Special Report:

Ministerial-directed Investigation: Review of Board of Inquiry Examining Serious Injury

February 17, 2005

André Marin, Ombudsman

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Executive Summary

1 In the fall of 2000, the complainant, a first year Officer Cadet at Royal Military College collapsed during a five-kilometre race. He suffered serious injuries as a result of unusual swelling in his leg muscles. The condition he developed, known as 'acute compartment syndrome', was so severe that it ultimately caused kidney failure and led to complications that endangered his life. The Officer Cadet survived, but was released from the Canadian Forces (CF) for medical reasons and has not been able to resume his career.

2 A board of inquiry (BOI) was convened on October 20, 2000, following complaints from the complainant's family. The family felt that their son's grievous injuries occurred because he had been pushed beyond his limits during a Canadian Forces Leadership and Recruit School program he had recently completed at St. Jean, Quebec. They suggested that, during that course, the complainant's Platoon had been subjected to excessive, even abusive demands, which caused the complainant to become exhausted and weakened, and which led to his ultimate collapse and the medical crisis.

3 The BOI submitted a report on December 19, 2000. It concluded that the complainant's treatment at St. Jean, while not without problems, did not contribute to his condition. The Board found that his injuries were a rare and unpredictable consequence of the complainant pushing himself too hard during the race. Not satisfied with the BOI's process or conclusions, the complainant and his family turned to then Minister of National Defence Art Eggleton, who subsequently referred the matter to my Office.

4 At the conclusion of my investigation, given the complexity of the facts and the systemic nature of some of my recommendations, I issued an Interim Report to the principal parties, including the complainant and his family, to allow them an opportunity to comment on my findings and recommendations. Taking into account the responses I subsequently received, this Final Report was prepared. It is submitted to the Minister of National Defence as a Special Report, based on paragraph 38(1)(b) of the *Ministerial Directives* for my Office. The comments I received on the Interim Report can be found at Appendix A of this report.

5 My investigation showed that the members of the BOI undertook their work in good faith and to the best of their abilities. At the same time, there were problems that affected the integrity of the Board's findings. Most significantly, the Board did not obtain expert medical evidence, and it misunderstood the medical information it did receive. The physicians consulted were not completely informed of the facts of the complainant's case and, in any event, did not have the requisite specialized training to support the BOI's conclusions. Accordingly, the Board was simply not in a position to come to the conclusions it did on the information it had.

6 I recommended in my Interim Report that an independent medical review of the cause of the complainant's injuries be conducted. I also noted that it was important that this review be conducted by experts external to the Canadian Forces and that those experts obtain information directly from the complainant about the circumstances leading up to his injuries. The Assistant Deputy Minister, Human Resources (Military) [ADM (HR-Mil)] was quick to agree with this recommendation and assigned authority to the Canadian Forces Medical Group to ensure that an independent medical review be conducted.

7 The board of inquiry members determined there were a number of problems in the training regimen at St. Jean, and made recommendations for improvement. During my investigation, I was able to confirm that substantial changes have since been made in training standards and practices, both at St. Jean and at Royal Military College. At St. Jean, the changes in training methods are being monitored. This response is encouraging. It is important, however, that momentum not be lost. I therefore identified the need for a formal system to track and report on the evaluations of the training regimen that are being conducted. I am pleased to report that this suggestion was quickly accepted by all parties, even before I made the formal recommendation (Recommendation #6) in my Interim Report.

8 It is evident that problems specific to the complainant's case have been taken seriously and are being effectively addressed. At the same time, it became clear to me that the errors that occurred in this case should not be considered completely isolated. I am particularly concerned that, given the BOI's composition and training, its members were not adequately equipped to undertake their task. Boards of inquiry perform too important a function for us to sit idle, without correcting the conditions that enabled these problems to occur. Therefore, I made recommendations in my Interim Report that were intended to provide longer-term improvement.

9 In my Interim Report, I recommended that the convening authority should provide reasons when a decision is made not to follow the usual procedure, provided in Defence Administrative Order & Directive (DAOD) 7002-1, to appoint a medical advisor to a BOI in cases of death, injury, serious illness or other health issue (Recommendation #2). I see this as important because it reinforces the idea that appointing medical advisors is the norm in such cases and ensures that the DAOD has been specifically and carefully considered when a medical advisor is not thought necessary. I also recommended that procedures be developed to ensure that no board of inquiry decision is made without adequate expertise, and that when a board relies on expert information, the expert is invited to review a draft report to ensure that his or her evidence has been properly understood (Recommendation #3). The ADM (HR-Mil) expressed disagreement with Recommendation #2 and with the heart of Recommendation #3. I carefully reviewed his reasoning but I am not persuaded by it. I therefore affirm these recommendations in this Final Report.

10 Two of my recommendations related more generally to training provided to board of inquiry members. At present, there is no formal training offered. In fact, training is less systematized for board of inquiry members than it is for officers conducting summary trials or harassment investigations, notwithstanding the critically important matters that BOIs engage in. The members conducting this very inquiry felt that specific training would have made their job easier. I agree. I believe that not only could training have eased their task – but also prevented some, if not all of the problems that occurred. I therefore recommended in the Interim Report that the CF develop a training package for BOIs (Recommendation #4) and that a directive be issued requiring boards to have at least one member who has been trained (Recommendation #5). The ADM (HR-Mil) did not support these recommendations, based largely on a cost-benefit analysis that, in my view, overestimates the costs and underestimates the benefits. I am therefore affirming these recommendations, with an additional provision in Recommendation #5 that recognizes exceptional cases where a board of inquiry could proceed without a formally trained member.

11 Finally, I was troubled by the exclusion of the complainant from the board of inquiry process. I appreciate that a board is an *ad hoc* process intended to arm decision-makers with information and advice, but the reality is that the facts found and recommendations made can have a profound impact on final decisions – decisions that can significantly affect the welfare of individual CF members. When those members have a direct and substantial interest in the outcome, as in this case, they should not be treated simply as witnesses and excluded from the process. Rather, they should be participants in the process. Not allowing a member to participate in an inquiry in which he is so intimately involved is alienating and frustrating, and can only compound a sense of grievance. Including him, on the other hand, can be cathartic, giving the member a sense of value and of being heard, and helping with closure where the matter under investigation is traumatic or troubling. Not only can increased participation contribute to emotional healing for the individual, but also can improve the quality of the Board's findings. It would surely have done so in this case:

- medical witnesses were left inadequately informed about the complainant's condition before the events in question;
- the Board gave inadequate attention to other cadets who shared the complainant's experiences; and
- one board member may have been influenced by his own uneventful survival of a training regimen as gruelling as the complainant's.

12 These problems would have been far less likely to arise had the complainant been given a voice. In an effort to reduce the likelihood of similar missteps in future, I have recommended that the practices that apply in most other forms of inquiry be adopted here; that is, persons with direct and substantial interest in the subject of the inquiry should be given standing (Recommendation #7). I have also recommended that a party with standing should have full rights of participation (Recommendation #8).

13 The ADM (HR-Mil) disagreed with these recommendations, primarily for reasons of flexibility and efficiency. I have reflected hard on the points he made. My belief that persons who have a direct and substantial interest in a BOI should also have standing has not changed. I see the lack of support for this recommendation as a squandered opportunity to make the process more open, more transparent, more humane and more effective. I do accept, however, that routinely providing full rights of standing to everyone with a direct and substantial interest may be unduly broad. I am therefore amending my recommendation in this Final Report. I believe that those who are granted standing should be entitled to notice of the inquiry, to attend and observe the proceedings, and to receive a copy of the complete report. I also recommend that the convening authority retain the discretion to extend a greater level of participation to parties with standing, where circumstances warrant. This would include the right to question witnesses, call evidence and make final submissions.

14 I see this report as an opportunity, not only to effectively resolve the problems created in the case at hand, but also to do the same in future cases as well. A demonstrated pattern of problems is not a necessary precondition of the need to improve systems, and it is unhealthy, in my opinion, to wait for a systemic collapse before building sensible protections. This case showed not only the possibility of error, but also the actuality of error. I ask the Canadian Forces to do something about it now by correcting the conditions that contributed to those failings.

15 Because of the systemic value and focus of my recommendations in this case, I am issuing this final report as a Special Report to the Minister of National Defence, pursuant to section 38(2)(b) of the *Ministerial Directives* for the Ombudsman's Office.

Complaint

16 This complaint was referred to the Ombudsman's Office for investigation by the former Minister of National Defence, the Honourable Art Eggleton. The complainant was a first year Officer Cadet at Royal Military College (RMC) in Kingston, Ontario, in the fall of 2000. He had completed the Basic Officer Training Course (BOTC) at the Canadian Forces Leadership and Recruit School (CFLRS) in St. Jean, Quebec, that summer. On September 17, 2000, he participated in a five-kilometre race, during which he collapsed. He was taken to Kingston General Hospital where he was diagnosed with acute compartment syndrome (severe swelling of the leg muscles in their compartments) and rhabdomyolysis (breakdown of the skeletal muscle) with renal failure. As a result of his injury, the complainant was medically released from the Canadian Forces in August 2002 and is currently receiving a disability pension under the *Pension Act* and long-term disability benefits from the *Service Income Security Insurance Plan.*

17 The complainant and his family believe that his injury was a direct result of over-training and over-exertion while at CFLRS. This resulted in his arrival at RMC for the First Year Orientation Camp (FYOC) physically and emotionally exhausted with no time to recover, and eventually led to his collapse during the race. The family alleges that instructors at CFLRS abused their authority and pushed the complainant and other recruits beyond their limits.

18 Given the serious nature of the complainant's injury, and the allegations of abuse of authority and harassment of cadets at CFLRS, the commander of the CF Recruiting Education and Training System convened a BOI to determine the possible short-, intermediate- and long-term causes of the complainant's injury.

19 The BOI concluded in its report, dated December 19, 2000, that the complainant's injury was not attributable to training conditions or protocols at CFLRS or RMC, but was rather the result of him over-exerting himself during the race at RMC.

20 On July 12, 2001, the complainant's father sent a letter to then Minister of National Defence complaining that the BOI results were flawed and that the matter had not been thoroughly investigated. The complainant was also upset that his neighbour, a family friend, was not permitted to attend a briefing organized by RMC staff to inform the complainant and his parents of the BOI conclusions. After internal consideration of the issue, the former Minister opted to refer the matter to the Ombudsman for an independent, external investigation.

Investigative Process

21 Ombudsman investigators conducted over 50 interviews, including interviews with the following:

- The complainant;
- The Commander of CF Recruiting Education, Training System and staff;
- The two CF officers who conducted the BOI;
- Witnesses who provided evidence to the board of inquiry, including the CFB Borden Base Surgeon and the former RMC Medical Officer;
- The Commandant and senior staff at RMC;
- The Commandant and senior staff at CF Leadership and Recruit school;
- Current and former instructors at CF Leadership and Recruit School;
- The commanders of the complainant's company and platoon during the Basic Officer Training Course;
- Twenty four officer cadets who attended the Basic Officer Training Course at the same time as the complainant;
- Twelve officer cadets who attended the First Year Orientation Camp at Royal Military College at the same time as the complainant;
- The CF Medical Officer, Force Protection Unit, Directorate of Medical Policy;
- The Director of Performance Health Promotion, CF Personnel Support Program.

