and Col Selbie would have discussed criteria for the selection of other Board members, such as being relatively close to the President's location so they could work together. This factor resulted in Maj Johnson's selection as a Board member.

11.3.2.1.1 Analysis

1591 I am not convinced that there is any conflict between BGen Ross' comments and his appointment of Col Selbie as President of the BOI. BGen Ross' comments, when taken in their full context, appear to refer to the need to take steps to ensure that, in the future, officers of appropriate rank and experience, with no connection to *the unit involved in the accident*, will be tasked with investigating serious training accidents or deaths. These comments were clearly made to address concerns about the original SI into MCpl Wheeler's death. By all accounts, BGen Ross was careful not to repeat the mistake by ensuring he did not appoint anyone with a connection to PPCLI to the 1997 BOI.

1592 With respect to the appointment of Col Selbie, there is no evidence to suggest that he was subject to any conflict of interest by virtue of any connection to 2 PPCLI or the training accident that led to MCpl Wheeler's death. Neither did Maj Johnson appear to have had any prior knowledge of the incident or

any connection to 2 PPCLI. Nor did my investigators find any evidence to establish a link between the fact that Col Selbie and Maj Johnson were artillery officers and any bias on the part of either officer. Although there were serious flaws in the BOI process and the ultimate results, I am not convinced that these were attributable to any conflict, bias or improper motive on Col Selbie's part or on the part of Maj Johnson.

1593 Maj Johnson was one of Col Selbie's principal staff officers working directly for him in Shilo; both he and Col Selbie had recently returned from Bosnia. There was clearly a direct superior-subordinate relationship between Col Selbie and Maj Johnson prior to the BOI. Given that members of BOIs should be independent and capable of forming their own views and conclusions based on the evidence, it would have been preferable for the convening authority to have avoided appointing anyone who had an established superior-subordinate relationship with any other member, particularly the President. That said, I am not convinced that the previous relationship between Maj Johnson and Col Selbie had any influence on the BOI process or its results.

11.3.2.2 Lack of Infantry Expertise on the BOI

1594 LCol (retd) Lapeyre complained that the BOI should have had the benefit of a Subject Matter Expert in the form of a more senior and experienced mechanized infantry officer. Originally, an infantry major with a background in mechanized operations and training was selected as a Board member. However, because he would not be available for the full course of the inquiry, he was replaced by Capt Price, shortly before the Board began its planning. Capt Price was also an infantry officer but had served only in a light infantry battalion — the First Battalion, Royal Canadian Regiment (1 RCR) — as well as in the Airborne Regiment, and in a reserve brigade as a regular support staff officer. Capt Price was the only infantry member on the BOI.

1595 In a letter to the CLS dated August 28, 1998, Col Selbie explained why the BOI did not request a Subject Matter Expert. He related these reasons to the scope of the Board's investigation:

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- The Board's Terms of reference did not direct us to make findings with respect to the suitability of the design of training and/or compare the design or conduct of Ex RAGING SURGE [sic] with CF norms established through testimony by SME [Subject Matter Expert].

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- We did not consider that we were required to investigate the nature or suitability of infantry tactics nor their employment by exercise participants. In any event, we did not investigate the actions of the elements being trained (i.e., the friendly force) which, had we done so, might have made the question of tactics germane. Rather we were called upon to investigate the actions of the enemy force and solely from the point of view of safety.

1598 My investigators asked Col Selbie about the need for a Subject Matter Expert. He responded that he felt reasonably confident in his ability to do what was required and that he felt there was sufficient expertise on the Board. In a later interview, Col Selbie told my investigators:

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> … I felt comfortable looking at the matter based on my experience. There wasn't an infantry officer, that is true. There was, however, a junior infantry officer on the board. Again, perhaps it is a matter for the sake of perception of fairness and all the rest of it. Would it have been a good thing to add a senior infantry officer on the board? Absolutely, probably, yes. But one always comes up against the practicalities and the realities of everyday life in the Army... more or less, the five members on the board had to be people with the organization [BGen Ross] commanded and he can usually direct people to do his bidding. It may have been, I don't know whether he looked at this or not but it would have been more difficult obviously for him to have gone to another Army area or something to find a senior infantry officer who was not part of the PPCLI regiment. Nonetheless, I am not certain, I am not satisfied in my own mind that not having a subject matter expert made a big difference in the end. Again, perception is another matter.

11.3.2.2.1 Analysis

1600 Chapter 21.08 of the QR&O deals with the selection of members for a BOI. This regulation indicates that the convening authority, shall, where the investigation may involve "technical or professional knowledge or skill" appoint, where practical, at least one member with the required qualifications.

1601 MCpl Wheeler was a member of a mechanized infantry battalion, killed during a unit training exercise. The terms of reference for the Board required findings on exercise planning and control, safety and responsibility, including the assessment of accountability and responsibility of all levels of command within the unit in the conduct of the training exercise.

1602 The ARB found that it was arguable whether Capt Price's appointment to the BOI satisfied the requirement for technical expertise. They noted that, although Capt Price would have been able to assess the actions of the Enemy Force Controller, he would have been less qualified to judge the relative standards of exercise preparation and conduct. He was also more limited in the professional sphere and lacked the experience to properly evaluate the performance of the unit's senior leadership.

1603 The ARB also found that a Subject Matter Expert would have been appropriate:

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> … the composition of the 97-BOI may have met the minimum requirements of technical expertise, but given the specific circumstances (re-investigating a potentially high-profile incident five years after its occurrence), the participation of an experienced infantry battalion commander as an SME would have been more appropriate in meeting the requirements for professional expertise. Alternatively, the 97-BOI could have called SMEs as witnesses.

1605 I agree with the ARB's assessment. The original selection of an infantry major as a Board member suggests the convening authority was aware at the beginning of the need for a more senior member with mechanized infantry experience. As noted above, Capt Price's expertise in this respect was limited.

1606 I acknowledge Col Selbie's point that the Board was not mandated to examine the suitability of the design of the training program, the nature or suitability of infantry tactics, or their employment by exercise participants. As

Col Selbie acknowledged, the Board was asked to submit findings with respect to the responsibility and accountability of individuals in the chain of command and direct participants in the exercise from the point of view of safety. However, these findings could not have been made without considering the context of the exercise, since dry training of a mechanized infantry battalion required the practical knowledge and expertise of an experienced infantry officer.

1607 In my view, the analysis and conclusions of the ARB demonstrate that a greater degree of professional and technical expertise was required to thoroughly examine the issues than was present on the BOI. In contrast, the ARB comprised a brigadier-general and two colonels. BGen Mitchell is an infantry officer who served most of his career with the Second Battalion, Royal Canadian Regiment (2 RCR), which he commanded from 1989 to 1991; he was also the Base Commander of CFB Petawawa and the Commandant of the army's Tactics School. Col Peters also joined the CF as an infantry officer, with 1 RCR, which he commanded from 1991 to 1993; he is currently Director of Cadets at the Royal Military College. Col Brough, the ARB's non-infantry member, was (at the time of the ARB) the Land Force Command Inspector; prior to that, he was an Armour Corps CO and a Director of Army Training.

1608 The different approaches taken by the ARB and the BOI highlight the advantages of looking at the exercise and accident with the aid of practical infantry expertise. The following are some examples where it was clear to my investigators that the additional practical experience and expertise present on the ARB shed a different light on certain issues which were key to the BOI's findings:

1609 • The ARB members did not support the BOI's recommendation to eliminate the use of APC periscopes with a live Enemy Force, since they saw it as a necessary step in the training process.

1610 • The ARB did not support the recommendation to implement a safety staff organization for the conduct of all unit dry training, since this would impose an onerous training burden with disproportionate practical value.

1611 • The ARB recognized that the use of FMCO 24-15 as a source of rules for collective field training was not appropriate, given that its intent was to regulate driver training.

1612 • The ARB considered that assessments of command responsibility are extremely difficult, when only a "snapshot" in time of that command is considered, without a broad understanding of the climate fostered by a particular CO and his or her command team. It concluded that a broader view is needed to reach a clearer and perhaps more useful understanding of decisions made and actions taken.

1613 • The ARB found that the BOI placed undue emphasis on the planning requirements for a minor counter-move of only one APC. It concluded that the counterattack plan itself was not the problem; it was the unsafe manner in which the plan was executed that contributed to the accident.

1614 • Similarly, the ARB found that the establishment of an exercise Chief Controller and an exercise control organization was not required by army or CF safety regulations or orders, for this or any other portion of a dry training exercise.

1615 I believe that the convening authority ought to have assigned a more senior officer with mechanized infantry experience to the 1997 BOI for several reasons, including the seriousness of the subject matter, and the fact that the BOI was directed to make findings of command accountability and responsibility as a result of an accident that occurred during a training exercise of a mechanized infantry battalion. Furthermore, the BOI's terms of reference state that planning, conduct and adherence to safety instructions and policies during training were directly at issue.

11.3.2.3 Procedural Fairness

1616 The BOI was convened August 15, 1997 and given a reporting deadline of October 31, 1997. The Board examined 23 witnesses and one medical expert, mostly between October 7 and 20. LCol (retd) Lapeyre had other commitments that prevented his attendance until the end of October. He flew into Winnipeg late on the night of October 29, and drove to CFB Shilo, where the Board was hearing witnesses. He then testified on the morning of October 30. He said that he was given limited time in which to familiarize himself with the case by reading a poor photocopy of the SI into the death of MCpl Wheeler.

1617 The BOI found that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death in failing to promote adequate safety and control of the exercise. It also found there was a supervisory vacuum when Maj Semianiw left CFB Suffield for an authorized house-hunting trip, leaving no clear direction as to who would be the exercise Chief Controller in his place, and that certain safety and training orders were in effect and applicable to the type of exercise conducted. LCol (retd) Lapeyre has been contesting all of these findings since he received the BOI Report in 1998.

1618 LCol (retd) Lapeyre also complained that the BOI was unfair in that he was not allowed to participate in the process in any way other than as a witness. That meant he could not have known about the possibility of adverse findings against him, or what those findings were likely to be. As a result, he did not have an opportunity to challenge the other evidence heard by the Board, to present additional witnesses or to make submissions, particularly with respect to any findings concerning any responsibility that might be attributed to him for MCpl Wheeler's death.

1619 LCol (retd) Lapeyre also felt that Board members had already reached specific conclusions about his involvement and responsibility for MCpl Wheeler's death before he appeared before the Board. LCol (retd) Lapeyre testified before the BOI on October 30, 1997. The Board's report was completed and signed on October 31. LCol (retd) Lapeyre argues that this would not have provided the Board with sufficient time to analyse and consider his evidence, compared with that of other witnesses, prior to finding that he and Col Semianiw were indirectly responsible for MCpl Wheeler's death.

1620 QR&O 21.10 provides that:

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> (4) Where in the opinion of the president, the evidence at any time during the sitting of a BOI appears likely to adversely affect an officer or non-commissioned member, the president may, in addition to receiving his evidence as a witness, permit the member to examine any evidence taken before his being called as a witness, to be present during the remainder of the inquiry and to make a statement.

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> (5) The officer or non-commissioned member referred to in paragraph (4) may request the president to:

1623 • ask a witness any further questions; and

1624 • call any further witnesses.

1625 Neither LCol (retd) Lapeyre nor Col Semianiw were advised that they were likely to be adversely affected by any of the evidence heard by the Board.

1626 In a letter to the CLS on August 28, 1998, Col Selbie noted that he consulted regularly with the JAG legal advisor assigned to the Board and, in his absence, another JAG legal advisor, and at no time did either of them advise him that there was a need to inform LCol (retd) Lapeyre that any evidence heard might adversely affect him or to afford him any of the rights referred to in QR&O 21.10.

1627 In his letter to the CLS, Col Selbie acknowledged that, according to QR&O 21.10(5), some witnesses were permitted to sit in on the testimony of other witnesses when, in his opinion, it was likely that the evidence could adversely affect them. The Enemy Force Controller and the APC driver had been given this opportunity, but not LCol (retd) Lapeyre or Col Semianiw. He indicated that he was concerned Col Semianiw's presence might create an atmosphere of intimidation that could affect the testimony of junior personnel. With regard to LCol (retd) Lapeyre, he indicated it was a matter of travel plans and limited time, as well as his belief that, as a retired officer, LCol (retd) Lapeyre was immune from any administrative action that might be taken against CF members still serving. Col Selbie also noted that LCol (retd) Lapeyre had left CFB Shilo without expressing any concerns about his appearance before the Board.

1628 Col Selbie described to my investigators his perspective with respect to LCol (retd) Lapeyre's complaint that he was not afforded sufficient procedural protections during the BOI process:

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> You had asked [at a previous meeting] about the whole notion of adverse findings. Certainly, when we spoke, I believe that our focus was on a definition of adversity that was defined as susceptibility to a charge under Code of Service Discipline or criminal law or, as I look at the CFAO, on civil proceedings. That was the mind-set I went into the Board with. Certainly we knew that the three years had passed since the events so that there wouldn't be an application of charge under military law but there was certainly a possibility that the Criminal Code would apply. We went into this focusing on the two

> that we saw most likely as being affected by this kind of thing, that was [the APC driver] and [the Enemy Force Controller]. As I looked at the CFAO again, there is no definition of adverse or adversity. Maybe there should be. Is a sullied reputation an adverse finding or if the outcome of your mention as being somebody who is indirectly responsible results in a sullied reputation in the mind of the receiver or others, does that constitute an adverse outcome? If so, again, we go back to the notion of giving people that right of reply, all the aspects of natural justice.

1630 I think the other point that the lawyer made when we were sitting, and certainly when I had read the CFAO was, as president of the board I had great leeway. The onus was on my shoulders to ensure fairness. Did I act to ensure fairness for one and all? I don't know if the others were to judge in the final analysis but I think, certainly Colonel Lapeyre, he perceived that he was not dealt with fairly. As we spoke about the other day, there is sometimes little difference between perception and fact. It was his perception that he was not dealt with fairly, well, then, maybe that is what counts.

1631 Another member of the BOI, Maj Johnson, confirmed to my investigators that the Board had arrived at most of its findings and conclusions prior to LCol (retd) Lapeyre having had an opportunity to testify before the Board and give his side of the story. Maj Johnson stated:

1632 I can't think there would have been a great deal [of work after LCol (retd) Lapeyre testified] because things had to be printed. So I can't think of a great deal. We probably had most of it pretty much figured out, but again I can't remember exactly what our mechanics were at the end. I remember we were trying to get the thing done. Colonel Selbie did a fair bit of work himself on it. We were all working together fairly late nights to get caught up on that. I don't think we thought the CO would have anything new to add that we hadn't already gleaned. He came in basically to reconfirm most of the stuff we already figured out. I really don't remember anything new coming up, except for his actual statement, that really changed our findings … We were writing it as we were going. As things were coming up, we were writing the most part, but we had to squeeze there to get it done to make the deadline ...

1633 What I remember specifically — what I think I remember specifically about our lead up to the last day is we actually even thought to ourselves, "Do we really need to bring in Colonel Lapeyre?" I remember us thinking that because he was a civilian at the time, I think .. and we pretty much figured everything out. We wanted him in for the sake of completeness. He was the commanding officer ... As the commanding officer, he was the first guy — I believe one of the first things he said was, "I was the commanding officer and, of course, I'm responsible for what happens in my unit. If something went wrong, yes, it was probably me." I'm pretty sure he said something like that in his statements. He was pretty forthright about everything. He was willing to take responsibility for those types of things. I can't remember exactly how the thought process went. I remember us saying, "We are bringing him all the way down here to answer a bunch of questions we think we already know the answers to."

11.3.2.3.1 Analysis

1634 Procedural fairness is considered to be an aspect of the natural justice due all Canadians participating in legal proceedings. It refers to rules and procedures to be followed by those in authority who can make adverse decisions about others, whether in formal court proceedings or in administrative proceedings such as a BOI. The purpose of these rules and procedures is to allow a person who may be negatively affected by a decision to be made aware of that possibility and given as much opportunity as possible to defend their interests before any decision is made. Procedural fairness also guarantees that the decision will be made by someone who is impartial and unbiased. The application of the rules and procedures varies according to the type of hearing and the rights at issue. But the basic premises of procedural justice are that a person should know when he or she is in jeopardy; should be informed of the case against him or her, as well as of any proposed adverse consequences; should be given a meaningful chance to respond to the allegations; and should be confident that the decision was made impartially and independently.

1635 The ARB found that LCol (retd) Lapeyre should have been provided with the procedural protections enumerated in QR&O 21.10. The ARB commented:

> **1636** Even though the applicable QR&O article is permissive rather than directive, the 97-BOI did not have sufficient grounds not to offer procedural protection. LCol Lapeyre (retd)'s availability, even if it was limited, was beside the point — the fact remains that an adverse finding was ultimately reached (finding him indirectly responsible for MCpl Wheeler's death) and he was not warned of potentially damaging testimony or given a fair chance to make representation and to question witnesses. The fact that evidence was being heard five years after the accident should have more clearly demonstrated the importance of extending procedural protection to LCol Lapeyre (retd). At the point where 97-BOI members determined that there could be adverse findings, LCol Lapeyre (retd) should have been informed and the 97-BOI proceedings should have been extended as necessary to allow his full participation, including the review of testimony. One of the most important responsibilities of the 97-BOI was to ensure the fairness of the process, and this was clearly not achieved.

1637 I agree with the ARB's assessment. Based on the timing, it seems to me that, by the time LCol (retd) Lapeyre appeared before the BOI, Board members believed they had sufficient evidence to find both LCol (retd) Lapeyre and Col Semianiw indirectly responsible for the death of MCpl Wheeler. In my view, during the course of their inquiry, Board members should have recognized that adverse evidence was being heard with respect to LCol (retd) Lapeyre and Col Semianiw, and that the Board was likely to find some degree of responsibility in MCpl Wheeler's death on their parts. In view of the history leading up to the BOI, including Mrs. Wheeler's concerns about a cover-up and lack of accountability, and the questions raised about the SI, it should have been clear that command responsibility was an issue that would arise during the Board's investigation. One would also have expected — given the Board's conclusions and the detail in which it analysed the issue of safety and the conduct of the exercise — that, fairly early on in the process, Board members would have identified testimony that would indicate some degree of responsibility by Col Semianiw and LCol (retd) Lapeyre, and would therefore be adverse to their interests.

1638 The fact that Board members had a specific time in which to complete their report or were functioning under time constraints, even if those constraints were created to some extent by LCol (retd) Lapeyre's unavailability, does not, in my view, justify the failure to provide LCol (retd) Lapeyre with the

opportunity to fully protect his interests. Indeed, had LCol (retd) Lapeyre been informed that adverse evidence was received by the Board and that adverse findings could very well be made against him, he may likely have made himself available earlier in the process.