22 Ombudsman investigators also obtained and reviewed a large amount of documentation, including the following:

- Case material collated by the complainant including his personnel file, college file from RMC, CF medical file, and medical documents from Kingston General Hospital;
- The board of inquiry terms of reference and report;
- Evidence received by the BOI including documents and transcripts of interviews;
- The complainant's Basic Officer Training Course and RMC files;
- Training logs for the complainant's platoon at the Basic Officer Training Course;
- Relevant Queen's Regulations and Orders (QR&Os), Canadian Forces Administrative Orders (CFAOs) and Defence Administrative Orders and Directives (DAODs);
- Terms of reference and reports of Summary Investigations conducted at RMC and CF Leadership and Recruit School;
- Basic Officer Training Course Candidate Standing Orders, as well as course training plans and relevant Training Directives.

Interim Report

23 At the conclusion of my investigation, an Interim Report was prepared in order to obtain initial feedback on our proposed findings and recommendations. In February 2004, copies of the Interim Report were provided to the ADM (HR-Mil), the Commandant of the Canadian Forces Leadership Recruit School, the Commandant of the Royal Military College, the members of the BOI as well as the complainant and his family. The responses and comments received were reviewed and considered in preparation of this Final Report. Copies of the responses can be found at Appendix A.

Issues

24 The following issues provided the focus of my investigation:

1. Was the board of inquiry's conclusion that the complainant's injury resulted solely from his participation in the five-kilometre race well founded?

2. Did the complainant's treatment during the Basic Officer Training course at the CF Leadership Recruit School in St. Jean and the First Year Orientation Camp at RMC contribute to his injury?

3. Was the complainant fairly treated during and after the board of inquiry process?

Summary of Facts

25 The complainant enrolled in the Canadian Forces on November 8, 1999, in the Regular Officer Training Plan. On July 2, 2000, he arrived at the Canadian Forces Leadership Recruit School at St. Jean, Quebec, to complete the Basic Officer Training Course. This course is the basic training course for regular force officer candidates entering the Canadian military.

26 The complainant's Platoon consisted of two sections and a total of 42 officer cadets. Their training consisted of classroom lectures, physical fitness training and general military training, which included field craft, drill and maintaining a military kit.

27 By August 26, 2000, the complainant had completed his training at St. Jean and arrived at RMC in Kingston, Ontario, to begin his academic training. With the other first year cadets, he was required to take part in the First Year Orientation Camp (FYOC) at RMC.

28 According to the RMC commandant, the FYOC is intended to help first year cadets understand the four 'pillars' at RMC; academics, athletics, bilingualism and military training. It also includes course registration, the distribution of books and uniforms and other matters related to the beginning of classes. The FYOC routine includes physical fitness, sports, classroom lectures and drill.

29 The race in which the complainant was injured took place on Sunday, September 17, 2000. The complainant collapsed towards the end of the race, near a building known as the "Stone Frigate." Senior cadets along the race route immediately came to his aid and took him to Kingston General Hospital in the private car of another cadet, as they believed this would be quicker than calling an ambulance. He was at the hospital within fifteen minutes of collapsing.

30 The complainant was accompanied to the hospital by his Flight Leader (a fourth year cadet) and his Squadron Commander, who contacted his parents to inform them of the injury. He was diagnosed with acute compartment syndrome and rhabdomyolysis with renal failure. Acute compartment syndrome is the severe swelling of the muscle in the compartments that hold them, causing pain as the muscles become constrained. It can lead to rhabdomyolysis (destruction of skeletal muscle), which takes place when muscle tissue breaks down and disintegrates into the blood stream. This muscle tissue then affects the kidneys, causing renal failure.

31 The complainant was admitted to intensive care because of his kidney failure. The next day, he had emergency surgery to relieve the swelling of the compartments in his legs. After a long recovery, he was released from Kingston General Hospital on November 7, 2000, and his ongoing care was transferred to the medical officer at the Canadian Forces Area Support Unit in Toronto.

32 The complainant and his family told the Director of Cadets at RMC that they felt the way he had been treated at CFLRS led to his injury; they alleged that the complainant's platoon was treated more harshly than others, and that his instructors had abused their authority.

33 The Director of Cadets, after discussion with the Commandant of RMC informed Major General (MGen) Daigle, Commander of the Canadian Forces Recruiting Education and Training System (CFRETS) of the complainant's allegations. CFRETS was responsible for both RMC and the CFLRS. Given the serious nature of the complainant's claims and the severity of his injuries, MGen Daigle convened a BOI in October 2000 to look into the matter. The Board's terms of reference included the following statement: *"to undertake research, interview witnesses and visit facilities required to ascertain the possible short, intermediate and long term causes leading to (the complainant's) injury."*

34 The two members of the BOI were selected from units not associated with either RMC or the CFLRS. Major (Maj) K. Smith of the Canadian Forces School of Electrical and Mechanical Engineering was appointed as President and Captain (Capt) J.C. Labelle from the Canadian Forces School of Administration and Logistics was the other member of the Board.

35 The BOI began its work on October 24, 2000, at RMC. Those who were required to testify were informed by their chain of command. Witnesses provided their evidence to the Board under oath. It was recorded and subsequently transcribed.

36 At RMC, the board members heard evidence from the complainant and his father, the commander of the complainant's squadron, the officer in charge of the FYOC, staff members and cadets. They also met with Capt Meunier, the RMC Medical Officer who provided them with literature from medical texts about the type of injuries suffered by the complainant.

37 On October 31, 2000, the Board travelled to the CFLRS at St. Jean, Quebec. There they heard evidence from the Commander of the complainant's company, the Company Sergeant Major, the complainant's Platoon Warrant Officer and the school Training Standards Officer and Chief Instructor, as well as officer cadets who had trained with the complainant at St. Jean.

38 The BOI submitted its report to the commander of CFRETS on December 19, 2000, concluding that the cause of the complainant's injury was "*over-exerting himself during the RMC First Year Road Race"*. The Board found that:

> *This is a very rare condition and no one could have predicted its occurrence. Acute Compartment Syndrome suddenly presents itself in the guise of shin splints… This case is extremely rare and is due to over-exertion during a particular event, it does not happen over a prolonged period of time. Therefore the injury was not attributable to training conditions or protocols at CFLRS Saint-Jean or RMC.*

Issue #1

39 **Was the Board of Inquiry's Conclusion that the Complainant's Injury Resulted Solely from his Participation in the Five-kilometre Race Well Founded?**

40 **Board of Inquiry Findings**

41 The board members said in their report that they had learned from discussions with Capt Meunier, the RMC Medical Officer, that the complainant suffered from acute compartment syndrome, an extremely rare and unpredictable condition. They noted that Capt Meunier believed the condition, in this case, was due to the unaccustomed exertion the complainant put out during the race. In her opinion, the complainant's injury could not have developed over a prolonged period of time; if it had, the complainant would have been suffering from pain every time he did physical training.

42 In their report, the board members referred to and relied on the following information which they indicate was given by Capt Meunier, based on her discussions with Kingston General Hospital specialists and from reading into the subject:

a. *Dehydration was never a factor in this incident;*

b. *The injury did not happen because of poor warm up;*

c. *Due to the nature and rarity of this type of injury, it is unpredictable and there are no symptoms until its actual occurrence;*

d. *The only plausible reason for this injury was the intense exertion (the complainant) put out during this particular event. It had nothing to do with him being over-fatigued or mentally exhausted. This particular condition happens to personnel who are in top physical condition (such as runners and (the complainant)) as these types of people are more apt to push themselves beyond their physical limits and overlook a level of pain that would cause the average person to stop*.

43 The board members reported that, at their request, a review of the complainant's medical records, which included information from the RMC Medical Officer about this injury, was conducted by the Base Surgeon of CFB Borden, Maj Wojtyk. They noted that Maj Wojtyk corroborated Capt Meunier's opinion that "*it is unlikely that (the complainant's) injury was precipitated by fatigue or a chronic condition related to his training.*"

44 The Board went on to find that the cause of the complainant's injury was his over-exertion in the RMC First Year road race.

> *(*The complainant*) was a highly motivated individual that pushed himself during this road race. He and the rest of his flight were also continually encouraged throughout the race by the other squadron personnel to do well as this event counted towards the Commandant's Cup. This condition he suffered is extremely rare and the onset is immediate. It does not occur due to fatigue and therefore BOTC (*Basic Officer Training Course*) and FYOC (*First Year Orientation Training Course*) were not the cause. No one could have predicted its occurrence. One might feel that the Road Race itself was the cause because it's designed to force people to push themselves. However, this type of competition helps build team spirit and cohesion, which is a fundamental part of the military 'raison d'être'. One might also consider that (the complainant), because of his drive and determination, was responsible as he pushed himself beyond his limits. However, these are the qualities that the CF is searching for when individuals are recruited into the military. Therefore, the BOI believes that no one is to blame for the injury.*

45 While concluding that the complainant's injury was not attributable to training conditions at St. Jean or RMC, they did find the complainant was required to participate in the road race as part of the First Year Orientation Training Camp and therefore his injury was attributable to his military service. This finding made the complainant eligible for certain disability benefits.

46 The BOI surmised that, "*there may have been a delay in the diagnosis of (*the complainant's*) condition, which caused it to be more severe than it should have been.*" However, they had no medical information shedding light on this issue, as Kingston General Hospital had not released the documents concerning the complainant's treatment in the emergency department. They noted that Maj Wojtyk had requested the information and would forward it as an addendum to his report.

47 The BOI made eight recommendations. None of them dealt with or referred to the cause of the complainant's injury. Four dealt with CFLRS and will be dealt with elsewhere in this report. Three addressed collateral observations about the availability of first aid at RMC, warm-ups for personnel and the structure of the chain of command at the First Year Orientation Course. Finally, the board members recommended that "*when a BOI is conducted on a person with an injury, it should be considered to have an MO (*Medical Officer*) as a member of the BOI."*

48 **The Complainant's View**

49 The complainant indicated that he felt in fairly good shape at the beginning of the race. Wanting to get a good start, he half-sprinted, half-jogged at the beginning and kept up that pace until, about half way through the race, he felt extremely fatigued and did not think he would be able to go on. He did not stop, however, as he said, "*we were told they did not want to see anyone walking"* and he prided himself on never giving up. He said that with about 200 metres left in the race, he felt very thirsty and everything became a blur. He went up an incline and his legs felt heavy, "like cement", and he collapsed.

50 The complainant felt that his BOTC platoon was subjected to many more physical tests and punishments than others. He said they had to work harder and, at the end of the course, their instructors admitted that they had set higher than normal standards. The complainant felt that the standards were always changing and that they could never be met. He believes he was physically and mentally depleted when he arrived at RMC and that this contributed to his injury during the race. He thought the BOI took too narrow a view, in that it focussed on events at RMC and not on his training at St. Jean. He noted that the board members interviewed only 5 or 6 of the 35–40 members in his platoon.

51 **Interview with the RMC Medical Officer, Capt Meunier**

52 The BOI met with the RMC Medical Officer, Capt (now Major) Meunier for approximately an hour and a half. The meeting itself was not recorded. However, at the end of the meeting, it was stated on tape that the board members had met with Capt Meunier and that she had provided them with information regarding the complainant's condition and the cause of his injury, including copies of portions from two medical texts, one on surgical diagnosis and treatment, which dealt with acute compartment syndrome, and the second from a textbook called "*Sports Medicine Prevention, Assessment, Management and Rehabilitation of Athletic Injuries"*, regarding compartment compression syndrome of the lower leg. The Board President indicated on the transcript that he might choose to call her back at a later date, and that he needed further medical advice.

53 Capt Meunier was a general practitioner in family medicine. She was not involved in the diagnosis or treatment of the complainant, but acted as a liaison between the military and Kingston General Hospital. She saw her role in meeting with the board members was only to summarize information provided to her by Kingston General Hospital. She could not remember the specifics of the meeting or the content of her advice.

54 Maj Meunier told Ombudsman investigators that she did not give the board members an expert opinion on the cause of the complainant's injuries, and she asserted that, in fact, she was not qualified to do so. In her view, the purpose of meeting with the BOI was to explain medical terminology and answer questions about what the physicians from Kingston General Hospital had said. When Ombudsman investigators gave her a copy of the BOI report, she said she was surprised to see that the board members had relied on information she provided in making their findings and that they had attributed specific conclusions to her:

> *Looking at the conclusions, it almost looks like they were using me as… well, not almost… it does… it looks like they were using me as an expert, or something. And that wasn't the role at all. I was never sat down and asked: "would you give your opinion of the events leading up to this, or the possible causes?" Not at all. It was more a case of: "could you… because we can't… provide the medical information relayed here?"…*
>
> *…And at no time was I ever directly to provide my opinion as a physician. You know… What do you think from start to finish? Because I didn't even have the information on the starting part of it. All I had was the information from the time he went to I.C.U. [intensive care unit] up until near discharge and then his transfer to the Rehab Centre.*

55 Maj Meunier explained to Ombudsman investigators that she thought the Board would seek expert advice on the cause of the complainant's injuries, as she was not an expert in the specialties of the doctors involved in the complainant's care. Further, she noted that, in her opinion, Maj Wojtyk, the Base Surgeon who provided a medical review to the BOI, did not have that kind of experience or expertise, either. She elaborated:

> *… I got the impression that the board of inquiry hadn't exactly proceeded in the way I understood that it would proceed, and I definitely was under the impression that any medical aspects of it were going to be pursued independently by an outside person—not me, not the M.O. (*Medical Officer*) from RMC, which is kind (*of*) involved and not KGH (*Kingston General Hospital*) medical professionals—rather, that an outside source would come in and look at the whole medical side of the matter….*

56 Maj Meunier had not seen the BOI Report until Ombudsman investigators gave her a copy. After reviewing its findings and conclusions, she said she did not agree with all of the conclusions attributed to her. She also said that she did not agree with several other statements in the report that seemed related to discussions the board members had with her, including the statement that acute compartment syndrome "*suddenly presents itself in the guise of shin splints*".

57 **Interview with CFB Borden Base Surgeon, Maj Wojtyk**

58 The Base Surgeon at CFB Borden, Maj Wojtyk, who was also the medical advisor to CFRETS, wrote to the BOI on November 16, 2000, saying that he had reviewed the complainant's medical files (CF 2034 and 2016) and information provided by the BOI, but that the medical information from Kingston General Hospital had not yet been made available.

59 His letter stated that the complainant suffered from acute compartment syndrome (increased pressure within the muscles) in both his legs and his feet, and that he required emergency fasciotomies (cutting through the skin and linings of the muscles involved) to relieve the pressure. It noted that the complainant went on to suffer complications, including rhabdomyolysis (destruction of skeletal muscle) with consequent renal failure requiring dialysis, that he also suffered complications of wound infection and multiple organ failure, and that his prognosis was uncertain.

60 In his letter, Maj Wojtyk gave the opinion that the complainant's problems were created by extreme exertion. He also said that "*intensive exercise, causing increased pressure within muscular compartments of the legs, is the root cause of the syndrome*." Maj Wojtyk also made reference to a variant of the same condition, called "Effort-related Chronic Compartment Syndrome", which he said is a "*well-known complication of repetitive exertion and seen frequently in military populations and athletes undergoing intensive physical training*."

61 Maj Wojtyk noted that his review of the complainant's medical file revealed no evidence of any complaints prior to the incident. He suggested that the complainant was enjoying very good health and fitness at the time of his injury, and from this concluded that it was unlikely the injuries were precipitated by fatigue or a chronic condition related to training. He stated in his letter to the Board:

> *In reviewing the information available, it appears that (*the complainant*) was the unfortunate victim to an injury caused by extreme exertion… Although physical training can cause Effort-Related Chronic Compartment Syndrome (ERCCS), there is no evidence to suggest that (*the complainant's*) training regimen caused him any problems to suggest he was developing ERCCS or that it caused his acute compartment syndrome.*

62 Maj Wojtyk told Ombudsman investigators that he has been in general practice since 1985. He did not recall discussing the specifics of the complainant's case with Capt Meunier, but he did remember talking about the issue of access to the Kingston General Hospital medical records. He did not have those records and based his opinion to the BOI on his review of the complainant's CF medical files.

63 In Maj Wojtyk's opinion, someone who suffered from compartment syndrome would be susceptible to it during future physical activity; it would be further exacerbated by over-exertion. He also noted that it is not uncommon to see mild cases of compartment syndrome in the military, because people run a lot. A condition as extreme as the complainant's, however, was rare.

64 In reviewing the complainant's CF medical file, Maj Wojtyk noted nothing to suggest any condition that would predispose him to developing compartment syndrome. He acknowledged, however, that he was not familiar with the complainant's training cycle and that he could not know for certain whether the complainant's prior training experience had an effect on his injury—it would depend on the intensity of training. He did indicate that someone could be predisposed to compartment syndrome if they did not allow themselves sufficient rest, and that the cumulative effect of over-exercise, possibly combined with lack of rest and sleep could contribute to the condition. He was not aware of any evidence that this was the case for the complainant.

65 Interview with Board of Inquiry President, Major Smith

66 Maj Smith was the officer commanding A company at the CF School of Electrical and Mechanical Engineering when he was tasked to preside over the BOI. At that time, he was in the midst of taking the presiding officers' course for summary trials and he also had experience as a harassment advisor and investigator. He had no affiliation with the Basic Officer Training Course or RMC and was not in the same chain of command. This was Maj Smith's first board of inquiry.

67 In preparing for the Board, Maj Smith and Capt Labelle (the second board of inquiry member) reviewed the relevant CF Administrative Orders and Directives, and *Queen's Regulations and Orders* and sought advice from the Judge Advocate General (JAG) legal advisor on procedures and how to question witnesses.

68 Maj Smith indicated that they obtained a medical opinion from Capt Meunier, but decided to verify this with someone who was not from RMC, so they sought out confirmation from Maj Wojtyk. He noted that originally Maj Wojtyk had suggested the possibility that the complainant's injury could have resulted from over-exertion during his training, but after researching the issue further he revised his opinion and indicated that he felt the injury was a result of the complainant pushing himself past his limits during the race.

69 The board members relied on the opinions of Capt Meunier and Maj Wojtyk to arrive at their conclusions, supplemented by research on the Internet and in medical journals. Maj Smith stated:

> *All of those things agreed that this incident happens because an individual has pushed themselves beyond their limits on one particular time. I went through basic training and I went through RMC, Royal Roads actually, and with the amount of sleep this individual was getting, in my opinion he could not have worn himself out. I know that I had a lot less sleep during my time during the basic training, but I wasn't looking at that. I also know that this guy does everything—did everything—at 100 percent. He almost pushed himself to his limit everyday. It came down to all the medical information that we had between those two people and there are two files. I am sure I have them in the statement that tells you about that injury that says that it's because a person has pushed themselves beyond their limits.*

70 Maj Smith thought that the board members could have asked for other medical opinions, but in his view, it was not necessary. He said, *"unless somebody can find some other information that it happens because of stress and fatigue, I don't think it was related to it at all."* Maj Smith felt that there was really no way to prevent what had happened to the complainant, as it was such a rare occurrence.

71 **Interview with Second Board of Inquiry Member, Capt Labelle**

72 Capt Labelle was the officer in charge of supply at the CF school of Administration and Logistics. This was his second BOI of this sort, the other having involved a suicide. He had also been involved with two or three BOIs that were more administrative in nature, dealing with changes of command and the end of a mission. Capt Labelle had spent five years at RMC and was familiar with the training program. He felt he was chosen for this particular BOI because this knowledge was thought to be helpful.

73 Capt Labelle told my investigator that the Board relied on Capt Meunier's opinion in forming its conclusions and that her opinion was confirmed by Maj Wojtyk. He noted that the Board recommended that a medical officer should be appointed to BOIs that had to consider a great deal of medical information. The members of this Board felt they did not have the expertise to arrive at their own conclusions, and instead had to rely on those of Capt Meunier and Maj Wojtyk. He added that the board members had wanted to speak to the complainant's treating physicians at Kingston General Hospital, but the doctors would not speak to them directly.

74 Other Information Regarding the Complainant's Medical Condition

75 Civilian doctors handled the majority of the complainant's medical treatment at Kingston General Hospital. The complainant's hospital file was not available to the board members during the inquiry. It was also not reviewed by Maj Wojtyk in giving his opinion, nor by Capt Meunier, although she had talked to the treating physicians. The military requested disclosure of the file from the hospital and had consent from the complainant for the release of his information. However, Kingston General Hospital had not provided the information by the time the Board issued its report on December 19, 2000. The documents were eventually released on February 2, 2001.

76 Ombudsman investigators interviewed Maj D. Menard, a CF medical officer in the Deputy Chief of Staff's Office for Force Health Protection and the Sports Medicine Consultant to the CF Surgeon General. The board members did not consult Maj Menard during their inquiry. It is clear, however, that his expertise could have been of assistance to them. According to Maj Menard, it would have been appropriate for the BOI to seek opinions from an emergency medicine specialist, an orthopaedic surgeon and a sports medicine expert when considering the cause of the complainant's injury.

77 Although Maj Menard was not in a position to provide an expert opinion on the cause of the complainant's injury, he did provide my Office with some general information on compartment syndrome. He said that, given the right circumstances, it is possible for anyone doing physical activity to develop compartment syndrome. Someone experiencing this condition may believe they are suffering from shin splints. Maj Menard clarified, however, that it is unusual to develop acute compartment syndrome to the point where the muscle begins to break down. He also indicated that such a compartment syndrome and/or rhabdomyolysis could be caused by a crushing type of injury. The use of protein powders, anabolic steroids or ephedrine, and dehydration can also be contributing factors. Dehydration could decrease the amount of fluid in the bloodstream, increasing the possibility that proteins enter the bloodstream, and leading to kidney impairment.