1639 At no time did the BOI warn LCol (retd) Lapeyre that adverse findings were likely. LCol (retd) Lapeyre denies having received witness statements for review. Although LCol Johnson believes he recalls that LCol (retd) Lapeyre received witness statements along with the other documentation he was given, it is clear that even if witness statements had been furnished to him, they were supplied the night before his testimony. He would not have had adequate time to review them. Moreover, not knowing of his own jeopardy, he would not have reviewed them with the kind of intensity one might otherwise expect. Furthermore from reading the transcript of LCol (retd) Lapeyre's testimony before the Board, it is clear that the Board did not put questions to him that would have alerted him to the fact that Board members were contemplating such adverse findings. As a result, he did not have the opportunity to respond to any accusations of wrongdoing on his part.

1640 Based on the timing of LCol (retd) Lapeyre's testimony and the BOI's reporting date, I find it very unlikely that the Board members were not aware that they were about to find him indirectly responsible for a death. I am therefore disturbed by the lack of procedural protections afforded to LCol (retd) Lapeyre. I should note that I believe Col Selbie was sincere when he described to my investigators what he understood "adverse effects" to mean. However, I also believe that he incorrectly interpreted the regulations in effect at the time.

1641 Since the 1997 BOI, a new Defence Administrative Order and Directive (DAOD) (effective February 2002) has been published governing the conduct of BOIs and affording procedural protections to persons who may be affected by adverse evidence. The new DAOD 7002-4 gives detailed direction as to when these protections should be afforded, by defining adverse evidence as evidence that:

1642 • suggests professional misconduct or incompetence;

1643 • suggests malfeasance; or

1644 • otherwise harms a person's reputation.

1645 It also cautions that an adverse finding with respect to a person must be supported by relevant adverse evidence.

1646 The new DAOD 7002-4 also requires that, if at any time prior to or during a BOI or SI, a CF member, DND employee or any other person appears likely to be adversely affected by the evidence, the President of the Board or the investigator (in the case of an SI) shall:

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- provide written notice to the person that he or she is likely to be adversely affected by the evidence;

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- advise the person as to whether or not he or she will be called as a witness by a BOI or requested to provide a statement to an investigator of an SI; and

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- include with the written notice a copy of the terms of reference.

1650 The new DAOD 7002-4 affords the following rights to anyone who may be adversely affected by a BOI so that these individuals can defend their interests. These rights, which are designed to ensure procedural fairness to the individuals, include:

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- prior to being called as a witness, the opportunity to review all relevant evidence heard by, or documents submitted to, the BOI;

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- to be present for the remainder of the investigation;

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- to make a concluding statement to the BOI;

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- to be advised of the right to request that:

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  - any witness previously heard be recalled;

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  - additional questions be put to any witness called by the BOI;

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  - additional witnesses be called; and

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  - a "letter of closure" be provided by the approving authority; and

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- the right to have counsel act on their behalf.

1660 In my view, Col Selbie did not understand the importance of providing the rights associated with procedural fairness to LCol (retd) Lapeyre. In fact, by his own admission, he was not aware that the meaning of adverse evidence, which should be the trigger to offer procedural protections to an individual, was not limited to evidence of potential criminal or civil liability. He was also not aware that the right to procedural fairness should not be limited to CF members, but should be available to anyone who could be adversely affected by the BOI, including former members like LCol (retd) Lapeyre.

1661 Recommendations made in other sections of this report should help to ensure that procedural fairness in administrative hearings is respected, such as the recommendation about training for BOI members. I encourage the designers of the course to include material that explains the purposes of the new DAOD, and the importance of offering procedural protections to individuals who may be adversely affected by the evidence at a BOI and of allowing them an opportunity to defend their own interests. I hope that proper training and refresher materials will help ensure the CF's BOI process is fairer and that all those appearing before such Boards are guaranteed all of the procedural protections due them under Canadian law.

1662 The new DAOD makes clear that the onus is on the President of the BOI or the investigator (in the case of an SI), prior to and during the inquiry, to be attuned to the likelihood that an individual may be adversely affected by the evidence. Once the President makes this determination, the affected person is entitled to notice and to the procedural protections set out in the DAOD. It is important that any training for BOI members makes this important obligation clear to members and reinforces the message that it is the President's job, not the witness', to assess whether or not a person may be adversely affected by the evidence. I can only assume the DAOD is careful to place the onus on the BOI (or SI) in recognition of the fact that Board members (or SI investigators) are best placed to assess the impact of the evidence they hear, as opposed to an individual witness who may not be privy to the same information, and therefore may not be aware of potential risks. That was certainly the case with LCol (retd) Lapeyre and Col Semianiw.

1663 Authorities in the chain of command responsible for reviewing and approving the results and recommendations of a BOI were required by CFAO 21-9, and (since 2002) are required by DAOD 7002-1, to ensure that:

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- the BOI has been completed in accordance with its terms of reference;

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- the evidence supports the findings and recommendations […]; and

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- members of the BOI are advised of any apparent errors, omissions or shortcomings relating to the conduct of the BOI.

1667 Failure to provide an individual who could be adversely affected by the BOI with the procedural protections set out in DAOD 7002-4 might be considered an "apparent error, omission or shortcoming relating to the conduct of the BOI." This view is particularly true of the DAOD, since DAOD 7002-1 specifically prohibits any adverse findings against a person unless "the BOI has complied with the instructions as to adverse findings … in DAOD 7002-4."

1668 DAOD 7002-1 codifies the obligation of review authorities in the chain of command to ensure that the results of a BOI are based on a thorough and complete examination of all relevant facts, and that individuals are treated fairly during the BOI process. An individual's entitlement to procedural protections when he or she might be adversely affected is not only related to the individual's right to defend his or her interests, but is also directly related to the fact that a BOI is an investigative vehicle whose purpose is to search for the truth. On the one hand, the procedural protections ensure such individuals are made aware of allegations against them — whether the allegations are direct or arise during the course of an inquiry — and allow such individuals to question witnesses, to present further evidence and to make submissions to the Board to defend their own interests. On the other hand, the same protections ensure that Board members have all the relevant information before them, so that their findings and conclusions are fully informed and accurate; that is, they have considered all sides of the story.

1669 In light of the importance of these procedural protections, it is my view that an additional safeguard is warranted: review authorities, when reviewing the results of BOIs, should be specifically required to ensure that any person who is likely to be adversely affected by the BOI is provided the procedural protections in DAOD 7002-4. It is imperative that any such flaws in the BOI process are identified and that action to remedy them is taken as soon as possible to minimize any potential prejudice to the affected individuals. I

believe a system should be in place to ensure, when someone has not been given the opportunity to defend himself or herself during an administrative inquiry, that he or she will be given such an opportunity before any adverse actions are taken.

1670 **I therefore recommend that:**

1671 **31. Defence Administrative Orders and Directive 7002-1 be amended to provide that review authorities, when reviewing the results of Boards of Inquiries, are specifically required to ensure that any person who is likely to be adversely affected by the results of the BOI was provided the procedural protections enumerated in QR&O 21.10 and DAOD 7002; and where any such person was not provided the procedural protections in DAOD 7002, no adverse action may be taken until that person is given a meaningful chance to respond to the adverse allegations and evidence.**

1672 The CF agreed with this recommendation.

1673 QR&O article 21.10(6) requires a BOI to keep a record of a request to question witnesses or to call additional evidence by anyone who believes he or she may be adversely affected by the evidence at a BOI. It does not however explicitly require any record to be made of the determination of whether a person is likely to be adversely affected by a BOI or of the reasons for making or not making such a finding. The section as it currently reads would also not, for example, ensure that requests to review evidence transcripts are recorded such as that which was made by LCol (retd) Lapeyre in this case. It would also not technically require a record to be made of any determination that a witness would be adversely affected by the evidence where the witness did not request to question or call any witnesses.

1674 In my view, QR&O article 21.10(6) is too restrictive to ensure that review authorities have a complete record before them with respect to the treatment of persons who may be adversely affected at a BOI. As this case has demonstrated, the failure to afford procedural protections to such persons can lead to flawed conclusions and result in unfair treatment. Review

authorities are meant to act as an additional safeguard to minimize the risk that this will occur. They must have a complete record of what transpired at the BOI with respect to the treatment of those adversely affected by the Board's conclusions, in order to carry out this important responsibility.

1675 To ensure that review authorities have a complete record before them, I believe that the relevant QR&O and any related DAOD should be updated so that it is clear that a complete record must be kept whenever an individual who feels likely to be affected by a BOI requests any of the procedural protections available. These provisions must also ensure that the BOI president's reasons for allowing an individual such procedural protections or denying a request are clearly stated as part of the record. This information is important to provide review authorities with the information they need to ensure that individuals have been treated fairly by the BOI process.

1676 **I therefore recommend that:**

1677 **32. Regulations and orders setting out procedures for Boards of Inquiries be amended to provide that a complete record is kept whenever an individual who is likely to be adversely affected by a BOI is afforded the procedural protections set out in DAOD 7002, or whenever an individual who feels he or she is likely to be adversely affected by a BOI requests and is denied the procedural protections set out in DAOD 7002. The record should include the reasons of the BOI President for affording or not affording the individual the procedural protections set out in DAOD 7002.**

1678 The CF agreed with this recommendation.

1679 In the Australian Defence Force, the requirements for natural justice are usually reflected in the Notice to Show Cause process. This process is an interesting feature of administrative law in the ADF. After an administrative hearing, a report is written with findings and recommendations. If, based on the report, administrative action (which includes everything from dismissal to a formal warning) is contemplated against an ADF member, the member is provided with notice of the proposed action and the evidence supporting the action. The member is then invited to "show cause" why such action should

not be taken against him or her. The proposed action can only be taken after the member has had the opportunity to respond to the allegations. This process also provides the member with the chance to advance evidence in his or her favour.

1680 The member should also have been extended procedural rights at the hearing. However, the Show Cause procedure occurs after the administrative hearing. This ensures that members will always be given the chance to defend their interests before adverse action is taken against them, even if they were not given that chance during the administrative hearing, or if they did not realize at the time that it would be necessary.

1681 The Australian Show Cause process provides an additional means of safeguarding individual rights by ensuring that individuals have a full opportunity to respond before administrative sanctions are imposed against them. Although it is beyond the scope of this investigation to conduct a full review of the system for imposing administrative sanctions in the military, I do believe that this process is worthy of closer examination. I would encourage the CF to further study how this model could be integrated into the Canadian system of military justice.

11.3.2.4 Maj Kaduck's Evidence

1682 In 1992, Capt Kaduck was the Friendly Force Controller and the next senior controller under Maj Semianiw's command. Under normal military procedures, if Maj Semianiw were unavailable, Capt Kaduck would take over his duties. When Maj Semianiw left CFB Suffield before the end of the exercise, that duty passed on to someone. The question of who had acted as Chief Controller in Maj Semianiw's absence became a pivotal issue in the 1997 BOI, and one of the bases for the Board's finding that Maj (now Col) Semianiw and LCol (retd) Lapeyre were indirectly responsible for MCpl Wheeler's death.

1683 In 1997, when BGen Meating (Commander 1 Canadian Mechanized Brigade Group) decided to look into Mrs. Wheeler's complaints about the 1992 SI, Capt (now Maj) Kaduck was his staff officer for Operations Plans and Training. Maj Kaduck was the one who contacted Mrs. Wheeler and compiled the information that prompted the BOI to be convened. As a

participant in the exercise, he was familiar with the file and the issues. Once the BOI was convened, Maj Kaduck accompanied Board members on a visit to CFB Suffield, where they viewed the site where the exercise and accident had occurred.

1684 The Board heard conflicting evidence on the question of who had been the exercise Chief Controller on the day of the accident: some individuals could not recall; some thought it was Capt Kaduck; and others believed it was "Call Sign Zero." Call Sign Zero is the control station on a radio network. On the 2 PPCLI command network, Call Sign Zero would normally have been manned by a duty officer or Non-Commissioned Officer (NCO) 24 hours a day when deployed. Col Semianiw testified that Capt Kaduck had taken over as Chief Controller and that there would have been a hand-over brief before he left. In his main testimony, Maj Kaduck testified that he had not been appointed exercise Chief Controller in Maj Semianiw's absence and that Call Sign Zero seemed to be filling the role of exercise Chief Controller on the day of the accident. Before the proceedings concluded, Maj Kaduck asked the Board for permission to clarify his testimony. In an additional statement on October 17, he said that he could not recall if he had been the exercise Chief Controller for the remainder of the exercise.

1685 On March 6, 1999, LCol Kaduck provided LCol (retd) Lapeyre with new information, indicating that he now recalled acting as the exercise Chief Controller in Col Semianiw's place. This information was forwarded to the Chief of the Land Staff.

11.3.2.4.1 Maj Kaduck's Knowledge Prior to the BOI

1686 LCol (retd) Lapeyre believed that Maj Kaduck's testimony before the BOI was influenced by the fact that he had access to information about the original SI into MCpl Wheeler's death, including a legal opinion provided to BGen Meating, Commander 1 Canadian Mechanized Brigade Group about the SI. As LCol (retd) Lapeyre explained to my investigators:

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> … that caused me to wonder whether or not Major Kaduck at the time had privileged information that caused him perhaps to manipulate his testimony at the BOI. Because perhaps he had been sensitized to the seriousness of the legal review that may have taken place.

1688 It is not clear that LCol (retd) Lapeyre was right in believing that LCol Kaduck had access to legal opinions before his testimony - LCol Kaduck does not recall ever seeing legal opinions and there is no proof that he did. What is uncontested however is that he played several roles that enabled him to have access to files that witnesses are not ordinarily shown. He was assigned for a time to act as liaison between 1 Canadian Mechanized Brigade Group and Mrs. Wheeler, and this gave him access to the Summary Investigation Report and other unknown documents so that he could assist Mrs. Wheeler. On another occasion he accompanied the Board of Inquiry to the accident scene at the outset of its investigation. To prepare for this he reviewed BGen Meating's file, which contained other documents and correspondence related to the case that did not emanate from him. LCol Kaduck had not asked for these responsibilities. They were assigned to him, and he was forthright with the Board of Inquiry about his knowledge of the documents. In his statement to the BOI on September 25, 1997, Maj Kaduck acknowledged that, prior to testifying before the Board, he had had the opportunity to study the original SI Report and had formed certain opinions about it. Specifically, he noted certain aspects of the report with which he did not agree, such as its acceptance of the Enemy Force Controller's claim to have been ground-guiding the APC. He had also taken issue with the choice of SI investigator, given the potential for a finding of responsibility on the part of one of his peers. Maj Kaduck also indicated that he did not agree with the SI Report's recommendation for administrative action to be taken against the APC driver, rather than to proceed with charges and a trial under the *National Defence Act*.

1689 In an interview with my investigator, BGen (now MGen) Meating indicated that, when he asked Maj Kaduck to act as liaison between 1 Canadian Mechanized Brigade Group and Mrs. Wheeler in 1997, he was not aware of his connection to the 1992 training accident at CFB Suffield that killed MCpl Wheeler. He said that, had he been aware of this connection, he would not have allowed Maj Kaduck to perform that function because of the potential for real and/or perceived conflict of interest:

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> I was looking for somebody to maintain regular contact with Christina Wheeler. Maj Kaduck never told me that he had been on the range that day. He never told me. If he had told me that he had been on the range that day, or that he was responsible for this, or that

1691 he was involved in it with [the Enemy Force Controller], I would not have given him that job, and I would not have allowed him to have been involved in the process of the paper, because there was a potential for him to be seen to be biased or perceived to be biased… He would have been conflicted … Also, with regard to the follow-on investigation, he would have seen that that would have been called into question — his role in it.

1692 According to LCol Kaduck, "[BGen Meating] knew that I had been involved in this accident and he asked me to contact Mrs. Wheeler." He told my investigators that he believed the reason BGen Meating asked him to call Mrs. Wheeler was that BGen Meating knew he had been a witness to the events. It is not important to make a factual determination on whose recall is right.

1693 In addition to his involvement with the file at 1 Canadian Mechanized Brigade Group, Maj Kaduck was asked, before the witness stage of the Board of Inquiry, to attend with the Board of Inquiry and with the Major who was in charge of the accident site to enable the Board of Inquiry to familiarize itself with the site and to construct a model of the site. Photographs were taken and a model was in fact constructed of the area where the mock village had been set up. In order to prepare himself for this assignment, Maj Kaduck reviewed BGen (now MGen) Meating's file. LCol (retd) Lapeyre contended that Maj Kaduck's involvement in this exercise was improper.

Analysis

1694 The ARB found the evidence of Maj Kaduck's involvement with the 1997 BOI to be limited to the fact that he provided evidence to the Board on October 15 and 17, 1997. It did not find any evidence that Maj Kaduck influenced any decision-making aspect of the BOI or any subsequent review of the Board's findings or conclusions. The ARB concluded that it could not determine "with any degree of certainty" that Maj Kaduck's testimony and memory of his participation in Exercise Surging Rage had been influenced by any inside knowledge. In arriving at this conclusion, the ARB noted that Maj Kaduck had told LCol (retd) Lapeyre in a letter dated March 16, 1999, "When I appeared before the Board, I made a conscious effort to give honest and unfiltered testimony."

1695 Regardless of whether Maj Kaduck's evidence at the BOI was directly or indirectly influenced by any knowledge of the issues gained either as a result of his position in 1 Canadian Mechanized Brigade Group Headquarters, or as a result of his review of BGen (now MGen) Meating's file and his attendance at the scene, his access to information that went beyond his knowledge as a witness would give rise to the reasonable perception that his testimony could have been tainted or affected by what he learned. LCol (retd) Lapeyre's concerns about the impropriety of assigning a witness to the roles that Maj Kaduck fulfilled and giving him access to files that are not normally shared with witnesses are entirely understandable.

1696 Moreover, Maj Kaduck's role with the Board of Inquiry at the accident site, particularly given his position as a former member of the 2 PPCLI chain of command, would cause a reasonable observer fully informed of the facts to apprehend that the Board of Inquiry could be biased. Maj Kaduck was given a role in the Board's task of creating the models that would be used during the hearing, a role that other witnesses were not given. He was also put physically with the Board of Inquiry where unrecorded discussions, possibly about the matter being investigated, could have occurred. He was an insider to the event. And official files were shared with him. The roles and information given to Maj Kaduck taint the perception that a reasonable observer would have of the Board of Inquiry process.

11.3.2.4.2 Meeting between Col Selbie and Maj Kaduck

1697 In his initial testimony, Maj Kaduck said that he had not been acting as the exercise Chief Controller on April 7, 1992. After concluding his testimony, he felt he should clarify his response about this. Maj Kaduck asked Col Selbie for permission to appear before the Board to clarify his statements. LCol Kaduck told my investigators that he met with Col Selbie privately in his office, where they discussed the issue.