78 There is no evidence, however, that the complainant had been using any of the above-noted substances, or that he suffered any crushing injury to his legs. Furthermore, the weather was not unduly warm; hot weather could contribute to dehydration. Although he could not say that the complainant's injury was caused by a cumulative effect of exercise over a period of time, Maj Menard felt it was unusual that a person who was perfectly fit and healthy with no predisposing conditions could develop such a severe compartment syndrome running a five-kilometre race on a day that was not overly hot. If the complainant were suffering from acute compartment syndrome at the beginning of the race, Maj Menard indicated that he would have expected that severe pain would have prevented him from starting the race.

79 Analysis, Findings and Recommendations

80 Both members of the BOI acknowledged that they relied heavily on the advice from the medical officers, Capt Meunier and Maj Wojtyk, in arriving at their conclusion that the complainant's injury was the result of over-exertion in the race. Maj Smith thought that their conclusion would have been different if the medical officers thought that the complainant's training experience could have contributed to his injury. Capt Labelle confirmed that the board members felt at a disadvantage because they were not medical officers and there was no medical officer on the Board.

81 In the circumstances, the Board's heavy reliance on the opinions of the medical officers raises questions about the validity of its conclusions about the complainant's injury.

- First, the medical officers' opinions were based on information provided to them by the Board, and on access to only part of the complainant's medical records.
- Second, the medical officers did not have access to all the evidence provided to the Board and never spoke to or examined the complainant.
- Third, neither medical officer had the special expertise needed in this case.
- Fourth, neither medical officer was given an opportunity to review the Board's report before it was issued.

82 These factors put the validity of the Board's conclusion that the complainant's injury was caused solely by a five-kilometre race into question. This should not be construed as an adverse comment on the board members. By all accounts, both members carried out their roles in good faith and to the best of their abilities. In my view, however, they did not have access to the expertise they needed to draw a reliable conclusion about the cause of the injury.

83 I agree with Maj Menard that it would have been appropriate for the board of inquiry members to solicit expert opinions from medical specialists in the appropriate disciplines. Moreover, a comprehensive medical opinion should have included a review of the facts about the complainant's training, as well as his complete medical records, including those from Kingston General Hospital.

84 I believe the Canadian Forces should retain a qualified independent medical expert or experts, in the areas of emergency medicine, orthopaedics and sports medicine, to re-examine the conclusion that the complainant's injury was caused solely by his participation in the five-kilometre race. Given the family's lack of confidence in the Board's conclusions, and in the military's ability to objectively determine the cause of the complainant's injuries, the expert should come from outside the Canadian Forces. This is not a situation where military knowledge or expertise is needed. The expert's review should include an examination and an interview with the complainant, a review of his training experience prior to the race, as well as a review of his complete medical records from all relevant sources. At the end of the expert's review, a written opinion should be provided to both the complainant and the Canadian Forces and attached to the BOI file and the complainant's CF personnel file.

85 **I therefore recommend that:**

1. **ADM (HR-Mil) order an independent medical review into the cause of the complainant's injury by experts from outside of the CF with expertise in the areas of emergency medicine, orthopaedics and sports medicine.**

86 I am pleased to report that, in his response to my Interim Report, the ADM (HR-Mil) agreed with this recommendation and authorized the Canadian Forces Medical Group to ensure that an independent medical review by experts is conducted. He has also undertaken to advise me of the results of this review when they become known. My Office will follow up with both the CF Medical Group and the complainant to monitor the implementation of this recommendation.

87 **Expert Witnesses and Boards of Inquiry**

88 Both BOI members acknowledged that they had no medical expertise and had to rely on consultations with CF medical advisors, journal articles, textbooks and the Internet to understand the complainant's condition. Both members clearly felt that having a medical officer as a member of the BOI would have been helpful. This issue was of sufficient concern that they recommended that when a BOI is conducted on a person with an injury, consideration should be given to including a medical officer as a member. I agree with this recommendation. A medical officer could have been instrumental in assessing the relevance of evidence the Board received, such as the complainant's training experience, and could have recognized more easily the need for expert advice in the pertinent medical specialties.

89 Chapter 21 of the *Queen's Regulations and Orders* (QR&O) governs the conduct of BOIs and summary investigations. Article (2) states:

> *In determining the composition of a board of inquiry, the convening authority shall:*
>
> *[…] (f) where the investigation may involve technical or professional knowledge or skill, appoint, where practical, at least one member with the required qualifications.*

90 QR&O 21.08 (4) allows the appointment of a civilian, should there not be a military person with the appropriate expertise available. As well, QR&O 21.14 allows the convening authority to appoint or arrange for the attendance of civilian or military specialists to advise a BOI. Defence Administrative Order and Directive (DAOD) 7002-1, which came into effect in February 2002, some 17 months after the complainant's injury, elaborates on this article:

> *In the case of a death, injury, serious illness or other health issue, a medical advisor should normally be appointed to the BOI.*

91 The complainant in this case was diagnosed with acute compartment syndrome and rhabdomyolysis with renal failure. The doctors involved in his treatment noted it to be a rare condition. This should have been sufficient to alert the convening authority to the need for medical expertise. Under the regulations at the time, this could have been accomplished by appointing a person with the relevant expertise as a member of the Board, or by appointing a medical advisor. Advisors to BOIs usually observe all the proceedings of the Board, and are available to board members throughout the process. In this case, an advisor could have had access to all of the information considered by the Board and could have been involved in the report writing process, verifying the Board's conclusions and making sure that any medical advice was understood.

92 I understand that sports injuries are not uncommon in the CF, and that appointing medical experts to every inquiry into a member's sports-related injury may not be necessary. In this case however, it should have been apparent that the Board was not being asked to inquire into a routine injury.

93 DAOD 7002-1 creates a presumption that in the case of a death or a serious medical issue, a medical advisor should normally be appointed to the BOI. As this case demonstrates, the presence of a medical advisor can be essential in ensuring thorough consideration and treatment of the issues. In my view, deciding not to appoint a medical advisor should be the exception, not the rule. A medical advisor should only be dispensed with when there is clearly no need for medical expertise.

94 To ensure that DAOD 7002-1 is taken into account by convening authorities, I think it is prudent that, when a BOI is convened to examine a death, injury, serious illness or other health issue, convening authorities be required to certify in a board's terms of reference that they have considered DAOD 7002-1. If they decide no medical advisor is required, they should state their reasons. This will provide assurance that the matter has been considered and will also inform board members why it was felt that a medical advisor was not necessary.

95 **I therefore recommend that:**

2. DAOD 7002-1 be amended to require that, in cases where a board of inquiry is convened to examine the cause of a death, injury, serious illness or other health issue and a medical advisor is not appointed, the convening authority should give reasons why no appointment was made.

96 The ADM (HR-Mil)'s response to my Interim Report did not support this recommendation and gave six reasons why the recommendation could not be accepted. None of them have persuaded me to withdraw the recommendation. I will respond to each one.

97 First, the ADM (HR-Mil) pointed out that convening authorities can make only a preliminary assessment, and may not appreciate that an advisor is required. This is true. However, the requirement that reasons be given will sharpen this preliminary determination. It will expressly require convening authorities to turn their minds to the possible need for an advisor, and to explain their reasoning when advisors are not appointed. This is far more likely to produce thoughtful decisions on the matter than the current regime, which does no more than authorize the appointment of advisors. Creating a presumption that a medical advisor will be appointed in certain types of cases is a rational way to ensure that preliminary assessments are made in a searching and careful manner.

98 Second, the ADM (HR-Mil) submits that the BOI president and members are in the best position to determine whether an advisor is needed. In some cases, that will be true. It is worth pointing out, however, that QR&O 21.14 empowers the convening authority, not the members of the BOI, to arrange for advisors. My recommendation meshes with the authority currently in the QR&O. Moreover, the processes for the Board to acquire an advisor once an inquiry has begun are awkward; they must apply for additional resources when their work is already in progress. While this may be necessary in some cases, using *ex post facto* applications as the routine way to determine the need for advisors is simply not efficient.

99 Third, the ADM (HR-Mil) suggests that there are a large number of investigations into sports-related injuries when no medical advisor is required. This may be true. My recommendation, however, does not require the appointment of expert advisors; it simply requires reasons where advisors are not appointed. Where no advisor is necessary, there is no reason to appoint one.

100 Fourth, the ADM (HR-Mil) suggests that the most appropriate time to explain for the record why an advisor was not appointed is not when a BOI is convened, but when the President explains why certain witnesses did not testify about a pertinent matter. With respect, this completely misses the point. The President's explanation is manifestly meant to state why witnesses who should have been called were not called; my recommendation is intended to ensure that information that should be available to a BOI is available. Moreover, my recommendation, that reasons be provided when an advisor is not appointed, is not intended simply to create a record of the decision. It is also meant to create a presumption that in certain cases, a medical advisor will be appointed, and that careful consideration is given before that presumption is dispensed with. Explaining why an advisor was not appointed at the end of the BOI comes too late to encourage correct decisions at a time when they can still do some good.

101 For this reason, I am also not persuaded by the fifth argument, namely that if there was a need for an advisor and it was missed, "subsequent reviewing authorities in the chain of command are fully empowered to direct a supplemental or new investigation." Why depend on revision? In this case, the reviewing authority did not discover the problems with the Board's findings in the course of his review. Why not create a system that will reduce the chances of needing additional investigation?

102 Finally, the ADM (HR-Mil) argues that my recommendation does not address the problem that arose in the investigation at hand. I disagree. Had the convening authorities been faced with an order that, under such circumstances, they appoint an expert advisor absent good reason not to do so, they would clearly have seen an advisor was needed. This case involved an obviously rare and serious medical condition. Had an advisor been appointed, the medical testimony obtained would have been recognized as inadequate, and the testimony received by the Board would not have been misconstrued.

103 The ADM (HR-Mil)'s response to my Interim Report appears to suggest that the BOI acted as expected by identifying the need for medical advice and "*(made) their observation the subject of a recommendation as opposed to returning to the convening authority to communicate the need for additional resources in view of the imperatives of their investigation*." As far as I am concerned, this way of proceeding is not the solution—it is the problem. Saying in their report that the BOI should have had additional resources, such as an advisor, is no substitute for the Board having those resources when it needs them. My recommendation is meant to accomplish this.