1698 Col Selbie told a CFNIS investigator in 2000 that he believed Maj Kaduck had discussed this matter with Maj Johnson. The CFNIS investigator informed him that Maj Kaduck was certain he had spoken with Col Selbie, whose advice had been that, if Maj Kaduck was not absolutely sure he had been the

Chief Controller, he should say that he did not recall. Col Selbie told the CFNIS investigator that it would not have been unusual advice, and that he may have been concerned that Maj Kaduck's change of heart was influenced by a conversation with Col Semianiw. He told the CFNIS:

1699 I can accept the fact that he came to see me in Shilo with a request to come before the board with a statement, and that it was not Maj Johnson that he approached but that it was me. I can accept that. I am certain that that was in fact the case. Would he have come to me at that point to say that he thought he was the chief controller? Again, I am trying to form a mental picture in mind's eye of him coming to see me in my office. I suspect that he must have introduced the element of some doubt that he was currently entertaining with respect to whether he was or was not the chief controller. And I can only imagine that then I would have said: unless you're 100 per cent certain one way or the other – what you want to tell us is what you earnestly believe to be the truth. And if it is "No, I wasn't", that's what we need to hear. If it is "Yes, I was", that's what we need to hear. If it is "I don't recall", that's what we need to hear.

1700 Col Selbie later told my investigators that he did recall meeting with Maj Kaduck and discussing his concerns about his testimony. He said:

1701 I recall sitting in my office in Shilo. He [Maj Kaduck] appeared in the doorway. He came in. I am not even certain that he sat down. It was a short conversation. He indicated that he wanted to come back and clarify this statement. I would have indicated to him "okay, let's do that." I don't — I have been thinking hard about did I — did we actually talk about what he was going to say.

1702 … I think it may have been the day after he gave evidence he came to see me in my office in Shilo and he said "I've been thinking about this. I think that I need to say or add to my testimony or clarify my testimony … yesterday." I said, "okay, I'll call you forward again and you can make your statement," which he did. The statement then became changed from a "no, I was not appointed chief controller," to "I do not remember" or "I cannot recall," something along those lines.

1703 Maj Kaduck was recalled by the BOI the next day and clarified his earlier testimony. He told the Board:

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> while I answered this question in the negative, upon further reflection I believe that my answer should have been, "I do not remember," as I have no specific memory of either being appointed Chief Controller nor of any other individual receiving this appointment when Maj. Semianiw departed.

11.3.2.4.3 Analysis

1705 By the time Maj Kaduck met with Col Selbie, it should have been apparent that the issue of who was exercise Chief Controller was an important one that would play a significant role in the Board's findings. Maj Kaduck needed to convey to the BOI that he had to clarify his initial testimony. In my view, however, his request should have been handled differently. There is no evidence of any motive or intent by Col Selbie to influence Maj Kaduck's evidence, nor indeed any evidence that he attempted to do so. However, it is easy to see how a private meeting between the President of an ongoing inquiry and a witness who had already testified and was asking to be recalled might give rise to perceptions of interference with the witness or of the witness imparting information off the record that could have influenced the outcome of the inquiry in some way. It is particularly important to avoid perceptions of undue influence when the subject matter of an inquiry is sensitive and the witness' evidence is controversial *vis-à-vis* others involved.

1706 It is clear to me that, at the time, Col Selbie did not recognize the potential impact of meeting privately with Maj Kaduck or the perceptions this event would give rise to. In my view, this issue is another illustration of the importance of training BOI members — to ensure that they are educated about the importance of such matters and how to conduct themselves when presented with sensitive situations. There were a number of ways in which Maj Kaduck's request could have been handled in a more open and transparent fashion, to avoid perceptions of interference or undue influence. The optimal response would have been for the Board to reconvene its proceedings and for Maj Kaduck to address his concerns openly, in front of the entire Board, on the record. Alternatively, Col Selbie could have advised Maj Kaduck to seek independent legal advice with respect to his concerns about his previous testimony, rather than meeting with him privately.

11.3.2.5 Request for Extension by LCol (retd) Lapeyre

1707 LCol (retd) Lapeyre was not compelled by the Board to give testimony, but appeared before the Board voluntarily. However, due to prior commitments, he could not attend the BOI before the end of October.

1708 LCol (retd) Lapeyre said that, due to the scheduling conflict, he requested an extension when they were first trying to work out the date of his testimony. According to LCol (retd) Lapeyre, at that time, Col Selbie told him he was unwilling to ask for an extension to the BOI's reporting deadline. LCol (retd) Lapeyre said he offered to contact BGen Ross to ask for the extension, but Col Selbie did not want him to do that.

1709 LCol (retd) Lapeyre arrived in Winnipeg late at night on October 29. According to LCol (retd) Lapeyre, he rented a car and drove to CFB Shilo, where he picked up a packet of documents from the Military Police (MP) office. He said he was provided with the entire SI, but there was not enough time in which to read all the documents, since he arrived at Shilo at midnight and was scheduled to begin his testimony at 8:00 the next morning. He said that, at the time, he felt it was important for him to review the documents as a way of refreshing his memory about what had happened five years earlier. It does not appear that there was any indication to him that earlier testimony at the BOI contained the basis for adverse findings against him.

1710 Col Selbie told my investigators he had denied LCol (retd) Lapeyre's request because he was determined to meet the October 31 deadline. When the CLS asked him to clarify his reasons, Col Selbie acknowledged there had not been enough time for LCol (retd) Lapeyre to review all the documents. In his letter to the CLS of August 28, 1998, Col Selbie wrote:

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> The limited amount of time LCol Lapeyre allowed for his trip to Shilo did not permit him to be present for previous witnesses' testimony or to review all the transcripts of evidence amassed at that late stage of proceedings … It is true that LCol Lapeyre did not have the same opportunity that other witnesses had to inform himself of prior testimony heard by the Board. However, this was principally the result of his travel plans and his desire to minimize the time he would be away from his work in Kingston.

1712 He explained that he had done his best to allow LCol (retd) Lapeyre to review the information within the strict time-line available, sending a packet of information and a driver to meet him at the airport so that he could review the documents on the drive to CFB Shilo. LCol (retd) Lapeyre, however, is adamant that he rented a car and drove himself, recalling that he had to drive in an ice storm.

1713 LCol (retd) Lapeyre now feels that, had he been given an opportunity to read transcripts of the other witnesses' testimony at the BOI, he would have known about and possibly been able to correct misconceptions by the Board. In particular, he points to the issues that he attempted to clear up once he read the BOI's Report: his questioning of which training safety directives were in effect at the unit in April, 1992 and what types of exercises they applied to; and his questioning of whether a full control staff (i.e., an exercise Chief Controller) had been required for the exercise on April 7. He believes that, had the deadline been extended, his testimony would not have been left to the last possible day, and he would have been able to more thoroughly review the testimony of the other witnesses and possibly help the BOI to come to more accurate conclusions.

1714 On March 20, 1998, in a letter to LGen Leach, the CLS, LCol (retd) Lapeyre wrote:

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> I volunteered to offer testimony at the Board, and the President thanked me for my participation. Prior to testifying, I asked the President for time to review pertinent documents before I gave my testimony, and this was denied. I offered to personally contact the convening authority to request additional time. It is important to note that the accident occurred five years before the Board convened, and my memory of the events was not fresh.

1716 There is some confusion over whether an extension had been requested. In his interview, BGen Ross indicated that he had granted an extension of an additional three or four weeks to the reporting time, at Col Selbie's request. However, there is no record of such a request, nor were the terms of reference amended to change the dates. In his interview with my investigators on April 25, 2002, Col Selbie indicated that he had not requested an extension:

1717 I got the final terms of reference; I knew what I was going to be doing on the 15th [of August]. There was some discussion about who would be the third member of the board up until the 29th [of August]. We went to Suffield on September 27 and I handed the report in on October 31. I could have asked for an extension I guess, that was within my power as the president. I didn't. I felt under some pressure to get this done.

11.3.2.5.1 Analysis

1718 The ARB was unable to make a definitive finding with respect to LCol (retd) Lapeyre's request for additional time to prepare before testifying before the BOI. The ARB noted that "there is simply no satisfactory way to establish the truth this long after the event." It considered that Col Selbie and LCol (retd) Lapeyre disagreed on the facts and that LCol (retd) Lapeyre's request for more time did not appear in any record of the BOI proceedings, nor did he provide any written evidence of his request. That said, the ARB concluded that the specific details were moot in light of its finding that LCol (retd) Lapeyre should have been afforded procedural protections once the BOI was aware that there was the potential for adverse findings to be made against him.

1719 I agree with the ARB's analysis of this issue. By the time he was preparing to testify before the BOI, the Board should have notified LCol (retd) Lapeyre of the possibility that adverse findings would be made against him, and should have given him an opportunity to defend his interests. In other words, he should have been permitted to fully review the evidence the Board had already heard; to further question witnesses and to call witnesses if he so desired; to fully prepare himself before testifying before the Board; and to make submissions to Board members. Although there is no record of LCol (retd) Lapeyre's request for an extension to prepare himself before he testified before the Board, it does not seem unreasonable to believe that he would have made such a request. Unfortunately, as the ARB found, it is impossible at this juncture to be certain.

1720 What is more important, however, is not whether the request was made, but that by the time LCol (retd) Lapeyre testified before the BOI, he was not in a position to know the full extent of the importance of his testimony, nor that there was a need to defend his own interests because specific findings of responsibility on his part were being considered by Board members.

11.3.2.6 Failure to Call All Relevant Witnesses

1721 After having received his letter of displeasure from the CLS, LCol (retd) Lapeyre sought and received permission to review the record of proceedings of the BOI. Once he had had an opportunity to review the evidence received by the BOI, LCol (retd) Lapeyre contacted the former 2 PPCLI Training Officer, who had also been the senior duty officer responsible for the set-up, manning and operation of the command post – Call Sign Zero. This officer provided LCol (retd) Lapeyre with information indicating that Capt Kaduck had been the Chief Controller on April 7, 1992. The duty officer at Call Sign Zero also identified a 2 PPCLI warrant officer as a potential witness who could confirm that Capt Kaduck had been the Chief Controller. As the 2 PPCLI Training Officer, the duty officer at Call Sign Zero would have received 1 Canadian Brigade Group Operational Training Policy Directive (OTPD 107), which dealt with safety procedures during training. In a faxed statement to LCol (retd) Lapeyre dated April 29, 1998, he indicated that, to his recollection, neither he nor the unit received an OTPD 107 related to vehicle safety before, during or after his tenure as Battalion Training Officer.

1722 LCol (retd) Lapeyre also believed that the staff officer for Operations Plans and Training of 1 Canadian Brigade Group should have been called to provide evidence to the BOI on the review of 2 PPCLI's training instruction, especially since Col Semianiw had testified that this instruction had been sent to Brigade Headquarters for review. LCol (retd) Lapeyre also questioned why the officers commanding the two companies involved in the training exercise as Friendly Forces had not been called as witnesses.

1723 In his response to the CLS's question about this issue in his letter of August 28, 1998, Col Selbie acknowledged that the BOI had not obtained statements with respect to the post-accident review of the exercise instructions by 1 Canadian Brigade Group Headquarters. His reasons were that its terms of reference did not require the Board to investigate the conduct of the original SI or the review of the incident by the chain of command in 1 Canadian Brigade Group. He also explained that Board members had contacted the former 1 Canadian Brigade Group staff officers for Administration and Personnel and for Operations Plans and Training to explore whether they had any information relevant to the incident itself, and concluded that they did

not. He noted that the former staff officer for Operations Plans and Training had offered to appear before the Board but that, based on the notes taken by Board member Capt Price, they were not sure what information he would have had to offer.

11.3.2.6.1 Analysis

1724 With respect to the allegation that not all relevant witnesses were heard by the BOI, the ARB noted that "re-evaluating the comprehensiveness of the evidence of a five year old BOI runs a real risk of trying to second-guess the thought processes of BOI members, especially in such inherently subjective areas as evaluating witness credibility." The ARB did comment, however, that it seemed reasonable that testimony by the Training Officer on the currency of exercise publications and exercise conduct, and by the officer commanding the administrative company on the issue of who was the exercise Chief Controller would have been useful to "better substantiate the 97-BOI findings that criticized unit leadership in these areas." The ARB commented that, despite Col Selbie's determination that the BOI had sufficient testimony to reach its conclusions, it believed that the BOI could have "expended more effort in establishing a better level of understanding, especially given the lapse in time since the accident and the potential adverse effects of the 97-BOI findings."

1725 I agree with the ARB's conclusion that the BOI should have expended more effort to establish a better level of understanding, particularly with respect to the issues of who was acting as the exercise Chief Controller on the day in question and the application of safety directives within the unit. Both issues were clearly not only points of contention between different witnesses, but also questions that a vital witness — Maj Kaduck — was not even able to answer with any certainty.

1726 The fact that the BOI's terms of reference did not specifically require a review of the SI or an examination of 1 Canadian Mechanized Brigade Group Headquarters' involvement with or review of the incident, does not, in my view, justify the BOI's failure to call additional witnesses on these important issues. It is not unreasonable to expect that, early on in the proceedings, the BOI would have identified the importance of the issues of who was exercise Chief Controller and the application of safety directives within the unit. Both questions were directly related to the issue of command responsibility with

respect to safety and ultimately with respect to MCpl Wheeler's death, clearly issues the Board was specifically convened to examine. This context should have indicated to Board members the importance of hearing all available evidence directly from each possible witness, including members of 1 Canadian Brigade Group Headquarters.

1727 In my view, this issue is another example of how failure to extend procedural protections to those likely to be adversely affected by the BOI impeded the Board in its fact-finding mission. Had the Board notified LCol (retd) Lapeyre and Col Semianiw of the possibility that their interests could be adversely affected and allowed them an opportunity to review the evidence of other witnesses, pose additional questions, call additional witnesses and make submissions, the Board would have been more informed prior to making any findings or conclusions.

11.3.3 Influence on the BOI President

1728 In 1997, BGen Ross, the convening authority for the BOI, was Commander of Land Force Western Area, while Col Selbie was the commander of CFB Shilo and therefore reported to BGen Ross. Beyond the views BGen Ross expressed about the accident which claimed the life of MCpl Wheeler, LCol (retd) Lapeyre contended that, as a result of his relationship with BGen Ross, Col Selbie had to be aware of his views, particularly about command responsibility. LCol (retd) Lapeyre believed that, based on correspondence and statements he made prior to the BOI, BGen Ross intended the BOI to find senior officers responsible for MCpl Wheeler's death.

1729 Col Selbie had his own views about the responsibilities of command, independent of those expressed by BGen Ross. During his interview with Ombudsman investigators, he indicated that:

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> They were little things, but I found it impossible, having just come back from being a contingent commander, I was very focused on responsibility. Remember too that we had gone through a period when the military as an organization had come under great scrutiny and found to be lacking in certain ways. Part of that was perhaps people not standing up and saying "I'm responsible."

1731 …[LCol (retd) Lapeyre] I think in his statement … said "I am the commanding officer and I am ultimately responsible for everything that's happened here." … [H]e should not be entirely surprised to see a statement or finding to the effect that he was indirectly responsible insofar as certain safety requirements were not fulfilled … Again, I think if you've gone through six months as a contingent commander of the organization you come under a certain amount of scrutiny and criticism for perhaps people evading responsibility. So I found it very difficult as I was writing the findings to say — to disallow or not to include the commanding officer at all … I think it would have been wrong to do that.

1732 Col Selbie has acknowledged that he was under extreme pressure to complete the BOI on schedule. He was aware that BGen Ross had plans to brief Mrs. Wheeler about the BOI in November 1997. Toward the end of August, he also received a call from MGen Jeffries, the Assistant CLS, who told him that the Base Commander Edmonton had chosen to take early retirement and that he (Col Selbie) would be posted to take up the position. He told my investigators:

1733 It was a lateral move but certainly there were broad responsibilities involved in the new job. I do recall saying to MGen Jeffries that I will look at this BOI. I believe the annual German-Canadian training conference … [occurred] at that point, so I would have been involved with that. So it was a very busy two months from the time I sort of got back from leave on return from Bosnia and when I had to report to Edmonton and get the report handed in on the 2nd of November. But, as I say, I remember saying this to MGen Jeffries that I have got this board to do. He said, "well, sorry, Jim, you are just going to have to get on with it and get all this stuff done properly and then proceed to your new job at Edmonton."

11.3.3.1 Analysis

1734 My Office's investigation did not reveal any evidence of any attempt on BGen Ross' part to influence Col Selbie, the conduct of the BOI or the Board's conclusions. There is no logical basis on which to attribute the shortcomings in the conduct of the BOI to any desire by Col Selbie or other Board members

to please BGen Ross by reaching predetermined results. Rather, in my view, the shortcomings in the BOI process reflect a lack of training in the proper conduct of BOIs, time pressures, and an inadequate understanding and application of the rules requiring procedural fairness.

1735 Although Col Selbie did not acknowledge that pressures of time influenced the results of the BOI, I believe they did. My view is based on the extremely close timing of LCol (retd) Lapeyre's testimony and the completion of the BOI Report, the incomplete treatment of some issues, and the fact that other witnesses were not called to pursue the central issues of who was the exercise Chief Controller and the application of safety directives within the unit. It is not clear exactly to what degree pressures of time affected the quality of the investigation and the BOI Report, but it is apparent to me that they were a factor.

1736 In addition to the time pressures, there may have been some confusion on the part of the Board of Inquiry about the difference between command responsibility and the attribution of blame. As the ARB pointed out, there is an important difference between the responsibility of a senior officer for what happens under his command, and blame for harm that one has caused or contributed to. If one is interested in "command responsibility," the only issue is, "who was in charge when things went wrong." If one is interested in blame the search is for failings and causes of an event, and there is discussion of sanctions. In defence of the BOI's findings, Maj Johnson has urged that, as CO, LCol Lapeyre would automatically be responsible for the death of a member under his command, something LCol (retd) Lapeyre acknowledged. Yet it is apparent that this Board of Inquiry was not tasked to find this form of command responsibility. It was clearly tasked to find what went wrong and what errors caused the tragic accident. Accordingly it identified what it concluded to be errors, it attributed "direct" and "indirect" responsibility, and although it was careful not to recommend sanctions, it considered whether sanctions should be imposed. Whether the word "blame" was used or not, this Board of Inquiry was focusing on what can only be described as "blame." The apparent confusion by the Board of Inquiry about the distinction between blame and responsibility caused it to underestimate how stigmatizing its findings would be. Two lessons can be learned as a counsel of prudence for the future relating to these confusing concepts. First, what needs to be understood is that when "responsibility" is being inquired into *based on alleged failings*, the inquiry is about blame, whether the word is used

or not. The processes used and an approach of caution in fact finding should reflect this. Second, there can be no "responsibility" of this kind – attributed fault for errors committed – in the absence of proof that those failings caused the consequence.

11.3.4 BOI's Finding of Indirect Responsibility by LCol (retd) Lapeyre

1737 LCol (retd) Lapeyre complained that the BOI's finding that he was indirectly responsible for MCpl Wheeler's death was unfair and unsupported by the evidence. The BOI found LCol (retd) Lapeyre to be indirectly responsible for MCpl Wheeler's death by failing to ensure that:

1738 • adequate supervision of the exercise control staff was provided on the departure of Maj Semianiw on April 6, 1997;

1739 • exercise instructions adequately addressed safety issues, including safety regulations in effect at the time of the accident that could have prevented MCpl Wheeler's death if they had they been enforced (specifically, the contents of 1 Canadian Brigade Group OTPD 107 and FMCO 24-15); and • all members of 2 PPCLI were made aware of pertinent safety regulations in effect at the time, which were designed and intended to prevent an accident of the type that befell MCpl Wheeler (specifically, those set out in 1 Canadian Brigade Group OTPD 107 and FMCO 24-15).

11.3.4.1 Chief Controller Issue

1740 The BOI heard conflicting evidence as to whether there had been an exercise Chief Controller on the day in question and who had been acting in that capacity.

1741 The evidence presented to the BOI can be summarized as follows:

1742 **The Friendly Force Umpire:** On October 9, 1997 he told the Board that Capt Kaduck would have been the exercise Chief Controller, and that Capt Kaduck briefed the company and the control staff on the morning of April 7, 1992.

1743 **Maj Kaduck:** On October 15, 1997, he told the Board that he was not certain who was the Chief Controller but thought it was the senior duty officer at Call Sign Zero. He denied that he had been appointed acting Chief Controller

in the absence of Maj Semianiw. On October 17, Maj Kaduck read a statement that said "… with respect to … whether I had assumed the duties of chief controller … I believe that my answer should have been 'I do not remember,' as I have no specific memory of either being appointed chief controller nor of any other individual receiving this appointment when Maj Semianiw departed."

1744 **The Enemy Force Controller:** On October 16, 1997, he told the Board it was his understanding (at the time of the BOI) that Capt Kaduck was Chief Controller at the time. When asked what his understanding was at the time of the accident, the Enemy Force Controller replied, "five and a half years ago I may have known who it was, four days ago when I showed up here I did not have a clue who it was, but then having read stuff … things are coming back, and I remember going back … and got orders for the next day from the Ops O [Maj Semianiw]. On that occasion it probably was, but I cannot say for certainty, it was probably Capt Kaduck who gave the orders for the next day, so he would have been, he would have been de facto controller." However, later in his testimony, he indicated that, in his mind, the person in charge of the exercise was the duty officer at Call Sign Zero or the CO. On October 30, 1997, the Enemy Force Controller was recalled; in response to a question about who he believed was acting as Chief Controller, he told the Board that he realized from the testimony that "no one was in control … there was no Chief Controller that day." (He had been allowed to sit in on the testimony of the others, and was attempting to clarify some of the issues based on the testimony of the other witnesses.)

1745 **Col Semianiw:** On October 17, 1997, he told the Board that the Chief Controller at the time was Capt Kaduck.

1746 **The major who had been put in charge of the accident scene:** On October 20, 1997, he told the Board that his "guess was that the colonel himself [LCol Lapeyre] took over … The actual control of the enemy force at that point, any instructions issued to the enemy force, if you tell me that Walter Semianiw was not there I don't know who would have picked up that role from him, who he would have delegated that to, I'm sorry, I don't know that."

1747 **LCol (retd) Lapeyre:** On October 30, 1997, LCol (retd) Lapeyre told the Board he believed that a replacement Chief Controller had been appointed, although one was not necessarily required, but could not recall who it had been.

1748 The duty officer who had been at Call Sign Zero on the day of the accident did not testify at the BOI.

1749 The BOI concluded that the departure of the exercise Chief Controller (Maj Semianiw) on the evening of April 6, 1992 created a supervisory vacuum within the exercise control organization. It noted that, prior to April 7, the exercise was well and properly supervised: all control staff understood their responsibilities and to whom they reported. However, the Board found that the same could not be said for April 7. It noted that the evidence indicated that the Enemy Force Controller was not clear as to who fulfilled the responsibilities of the Chief Controller following Maj (now Col) Semianiw's departure and that, while some witnesses presumed that Capt (now Maj) Kaduck would have acted in Maj Semianiw's place, Maj Kaduck did not recall having been so appointed. The Board also noted that both Maj Kaduck and the Enemy Force Controller had testified they believed that the duty officer in the battalion command post (Call Sign Zero) was acting as Chief Controller for the final day of the exercise. The Board further noted that Col Semianiw testified that he believed he had handed over his responsibilities to Capt Kaduck, although he did not specifically recall a hand-over brief, and that he believed LCol Lapeyre was aware of and approved the change. However, LCol (retd) Lapeyre did not recall having appointed, or having approved the appointment of, a replacement for Maj Semianiw.

1750 It should be noted that the propriety of Maj Semianiw's departure from CFB Suffield has never been an issue during any of the investigations. Maj Semianiw arranged and got the necessary approval for his house-hunting trip that required him to be absent from CFB Suffield at the end of Exercise Surging Rage. Rather, the question revolved around what provisions were made to provide for his absence.

1751 The BOI did not consider that Capt Kaduck was the next senior controller on the day in question and that, by practice, he should have assumed the duties as the Chief Controller on the exercise.

1752 The Board's conclusion that there was a supervisory vacuum on April 7 led, in part, to the BOI's finding that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death. BGen Ross, the Commander of Land Force Western Area and the convening authority for the BOI, reviewed the Board's findings and came to the following conclusion in his review, dated November 19, 1997:

1753 > The Commanding Officer bears the ultimate responsibility for the safety of his soldiers. In this instance, the principal shortcoming was failing to ensure that an alternate Chief Controller was appointed and properly briefed.

1754 During the CFNIS perjury investigation, the CFNIS investigator asked Col Selbie about the Board's inquiry into who was the Chief Controller on April 7, 1992. Col Selbie responded that, because the Board was very intent on determining whether MCpl Wheeler held a certain amount of responsibility for his own death, it may well have not investigated other areas with the same determination to reach a definitive conclusion. Specifically asked if the Board had missed something in questioning Maj Kaduck about his role replacing Maj Semianiw during his absence, Col Selbie responded that he was completely open to the fact that the line of questioning may not have been taken to its logical conclusion.

1755 > The CFNIS investigator: Again, if we could conclude, we agree that perhaps there could be concession given to the fact that maybe further exploration of this issue could indeed prove that on that day LCol Kaduck was in fact the chief controller. Would that be fair to say?

1756 > Col Selbie: Yes. I think it is fair to conclude that it would certainly be within the realm of possibility that if an investigative body were to reconvene — another board, for instance — to examine solely that fact and to speak again to all of the people who would have had some knowledge of the appointment of chief controller, it is certainly possible that they could have reached a hard and fast conclusion.

1757 > The CFNIS investigator: Again, you mentioned that this wasn't one of the key focal points of the BOI in their line of questioning.

1758 > Col Selbie: No … Our key focal point was that we wanted to know why MCpl Wheeler reached his untimely death …

11.3.4.1.1 Analysis

1759 The ARB, in its analysis of the issue of who had been Chief Controller on April 7, 1992, noted that, under the regulations applicable to the type of training conducted, there was no requirement for an exercise Chief Controller. In addition, the ARB stated:

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> Given the contradictory nature of the testimony before the 97-BOI, especially the testimony of then Maj Kaduck, it is understandable that the BOI could not be absolutely certain "… that on 7 Apr 92, an officer was effectively executing the function of Exercise Chief Controller whereas one had on the previous days of the exercise." However, in 1997, the 97-BOI did not have available to it the information that later came to light, especially the information provided by LCol Kaduck and the CFNIS investigation of 27 Dec 00 that concluded he was in fact the Exercise Chief Controller on the day of the death. With this information now available to the ARB, we reached a different conclusion than did the 97-BOI.

1761 The ARB wondered why the 1997 BOI gave greater credibility to the testimony of those who could not clearly remember or readily identify the exercise Chief Controller that day, when the others appeared to remember clearly:

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> When faced with contradictory testimony, and taking into account the fact that such testimony was being offered five years after the exercise was conducted, we especially question why a greater weight of credibility was given to Capt Kaduck as opposed to Maj Semianiw. We were unable to come to any conclusion on this matter.

1763 It is clear to me that the quality of evidence, that is, the testimony given before the Board, was weakened by the passage of time over the five years since MCpl Wheeler's death. A review of the transcripts of witnesses' testimony shows that memories had dimmed significantly — no one really remembered. The BOI Report echoed this view in its statement that "the board discovered that the memory of events of the majority had been significantly eroded by the passage of time."

1764 CFAO 29-9, in effect in 1997, included the direction, "The findings are the most important part of the minutes and must be clearly supported by the evidence contained in the minutes, including any exhibits or annexes"

(paragraph 25). It also included, in the responsibilities of the review authorities, ensuring "that the evidence supports the findings and recommendations" (paragraph 38 (b)).

1765 Since 1997, it has become clear that the finding against LCol (retd) Lapeyre and Col Semianiw, based on the Board's conclusion there was confusion about who the Chief Controller had been, was not supported by the evidence as required by the regulations governing BOIs. I believe this error is explained by the fact that Board members were not aware of the strength of the evidence that should be present to support such a finding. I hope this kind of error will be prevented in the future by thorough training and refresher materials for BOI members.

1766 The BOI Report contained a Statement by the Board, which explained that, after hearing conflicting testimony, members determined to give more weight to the testimony of the Enemy Force Controller and Maj Kaduck than to Col Semianiw's. I see this statement as an acknowledgment that the BOI considered these two witnesses as having made the most diligent efforts to recall the events of 1992 and to report these events accurately to the Board. Not having observed the testimony at the BOI, I am not in a position to dispute such a determination, nor is it my role. However, given a witness' own conflicting evidence — both the Enemy Force Controller and Maj Kaduck said different things at different times on the subject of who was the exercise Chief Controller — a more complete explanation should have been provided as to why the Board considered certain statements more credible than others.

1767 Col Selbie acknowledged to the CFNIS investigation that the Board was not as concerned about supporting its determination that there had been a supervisory vacuum as it was about some of its other conclusions. He partly attributed this focus to the terms of reference, which did not instruct the Board to examine matters related to the conduct of the exercise. However, the determination that there was a supervisory vacuum became one of the bases for finding LCol (retd) Lapeyre and Col Semianiw indirectly responsible for MCpl Wheeler's death. It was within the Board's terms of reference to determine responsibility "… by commenting on the accountability and responsibility of all levels of command … in the conduct of Ex Surging Rage

[and] by determining, if possible, those person(s) responsible for MCpl Wheeler's death …" Responsibility for a death is one of the most serious adverse findings possible, and it resulted in what some people clearly felt were punitive measures against LCol (retd) Lapeyre and Col Semianiw.

1768 I agree with LCol (retd) Lapeyre's complaint that the BOI's finding that there was a supervisory vacuum and that he was indirectly responsible for the death of the MCpl Wheeler was fundamentally flawed and unfair. The BOI Report did not address the issue of whether a Chief Controller was required for the type of exercise being conducted, nor did it explain the logic required to conclude that there was a link between the confusion over the Chief Controller and MCpl Wheeler's death. In my view, these two determinations were also necessary before reaching any conclusion with respect to LCol Lapeyre's indirect responsibility for MCpl Wheeler's death.

11.3.4.2 Findings about OTPD 107

1769 The BOI found LCol (retd) Lapeyre indirectly responsible for MCpl Wheeler's death, in part because he failed to ensure that exercise instructions adequately addressed safety issues — including safety regulations set out in OTPD 107 — and that all members of 2 PPCLI were made aware of the pertinent safety regulations set out in OTPD 107. The relevant part of the directive reads "Armd vehs [armoured vehicles] will stand off a min [minimum] of 50 m [metres] when there is any doubt as to the exact loc [location] of dismtd tps [dismounted troops]." The Board felt that the accident could have been prevented had LCol Lapeyre ensured that everyone involved in the exercise was aware of the rule and stressed the importance of adhering to it.

1770 There was conflicting evidence about which directives and orders were in effect and applicable to the exercise in April 1992. LCol (retd) Lapeyre pointed out that Col Semianiw told the Board that the unit had not received OTPD 107 prior to the exercise. However, the BOI found that OTPD 107 had been in effect and that the unit had failed to follow the safety regulations set out in the training directive. The Board based its finding on the existence of a unit Standard Operation Procedure (SOP) manual dated four years earlier, which used identical wording to that in the training directive.

1771 During the Board's proceedings, Col Semianiw testified that 2 PPCLI had not received OTPD 107 while he was with the unit and certainly not in time to incorporate it into the exercise instructions. Following LCol (retd) Lapeyre's complaint, the CLS asked Col Selbie to clarify this aspect of the Board's findings. In a letter dated August 28, 1998, Col Selbie responded:

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> The Board concluded that 1 CMBG OTPD 107 had been received prior to the promulgation of the exercise instructions based on two pieces of circumstantial evidence. The first of these is Battalion SOP 3003 (included in a volume of 2 PPCLI SOPs dated 15 Nov 89) that repeats, practically verbatim, the content of 1 CMBG OTPD 107 (with the exception of the stipulated safety paragraph.) The second piece of circumstantial evidence is the inclusion, as an annex, of OTPD 107 (including the Safety Paragraph) in the report of the original summary investigation of the incident. This report was reviewed and approved by LCol Lapeyre at which time we are unaware that he disputed or otherwise commented on the validity or applicability of OTPD 107.

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> It is true that the Board did not receive testimony from the Battalion Training Officer of the day nor did we conduct a search of the 2 PPCLI correspondence register from the period in question. With the benefit of hindsight, perhaps we should have done so. As it stands, our finding is based solely on evidence we received during the proceedings of the Board.

1774 The BOI's assumption that the inclusion of the OTPD with the SI Report proves that it was received by the unit prior to the exercise is contradicted by Annex C of the BOI Report, which contains a review of the draft SI Report conducted by the staff officer for Administration and Personnel of 1 Canadian Brigade Group. The draft SI Report sent to 1 Canadian Brigade Group for review did not refer in any way to OTPD 107. In his reply to the Commanding Officer of 2 PPCLI dated May 30, 1992, the staff officer for Administration and Personnel advised that "1 CBG OTPD 107 contains instructions on vehicle movement in the vicinity of dismounted soldiers. This should be referred to and included with unit standing orders or exercise instructions in the investigation." The reference to the OTPD in the 1992 SI Report was included in the response. This could explain why reference was made to it in the final draft of the SI Report, despite LCol (retd) Lapeyre's contention that it had not been received at the unit prior to the exercise.

11.3.4.2.1 Analysis

1775 The ARB questioned the factual basis for the BOI's conclusion that the OTPD was in effect at the time of the exercise. The relevant section of the ARB report reads:

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> LCol Lapeyre (retd) maintains that OTPD 107 had not been received by the unit in time for inclusion in the exercise instructions. OTPD 107 was issued in Jan 92, and he signed off the Exercise SURGING RAGE instruction on 14 Feb 92. The 97-BOI concluded differently based, in the opinion of the ARB, on limited circumstantial evidence. The 97-BOI did not obtain proof of receipt of the OTPD by 2 PPCLI, either through examination of the 2 PPCLI Correspondence Log, or through an interview with the Battalion Training Officer … The ARB does not support the 97-BOI finding that verbatim extracts of OTPD 107 contained in unit level SOPs constitutes proof of receipt of the OTPD. This training directive may have been circulated in draft form, or even constructed from existing unit level procedures and therefore verbatim quotation should not be regarded in any way as proof of receipt of the final document. The ARB contends that undue emphasis was placed by the 97-BOI on non-compliance with this directive without sufficient proof of its receipt within 2 PPCLI in time for inclusion in the Exercise SURGING RAGE instructions.

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> It was also unclear to the ARB why the 97-BOI insisted on placing so much emphasis on the lack of a unit safety briefing … and on the apparent lack of a written AFV [armoured fighting vehicle] safety paragraph in the exercise instruction.

1778 The ARB went on to say that the BOI applied some very stringent expectations of the CO for what was, in reality, a simple, routine dry training exercise in full daylight: "In an effort to determine responsibility, the BOI might have lost its perspective of realistic infantry training."

1779 There is additional reason to believe that the ARB was correct in finding that the reasoning of the Board of Inquiry about the arrival of OTP 107 was questionable. The OTPD was issued in 1992 and the SOP manual was dated 1989; the manual cannot therefore be circumstantial proof that OTP 107 was received before the accident. Furthermore, if the OTPD had been received prior to the SOP manual being drafted, one would have expected it to have been incorporated into the SOP manual in its entirety.

1780 I do not make these points to embroil myself in a factual controversy. I make this point simply to illustrate the dangers of making important findings that will find fault, without exercising great caution. The BOI had the power to demand solid proof of receipt of the OTPD before making a finding that an officer had failed in his responsibilities by ignoring an order, but it relied on circumstantial evidence that was not up to the task. A more thorough investigation – whether by benefit of appropriate expertise, or as a result of the evidence that might have come to light had LCol (retd) Lapeyre or Col Semianiw been given the procedural protections they were due — may have supported other conclusions.

1781 My investigators attempted, more than 10 years after the fact, to pinpoint the date when 2 PPCLI received OTPD 107. The current 2 PPCLI chief clerk stated that the unit only began maintaining correspondence logs on his arrival in 2001. He said that he had conducted a review of old records at 2 PPCLI, after which most were destroyed. He informed us that, today, there was no way to determine with precision when OTPD 107 had arrived at the battalion.

1782 In the section of this report entitled "Initial Investigation of Deaths and Serious Injuries," I make the point that all relevant documents and records must be secured immediately after a death, and reviewed in MP and CFNIS investigations. The issue of whether the unit had received OTPD 107 prior to the exercise amply demonstrates that the principle applies equally to administrative investigations. The ARB also addressed the matter by recommending that all records, orders and documents related to a matter under investigation be frozen. I fully support this recommendation.

1783 **I therefore recommend that:**

1784 **33. DAODs be amended to require that all relevant documents, including applicable rules, regulations, orders and procedures, be copied immediately following an unexpected death, and be maintained as part of the record of any subsequent administrative investigation, including a BOI into the incident.**

1785 The CF agreed with this recommendation.

11.3.4.3 Application of FMCO 24-15

1786 The Board determined that, in addition to the OTPD, FMCO 24-15 (*Driver Training Standards and Qualifications*) applied to Exercise Surging Rage. FMCO 24-15 required a crew commander for the movement of armoured vehicles "at all times" (paragraph 18) and ground guides when backing up or manoeuvring in restricted areas (paragraph 19). As a result, the Board held LCol (retd) Lapeyre responsible for not educating the battalion about the importance of the safety precautions in FMCO 24-15.