104 It is possible that in some circumstances, an injury that originally seemed routine, might in the end require a greater degree of medical expertise than was first imagined by the convening authority. In those instances, I believe that if BOIs already underway determine that some special expertise is needed, they should request and be given those additional resources. When this is necessary, there should be guidelines about how that expertise is to be gathered, documented and relied upon. The guidelines should ensure that an expert witness is given all of the information they need to provide an informed opinion, and should allow the Board to seek an extension of time, if needed, to allow the expert to consider that information. It should also be made clear that experts should be examined formally, as witnesses, so that their testimony is recorded and the transcripts are attached to the Board's final report. This would allow the Board to review the testimony, as needed, to ensure that it is fully understood. It also provides assurance to authorities who review the Board's report that the findings are supported by the testimony of any expert witness. Finally, when a Board makes findings or recommendations based on information provided by an expert witness, the Board should give the witness an opportunity to review the report, so the witness can ensure that the Board understood the testimony and that the findings flow logically from it.

105 **I therefore recommend that:**

3. **Procedures be developed for boards of inquiry to ensure that when medical expertise is sought, experts have access to all relevant information collected by the Board; the evidence provided by the experts is properly documented; and the experts have an opportunity to review any reports that rely on their advice to confirm that it is properly understood and applied.**

106 The ADM (HR-Mil)'s response to my Interim Report agreed with the principle that experts should have access to relevant information collected by the Board, and should be able to assure themselves that the information they provided is properly documented. However, he concluded that "*the current direction in DAOD 7002 is sufficient to address the needs identified*." I cannot agree. The existing procedures and direction were not sufficient in this case. They did not ensure a comprehensive and informed conclusion. This is why I recommend that specific procedures be developed to ensure that access to all information is furnished, and expertise assured. I take no comfort in the observation that one would expect a medical expert to be tasked to review the relevant records and to produce a written report for submission. That expectation was not met in this case.

107 In his response, the ADM remarked that "*expert medical witnesses do not review BOI reports when they themselves have served as witnesses*." My point is that they should do exactly that when a Board purports to rely on their testimony. This case shows why. The medical evidence was misunderstood. Expertise that she did not have, and conclusions that she did not draw, were attributed to Capt Meunier without her knowledge and without an opportunity for comment.

108 There is nothing inconsistent between this recommendation and the role of a witness **as** witness, or with the requirement that a decision be arrived at on the evidence. Where expert evidence is misunderstood, as it was here, the evidence does not provide the foundation for the decision – the misunderstanding does. The procedure I recommend is a simple safeguard to ensure that evidence given is understood and used properly.

109 Finally, the ADM (HR-Mil) suggests that the procedure for recalling witnesses provides an adequate safeguard. Again, I cannot agree. Before a witness is recalled, a BOI has to see the need for clarification or additional information. When that is the case, the power to recall may be suitable. However, it will be of no use in instances like this one, where the board members honestly believed they had the right and sufficient information.

110 I am not persuaded that Recommendation #3 is unnecessary. In my view its acceptance and implementation will make it far less likely that a case like this will be repeated in the future.

111 **Training of Board of Inquiry Members**

112 Preparing to conduct their inquiry, the board members reviewed the orders and regulations governing BOIs set out in their terms of reference. They also consulted with their legal advisor who was the Deputy Judge Advocate General for CFB Borden, and who provided information on the administration of oaths and other procedural issues. Although not a member of the Board, the legal advisor was available to answer legal and procedural questions throughout the inquiry.

113 The board members both felt that their job would have been easier if they had received specific training on the conduct of a BOI, including procedures for questioning witnesses and investigative interview techniques, administrative procedures for tracking and marking exhibits, and strategies for report preparation. The board members also reported that they felt frustrated by the lack of administrative support available during the inquiry. They spent much of their time on administrative tasks, and thought that the help of a clerk could have freed them from duties such as contacting witnesses, organizing interviews, tracking exhibits, etc. so that they could focus on the substantive issues.

114 Apart from the governing orders and regulations, there is no guidebook, document or specialized training course to which officers tasked to BOIs can turn for guidance on how to conduct a proper inquiry. The idea of training CF members who are called upon to provide specialized services as a secondary or collateral duty is not new. Officers tasked with presiding over summary trials complete a specialized legal training course and are certified by the Office of the Judge Advocate General. Training includes a self-study package and a two-day course covering legal and procedural issues.

115 A five-day training program is also available for CF members who conduct harassment investigations. The course teaches participants the proper procedures for investigating harassment complaints, ensuring that the rights and responsibilities of all parties are respected. It provides information on administrative requirements, developing an investigation plan, interviewing skills and how to analyse findings. The training includes lectures, discussions, role-play and case studies. DND/CF Harassment Guidelines and Procedures also contain detailed guidance for harassment investigators on their responsibilities and the steps that must be followed in handling a complaint.

116 The Director of Law/Human Resources in the Office of the Judge Advocate General advised that the JAG holds lectures on the conduct of BOIs on an *ad hoc* basis for units across the country. There is, however, no requirement that those serving on BOIs be certified or have any specific training. The JAG office agreed that a training package and/or a course could be useful, not for all CF members, but for those who were likely to be appointed to a BOI. Such a package could focus on the members' responsibilities, procedures for administering oaths, proper questioning techniques, analysing evidence and report writing.

117 I realize that the creation of a training package and the implementation of a training program will involve an investment of time and resources. It may also affect the selection of officers available to serve on boards. But, in my view, the investment is worthwhile. BOIs are important tools for the CF chain of command: their findings can have significant consequences for individual CF members and for the system. The issues a Board deals with can range from simple and straightforward issues affecting one individual, to serious and complex problems affecting an entire unit or rotation on deployment. BOI findings may result in administrative consequences for individuals; they may affect eligibility for pensions and benefits or even a member's release from the CF. Systemic recommendations may prevent future accidents, deaths or injuries. But regardless of the complexity of the questions to be answered, if a Board is to gather evidence and make factual findings and determinations, it is imperative that board members have the proper training and skill sets.

118 **I therefore recommend that:**

4. **The CF develop a training package designed to train members on conducting thorough and objective investigations, within the legal and procedural frameworks in place for boards of inquiries.**

5. **The CDS issue a directive that, absent exceptional circumstances, each board of inquiry must include at least one member who has completed the approved training for board of inquiry members. Where it is not possible to constitute a board of inquiry that satisfies this requirement, the reasons why, including steps taken to include at least one trained member, must be furnished by the convening authority.**

119 When I made those recommendations in my Interim Report, ADM (HR-Mil) did not support them. His response implied that training was not warranted when one balanced the costs of developing and delivering a training program with "*the tangible benefits that might be expected to accrue in the quality of the investigations conducted by BOI members*." I could not disagree more. As a simple proposition, I am convinced that education improves quality. That, of course, is why the Canadian Forces has seen fit to develop structured education programs for summary trials and harassment investigations. As I have just noted, the BOI process is an equally 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 those other instances, would not also accrue with BOIs.

120 The task of a BOI is not a simple one, requiring only common sense and a basic skill set. Boards administer oaths, compel testimony, question witnesses, create records, receive terms of reference defining their authority, handle exhibits, deal with theories of causation, explain the testimony of experts, evaluate credibility, organize evidence and make adverse findings. These are tasks ordinarily performed by legally trained people or professional decision-makers. Boards do not make final decisions but they have all the trappings of courts and apply all the skills of judges. While intelligent people with common sense and analytical skills may cope, it is short-sighted folly in my view to suggest that no material improvement in decision-making is likely to result from formal training.

121 I am compelled to reject the suggestion that all essential instructions and guidance to conduct a BOI are already contained in the QR&Os and DAODs. These highly technical documents read in places like legal statutes. While they do describe the basic procedural structure, it is unrealistic to think that merely reading these documents, even with access to a legal advisor, provides the skills necessary to conduct a good hearing into matters that may have grave consequences. Indeed, the QR&Os and DAODs say nothing about things like the manner of questioning witnesses, evaluating evidence or maintaining an appearance of objectivity. It bears saying again that in this very case the board members said they would have benefited from training.

122 I also do not agree with ADM (HR-Mil)'s statement that, "*in the absence of evidence to suggest a broad systematic problem concerning the conduct of BOIs, the recommendation cannot be endorsed*." Even if this were true, there is no reason not to consider measures for improvement. Moreover, asking for proof of systemic problems before considering obvious ways to improve the BOI system is particularly unpersuasive, given that, historically, there have been no external review mechanisms for BOIs that might identify whether or not systemic problems exist. I have every confidence that training would improve the quality of BOIs.

123 As for costs, education always costs money. But it can also save money if it increases productivity and quality. Furthermore, even if there is no net dollar gain, there will be a net quality gain. What cannot be overlooked in any cost/benefit analysis are the costs 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 BOIs or for defending the system on the grounds that these are ordinary decision-making exercises calling for ordinary levels of skill that require no training. Recommendation #4 is important. I am not persuaded otherwise.

124 I have recommended that at least one member of the BOI has approved training. If the training package I recommend is taken seriously, there should be a sufficiently large pool of trained personnel capable of conducting BOIs so that at least one member with the necessary qualifications can be found. The ADM (HR-Mil) argued this requirement would "*pose a significant risk of adversely impacting on the ability of service authorities to utilize the BOI mechanism to expeditiously and efficiently investigate and report on an incident or problem area in the CF*." What evidence supports this statement is not clear. In order to help mitigate any risk however, I have modified the recommendation to provide that, when it is not possible to appoint at least one trained member to a BOI, the inquiry go ahead with a statement from the convening authority with respect to the reasons why, including the steps taken to appoint a trained member.

Issue #2

125 **Did the Complainant's Treatment during the Basic Officer Training Course at the CF Leadership Recruit School in St. Jean and the First Year Orientation Camp at RMC Contribute to his Injury?**

126 **Basic Officer Training Course**

127 The BOI interviewed and received statements from 24 officer cadets. Only 5 had been in the complainant's BOTC platoon, which had approximately 40 platoon members. The other 19 officer cadets interviewed were with the complainant at RMC. The Board also interviewed five of the complainant's instructors from St. Jean.

128 At least one of the cadets that Ombudsman investigators spoke to was surprised he had not been interviewed by the BOI. The complainant was also surprised that so few of his fellow cadets from BOTC had been interviewed. He felt that the board members focussed primarily on the events at RMC FYOC because they were already convinced that his injury was a result of his participation in the five-kilometre race. The complainant felt that, because of this focus, the board members did not give enough consideration to his BOTC experience during the summer and didn't examine what impact this experience may have had, and what role it may have played, in his injury.

129 For their part, the BOI members felt that the cadets they interviewed gave them enough understanding of what occurred at the BOTC, and further interviews were not needed. They noted that the complainant was in excellent physical condition before beginning BOTC, and that he was a highly motivated team player who put maximum effort into everything he did. They also noted that his platoon was held to higher dress and room standards than other platoons in their company. The complainant was terrified of failing inspections, and he and other cadets would ignore the lights-out policy to prepare for inspections in the middle of the night. The Board also identified a number of other factors that contributed to additional levels of stress in the complainant's platoon, such as the following: contradictions over dress and room standards among the staff; the timing of inspections; the fact that other platoons had lower standards and were given leave two weeks earlier; and the fact that the lights-out policy was not enforced.