1787 LCol (retd) Lapeyre has argued in a number of pieces of correspondence that FMCO 24-15 was never intended to be a collective field training regulation, stating that it was meant to govern driver training only. When the CLS asked Col Selbie to clarify the BOI's findings about the applicability of FMCO 24-15, Col Selbie replied that a number of witnesses had told the Board they believed there was a rule about APCs requiring a crew commander. He stated that, even if the FMCO was not meant to apply to the type of training in question, based on the testimony, there was at least a tacit rule requiring the use of a crew commander. The ARB agreed with LCol (retd) Lapeyre when it concluded, "The use of FMCO 24-15 as a source of rules for collective field training is not appropriate given that its intent is purely driver training."

11.3.4.3.1 Analysis

1788 Having read the order, I agree with LCol (retd) Lapeyre and the ARB that FMCO 24-15 was not intended to govern field training. It is clear to me the order was not intended to cover force-on-force combat training exercises. The first paragraph reads:

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> The aim of this order is to detail the standards and procedures required to qualify military personnel as basic drivers to operate SMP [standard military pattern] wheeled, tracked and armoured vehicles in the FMC [Force Mobile Command].

1790 The next two paragraphs go on to deal with driver training on armoured and other vehicles in the military, and the paragraph after that concerns the standard military driving test. In contrast, the stated aim of OTPD 107 is to "outline the procedures to be taken to ensure the safety of tps [troops] and eqpt [equipment] during trg [training]."

1791 If the BOI had appreciated the purpose and scope of the FMCO, it could not have faulted anyone in the control or safety staffs for not enforcing the order. The purpose of the training exercise was not to train an APC driver, but to conduct company-level, force-on-force battle training. Col Selbie argued that there was at least a tacit rule requiring a crew commander, based on the fact that almost all of the witnesses stated they were aware of such a rule and had been aware of it during the exercise. Our investigation supports Col Selbie's contention; it appears that, in mechanized units, the need for a crew commander was well known and tacitly accepted. Indeed, the Enemy Force Controller always maintained that he ground-guided the APC to compensate for the lack of a crew commander. However, the fact that virtually all of the unit's members knew of the importance of having a crew commander does not support the BOI's conclusion with regard to LCol (retd) Lapeyre's failure to ensure safety procedures were known; rather, it supports the contention that the CO made sufficient efforts to stress this and other relevant safety precautions.

1792 This issue provides another example of information that would have come to light with the benefit of proper expertise, or if LCol (retd) Lapeyre and Col Semianiw had been afforded the opportunity to respond to matters about which their judgement and actions were called into question.

11.3.5 Review of BOI Findings

1793 BGen Ross, Commander of Land Force Western Area, convened the BOI in 1997, appointed a President and members, and set the terms of reference that governed the inquiry. As the convening authority, he was the first level of review for the BOI Report. After BGen Ross, the report went to LGen Leach, the CLS, for review. Since the BOI investigated the death of a CF member, regulations required it be approved by or on behalf of the CDS. Under the regulations for the review of BOIs, BGen Ross and LGen Leach are considered review authorities, and Gen Baril, as the CDS, is considered the approving authority, or final level of review.

1794 According to CFAO 21-9, the review authority is responsible for ensuring that the Board has been completed in accordance with its terms of reference, and that the evidence supports the findings and recommendations; if further evidence, corrections or amendments are required, the review authority is

responsible for causing the Board to reassemble. The convening authority is also, in addition to his responsibilities as a review authority, required to ensure that Board members are counselled about any apparent errors, omissions or shortcomings related to the conduct of the Board. The authority who convened the investigation and any review authority must endorse the minutes by concurring or not concurring with the findings and recommendations and, if not concurring, state their reasons.

11.3.5.1 Review by BGen Ross

1795 BGen Ross, Commander of Land Force Western Area, concurred with the findings and recommendations of the BOI. Concerning responsibility, he stated in his letter to LGen Leach, the CLS, on November 19, 1997*:*

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> 7. The Commanding Officer bears the ultimate responsibility for the safety of his soldiers. In this instance, the principal shortcoming was failing to ensure that an alternate Chief Controller was appointed and properly briefed. As the member has retired from the Canadian Forces, the only action available to the Canadian Forces is a letter of censure.

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> 8. With regard to the responsibility of the Chief Controller, there are reasonable grounds to believe that this tragedy may have been avoided if he had been present to perform his duties during the battalion-controlled, force-on-force portion of the training, or had made the appropriate arrangements to appoint and brief a Chief Controller to act in his place. I recommend that he receive a reproof for failing to properly supervise the safe conduct of the training.

1798 BGen Ross also commended the Board's President and members for their efforts in conducting a very thorough and professional inquiry. BGen Ross did not inquire about whether LCol (retd) Lapeyre and Col Semianiw had been notified that adverse findings might be made against them, or whether they had been afforded the opportunity to hear evidence and be represented at the BOI as provided for by CFAO 21-9. There is also no indication that he questioned the basis for the Board's conclusion that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death, or the BOI's findings about the Chief Controller and training directive issues.

1799 My investigators asked BGen Ross whether he felt there was a duty to make someone aware that they or their actions have become the focus of an inquiry. BGen Ross responded:

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> I don't think he [the president] owes an obligation to go to certain individuals and say, "this is what I am thinking. This is what I am going to recommend to the convener of the BOI." I don't think he has to do that. In fact, we don't do that … Serious incidents go directly to the Chief of Defence Staff who will be briefed and will have a discussion with the Commander of the Army, the Navy and the Air Force, or whoever, on the circumstances, the issues, the seriousness, what degree of accountability do we have here or not. Before you do that, are you going to go back to individuals and discuss it with them. I don't think you should. I certainly didn't. Selbie didn't.

1801 At the conclusion of the interview, in the knowledge that LCol Kaduck had come forward to say that he had been the Chief Controller, BGen Ross was offered an opportunity to comment on any concerns that he might have felt needed following up. He responded:

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> I don't think so. I am not sure that I would have done anything differently, looking back on it. I still would have responded to Christina Wheeler's questions as forthrightly as I did. I am not sure we could have done it any faster than we did it. I am somewhat disappointed that the officers involved protested so long and loud unnecessarily.

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> I think I agree with your comment that after the president has finished his work, written his report and before we publicly tell people, that we could sit down with the people that are affected and review the Board with them. In this case, would it have changed our view of Jay Lapeyre? No, because it didn't matter what he said. He could have said nothing whatsoever. He is still by function, by design, partially accountable as the Commanding Officer in the course of the National Defence Act. I am somewhat disappointed that Jay has given himself too much heartache for too long unnecessarily.

11.3.5.2 Review by LGen Leach

1804 The second level of review was performed by LGen Leach, the CLS, for whom a preliminary review was conducted by the DLP. DLP staff members identified deficiencies in evidence and pointed to subjective findings, conflicting evidence and weak conclusions. They also pointed out that there was no causal relationship between what LCol (retd) Lapeyre had been found to have done (or not done) and MCpl Wheeler's death.

1805 Despite their own preliminary review, the DLP staff recommended that the CLS send a letter to LCol (retd) Lapeyre advising him of the Board's findings, with the observation that what appeared to be inadequate supervision was not clearly causally connected to the accident. The DLP staff also recommended verbal counselling for Col Semianiw, or that the CLS send him a letter similar to LCol (retd) Lapeyre's.

1806 The CLS concurred with BGen Ross' comments and recommendations, except for the recommendations for a letter of censure to LCol (retd) Lapeyre and a reproof for Col Semianiw. In his letter to the CDS on March 5, 1998, he stated:

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> There must be follow up action for these two officers, but a letter of censure and a reproof may or may not be the appropriate means. After considering the JAG advice … on this matter, I am of the opinion that although LCol Lapeyre and Maj Semianiw erred in their supervisory duties, their respective failures do not amount to indirect responsibility for MCpl Wheeler's death. It is not clear from the evidence that inadequate supervision by the CO, or the supervisory vacuum created on the departure of Maj Semianiw, had a causal connection to the accident. [The Enemy Force Controller] had testified that he was knowledgeable of the required safety orders. The evidence also indicated that the breakdown in positive safety control occurred between [the Enemy Force Controller] and [the APC driver].

1808 Following discussions with the CDS, LGen Leach chose to pursue an administrative response with both LCol (retd) Lapeyre and Col Semianiw. He decided to verbally counsel Col Semianiw on his shortcomings and provide a record of such counselling on his unit personnel file. With respect to LCol (retd) Lapeyre, LGen Leach decided to write him informing him of the following: the BOI's findings with respect to the CO's failures and

deficiencies; the conclusion that he erred in his supervisory duties; the CLS's disagreement with the Board's conclusion of indirect responsibility for MCpl Wheeler's death; and, finally, that the CDS had directed that he be formally advised of the findings and made aware that his performance had been found deficient.

1809 My investigators asked LGen Leach why he took the action he did. He responded:

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> … the only thing that I can recall was that there was a debate about the issue of letters going to the officers as to whether that was the right thing to do, or not the right thing to do, was there a basis upon which to do it; if the letter was going to go out, what were the right words that would convey the intent …

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> … I recall two things that I felt were pushing on me. One was, General Ross … General Ross, in my view [was doing] a very good job of following up on the board and with the family … I believe that it is safe to say that he had about as much trust from the Wheeler family as anybody, in that he was seen to be taking action to try and gain some resolution. When you get into that situation, being that you are a human being, you can get too far into it. My feeling at the time was that I was not suggesting that he was too far into it, but I knew I had some accountabilities for other people. In my appointment I had accountability for everybody who was involved … In looking at a BOI, you have to try and take care of the process … the victims … the potential indirect victims to make sure that justice, as much as you can, is done …

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> The intent with the letters ... was to let the officers who were concerned know that in the resolution of this matter of some six years ago ... that they were deemed to have some responsibility, to probably cause them in their conscience to think about what they had done or what they had not done or, given a chance to do it again — or given the opportunity to teach other people how to deal with situations ... The letters also would serve … as a reminder ... to all people who find themselves in positions of accountability, that you really are accountable …

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> How this ever gets reported or understood I am not really sure. But everything that went on in most of the 1990s was about people trying to be aware of what being accountable really means, and what taking

> care of business really means, and why when something happens you investigate it to the hilt the day or the day after it happened, and why you should not be upset when you don't get around to digging down into it for a number of years subsequently. Why people are annoyed? They are annoyed for a very good reason, and that is you didn't take care of business at the time …

11.3.5.3 Review by Gen Baril

1814 Gen Baril, the CDS, was the approving authority and the final level of review. In an undated minute on the CLS's letter, Gen Baril approved the BOI's recommendations — except those dealing with indirect responsibility for MCpl Wheeler's death on the part of LCol (retd) Lapeyre and Col Semianiw — and approved the action proposed by LGen Leach. There is no evidence of further review by the CDS or his staff.

1815 LCol (retd) Lapeyre believes that Gen Baril was in a conflict of interest due to the fact that, while CLS prior to 1997, then-LGen Baril had been involved when the decision to convene the BOI was made. LCol (retd) Lapeyre told my investigators that he believed BGen Ross had briefed LGen Baril on the reasons for convening the BOI. LCol (retd) Lapeyre told my investigators:

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> If he [BGen Ross] said to MGen Crabbe prior to the Board being convened that he thought it was a unit cover-up and he referenced the [BOI into the 1995 training death at CFB Suffield] which was determined to be a bit of a unit problem, there is the possibility that the approving authority was prejudiced by the comments of General Ross in making a statement as to the process and the new evidence that was being brought to bear to cause the BOI to be conducted.

1817 LCol (retd) Lapeyre also expressed concern that similar comments had been made to Gen Baril when he was the CLS and that these comments affected his decision to approve the BOI, as CDS. He told my investigators:

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> I may be making a bit of an assumption there but given the facts that I know today and statements that were made by the convening authority, I have no reason to believe otherwise than that he would have made prejudicial comments to the Commander of the Army who later becomes the CDS and approving authority for the Board.

11.3.5.4 Analysis of the Review Process

1819 The ARB acknowledged that one of the issues raised by LCol (retd) Lapeyre was the CLS's decision to proceed to make the BOI results public, despite the fact that he was aware of some of the flaws in the BOI. Nevertheless, in reviewing LGen Leach's actions, the ARB restricted itself to addressing the actions taken after the BOI had been approved. The ARB did respond, generally, to LCol (retd) Lapeyre's allegations that various senior CF officers acted out of prejudice against him, finding no proof of prejudice.

1820 The results of the ARB have demonstrated significant flaws with the conduct of and conclusions of the 1997 BOI. It is my opinion that the BOI into MCpl Wheeler's death was not, in many respects, conducted as it should have been, despite some good findings and recommendations. Some examples that support my opinion are: the failure to call a Subject Matter Expert; the failure to pursue the resolution of conflicting evidence with sufficient rigour; the failure to provide procedural protections to LCol (retd) Lapeyre and Col Semianiw; the failure to establish a better understanding by calling additional witnesses; the failure to be transparent in explaining the Board's finding that specific witnesses were more credible than others or that certain statements of a given witness' testimony were more believable than other statements by the same witness; and the failure to ensure that the evidence supported the findings.

1821 It is clear that, by the time LGen Leach had the report, his staff had identified a number of flaws. While LGen Leach did not ignore these flaws, he nevertheless chose to proceed by slightly modifying the way some of the recommendations were implemented, rather than by reconvening the BOI. According to the regulations, the comments of review authorities become part of the record to be considered by subsequent review levels and the approving authority, so LGen Leach's comments officially became part of the file. Since then, these flaws have been magnified by the new information that came to light about the Chief Controller. The fact that, six years after the BOI, the matter was still being examined by an ARB and the Ombudsman's Office demonstrates how fundamentally flawed the BOI was.

1822 LGen Leach's decision to modify the consequences and send what his staff believed to be a flawed BOI Report, even if along with his comments, to the CDS for approval compounded the unfairness to LCol (retd) Lapeyre, and did nothing to encourage what should have been the goal of the BOI — finding the facts and, based on those, recommending corrective action.

1823 The CDS at that time, Gen Baril, supported the conclusion of LGen Leach. My Office's investigation did not uncover any evidence to show that Gen Baril was unduly influenced in his conclusions at any point. Gen Baril also does not appear to have been attuned to the flaws with respect to the BOI's process, including the fact that LCol (retd) Lapeyre and Col Semianiw were not given an opportunity to defend their interests during the conduct of the inquiry.

1824 I understand that once the CDS approves a BOI, revisiting the issues or re-opening the investigation is likely to become very difficult. Considering that LCol (retd) Lapeyre did not even know about the findings against him until after Gen Baril's approval, the entire BOI process, including the review process, left LCol (retd) Lapeyre with very little chance to make his case. By sanctioning a flawed process and inaccurate conclusions, the review process perpetuated the unfair treatment of LCol (retd) Lapeyre.

11.3.6 Release of BOI Results

11.3.6.1 Request to Defer Public Release

1825 Following the CDS's approval of the BOI Report, LGen Leach counselled Col Semianiw and wrote a letter to him recording deficiencies in his performance. He also wrote a letter of displeasure to LCol (retd) Lapeyre. The letter, dated March 18, 1998, related the Board's findings as they pertained to the CO's role. It indicated that LCol (retd) Lapeyre had erred in his supervisory duties, noted that the CLS and the CDS disagreed with the Board's conclusion that he was indirectly responsible for MCpl Wheeler's death, and related the CDS's direction that LCol (retd) Lapeyre be formally advised of his deficient performance. Concerning the public release of the BOI's Report, the letter stated:

1826 I must advise you that once I receive confirmation that you have received this letter, your name, and the statement that you have been found to have erred in your supervisory duties, may be made public as part of the release of the Board to the public and as part of a news release regarding these events.

1827 LCol (retd) Lapeyre replied very quickly to the CLS in a letter dated March 20, 1998. He expressed his concern that the Board's findings made recommendations that sullied his reputation, and that a public announcement in the near future might indicate that he was to blame or culpable for the incident. He noted that he had not been provided with a copy of the BOI Report, that he had not been allowed to read his testimony taken during the Board's proceedings, that he had not been provided time to read pertinent documents prior to testifying and that his offer to contact the convening authority to request additional time had been rejected. He considered that the Board's findings were unsubstantiated and unfair. He also made the following requests:

1828 I request in writing a more complete explanation of the circumstances and factors that resulted in your decision not to hold me "indirectly responsible". I do not understand why the Board would make this recommendation in the first instance, nor why you and the CDS have rejected it.

1829 In addition, I request that you withhold any public announcement until I have had the opportunity to review the evidence that led the Board members to make a judgement against me. I consider this to be a reasonable request, and one that should provide me with a more complete understanding of the circumstances, especially if I am approached by the press.

1830 LGen Leach responded positively to the first request, but denied the second. A letter to LCol (retd) Lapeyre dated March 31, 1998, signed by the Assistant CLS for LGen Leach, advised him that he could request a copy of the minutes of the Board or, if he visited Ottawa, his staff would make a copy of the BOI Report available to him. However, the letter informed LCol (retd) Lapeyre, findings of fact as to acts and/or omissions did not constitute personal information and could not be severed from the Board's report under the *Privacy Act* or *Access to Information Act*. The letter further stated:

1831 Your request that I withhold any public announcement until you have had the opportunity to review the BOI must be denied. In the circumstances of this case, I consider that the public interest in disclosure clearly outweighs any invasion of privacy that could result from the disclosure. This incident has been a source of heartache to Mrs. Wheeler and of concern to the Canadian public for over five years. It is now time to make this incident public, learn from and be accountable for our mistakes.

1832 On April 3, 1998, a news release was issued by Army Public Affairs, from Edmonton (where Land Force Western Area is headquartered). The full text of the release was as follows:

1833 Military Apologizes to Soldier's Widow

1834 EDMONTON — On behalf of the army, Brig.-Gen Dan Ross, the commander of land forces in Western Canada, has apologized to the widow and family of Master-Cpl. Rick Wheeler for the general manner in which the soldier's case was handled, six years after he died in a tragic training accident at CFB Suffield, Alta. Ross flew to Victoria Friday to personally brief the widow and family members on the findings of a BOI into the soldier's death.

1835 On April 7, 1992, Master-Cpl. Rick Wheeler, a member of the 2nd Battalion, Princess Patricia's Canadian Light Infantry, was run over by an armoured personnel carrier during a training exercise. The initial investigation into the accident found that an Exercise Controller, the vehicle driver and Wheeler himself were responsible for the accident.

1836 A BOI was convened on August 15, 1997, after several attempts by Mrs. Wheeler to obtain more information about the death of her husband, to review all aspects of the accident, including the findings of blame and the actions taken against individuals who had been found to be at fault.

1837 The Board, chaired by Colonel Jim Selbie, conducted a rigorous examination of all aspects of the accident, including the involvement of the chain of command and the potential for any leader on the scene to have taken action to prevent the accident. The BOI was completed last October and the Chief of the Defence Staff has accepted its conclusions, based on the recommendation of the commander of the army. The most significant finding was that MCpl Wheeler was in no

way responsible for his own death. The Board determined that this tragedy occurred as a result of a series of individual failings or omissions coupled with violations of established safety regulations which increased the chances of a serious incident.

1838 "Losing a soldier in training or on operations is a loss felt by the whole military community," said Gen. Maurice Baril, the Chief of the Defence Staff. "Master-Corporal Rick Wheeler was not responsible for what happened to him. It is my sincere hope that this admission, coupled with our heartfelt apologies to Mrs. Wheeler and the soldier's family and our resolve to do what has to be done to reduce the possibilities of accidents like this in the future, will help the healing process."

1839 The Board found that the driver of the vehicle and the controller of the force acting as enemy during the exercise were directly responsible for the accident. It was also determined that two senior officers — the officer in charge of the range that day, and the unit commanding officer — erred in their supervisory responsibilities.

1840 After the initial investigation, the driver and enemy force controller had administrative action taken against them. After a careful review of all factors in this accident, and considering the members' personal circumstances, the Board determined that the action taken against them was appropriate and that further measures were not warranted.

1841 The senior officer still in the military has been personally served with a formal letter of counselling by the commander of the army and this letter placed on the officer's personnel file. The second senior officer involved has since retired, and was hand-delivered a formal letter of displeasure advising him of the results of the BOI and its findings.

1842 "Realistic training for operations up to and including war is often a dangerous undertaking," said Lt.-Gen Bill Leach, commander of the army. "While there are very real risks given the types of equipment, tempo and nature of the effort involved, training does not have to be unsafe, and the army's overall record in this respect is outstanding. Notwithstanding, improvements are possible and will be actioned as a matter of priority."

1843 As a result of this accident and the follow-on investigations, several modifications to the training safety regulations have already been implemented, and the main Canadian Forces field training safety

> manual will be reviewed for further changes or additions. An army-wide message will also be issued shortly re-emphasizing the importance of detailed safety briefings to all personnel prior to conducting live-fire or dry (no real ammunition being used) training.

1844 A memorial cairn will be erected in the very near future at the site of the accident to recognize MCpl Wheeler's death. The commander of the army will participate in the dedication ceremony.

1845 In reviewing the process by which the CF released information about the BOI, the ARB essentially reiterated the Privacy Commissioner's findings that the proper process had been followed; that is, the Privacy Commissioner had been informed of the intent to release personal information in the public interest. The ARB concluded that the media release – including comments made to reporters by BGen Ross – contained both the BOI's finding of indirect responsibility and LGen Leach's milder finding of supervisory error. The ARB concluded that the publication of this information negatively affected LCol (retd) Lapeyre's reputation.

1846 I recognize that the decision to release the BOI results despite LCol (retd) Lapeyre's request was not made in a vacuum. There was a great deal of pressure to release the results of the investigation, to Mrs. Wheeler in particular. In the end, that was done, at the cost of LCol (retd) Lapeyre's interests. I believe that was unfair to LCol (retd) Lapeyre, especially considering that the BOI's results had already been questioned, and that LCol (retd) Lapeyre had no opportunity to respond to the findings against him. It would have been prudent to have allowed LCol (retd) Lapeyre the opportunity to review the BOI, and to give him the chance to respond. This could have been done within strict time-lines, or deadlines, which I am certain LCol (retd) Lapeyre would have understood and adhered to. Mrs. Wheeler could also have been briefed privately and in confidence about the state of the BOI and the reason for the delay. After all, it was the Wheeler family who anxiously awaited the results, not the public at large.

1847 The *Privacy Act* required, in this case, the balancing of conflicting interests: LCol (retd) Lapeyre's interests in protecting his reputation and the Wheeler family's interests in finally receiving what they were told would be the definitive word on the cause of MCpl Wheeler's death. Clearly, the CF had trouble balancing these two interests, and it decided to address the Wheeler family's concerns at the expense of LCol (retd) Lapeyre.

1848 The fact that there was some question as to the accuracy of the findings at the time when they were made public only increases the unfairness to LCol (retd) Lapeyre. I must clarify that I am not convinced that the unfairness occasioned LCol (retd) Lapeyre was the result of any bias or conflict of interest. The unfair impact on LCol (retd) Lapeyre was, in my view, the product of a systemic failure as opposed to the result of individuals' decisions. At the time, the CF was under considerable pressure to ensure a thorough inquiry was conducted and that the results of this inquiry were made public, so as to demonstrate that the organization as whole was open, transparent and — most importantly— accountable. This pressure, in my view, contributed to a flawed process and conclusions that the CF leadership subsequently — after the ARB — found to be unsound. The public release of these flawed conclusions caused unjust prejudice, pain and anxiety to LCol (retd) Lapeyre and his family.

11.3.6.2 Public Release of BOI Results

1849 Media coverage of the BOI results reported that BGen Ross found that LCol (retd) Lapeyre had not provided proper supervision of control staff and that Col Semianiw was blamed for leaving amid confusion over who was in control. The newspapers reported that LCol (retd) Lapeyre was issued "a letter of displeasure" in retirement. Some newspapers reported that BGen Ross had determined that their actions or omissions amounted to "indirect responsibility for Master Cpl Wheeler's death" and that this conclusion had been overturned by LGen Leach. A review of articles on the subject reveals additional statements attributed to BGen Ross:

1850 Ross said the letter won't affect Lapeyre but could damage Semianiw's advancement. (*Vancouver Province*, April 8, 1998 and other papers)

1851 Brig-Gen Ross said the letter won't affect Lt-Col Lapeyre, but could damage Maj Semianiw's advancement in the forces. "A three-year statute of limitations has passed and no further military action will take place," Brig-Gen Ross said … "I didn't do this (the BOI) to undo the damage, said Brig-Gen Ross. I did this to get Christina Wheeler closure – to get the facts and the truth. I think I've achieved that." (*Ottawa Citizen*, April 8, 1998)

1852 "The letter (of counselling) has serious consequences for Semianiw, who is still in the military," Ross said. "That piece of paper stays (on the record) forever," he said. "It affects everything. Whenever you consider that officer for a promotion or something, that's on his record. But more importantly his reputation is basically destroyed in the eyes of his fellow officers and servicemen." (*Edmonton Journal*, April 28, 1998)

1853 LCol (retd) Lapeyre felt that BGen Ross exaggerated the seriousness of the actions taken against Col Semianiw and himself to the media to appease the media and the public, and to prevent criticism of the DND/CF for not taking serious action against senior officers. As evidence, LCol (retd) Lapeyre cited BGen Ross' public statement that Col Semianiw's career would be seriously affected by having the letter of counselling placed on his career file, when in fact there is a difference between a career file and a personnel file.

1854 When BGen Ross was interviewed by my investigators, he indicated his belief that the disclosure of findings and information about the BOI came from the family and not in any organized fashion from DND. He was specifically asked if he had made the statement "That piece of paper stays on the record forever [… and] affects everything … his reputation is basically destroyed in the eyes of … officers …" He replied he had said that to Mrs. Wheeler, and not directly to any reporter.

1855 On April 29, 1998, the Director, Land Personnel wrote the following note to MGen Jeffries, the Assistant CLS, outlining the concerns that had been brought forward to him by LCol (retd) Lapeyre and Col Semianiw about the media coverage:

1856 I received many calls from Col Semianiw and Jay Lapeyre yesterday concerning the attached article (The Edmonton Journal, Tuesday, April 28, 1998). [Col Semianiw] believes there is a disconnect between what the Commander [LGen Leach] said to him during his interview and what BGen Ross has said publicly. Perhaps BGen Ross' last sentence (…his reputation is basically destroyed in the eyes of his fellow officers and servicemen) is a little too strong.

1857 MGen Jefferies sent a return minute to the DLP on May 7, 1998 indicating that he had spoken with BGen Ross and that BGen Ross's intent in answering the reporters' questions "was to assure the reporters that senior officers had not gotten off 'scot free' as was their perception … In essence his intent was to save further public humiliation rather than cause more …"

1858 On March 29, 2000, LCol (retd) Lapeyre formally complained to the Privacy Commissioner about the public comments on the BOI results, as well as other issues. With respect to the public comments, he indicated to the Privacy Commission that:

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> I object to the comments attributed to senior officers in the print media based on a non-judicial inquiry the Wheeler BOI during period of April 1998 — December 1998 and the fact that the comments by BGen D Ross appear to be intentionally exaggerated for personal reasons (to placate the media rep specifically B. Bergen — Calgary Herald). Secondly, these comments do not appear to follow the intent of his superior's direction to him on this matter (provided in a letter from CLS to Commander LFWA dated 18 March 1998). We now know that the Wheeler BOI was seriously flawed, this was indicated to CLS late March 1998 but he took no action to prevent the actions of his subordinates in delaying the press release or advising his superiors of a flawed Departmental position on this matter which directly involved the MND.

1860 In a letter to LCol (retd) Lapeyre of May 9, 2001, the Privacy Commissioner of Canada agreed with one of his complaints, but responded to this one as follows:

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> In investigating this portion of your complaint, we examined news articles which followed the April 3 disclosure of the Summary and correspondence. The articles generally outline the 1992 accident at CFB Suffield, the events which followed and the findings and recommendations of the BOI. Our examination has satisfied me that, for the most part, the information which appears in the articles was taken directly from the correspondence released on April 3 under paragraph 8(2)(m) of the Privacy Act. One article which contains the statement that the letter you received from the CLS would not affect you, was not taken from the Summary or the letters. Again, I am of the view that this statement constitutes a personal opinion and that expressing such an opinion does not violate the Act.

11.3.6.2.1 Analysis

1862 As mentioned in the previous section, the ARB found that harm had been done to LCol (retd) Lapeyre's reputation, based on the fact that the CF had released information about the BOI's stronger finding of indirect responsibility (to Mrs. Wheeler, the media and within 1 Canadian Mechanized Brigade Group), when it was known the CLS had in effect substituted it with a finding of improper supervision. However, the ARB found no evidence that any of the decision makers had acted out of prejudice against LCol (retd) Lapeyre.

1863 Whether BGen Ross spoke directly to reporters or relayed information to Christina Wheeler is less important in my view than the fact that inaccurate information about Col Semianiw and LCol (retd) Lapeyre was ultimately reported in the media and attributed to BGen Ross, a senior CF official. Even if BGen Ross only made the comment in question with respect to Col Semianiw, and only made it to Mrs. Wheeler, he did so in the context of formally advising her of the BOI results, with the knowledge that she had spoken publicly about the CF's handling of the investigation into her husband's death and would likely do so again. In addition to the consequences to Col Semianiw's and LCol (retd) Lapeyre's reputations, BGen Ross' characterization of the results of the BOI did a disservice to Mrs. Wheeler.

1864 I also note that the CF had clearly made a decision to publicly release the information about the BOI results, as is reflected in LGen Leach's letter to LCol (retd) Lapeyre dated March 18, 1998, advising him that DND would not defer any public announcement of the BOI results to allow him to review the BOI evidence. That letter stated, "It is now time to make this incident public, learn from and be accountable for our mistakes." It is clear to me that this sentiment governed the whole of the CF's actions with respect to the public release of the BOI results and the involvement of Col Semianiw and LCol (retd) Lapeyre in MCpl Wheeler's death.

1865 BGen Ross' comments about the BOI results were made as part of his responsibility, as Commander of Land Force Western Area, to inform Christina Wheeler, as well as the public, of the results of an important inquiry into the death of a CF member. What is unjust here is that the information that was ultimately reported to the public at large — that LCol (retd)

Lapeyre's and Col Semianiw's actions on the day in question were deficient and that the original BOI had found LCol (retd) Lapeyre indirectly responsible for MCpl Wheeler's death — reflected findings that were arrived at after an unfair and flawed process.

1866 The comments attributed to BGen Ross reflect an overall desire by the CF to be seen as open, transparent and accountable by holding those in charge of the exercise responsible and demonstrating that they took harsh and swift action. In my view, the desire to show the organization was embracing accountability blinded those responsible and prevented them from pursuing serious concerns about the accuracy of the BOI's findings about who was responsible for MCpl Wheeler's death. Their demonstration of accountability was done at the expense of LCol (retd) Lapeyre, without seeking assurances that he had been afforded fair treatment, including an opportunity to defend himself.

11.3.7 Requests for a Review of the BOI

11.3.7.1 Delay in the CF's Response to LCol (retd) Lapeyre's Complaints

1867 On April 2, 1998, in response to his letter of counselling, Col Semianiw also expressed concerns about the shortcomings in the conduct and findings of the BOI. In his letter to the DLP, he referred to the fact that the unit Training Officer at the time of MCpl Wheeler's death could provide evidence supporting Col Semianiw's testimony about which safety orders had been held by 2 PPCLI, and about who had been the acting Chief Controller (Capt Kaduck). The letter also contained information about the conduct of the BOI, and asserted that procedural protection had not been offered to Col Semianiw.

1868 In a minute added to Col Semianiw's letter, MGen Jeffries, the Assistant CLS, stated, "The letter provides no new information and the information was known by the Board. We could ask the Board President why he found as he did."

1869 On May 26, 1998, LCol (retd) Lapeyre faxed to the new DLP section head for Personnel Services statements by the former unit Training Officer made in response to LCol (retd) Lapeyre's inquiries. These statements confirmed that the Training Officer (who had also been the staff officer at Call Sign Zero on April 7, 1992) was aware that Capt Kaduck had been the acting Chief Controller and that OTPD 107 had not been received by 2 PPCLI during his tenure as Battalion Training Officer.

1870 In response, on July 14, 1998, LGen Leach forwarded the concerns of LCol (retd) Lapeyre and Col Semianiw to Col Selbie, the former President of the BOI, to answer the questions that had been raised. Col Selbie responded on August 28, 1998. The CLS responded to LCol (retd) Lapeyre on December 7, 1998, indicating that his questions had been referred to Col Selbie for clarification and providing him with Col Selbie's responses. LGen Leach also explained that the information about the BOI's findings that had been released was not considered LCol (retd) Lapeyre's personal information under privacy legislation. He reiterated that the letter of March 18, which had previously been referred to as a letter of censure "was meant to be *informative* in nature … [and was] not intended to serve as an administrative or pseudo-disciplinary measure."

1871 LCol (retd) Lapeyre wrote to the CLS on March 9, 1999, taking issue with his letter of December 7, 1998 and pointing out flaws in Col Selbie's response. In a postscript to the letter, he wrote:

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> I received an unsolicited telephone call at my residence late afternoon 06 March 1999 from Major Kaduck. The telephone call was in reference to the Wheeler BOI; during our conversation Major Kaduck stated that it was never his intention to deny the fact that he replaced Semianiw in his duties on 06 April 1992. I further stated that I intended to relay this information to the G1 [staff officer for Administration and Personnel] CLS to which he stated no objection. I am in the process of obtaining a full statement from Major Kaduck in this regard.

1873 A staff memorandum to the DLP on March 11, 1999 recommended, among other things, that on receipt of Maj Kaduck's statement a public announcement be made clarifying that Col Semianiw and LCol (retd) Lapeyre had not failed in their duties, but that incomplete or inaccurate information may have led the BOI to reach those conclusions. The memo

recommended that letters be sent to Col Semianiw and LCol (retd) Lapeyre explaining the measures being taken and apologizing for the trauma caused to them. It also recommended that the Commander of Land Force Western Area be directed to withdraw the summary of the BOI Report (in which Col Semianiw and LCol (retd) Lapeyre were identified) that was being circulated within 1 Canadian Mechanized Brigade Group as a training aid.

1874 MGen Jeffries, the Assistant CLS, discussed the recommendations with the CLS, and a legal opinion was sought. Subsequently, in a minute dated April 23, 1999, MGen Jeffries advised the CLS:

1875

> Legal opinion is vague, but consistent with earlier advice — there is not "clear and unequivocal evidence" therefore Lapeyre and Semianiw deserve the benefit if there is doubt. The staff believe their earlier recommendations remain correct. I agree. If we act now, we may be able to defuse further repercussions. If not, Lapeyre may blow up and we will wind up investigating the investigators …

1876 On June 3, 1999, LGen Leach wrote to the Judge Advocate General (JAG) and the Canadian Forces Provost Marshal with information copies to the CDS and the DLP, seeking further advice. He noted:

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> Despite the fact that DLP staff and DJAG/COS [Deputy Judge Advocate General / Chief of Staff] have offered analysis and advice … I continue to be uncomfortable with the fair and right course of action. Given that one of the key actions being debated is my letters to Col Semianiw and LCol (retd) Lapeyre, I must be personally convinced that the original act of sending the letters should be reversed.

1878

> I honestly do not know how to assess the right weight to the new evidence provided by Maj Kaduck. Can I simply accept it at face value and revise my approach. Can I ignore it; can I get some sort of analysis of the credibility factor through an NIS Investigation? What are the implications of the seven-year time gap between the death and today?

1879

> My personal position is that I agonized long and hard before I sent the two letters, worded as they were. Not all of the advice in late 1998 pointed to me taking that action but I did. I am in a similar situation again, as some of the advice is that I should rescind the letters. If everything is so clear and simple, why is it here, seven years later?

1880 I would appreciate whatever advice you can provide at the earliest opportunity.

1881 Meanwhile, LCol (retd) Lapeyre had written to LGen Henault, the Deputy Chief of the Defence Staff (DCDS), in March 1999, seeking assistance in resolving the issues he had raised with the CLS. On April 29, 1999, LGen Henault responded, stating that the CLS was reviewing the allegations and that, given the CLS's involvement, he did not feel it was appropriate for him to get involved as well.

1882 LCol (retd) Lapeyre had also written to the Provost Marshal, requesting an investigation into "intolerable harassment by senior officers as the result of comments made in public, documents circulated relating to the Wheeler BOI and lack of resolve in taking action" based on the evidence he provided. In a letter dated July 7, 1999, the Provost Marshal advised LCol (retd) Lapeyre that she had directed the CFNIS to conduct an investigative review of the entire file, and that he would be advised of the results that pertained to his concerns.

1883 On March 2, 2000, Inspector (Insp) Grabb, the Officer Commanding (OC) the CFNIS, Sensitive Investigations Detachment, wrote to LCol (retd) Lapeyre to tell him that he had been directed to proceed only with the investigation of two specific allegations as follows:

1884 • any criminal offences arising as a result of MCpl Wheeler's death; and

1885 • potential charges arising from Maj Kaduck's testimony at the BOI.

1886 In early March 2000, an investigator was assigned to investigate the possible charges arising from Maj Kaduck's testimony.

1887 On September 3, 2000, LCol Kaduck wrote to the CLS, LGen Jeffery, encouraging him to take action to resolve LCol (retd) Lapeyre's complaints:

1888 … In March 1999, I sent a letter to LCol (retd) Lapeyre stating that I had come to realize that I had indeed been the Chief Controller on the day in question [the day of MCpl Wheeler's death]. I invited him to use my letter as evidence in his efforts at having the conclusions of the Board revisited. In the fifteen months since then, there has not

> apparently been any action taken to redress the damage done to the reputations of LCol Lapeyre and Col Semianiw. I have therefore decided to write to you directly, in the hope that you will review this matter.