130 The complainant and his family believed that, as a result of his treatment at the BOTC, the complainant arrived at RMC physically depleted, fatigued and stressed and that this could have contributed to his injury and collapse during the race. The complainant told the BOI:

> *Well, I think – I really do think now that it had a bit to do with St. Jean and, you know, a lot of us asked our Lieutenant, you know, why was our platoon so much harder and he just said, "Oh, the standard's higher. We just demanded more of you."… right? And like, it could be a case of me personally being, I'm not like trying to blow my own horn but you know, being such a hard worker and demanding a lot of myself and that, right? But you know, I'm sure that whole summer of getting, you know, four - average four - hours of sleep a night, working for the rest of the 20 hours kind of thing. I'm sure that can't do well on a body. And not having time to recuperate, you know… going on leave and still, you know, working like a dog, that kind of thing, which is probably my fault, but I'm sure that kind of – the excessiveness of the Basic Officer's Training Course, I'm sure it had something to do with it now because a lot of people say this is due to over-working, what I have… And it's due to over-training and not having time to recuperate, allowing your muscles to recuperate. And that's exactly what I – that's exactly my case. I did not – I didn't have time to, you know, let my muscles you know, kind of cool down, let my body cool down kind of thing and…And if that's the case, I'm sure, you know going on St. Jean… that platoon, for the summer, kind of set the wheel in motion.*

131 The complainant told the BOI that if any recommendation could be made, he would like to see a recommendation to the effect that each platoon at St. Jean be treated in the same way and be required to meet the same standards.

132 The members of the complainant's platoon who were interviewed by my investigation team said they were inspected more often than other platoons, and that this led to a heavier workload. They also felt that they had not achieved weekend leave when they ought to have done. Moreover, one cadet said that their platoon members were mad at the course staff because, after talking to other cadets, they realised they did more physical fitness training than anyone else. Compared to others in their BOTC, their platoon was the most "hard-core". Other cadets also indicated that the platoon was forced to work harder than other platoons and the Platoon Warrant Officer was adamant that high standards be met. At the same time, some cadets believed that the Warrant Officer did a good job and that, in the long run, the high standards worked to their benefit because they felt better prepared for RMC.

133 Some cadets complained that they did not have weekend leave, but were instead required to do 'change parades', which involved assembling, returning to their room by running up seven flights of stairs to change into another set of kit, then reassembling. This was then repeated with yet another set of kit. They did not see that there was any training benefit to this action; rather they saw it as a form of punishment.

134 A number of the cadets in the complainant's platoon said they were tired during BOTC because they had to stay up late preparing their kit for morning inspections; there was just not enough time in the day to achieve the standard expected by the instructors. The complainant reported that he generally woke up at 0330 or 0400 hours in order to get ready for inspections and that he never slept under the covers of his bed, as he never had enough time to make it in the mornings. He thought his instructors knew the cadets were not following the lights-out policy, and that they had to have realized it was impossible to do all the work required to pass inspections without working late into the night or early in the morning.

135 The complainant was clearly afraid that if he did not work hard enough he would not pass the rigorous inspections. He also felt that the standards were constantly being raised. If cadets did not pass an inspection, they would receive a "conduct" against them, and if they had five conducts they would be sent to a Performance Review Board, which could terminate their training.

136 Some cadets said that course instructors abused their authority during a field exercise by not permitting the cadets to set up camp one night, forcing them to sleep in the rain under ground sheets. However, others said that the cadets themselves, not the instructors, decided not to set up camp because the exercise went late into the night and time allotted for sleep would have been reduced by the time it took to set up camp.

137 Some cadets alleged that one of their instructors acted inappropriately, and that he often yelled at the platoon members in a degrading way. However, others thought his loud manner was just part of the training program and a means of instilling discipline. As an example of inappropriate behaviour, frequent references were made to an incident where a C-7 rifle broke the window of a cadet's room. Many of the cadets believed, or had heard, that the instructor threw the rifle through the window while trashing a room. However, the cadet whose window had been broken said the rifle was laid on the bed for inspection and, when the instructor tore the bed apart because he felt it was not properly made, the rifle was sent flying through the window.

138 Cadets also complained about the use of a physical punishment called 'the crab', which required them to remain in a push-up position, putting their weight on their fingertips and toes with their rear ends in the air. Some cadets said they had to hold this position for a few seconds, others said a few minutes. It was alleged that the crab was used as a punishment for not completing drill or other tasks properly.

139 The complainant's platoon was led by a Lieutenant and had a Warrant Officer, a Sergeant, and a Petty Officer, 2nd Class, assigned as instructors. Inspection standards were to be consistently applied to all students and monitored by the Company Sergeant Major (CSM). According to the CSM, the complainant's platoon was one of the best platoons for inspections. He felt that this showed the instructors were very strict and set high standards for their students.

140 According to the platoon Sergeant, the instructors set high standards for proper dress, deportment and performance during drills. This was not unusual; he expected the same in any course he taught. The other instructors in the platoon shared this sentiment.

141 The official lights-out policy at the BOTC was from 2300 hours to 0500 hours. One of the instructors was assigned to enforce the policy each night. However, the policy was difficult to monitor, given that each cadet had his or her own room and that some cadets worked after lights-out, despite the policy.

142 The instructors felt the cadets had sufficient time to complete their tasks before lights-out at 2300 hours. However, they said that, during the first part of the course, members of the complainant's platoon had serious problems with time management. Some cadets did not make good use of their evenings to prepare for morning drills and inspections. One instructor said he had to have a discussion with his section about time management and getting things done by 2300 hours. The platoon Sergeant told us the most common complaint from officer cadets was that they didn't have enough time to complete their academic work or prepare for morning inspection. He had suggested to the cadets that, instead of working individually, they pool their talents and work as teams. He also suggested that they make timelines and assign themselves certain amounts of time to complete tasks.

143 The platoon Warrant Officer acknowledged that the "crab" position was used with students, but said it did not happen on more than three occasions. The Petty Officer indicated that he knew of the crab being used only once. The instructors referred to the crab as "the waiting position". They acknowledged it could be uncomfortable but did not see it as painful.

144 During the complainant's time at CFLRS, the Platoon Lieutenant conducted physical training at 05:30. The training consisted of circuit training (sit-ups, push-ups and similar exercises) and runs around the "Mega", a large building where the school is located at St. Jean. The distance increased through the course from about one to five kilometres. The platoon ran as a group, encouraging the slower runners to maintain the pace. When cadets fell behind, the group would circle back to pick them up. The stronger runners, including the complainant, would encourage the weaker ones. On occasion, during the hotter summer days, some recruits passed out on the runs and some vomited.

145 According to CFLRS staff, physical fitness training is no longer conducted at the platoon level but is the responsibility of the Personnel Support Program whose instructors are formally trained. This ensures that training standards are applied uniformly to all cadets. Witnesses who attended BOTC after the summer of 2000 confirmed this change.

146 Although the BOI did not find the training conditions at St. Jean caused the complainant's injury, they identified three concerns to be addressed by the chain of command at CFLRS:

- the possibility that an instructor instructing the complainant's group had harassed cadets and abused his authority;
- an incident involving alcohol abuse during the course party (this was addressed by the BOI; however, it was not directly related to the complainant's complaints); and
- the enforcement of sleep policy and inspection standards.

In response, the Commander of the CFLRS ordered three separate summary investigations to examine those issues.

147 The Summary Investigation (SI) into course inspection standards was conducted by the Leadership Division Standards Warrant Officer. The investigation found that the complainant's platoon instructors had established a standard of *"dress, deportment and personal conduct [inspections] that was more demanding than most other PLs [platoons] at that time."* As well, the lights-out regulation was paid scant attention. Students violated the policy and worked later and apparently, no one monitored or questioned this. The investigation also found that the policy governing the granting of weekend leave based on course performance was vague and could be subjectively interpreted, and that the standard for inspections was "inconsistent, vague and open to wide interpretation".

148 The SI recommended that adherence to the lights-out policy be emphasised through the development of a standard operating procedure and spot checks, that a clear policy be developed for granting weekend leave as well as that progressive and better defined inspection standards be adopted.

149 The SI into the actions of an instructor found that he had forced students to use the crab position as a form of punishment, and that his actions during the morning inspection that caused the rifle to break a window were excessive, contrary to school policy and an abuse of authority.

150 The complainant did not receive copies of the SI reports and was not aware of their conclusions or recommendations.

151 RMC First Year Orientation Camp (FYOC)

152 The complainant had a few hours off after the graduation parade at the CF Leadership Recruit School and the next day he left for RMC, arriving on August 26, 2000, to take part in the FYOC. The FYOC program ran until October 1, 2000. The complainant was injured on September 17, 2000.

153 While at RMC, the complainant says he got a solid six hours of sleep and ate well, but found the physical training standards a bit higher:

> *Whereas I left St. Jean, you know, still exhausted and I go right to the Military College where it's, you know, not as bad as St. Jean with respect to inspections and staying up late, because there they make you go to bed at 11, wake you up at, like 5:30 - 6, right? But it's still hard work. And again, I wouldn't give up on the runs and the P.T.s [physical training] were a lot harder and I'd, you know, raise my level to go to that P.T.*

154 The complainant felt that, when he got to RMC, a lot of people who had been in his platoon at St. Jean were going to the sick bay with knee problems and other injuries. He attributed this to the fact that the physical training was a step more difficult at RMC than at St. Jean. He also felt that the stress and pressure and work that his platoon had been subject to at St. Jean contributed to the increased injury rate.

155 The complainant stated that his Squadron was treated fairly at RMC. He said there was another squadron that had *"really hardcore"* section commanders, but that he did not feel harassed by his section commanders or anyone. In his view, his Squadron was treated *"basically the same as the other squadrons and they were fair."*

156 Prior to the race, the complainant did not recall being sore or that his legs hurt. He did, however, feel tired. He acknowledged that when he was tired, he would keep going and would not stop to rest or recuperate. He attributed this to his work ethic. The complainant's father noted that, when the complainant had called home on the Friday before the race, he sounded very tired. The Saturday before the race he participated in an obstacle course race where he was noted to have excelled at the "leopard crawl". The complainant acknowledged that during the race he felt *"really really really tired,"* but he was running hard and he did not want to give up.

157 The complainant's Flight Section Commander said that, while he was at RMC, the complainant was very dedicated and motivated, very strong in PT and very strong academically. She noted that his personal goal was to help those who were not as strong. The Flight Section Commander did not think that the complainant's experience at the FYOC was responsible for his injury. However, she felt some things that happened during the Basic Officer Training Course might have had an impact. The BOI members stated that she could not elaborate on this because she had not been a participant in the course and the information she could provide would be hearsay.

158 The Flight Section Commander noted that the complainant was feeling tired on the Thursday before the race. She said she had asked him if he needed to see the medical officer and that he replied that he did not think it was necessary.

159 The BOI noted that the FYOC was more demanding than the Basic Officer Training Course and that cadets at RMC did physical training twice a day. They noted that the RMC cadets interviewed indicated that the complainant was not exhibiting any unusual symptoms relating to fatigue or illness before the day of the race and that he had no problems with physical training. They said he always pushed himself and he continually encouraged others in his squadron and helped them.