1889 On October 19, 2000, the Provost Marshal forwarded the results of the CFNIS investigation to the Vice Chief of the Defence Staff, the CLS and the Commander of Land Force Western Area. The investigation report concluded that there was no evidence of criminal conduct in relation to the accident that killed MCpl Wheeler. The report also noted that allegations of perjury and allegations of breaches of the *Privacy Act* were still under investigation. Finally, the report indicated that, since LCol (retd) Lapeyre's allegations of harassment did not amount to criminal or service offences, they were being referred back to the chain of command for appropriate administrative action.

1890 The final CFNIS investigation report, issued December 2000, concluded that then-Capt Kaduck had indeed been the Chief Controller on the day of MCpl Wheeler's death. The report contained a time-line, which noted, "All inquiries support the notion that LCol Kaduck was, in fact, the Chief Safety Control Officer on 7 Apr 92."

1891 The report concluded, however, that there was insufficient evidence on which to base perjury or other charges under either the *Criminal Code* or the *Code of Service Discipline*, stating that it could not be proven that Maj Kaduck was aware he had been the Chief Controller when he testified at the BOI.

1892 In February 2001, Col Semianiw sent an e-mail to the Executive Assistant to the CLS, asking "what and when will the Army repair the damage to my career?" On March 16, 2001, the CLS wrote to LCol Kaduck, LCol (retd) Lapeyre and Col Semianiw, indicating he had directed a final staff review and would advise them of the results in due course.

1893 LCol (retd) Lapeyre met with the CLS in Kingston on June 20, 2001. According to LCol (retd) Lapeyre, at that time LGen Jeffery offered to convene a review board consisting of a brigadier-general and two colonels. LGen (retd) Jeffery recalls taking a flexible position on the possible processes, but he was of the clear view that an internal army investigation was vital. However, LCol (retd) Lapeyre insisted on an Ombudsman's investigation since he had lost confidence in the CF.

1894 LCol (retd) Lapeyre came away believing that the two had agreed that the approach to resolving the issues would be discussed further, until they both agreed on a course of action. By 20 July 2001, with no answer from LGen Jeffery, LCol (retd) Lapeyre appealed once more to the Minister of National Defence for an Ombudsman's investigation.

1895 The CLS offered Col Semianiw and LCol (retd) Lapeyre the opportunity to resolve the issues by mediation, but LCol (retd) Lapeyre declined, on January 18, 2002, saying he felt that mediation would not resolve what he saw as a leadership issue within the CF.

1896 LGen Jeffery convened the ARB on May 3, 2002. The ARB's mandate was to examine LCol (retd) Lapeyre's complaints about the conduct of the BOI into MCpl Wheeler's death, and to advise the CLS with regard to the BOI's findings and recommendations, and the actions taken as a result of the BOI. The ARB members, secretary and legal advisor were provided with the documentary evidence (primarily the BOI Report, follow-up correspondence and the CFNIS report), which they reviewed individually before analysing it as a group. Under their terms of reference, they were not intended to conduct interviews or seek new evidence. They were not specifically asked to inquire into any of the issues raised by MCpl Wheeler's family.

1897 The ARB completed its report and forwarded it to the CLS on January 28, 2003. The ARB disagreed with some of the BOI's conclusions concerning the preparation, conduct and supervision of Exercise Surging Rage in 1992 and identified shortcomings in the conduct of the BOI. The CLS wrote the CDS on May 29, 2003, indicating that the BOI's conclusions that LCol (retd) Lapeyre and Col Semianiw had erred in their supervisory duties and that there existed a supervisory vacuum on the day of MCpl Wheeler's death were no longer accurate and supportable. On September 4, 2003, the CDS approved amendments to the 1997 BOI conclusions. The ARB Report called for revising some of the BOI's original findings, particularly with regard to the lack of safety briefings, the required level of supervision and the appointment of a replacement Chief Controller.

1898 On November 5, 2003, the CLS wrote to Mrs. Wheeler and LCol (retd) Lapeyre informing them of the changes to the Board's conclusions. The Commander of Land Force Western Area, briefed Mrs. Wheeler on the ARB

Report and its consequences on November 20, 2003. At that meeting, she was provided with a copy of the ARB Report, from which the personal information of other parties — primarily LCol (retd) Lapeyre — had been severed.

1899 LCol (retd) Lapeyre was informed of the results of the ARB on November 19, 2003. He was provided with a copy of the report with the personal information of other parties deleted; however, since most of the personal information in the report was his, his copy was close to complete. In response to a request from my office, he provided Mrs. Wheeler with his copy of the ARB Report.

11.3.7.1.1 Analysis

1900 The ARB did not support LCol (retd) Lapeyre's complaint about the delay in the CF's response to his complaints about the BOI process and conclusions. In its report to the CLS, the ARB informed him that they found the CLS and his staff had exercised due diligence in handling the situation:

1901

> A period of over 2 years and 9 months has elapsed between 20 Mar 98 […] and 17 Jan 02, when it was found that the Ombudsman had fulfilled his request and initiated an investigation. While the period might appear to be excessive … The allegations raised … of unwarranted delays by the CLS in addressing his concerns, that there existed an unwillingness by the military leadership to investigate his complaints, and that the evidence he presented was rejected and/or ignored, are not supported by the evidence.

1902

> On the contrary, there is clear evidence of due diligence in the handling of the complaint by the CLS. However, the ARB was not capable of properly assessing the 17 months taken by the CFNIS to investigate the issues related to Maj Kaduck's recollection of events.

1903 This is an area where I must disagree with the ARB's conclusions. In my view, LCol (retd) Lapeyre's complaint about the chain of command's delay in dealing with his concerns and in taking action to remedy the injustice occasioned him is overwhelmingly justified.

1904 Both LCol (retd) Lapeyre and Col Semianiw had raised serious issues with respect to the fairness of the BOI process and the accuracy of the Board's conclusions pertaining to them by the end of May 1998. At that time, it was

apparent that there was additional evidence as to who was acting as the exercise Chief Controller on the day of MCpl Wheeler's death and whether OTPD 107 had been received by the unit. These two key elements had provided the foundation for the conclusions that LCol (retd) Lapeyre and Col Semianiw had been deficient in their supervisory duties, and that LCol (retd) Lapeyre was indirectly responsible for MCpl Wheeler's death. Indeed, by the end of May 1998, the CLS was actively seeking advice on how to proceed in addressing the concerns raised. Nothing in the advice prevented swift action being taken to reconsider the BOI's conclusions.

1905 By March 1999, the CLS had been provided with additional and compelling evidence that Maj Kaduck had been acting as the Chief Controller on the day in question. Indeed, CLS staff, as evidenced by the DLP's memorandum of March 11, 1999, clearly saw a need to set the record straight and to acknowledge that the BOI's conclusions were incorrect.

1906 In my view, the chain of command had the information necessary to take steps to attempt to remedy the injustice occasioned LCol (retd) Lapeyre even before the decision was made to launch a criminal investigation. It was not necessary to wait until the conclusion of these investigations in December 2000 to acknowledge that LCol (retd) Lapeyre had not been treated fairly during the BOI process and that the BOI's conclusions and results, which were clearly damaging to his reputation, were unreliable.

1907 I agree with LCol (retd) Lapeyre's assertion that the CF leadership failed in this case. The approach that appears to have been followed was for each involved party in the chain of the command to scrutinize what legal obligation he had to act, and to rely on the other party to take action. For over three years, despite mounting evidence, no one stepped forward to acknowledge that something had gone wrong with the BOI process, and accept responsibility for the flawed results or attempt to remedy the harm done.

11.3.7.2 Destruction of Copies of the BOI Report

1908 On April 2, 1998, the Land Force Western Area staff officer for Administration and Personnel released the BOI and follow-on correspondence (including the letters to Col Semianiw and LCol (retd) Lapeyre) to the Commander of 1 Canadian Mechanized Brigade Group. 1

Canadian Mechanized Brigade Group was directed to release the documents to all units in the Brigade to be used as a learning tool in preventing future accidents. On April 9, the documents were distributed to all 1 Canadian Mechanized Brigade Group units.

1909 On April 30, 1999, the Land Force Western Area staff officer for Administration and Personnel sent a letter to 1 Canadian Mechanized Brigade Group Headquarters directing that copies of the original 1997 BOI Report, which had been distributed as training material, be destroyed. In a return communiqué dated August 11, 1999, he was informed that, based on unit responses, the order to destroy the documents had been carried out. The Land Force Western Area staff officer for Administration and Personnel indicated to my investigators that he believed this direction was in response to a phone call from CLS staff indicating that objections had been raised to the distribution of the BOI Report to 1 Canadian Mechanized Brigade Group units. He explained in his letter of April 1999 that the destruction of the documents was required due to new information that might affect the contents and findings of the documents.

1910 LCol (retd) Lapeyre felt that the fact that the BOI Report was destroyed was evidence that the chain of command was aware that the results of the BOI were questionable and could not be relied on for training purposes. He questioned why no follow-up action was taken once the direction was made to destroy the training copies of the report. He also felt that the CFNIS should have investigated the destruction of the copies of the BOI Report and the reasons behind the direction to destroy them.

1911 For its part, the CFNIS determined that this aspect of LCol (retd) Lapeyre's complaint would best be handled by the Privacy Commissioner. The Privacy Commissioner, in a letter to LCol (retd) Lapeyre on May 9, 2001, indicated that he could not find any violation of the *Privacy Act* in the destruction of the copies of the BOI Report. He considered that the documents were copies of the original and were not the only copies; although their destruction may not have been within military regulations, it did not hinder LCol (retd) Lapeyre's ability to get access to the information contained in the report.

1912 LCol (retd) Lapeyre's more pressing question appears to have been why no action was taken to address his complaint about the BOI results, given his suspicion that concerns about the validity of the BOI's findings are what

motivated the direction to destroy the copies of the report. The ARB noted that LCol (retd) Lapeyre had previously complained about the distribution of the BOI Report and that the direction issued by Land Force Western Area Headquarters to destroy those copies was intended to address these concerns. There is no reason to doubt this conclusion. That said, the timing of the direction to destroy the copies of the BOI Report in April 1999 cannot be ignored. During this time period, LCol Kaduck's admission that he had been the exercise Chief Controller was becoming known, and recommendations were also being put forward to the CLS to withdraw the letters of displeasure to LCol (retd) Lapeyre and Col Semianiw.

1913 In my view, the direction to destroy the copies of the BOI Report, whether or not it was in response to LCol (retd) Lapeyre's complaint about its distribution, is another indication that authorities in the CLS had serious cause, as early as the spring of 1999, to question the soundness of the BOI conclusions and — at the very least — acknowledge the need to set the record straight. While the destruction of the copies of the BOI Report might have been intended as the first step in remedying injustices that resulted from the BOI it does not explain why there was no attempt to remedy the injustice occasioned LCol (retd) Lapeyre, as I have already noted above, until over four years later when the ARB's recommendations were accepted.

11.3.8 CF Provost Marshal Investigation

1914 LCol (retd) Lapeyre complained that the CFNIS investigation did not address all of the complaints he had submitted to the Provost Marshal. These included allegations of misconduct and harassment on the part of senior officers and complaints about the destruction of the copies of the BOI Report that had been distributed within the army. He indicated to my investigators that he had assumed that the CFNIS was in fact investigating all of his allegations, until some five months after the investigation had commenced. The CFNIS investigations were ultimately restricted to investigations into possible criminal charges arising from the accident itself, and potential charges arising from Maj Kaduck's testimony at the BOI.

1915 LCol (retd) Lapeyre had written to the Provost Marshal, on May 10, 1999 to complain about the way he had been treated throughout the BOI process. In his letter, he referred to the "intolerable harassment … by senior officers as

the result of their comments made in public, documents circulated relating to the Wheeler BOI and lack of resolve in taking action based on evidence provided by the complainant." In support of his contentions, he included much of the same evidence he had already provided to the CF.

1916 The Provost Marshal advised LCol (retd) Lapeyre in her letter of July 7, 1999 that an "investigative review of the entire file" would be conducted. An initial review of the allegations was conducted by the Acting Deputy Provost Marshal, CFNIS. The review concluded that there was no evidence of any Code of Service Discipline or Criminal Code offences. This assessment was communicated in a letter to Insp Grabb on July 8, 1999.

1917 Insp Grabb wrote the Provost Marshal on February 1, 2000 to advise her of his assessment of LCol (retd) Lapeyre's complaints. He indicated:

1918

> It is my professional assessment that the allegations [by LCol (retd) Lapeyre] of misconduct and harassment fall outside of the mandate of the CFNIS and should be handled in the appropriate administrative, civil-court and/or Federal Court settings. There is no evidence to support the suggestion that the actions of the chain of command and the BOI panel amounted to service or criminal offences. Although open to legitimate criticism in hindsight, their actions were apparently undertaken with due diligence and after lengthy consultation with experienced legal counsel.

1919 The Provost Marshal agreed with this assessment and, on February 24, 2000, Insp Grabb was directed to proceed with investigations into whether there was evidence to charge Maj Kaduck with perjury based on his testimony at the BOI and whether any Criminal Code or other statutory offences had been committed on April 7, 1992.

1920 In an interview with my investigators, Insp Grabb indicated that, despite the previous assessment by the Acting Deputy Provost Marshal, CFNIS that there was no evidence of Criminal Code or Code of Service Discipline offences on the part of senior officers, he did not exclude this possibility during his investigation and proceeded to gather the facts before determining how to proceed. He further indicated that he never experienced any attempt to interfere with his investigation by or on behalf of the Provost Marshal and that, at the end of the day, he was "satisfied that all of the bona fide complaints were addressed."

1921 Insp Grabb acknowledged that, at the time, he was also involved in another high-profile investigation, which was his priority:

1922 > The approach I took at this time was to set out to gather the facts. Also, this coincided with the initiation of the so-called Croatia soil sample […] criminal investigation task force. So from this point on and for the next year, eight months, my principal focus in the NIS in this capacity as I described was conducting and coordinating that particular task force.

1923 > The Master Corporal Wheeler investigation and a couple of others that I directly conducted were done piecemeal, whenever the time permitted over the following months.

1924 In relation to LCol (retd) Lapeyre's specific complaints to the Provost Marshal, Insp Grabb told my investigators he was aware of LCol (retd) Lapeyre's view that the destruction of documents and the possibility of *Privacy Act* violations should have formed part of the CFNIS investigation. However, he explained, the matter was referred to the Office of the Privacy Commissioner because the Commission had the legislative jurisdiction as well as the expertise to investigate alleged violations of the *Privacy Act*. As the Privacy Commissioner pointed out, the destruction of copies of a record is not a criminal matter.

1925 The CFNIS investigation was completed on December 27, 2000. No charges were laid as a result of the investigation.

11.3.8.1.1 Analysis

1926 The ARB concluded the following with respect to LCol (retd) Lapeyre's complaint about the CF's delay in addressing his complaint about the BOI results:

1927 > Although the question of why the CFNIS took so long to complete its investigation remains unanswered, the question of what corollary action could have been taken in the intervening 17 months has been considered by the Administrative Review Board. The ARB noted that it is the current practice throughout the CF to hold in abeyance administrative action pending the completion of Military Police investigations and disciplinary/judicial proceedings. If the results of these investigations had been different in all likelihood, charges

> would have been prepared and the matter referred to the Director Military Prosecutions for an eventual court martial. Hence, no staff action was initiated before 27 December 2000 as to not interfere with the CFNIS investigation.

1928 The Ministerial Directives for the Ombudsman's Office preclude my Office from reviewing the charge-laying discretion of the MP. That said, it is within the role of my Office to review internal investigations and processes to ensure they are conducted fairly. My investigation uncovered no evidence to indicate there was any attempt to interfere with the CFNIS investigation or to limit its scope. The decision not to investigate LCol (retd) Lapeyre's allegations of harassment and misconduct against senior officers was based on the CFNIS's mandate to conduct investigations into alleged criminal and service offences. My Office did not find any basis for questioning the CFNIS' assessment that LCol (retd) Lapeyre's complaint did not raise evidence of such offences.

1929 Almost 22 months passed between the time that LCol (retd) Lapeyre first notified the CLS that Maj Kaduck recalled being the Chief Controller, until completion of the CFNIS investigation. The chain of command clearly made a decision to defer any action with respect to LCol (retd) Lapeyre's concerns about the unfairness of the BOI process and the Board's conclusions until the CFNIS investigation had concluded. This decision was taken despite internal recommendations that a public announcement be made clarifying that Col Semianiw and LCol (retd) Lapeyre did not fail in their duties, but that incomplete or inaccurate information may have led the BOI to reach those conclusions, and despite a written statement from Maj Kaduck himself that he had been the Chief Controller.

1930 I am also cognizant that there was (and currently still is) an unwritten policy within the CF that administrative investigations are put on hold when a criminal investigation is launched into the same incident or subject matter, as the ARB noted. This is a general policy designed to protect the integrity of the criminal investigation and any subsequent proceedings.

1931 Although there are some risks posed to the integrity of a criminal investigation when there are other investigations or administrative actions being contemplated at the same time, such risks can be managed. For example, my Office's mandate contains specific provisions so that my Office's investigations can proceed while any related criminal investigation is ongoing, provided that criminal investigators are given priority with respect to interviewing witnesses.

1932 This practice is not inconsistent with civilian practice, in which criminal and regulatory or administrative investigations can take place concurrently as long as the criminal investigation is given priority. My Office communicated with the Deputy Provost Marshal—CFNIS, who confirmed that, from the CFNIS perspective, there is no requirement to hold off on an administrative investigation until the related criminal investigation is concluded, provided the integrity of the criminal investigation is preserved.

1933 This was clearly an exceptional case. In my view, there was nothing to prevent the chain of command from taking action to address LCol (retd) Lapeyre's concerns about the BOI process and how he was treated, as long as these actions did not prejudice the CFNIS investigation. At a minimum, there should have been consultation between the chain of command and the Provost Marshal to determine whether any steps could be taken to acknowledge the deficiencies in the BOI's process and the unfair treatment of LCol (retd) Lapeyre, without affecting the criminal investigation.

11.4 Overall Treatment of LCol (Retd) Lapeyre by the DND/CF

1934 In his complaint to my Office, LCol (retd) Lapeyre has alleged that all of the senior officers involved in the various aspects of his case were aware of the injustices to him, and yet they failed to take appropriate action. He feels that this failure on the part of each of these individuals amounts to an abuse of authority.