160 Although they did not find training conditions or protocols at RMC responsible for the complainant's injuries, the board members had three concerns about the First Year Orientation Camp. First, they noted that there were no designated first aid personnel, or a roving first aid vehicle, for the five-kilometre race. Second, they felt that, prior to the race, there should have been a standard warm-up session with qualified personnel. Third, they commented that during the camp, squadron commanders were tasked with administration only and were not part of the chain of command. Rather, a special command organization was created solely for the first year orientation camp. The Board felt this was confusing both to students and to squadron commanders.

161 In September 2000, the Director of Cadets, Col. Lacroix, ordered a Summary Investigation into allegations of unfair training practices and harassment during the First Year Orientation Camp for 2000. The Investigation was completed in October 2000, concluding that incidents of inappropriate training practices, including the use of physical punishment had occurred. These were found to have been the result of insufficient staff training, insufficient education of first year cadets who were not aware of specific training policies, and limited direct supervision of activities because the officer in charge had too large a span of control. Recommendations were made to provide staff with detailed instructions on the types of training activities permitted, and also to require that staff submit a detailed daily description of their planned training activities.

162 The unfair training practices identified in the SI appear to have occurred primarily in two squadrons during the camp, with some less frequent occurrences in the others. The complainant's squadron was minimally affected with only a few isolated incidents of short-timing for tasks and rooms being trashed. The complainant corroborated this; he did not feel harassed or treated unfairly as a result of any of this kind of incident.

163 **Analysis, Findings and Recommendations**

164 The complainant's assertion that his platoon was forced to adhere to high, almost impossible standards throughout the Basic Officer Training Course at St. Jean and that he consequently arrived at RMC both physically and mentally exhausted, is well and independently confirmed. The evidence uncovered by the BOI, the ensuing summary investigations and my Office's own investigation all paint a picture of the complainant and his platoon mates being held to exceptionally high standards by their instructors during the course. They were required to work harder and perform better than cadets in other platoons in order to obtain leave and were left with the feeling that their performance constantly needed to be improved. In order to meet the standards, the complainant and others frequently violated the lights-out policy, waking in the early hours of the morning after only a few hours' sleep, in order to prepare for morning inspections. This led the board of inquiry members to conclude that "*most officer candidates did not follow the 2300 hrs curfew and thus became sleep deprived. As well there was a definite difference in inspection standards between platoons, even in the same company*."

165 The complainant went immediately from BOTC to RMC for the First Year Orientation Camp. Although he got more sleep at RMC, and he found the inspections less stressful, the complainant was also doing increased physical training and he was continually having to push himself harder and harder.

166 I agree with the complainant that the BOI members appeared not to have put much emphasis on what happened in St. Jean, but rather focussed their attention on the complainant's experience at RMC. This is not an adverse comment about the members of the Board who were clearly concerned for the complainant, and seemed to genuinely wish to get to the bottom of what caused his injuries. However, from the review of their leading and suggestive questioning of some of the witnesses, it is clear that, even before the end of the inquiry, the board members' thought the complainant was very driven and pushed himself very hard and that his performance during the five-kilometre race was likely responsible for his injuries. The following exchanges are examples of some of this questioning:

> ***Q.*** *...he would help - the picture that we're getting of him is that if he had to, he would help a guy or a group of people to succeed in a goal, whether that goal was to climb a mountain or come up with a solution to a problem?*
>
> ***A..*** *Yes, sir.*

Q. *And he wouldn't just – he wouldn't just put in his two cents worth, he would try to make sure that he put his 120 percent or whatever he possibly could, whatever he could contribute to that, plus more, he would contribute?*

A. *Yes, sir.*

Q. *Okay, because that's – that's the way we're seeing him. On the run were you – were you there during the day of the run? … How did he appear mentally and physically, say the day before or the day of the race?*

A. *As per normal, except that I'm not sure of the exact date, like the race was on a Sunday and I believe it was the Thursday or Friday before. Well, it would have been the Thursday because we didn't tuck them in on the Friday. Ms. […] did it then, but it was the Thursday like around then, he was saying that he was feeling tired and I asked him if he needed to go MIR [medical inspection room] the next day, and he said no, and he kind of laughed that he was feeling tired because, like I don't think it's something that happened to him very often, and he said that he expected it was what everyone would feel, like you know it's the end of the third week, everyone is going to be tired.*

Q. *However, on the Saturday before that he won the leopard crawl?*

A. *Yes.*

Q. *Doesn't sound like a tired guy?*

A. *No.*

(Interview with complainant's Flight Section Commander, RMC, October 25, 2000)

Q. *Okay. Did – do we have anything else? Do you have anything else that you might be able to give us as to why this incident might have happened? Maybe you believe that he had a certain character, he drove himself too hard, he didn't eat that day or something like that? Any other information you could give us that might assist us in the board of inquiry or...*

A. *Yeah, I know, like in school and everything he was pretty – pretty dedicated, so that he always was like – he always pushed himself pretty hard…*

(Interview with another officer cadet in complainant's Flight, October 25, 2000)

167 The degree to which the complainant's cumulative experience at the Basic Officer Training Course, followed immediately by the First Year Orientation Camp, could have contributed to his developing compartment syndrome and ultimately to his collapse during the five-kilometre race at RMC is unclear. But in my view, the possibility that a course of rigorous training may have contributed to the complainant's injury was not fully explored by the BOI.

168 Maj Wojtyk, who provided a medical opinion to the Board, told Ombudsman investigators:

> *I would say I don't know for certain, but depending on their training intensity, there is an additive effect on the development of compartment syndrome. If you do train too frequently, you may be predisposed to it. If you don't allow yourself sufficient rest, you may be giving yourself some future problems. You do have to train and then rest, then train and rest.*

169 Maj Wojtyk acknowledged that he was not familiar with the complainant's training cycle. He also seemed unaware of the treatment of the complainant's platoon during the BOTC, the denial of leave, the violation of lights-out policies and the fact the complainant was extremely stressed and increasingly exerting himself in order to pass platoon inspections. He also did not appear to know that the complainant went immediately from St. Jean to RMC with no time to recover, or that he felt he had to work at a higher level of physical training there. Maj Wojtyk told Ombudsman investigators:

> ***A.*** *Even taking a very fit person like (the complainant), I'm sure he would have been able to undergo all of the rigorous military physical training without any problem. With the suggestion that he ran the race to win, again, it's supposition that this caused his compartment syndrome, or that this was a factor in it. But it is not unreasonable to extrapolate that, if he did run too quickly, he could have put himself at risk.*
>
> ***Q.*** *But is it possible a cumulative effect of over-exercise and possibly lack of rest and sleep over an eleven-week period could contribute to this?*
>
> ***A.*** *Oh, yes.*

170 This case clearly demonstrates that a medical opinion will depend largely upon the facts provided to person giving it. If they do not have all the facts, their opinions and conclusions are unlikely to be accurate. I have already recommended that the CF retain independent experts to provide an opinion on the cause of the complainant's injuries. It is important that these experts have an opportunity to interview the complainant about his training experience at St. Jean and be able to evaluate the impact the complainant felt this had on his physical and mental condition. They should also have access to the BOI report and the report of the summary investigations conducted at St. Jean.

171 Training Practices and Standards at Basic Office Training Course

172 The summary investigations at St. Jean confirmed that the training standards applied to the complainant's platoon were more demanding than normal and that the complainant and his course mates were subject to harsher and stricter treatment than other cadets. As a result of these findings, specific recommendations were made to create training standards, which can be applied more uniformly by instructors.

173 An Ombudsman investigator travelled to St. Jean in November 2003 in order to determine how training standards for the Basic Officer Training Program had changed. The investigator met with Lieutenant Colonel (LCol) Bariteau, Commandant of CFLRS who was very cooperative and supportive of my Office's follow-up in this case. The investigator reviewed documentation on training standards, inspections and course instructions and was given a detailed briefing by Maj Mercier, the Commandant's assistant, who described the shortcomings of the previous program and the new policies and procedures that had been adopted to correct them.

174 Since 2003, the BOTC has been restructured and divided into a nine-week Initial Assessment Period (IAP) and a five-week Basic Officers Training Program. LCol Bariteau also said that in the near future, CFLRS hopes to standardize the IAP, so that officer cadets receive the same nine weeks of general military training as non-commissioned members.

175 In an effort to improve inspection standards, all BOTC instructors are now required to take a four-hour course related to inspections. Instructors also take philosophy and ethics courses, which encourage them to be more approachable and accessible to students.

176 We learned that, in the process of re-evaluating inspection standards and the way they were applied, training officials discovered that the previous daily inspection system had been stacked against the officer cadets. Instructors routinely followed a practice where the highest possible mark a cadet could attain was 7/10, with each imperfection deducted from seven. We were informed that the highest possible mark is now 10/10.

177 We also confirmed that the materials available to instructors and cadets to illustrate expectations for inspections have been significantly improved. In 2000, officer cadets had to rely on a handbook with grainy black and white photographs showing the proper layout of their kit. In 2001, the school began to put up crisp colour photos in each room, giving the cadets a clear and realistic model to work towards.

178 Since 2001, the Standards Division of CFLRS has focussed on day-to-day training operations. The head of the Standards Division may show up unannounced at exercises or marches to monitor how standards are being applied. The Standards Division is in a separate chain of command and can therefore monitor more effectively and objectively. Random checks by Standards Division personnel should also help prevent harassment or abuse related to training standards and can ensure more consistent treatment. CFLRS Standards staff were unable to provide information, however, about how many evaluations and spot visits had been actually conducted, with what frequency they were conducted, or what the results had been. It seems ironic, but there is no standardized record-keeping system to track that information.

179 Based on the information collected during my investigator's visit to CFLRS, I am pleased to report that the issues identified by the BOI and the subsequent summary investigations appear to have been taken seriously. Concrete steps have been taken to improve course standards and the way they are monitored, training for instructors as well as the materials available to staff and cadets to illustrate inspection expectations. I commend these efforts and I am encouraged that current senior leadership is attuned and committed to fair and consistent training standards. It is important that the monitoring and evaluation of applied inspection standards continue. This case has shown clearly how harsh and inconsistent applications of 'standards' can have a negative and destructive impact on cadets' experience. It is equally important that ongoing assessments of the way standards are applied in practice be part of a formal evaluation system. The results of evaluations and their results must be tracked by CFLRS Standards staff so that emerging trends or problems can be reported regularly to the CFLRS Commandant.

180 **I therefore recommend that:**

6. CFLRS Standards Division implement a formal system to track the evaluation of the application of training standards and issue a regular formal report to the Commandant of CFLRS on the number of evaluations conducted, their results and emerging trends or issues.

181 I am pleased to report that action was swiftly taken to implement this recommendation, based upon my investigator's observations during his visit to St. Jean. It is a testament to the co-operation we received from LCol Bariteau and the staff at CFLRS that this step did not have to wait until this report was issued.