1935 LCol (retd) Lapeyre noted that, of those involved in the 1997 BOI and the review process, a large number were artillery members. He pointed to LFWA and CLS staff officers, including several DLPs; BGen Ross, who was Commander of Land Force Western Area and the convening authority for the

BOI; Col Selbie, the BOI President; and Maj Johnson, one of the Board members. LCol (retd) Lapeyre felt his complaints were not given the credence they should have been because of the relationships among the officers responsible for reviewing them. Instead, he believed, there was a tendency to accept assurances by colleagues in the CF system that the complaints were not founded. LCol Lapeyre estimated that, in all, no fewer than 50 senior officers in the CF were aware of some aspect of the injustice in his case.

11.4.1 Analysis and Conclusion

1936 LCol (retd) Lapeyre's complaints of abuse of authority are indicative of his level of frustration and anger after spending years to obtain justice. He went to great lengths to identify to senior authorities the weaknesses in the BOI's proceedings. He brought forward witnesses that threw the Board's findings into doubt and he continued to pursue redress, without success. He continued to pursue his case, while a seemingly unconcerned army bureaucracy failed to take timely action, even after LCol Kaduck came forward and acknowledged in writing that he had been acting as the Chief Controller on the day of MCpl Wheeler's death. It is not unreasonable that LCol (retd) Lapeyre came to believe that a conspiracy existed to hold him responsible for MCpl Wheeler's death.

1937 My Office's investigation did not find any evidence that the individual officers involved in the review of LCol (retd) Lapeyre's complaints were improperly influenced because of their affiliation with the artillery or for any other reason. My Office's investigation also did not find evidence that would point to abuse of authority on the part of any individual officer. However, it is fair comment to say that, in hindsight, many of those involved could have acted differently and should have taken swifter action to effectively deal with LCol (retd) Lapeyre's complaints.

1938 That said, in my view, there is nothing to be gained by analysing the actions of any individual in isolation. Nor is it constructive at this stage to attempt to point fingers, lay blame and, indeed, create additional scapegoats. That would be counterproductive and prevent much-needed closure in this case.

1939 The injustice that has been occasioned LCol (retd) Lapeyre is not the result of misconduct or abuse on the part of any individual. In my view, the blame lies at the feet of the entire CF system and the chain of command as a whole. In

this case, the system failed to respond appropriately at each and every level, and at each stage of the process — from the BOI and the numerous reviews of its results, to the lengthy delay in responding to the revelation that LCol Kaduck recalled that he was indeed the exercise Chief Controller on the day of MCpl Wheeler's death. All of these failures compounded an injustice that damaged LCol (retd) Lapeyre's reputation and left him, at each point, more and more frustrated, alienated and sceptical that the system would ever serve him fairly. The same failures in the system also occasioned an injustice to MCpl Wheeler's family, as this report clearly demonstrate.

1940 Quite frankly, the injustice originally occasioned LCol (retd) Lapeyre should have been remedied a long time ago. Many opportunities have been missed to correct the injustices which were occasioned him. LCol (retd) Lapeyre's unfair treatment is deserving of acknowledgement and apology at the highest level.

1941 The ARB also found that LCol (retd) Lapeyre suffered negatively as a result of the flawed BOI, as well as a result of the publication of the BOI, and his reputation was probably negatively affected. The ARB recommended that appropriate corrective measures and means to effect such with respect to LCol (retd) Lapeyre be taken. I strongly encourage the CDS to ensure that this recommendation is followed, which will thereby assist in bringing closure to this matter for LCol (retd) Lapeyre.

1942 It is my hope that this report, which will ultimately be issued publicly, will be of some assistance in setting the record straight with respect to the circumstances surrounding MCpl Wheeler's death and how LCol (retd) Lapeyre, as well as the Wheeler family, were not well-treated during the ensuing processes and investigations.

1943 **I therefore recommend that:**

1944 **34. The Chief of the Defence Staff ensure that LCol (Retd) Lapeyre receives the appropriate compensation to acknowledge the unfair treatment he received during the investigation of MCpl Wheeler's death.**

1945 The department's response to this recommendation was:

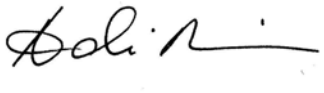
1946

> Agree in principle. The DND/CF recognizes the trials that LCol (Retd) Lapeyre has endured during the investigation of MCpl Wheeler's death. The departmental OPI for compensation claims, DND/CF LA CCL, has no authority, however, to settle this matter without first receiving a claim from LCol (Retd) Lapeyre. Were such a claim to be received by CCL from LCol (Retd) Lapeyre, it would receive the sympathetic consideration that any meritorious claim against the Crown would receive.

1947 In my view, given the findings outlined in my Office's report, the unfair treatment of LCol (retd) Lapeyre and the stress he has suffered is deserving of an acknowledgement at the highest level by the Chief of the Defence Staff. I understand that LCol (retd) Lapeyre, having had the opportunity to read my Office's interim report on the investigation into his complaints, has expressed an interest in mediation in order to settle his complaints directly with DND/CF and to put an end to this lengthy ordeal. It is my understanding that no formal legal claim or lawsuit is necessary to initiate such a process. This should particularly be the case given the fact that a previous offer of mediation had already been initiated by the Chief of the Land Staff without any formal legal claim from LCol (retd) Lapeyre.

1948 I am calling upon the Chief of the Defence Staff to take the appropriate steps to ensure that a mediation process takes place as quickly as possible and to issue the necessary instructions to military legal advisors to ensure as part of this process, that LCol (retd) Lapeyre receives reasonable compensation which is commensurate with the degree of unfair treatment outlined in my Office's report, as well as the internal Administrative Review Board findings.

1949 LCol (retd) Lapeyre and the Wheeler family are both deserving of closure in what has been a lengthy saga. Now that both the internal ARB and my Office's investigations are concluded, it is my hope the CF will respond swiftly to my Office's recommendations so that the final chapter in this lengthy injustice can be closed.



André Marin
Ombudsman

December 20, 2004

Appendix A: Summary of Recommendations

1950 **1. CFAO 24-6 be amended to provide that CFNIS shall be notified immediately of an unexpected death or serious injury of a member. Upon such notification, the CFNIS will conduct an assessment of the circumstances to determine whether a CFNIS investigation is warranted.**

1951 **2. CFAO 24-6 specifically indicate that, in the event of an unexpected death or serious injury of a member, the following steps shall be taken by the chain of command immediately upon notifying the CFNIS:**

1952 - **the scene shall be secured once all measures necessary are taken to preserve life or prevent any further danger to individuals;**

1953 - **all potential witnesses shall be instructed not to speak about the incident to any other person until they have met with investigators;**

1954 - **witnesses shall be segregated wherever there is a concern that they may discuss their evidence or at the request of the CFNIS; and**

1955 - **no investigative steps should be taken without express permission from the CFNIS, unless necessary to preserve perishable evidence. In such cases, the CFNIS shall be advised of all steps taken.**

1956 **3. The CF amend the applicable rules and/or regulations to provide that it is mandatory to convene a BOI to investigate unexpected non-combat deaths.**

1957 **4. CF regulations and orders concerning SIs and BOIs be amended to require at least one member of any BOI convened to investigate a death to have completed a training course in investigative techniques and procedural fairness.**

1958 **Prior to the start of a BOI convened to investigate a death, the president and all members of the BOI receive a refresher training package, which should focus on procedural fairness and investigative principles.**

1959 **5. When there has been a death, the convening authority appoint a person with expertise in the conduct of complex investigations of serious incidents to assist the BOI members.**

1960 **6. Each unit ensure that all members review their PEN forms on a yearly basis, and prior to any major training activity or lengthy out-of-area deployment.**

1961 **7. The CF put in place direction to ensure that, when notifying a CF member's next of kin of a death, the assigned chaplain is from the deceased member's unit or, if that is not possible, is given as much background information as is available about the member.**

1962 **8. The most senior CF officer available, accompanied by a chaplain, personally inform the next of kin of the death of a member who has died unexpectedly.**

1963 **9. The CF put in place direction and guidelines that ensure that the next of kin of deceased members are given whatever immediate assistance they may require after notification.**

1964 **10. CF policy be amended to require the commanding officer of the deceased member's unit to assess whether or not secondary next of kin should be notified personally by a senior officer. This assessment should be made in consultation with the primary next of kin where practical.**

1965 **11. CF policy be amended to require that a Liaison Officer be assigned to provide support and assistance to extended family members in the event of the death of a CF member, up to or shortly after the funeral of that member.**

1966 **12. The CDS issue a CF-wide directive that the families of CF members who die in circumstances related to duty be provided with all information relevant to the death, the circumstances surrounding the death, copies of all investigations into those circumstances and any subsequent developments, on a priority basis and as soon as such information is available.**

1967 **13. CF directives on casualty administration and CFNIS operating procedures be amended to direct that assistance be provided to families of deceased members, and that best efforts be made to ensure they are able to obtain information from provincial authorities, including autopsy and coroner's reports and medical files, as soon as possible after the member's death.**

1968 **14. Regulations and policies be amended to allow the person designated on the Personal Emergency Notification (PEN) form as the recipient of the deceased member's personal information to have the same rights of access as the CF member would during his or her lifetime, whether under the *Privacy Act* or as a result of departmental regulations or policies.**

1969 **CF directives for casualty administration and directives relating to access to information and privacy be amended to direct that, whenever a request is made to provide information to the family of a deceased member, such requests will be processed so that:**

1970 • **they are handled on a priority basis by experts in the subject matter and analysts;**

1971 • **a compassionate, open and transparent approach to administering access to information and privacy legislation is taken;**

1972 • **special consideration is given to the liberal application of the discretionary exceptions in the legislation, including obtaining consents for the release of third parties' personal information;**

1973 • **the assigned analyst maintains communication with the family or the Assisting Officer; and**

1974 • **when the information requested is ready for release, the assigned analyst and any subject matter expert who prepared the information make themselves available to explain to the family how the request was prepared, what information was included and the reasons for any exclusions and/or severances, and to discuss any questions.**

1975 **15. CF regulations be amended to direct that where a Board of Inquiry is convened for the purpose of investigating the unexpected death of a CF member, the family of the deceased member shall be notified of the decision to convene the Board and provided with a prima facie right to full standing in the proceedings.**

1976 **16. After the conclusion of all formal processes with respect to the unexpected death of a CF member, including the BOI, a CF contact person be designated to maintain contact with the surviving family, if they wish, and to inform the family of any significant developments, including the implementation of any recommendations made by the BOI and any subsequent reviews or appeals related to its findings and conclusions.**

1977 **17. The CF develop guidelines for commanding officers on the selection of Assisting Officers for next of kin of CF members who have died unexpectedly.**

1978 **18. The CF develop a training module to introduce officers to the role and responsibilities of Assisting Officers to the families of deceased CF members, including the special needs of families in such situations.**

1979 **19. The CF create and distribute to all Formations, Bases, Wings and units, a standard guide for Assisting Officers containing information to assist them in providing advice and support to families of deceased CF members, including a list of available resources.**

1980 **20. The CF create a formal mechanism that would provide Assisting Officers with the support of a team of specialists.**

1981 **21. CF directives with respect to casualty support be amended to direct that the commanding officer of a unit, when appointing an Assisting Officer to the family of a deceased CF member, arrange for a second officer to act as back-up should the original Assisting Officer become unavailable for any reason.**

1982 **22. CFAO 25-1 be amended to provide for the return of all personal effects to the next of kin as soon as possible, save in exceptional circumstances. The return of personal effects should not be contingent on the return of any outstanding public property by the next of kin, or the conclusion of a Committee of Adjustment.**

1983 **23. CF directives assign responsibility and the CF provide funding to a specific agency to ensure that families of deceased CF members are offered the opportunity to receive counselling with either a CF or civilian caregiver if they so desire. This agency should work directly with the Assisting Officer to ensure that counselling services are offered and available.**

1984 **24. CF directives on casualty administration be amended to direct that Assisting Officers ensure that families of CF members who die unexpectedly are made aware of the services available to them through local MFRCs and are provided with information on how to contact them, and that local MFRCs are advised of the death of a CF member as soon as possible so they are aware of the potential need for services.**

1985 **25. That the immediate family members of any CF member who dies unexpectedly related to duty be offered and issued a Military Family Identification Card if they so desire, allowing them access to DND facilities. The Assisting Officer should ensure this is done.**

1986 **26. CF directives for casualty administration be amended to direct that a tangible, formal recognition of the service of a CF member killed on duty be provided to the member's family, within a reasonable time after the member's death, and that appropriate funding be made available through the Director of Casualty Support and Administration. The form of this recognition should be determined by the member's unit, taking into account the circumstances of the member's service and the wishes of the family.**

1987 **27. The CF develop and put in place a Web site to provide information and resources to families of deceased CF members.**

1988 **28. The CF develop and implement a national policy for support to families of deceased CF members, which ensures all needs are covered and defines specific responsibilities for each area of support.**

1989 **29. The CF develop and implement a Case Management system to coordinate, monitor and track the support provided to next of kin.**

1990 **30. The Chief of the Defence Staff take action to acknowledge the unfair treatment that the immediate family of MCpl Wheeler received during the investigation of MCpl Wheeler's death, and ensure that appropriate measures are taken to ensure redress so that adequate closure can be obtained by the family.**

1991 **31. Defence Administrative Orders and Directive 7002-1 be amended to provide that review authorities, when reviewing the results of Boards of Inquiries, are specifically required to ensure that any person who is likely to be adversely affected by the results of the BOI was provided the procedural protections enumerated in QR&O 21.10 and DAOD 7002; and where any such person was not provided the procedural protections in DAOD 7002, no adverse action may be taken until that person is given a meaningful chance to respond to the adverse allegations and evidence.**

1992 **32. Regulations and orders setting out procedures for Boards of Inquiries be amended to provide that a complete record is kept whenever an individual who is likely to be adversely affected by a BOI is afforded the procedural protections set out in DAOD 7002, or whenever an individual who feels he or she is likely to be adversely affected by a BOI requests and is denied the procedural protections set out in DAOD 7002. The record should include the reasons of the BOI President for affording or not affording the individual the procedural protections set out in DAOD 7002.**

1993 **33. DAODs be amended to require that all relevant documents, including applicable rules, regulations, orders and procedures, be copied immediately following an unexpected death, and be maintained as part of the record of any subsequent administrative investigation, including a BOI into the incident.**

1994 **34. The Chief of the Defence Staff ensure that LCol (Retd) Lapeyre receives the appropriate compensation to acknowledge the unfair treatment he received during the investigation of MCpl Wheeler's death.**

Appendix B: List of Acronyms

AO	Assisting Officer
ADF	Australian Defence Force
ADM (HR-Mil)	Assistant Deputy Minister (Human Resources—Military)
ADM Pers	Assistant Deputy Minister, Personnel
APC	Armoured Personnel Carrier
ARB	Administrative Review Board
BGen	Brigadier-General
BOI	Board of Inquiry
Capt	Captain
CBG	Canadian Brigade Group
CD	Canadian Division
Cdr	Commander
CDS	Chief of the Defence Staff
CER	Combat Engineer Regiment
CF	Canadian Forces
CFAO	Canadian Forces Administrative Orders
CFB	Canadian Forces Base
CFLA	Canadian Forces Legal Advisor
CFNIS	Canadian Forces National Investigation Service
CFP	Canadian Forces Publication
CFPM	Canadian Forces Provost Marshal
CFSU(O)	Canadian Forces Support Unit (Ottawa)
CLS	Chief of the Land Staff

CMBG	Canadian Mechanized Brigade Group
CO	Commanding Officer
Col	Colonel
Const	Constable (RCMP)
CWO	Chief Warrant Officer
DAG	Departure Assistance Group
DAIP	Director, Access to Information and Privacy
DAOD	Defence Administrative Order and Directives
DAT	Director of Army Training
DCDS	Deputy Chief of the Defence Staff
DCSA	Director of Casualty Support and Administration
DFS	Director, Flight Safety
DLP	Director Land Personnel
DND	Department of National Defence
DPLS	Director of Personnel Legal Services
EA	Executive Assistant
EAP	Employee Assistance Program
Ex OPI	Exercise Office of Primary Interest
FMC	Force Mobile Command
FMCO	Force Mobile Command Order
GCI	General Court of Inquiry (Australia)
Gen	General
Insp	Inspector
ISAF	International Security Assistance Force (Afghanistan)

IO	Intelligence Officer
JAG	Judge Advocate General
LAIT	Land Accident Prevention and Investigation Team (UK)
LAV	Light Armoured Vehicle
LCdr	Lieutenant-Commander
LCol	Lieutenant-Colonel
LFCI	Land Force Command Inspector
LFCO	Land Forces Command Order
LFDTS	Land Force Doctrine and Training System
LFWA	Land Force Western Area
LGen	Lieutenant-General
Lt	Lieutenant
Maj	Major
Marlant	Maritime Forces Atlantic
MCpl	Master Corporal
MFRC	Military Family Resource Centre
MGen	Major-General
MOD	Ministry of Defence (UK)
MP	Military Police
NCM	Non-Commissioned Member
NCO	Non-Commissioned Officer
NDHQ	National Defence Headquarters
NOK	Next of Kin
OC	Officer Commanding

OC Cbt Sp Coy	Officer Commanding Combat Support Company
OPI	Office of Primary Interest
OTPD	Operational Training Policy Directive
PEN	Personal Emergency Notification
PER	Personnel Evaluation Report
POQC	Presiding Office Qualification Course
PORT	Presiding Officer Re-Certification Test
PPCLI	Princess Patricia's Canadian Light Infantry
Pte	Private
QETE	Quality Engineering Test Establishment
QR	*Queens Regulations* (UK)
QR&O	*Queen's Regulations and Orders*
RAF	Royal Air Force (UK)
RAN	Royal Australian Navy
RCHA	Royal Canadian Horse Artillery
RCMP	Royal Canadian Mounted Police
RCR	Royal Canadian Regiment
RMP	Royal Military Police (British army)
retd	retired
RN	Royal Navy (UK)
RNA	Royal Netherlands Army
SCOTS	Standing Committee on Training Safety (UK)
Sgt	Sergeant
SI	Summary Investigation

SIB	Safety Investigation Board (Netherlands/British army)
SISIP	Service Income Security Insurance Plan
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SORT	Special Ombudsman's Response Team
UER	Unit Employment Record
UK	United Kingdom
UPR	Unit Personnel Record
UPS	United Parcel Service
US	United States
USAFI	United States Air Force Instruction
VAC	Veterans Affairs Canada
VAP	Victim Assistance Program
WO	Warrant Officer

Appendix C: Complainants' Response to *Interim Report*

When a Soldier Falls:

Reviewing the Response to MCpl Rick Wheeler's Accidental Death

When a Soldier Falls:

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Appendix D: DND/CF Response to *Interim Report*

When a Soldier Falls:

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Appendix E: Other Responses to *Interim Report* by Interested Parties

When a Soldier Falls:

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Appendix F: Letter to the Minister of National Defence