182 Situation at RMC

183 My investigator also interviewed Colonel Peters, Director of Cadets at RMC to determine what changes had been made at RMC since the FYOC in 2000. Colonel Peters noted that in 2000, FYOC was mainly run by senior cadets. The First Year Orientation Program (FYOP), as it is now called, is currently managed by permanent RMC staff. The senior cadets, who now support the permanent staff, arrive a week before the start of orientation. During that week, they receive training in administrative procedures, harassment issues, how to complete accident reports, physical training, etc.

184 We were also informed that the five-kilometre run is no longer part of FYOP; instead, officer cadets spend a month training for the obstacle course, which has been redesigned to minimize injuries. A safety vehicle, First Response Team and medical tent are on-site in case of emergencies.

Issue #3

185 **Was the Complainant Fairly Treated During and After the Board of Inquiry Process?**

186 **Treatment of the Complainant During the Board of Inquiry**

187 During the BOI process, the complainant was treated as a witness. He was interviewed by the board members for approximately one hour and twenty minutes on October 25, 2000, and signed consent forms to allow the BOI members access to his medical and personnel files including the records at Kingston General Hospital. His father also provided evidence to the board members.

188 Beyond providing his own evidence, the complainant was not allowed to participate in the BOI process. Once he did this, his involvement ended. He had no way of knowing to whom the Board spoke to or what information was collected during the inquiry. He was not permitted to hear or to question witnesses who testified about the possible causes of his injury, nor was he able to question or provide information to those who gave medical opinions to the inquiry. He also had no opportunity to make submissions to the Board before they made any findings or conclusions.

189 Existing orders and regulations governing BOIs do not specify the degree of participation someone in the complainant's position should have in an inquiry such as this. The terms of reference establishing the Board were silent on this point.

190 **After the Board of Inquiry**

191 The BOI issued its final report on December 19, 2000. Col Lacroix, the Director of Cadets, also the Acting Commandant at RMC, felt obliged to inform the complainant of the Board's findings even though DND/CF regulations did not permit him to have a copy of the Board's actual report without an application under the *Access to Information Act.* To that end, in March 2001, Col Lacroix sent a briefing team to the complainant's home to give him and his parents the results of the BOI. The briefing team included the complainant's Squadron Commander, the RMC Public Affairs Officer and the school Chaplain. Col Lacroix wrote a letter, outlining the Board's findings, which was given to the complainant during the briefing.

192 Prior to the briefing, the complainant told the team that a family friend with some knowledge of military matters would also attend the meeting as a support to him. A member of the briefing team was concerned about the friend's attendance as he knew him to be a public figure who, he felt, had previously been critical of the military in a news documentary. The team decided that the briefing would not go ahead if the friend attended. The complainant's family did not agree with this decision; they were upset and felt the CF should not have the right to control who was present at the briefing in their own home. But they agreed the friend would not attend.

193 The briefing went ahead with only the complainant and his parents. They were given Col Lacroix's letter, as well as information about benefits available to the complainant, including disability insurance and pension benefits. The meeting was described as congenial, although the family was visibly unhappy with the BOI results.

194 Why was the friend not permitted to attend the meeting? A memorandum from the RMC Adjutant subsequently outlined the reasons. First, there was a concern that the BOI results may have contained personal information about persons other than the complainant. Second, the complainant did not know what personal information about him was going to be discussed and thus he was not able to give fully informed consent to have this released in front of the family friend.

195 It should be noted that, even before the briefing, the complainant had applied for a copy of the BOI report and exhibits under the *Privacy Act* on January 31, 2001. His request was received by the DND Access to Information and Privacy section on February 23, 2001. On August 27, 2001, the complainant received 1259 pages of documents including the BOI report, statements and transcripts of the testimony. Portions of the documentation were blacked out, based on exemptions claimed by DND/CF under the *Privacy Act.* This blacked out information included personal information about other CF members, such as names and service numbers.

196 **Background Information on the Conduct of Boards of Inquiries**

197 Under the *National Defence Act*, a BOI has the power to investigate and report on matters related to the Canadian Forces. BOIs and summary investigations are governed by Chapter 21 of the QR&Os and their procedures were set out in CFAO 21, replaced by DAOD 7002 in February 2002.

198 A BOI functions as an administrative tribunal. Although not required to adhere to the same strict rules of evidence as a court, board members have the power to summon witnesses, compel testimony, and administer oaths. Testimony is usually taken under oath or solemn affirmation, recorded on tape and transcribed. Members of a board may also take personal notes of the proceedings. Documentary and physical evidence is formally labelled and received as an "exhibit".

199 Unless the authority that convenes a BOI directs otherwise, the president of the Board fixes the date, time and place the inquiry will assemble. Notice is given to members of the Board, witnesses and other interested parties. Board proceedings are not open to the public unless directed by the convening authority. The only persons that may be present while witnesses testify are the members of the Board, advisors to the Board as well as the witness and their counsel.

200 Article 21.10 (4) of QR&O 21 provides that where a board president thinks that evidence is likely to be adverse to a CF member, the president may, in addition to receiving the member's evidence as a witness, permit the member to examine any evidence provided before the member's testimony, and allow him or her to be present during the remainder of the inquiry and to make a statement. DAOD 7002-4, which elaborates on this article, defines "adverse evidence" as evidence suggesting professional misconduct or incompetence, malfeasance, or which otherwise harms a person's reputation.

201 Under DAOD 7002-1, a "letter of acknowledgement and closure" is provided to a person whose complaint resulted in a BOI. As well, a board must provide a "letter of closure" to a person who may be adversely affected by an investigation, if that person requests it. Letters of closure state whether or not a finding or recommendation was made against the person. If a finding or recommendation has been made, the details must be stated, along with a statement of any subsequent action taken, or an explanation why action was not taken.

202 **Other Inquiry Models**

203 Section 24.1 (1) of the *Royal Canadian Mounted Police Act* (RCMP Act) authorizes a board of inquiry to be established to investigate:

> "*any matter connected with the organization, training, conduct, performance of duties, discipline, efficiency, administration or government of the Force or affecting any member or other person appointed under the authority of this Act.*"

204 Counsel with RCMP Legal Services told us that BOIs under this section of the RCMP Act have only been convened two or three times in the recent past, when public interest necessitates an inquiry. One reason why this section is not used very often is that, in the RCMP context, there are other avenues for inquiry available, such as the RCMP External Review Committee, and the Commission for Public Complaints against the RCMP.

205 Section 24.1 (4) of the RCMP Act provides that any person whose conduct or affairs are being investigated, or who satisfies a board that he or she has a substantial and direct interest in the matter before the Board, shall be given a full opportunity to present evidence, to cross-examine witnesses and to make representations before the Board in person or through counsel or a representative.

206 Other models that provide for public inquiries, such as the federal *Inquiries Act*, the Ontario *Inquiries Act* and the Ontario *Coroners Act*, also provide that persons with a direct and substantial interest in a hearing may apply for standing. Once granted, full rights of standing mean that the person is usually permitted to be present at the inquiry, to be represented, to make submissions and to question and present witnesses. Under the Ontario *Coroner's Act*, for example, 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*."[1] Someone who has been granted standing at a coroner's inquest may be represented by counsel or an agent, has the right to call and examine witnesses, present arguments and submissions as well as cross-examine other witnesses in relation to the person's interest in the proceedings.[2] In addition, s. 26 (1) of the *Coroners Act*, allows members of a 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.

207 **Analysis, Findings and Recommendations**

208 **Participation in the Board of Inquiry Process**

209 Pursuant to the order signed by MGen Daigle, Commander of CFRETS, the purpose of the BOI in the case at hand, was to "*investigate the circumstances surrounding the injury of [the complainant] on 17 September 2000 at or about the grounds of the Royal Military College of Canada*." The Board was directed to "*undertake research, interview witnesses and visit facilities required to ascertain the possible short, intermediate and long term causes leading to [the complainant's] injury.*"

210 The complainant clearly had a direct interest in the outcome of the BOI. The Board's purpose was to determine the cause of his injury, including whether the injury was attributable to his military service. The Board's conclusions would affect him in a number of ways, including his eligibility for a disability pension, disability insurance and other possible benefits. As well, the determination of the cause of his injury, and whether he may have contributed or been responsible for it, was obviously of great personal interest and importance to him.

211 Under the strict definitions in DAOD 7002-4, it is unlikely that the complainant would have been considered someone likely to be adversely affected; therefore, such procedural protections were unavailable to him. This left him with no avenue to attain standing; neither the CFAO in effect in 2000, nor the current DAOD or QR&O, provide persons who have a direct interest in the results of an inquiry with any rights in the inquiry process, including the right to apply for any form of standing before the inquiry.

[1] Ontario *Coroner's Act*, s. 41 (1).
[2] Ontario *Coroner's Act*, s. 41 (2).

212 Despite the fact that the Board's very purpose was to determine the cause of his serious injuries, we have seen that the complainant had little input or involvement in the BOI process. In my view, he should have been entitled to participate. His participation should have included an opportunity to attend the proceedings, hear evidence and examine exhibits, question witnesses, including the medical witnesses who gave information and opinions about the potential cause of his injuries, call witnesses and make submissions. At the end of the process, he should have been entitled to a copy of the Board's report without having to apply for one under the *Access to Information Act* and *Privacy Act*, then wait months for it to be delivered.

213 Had the complainant been allowed to participate, it is likely that the Board's examination of the cause of his injury would have been more complete and the need for additional medical expertise would have been clear. The complainant would have had the opportunity to question the RMC Medical Officer and the Base Surgeon who provided information and medical opinions, and to call witnesses from the Basic Officer Training Course who he felt could corroborate his evidence about his experiences there and the impact they had on him. All of this would have resulted in the Board's getting more comprehensive medical information and hearing about the complainant's training schedule and experience at the BOTC. It seems reasonable to think that, with that evidence, the Board would have arrived at a more informed conclusion.

214 As a quasi-judicial proceeding, a BOI is convened to investigate and make findings and recommendations where the gravity of a situation and its potential impact merit a formal inquiry, rather than an internal summary investigation. DAOD 7002-2 states that a summary investigation normally investigates "minor, straightforward and uncomplicated" matters. BOIs investigate more complex and more important matters. I understand that the JAG is developing formal guidelines to determine whether an incident will be investigated by a board of inquiry or a summary investigation.

215 Although a BOI is not adversarial or necessarily public, its purpose is ultimately to get at the truth. It is a fact-finding process. The reason for allowing the participation of parties with a substantial and direct interest is to assist in the search for truth. Persons who have a direct interest, and who by virtue of this interest are likely to have an in-depth knowledge of the subject, will open up the search through their questions of witnesses, their submissions and possibly by presenting additional evidence. The information they present may represent a certain view and it may not always be accepted by the Board, but their participation provides an additional and important safeguard to ensure that the subject matter is thoroughly and completely examined.

216 In my view, the CF should amend the current regulations to reflect the more contemporary scheme adopted by the RCMP and other inquiry models. It would then allow CF members with a substantial and direct interest in a matter to apply to the convening authority for standing, which would include the following rights:

- to receive notice of the Board's terms of reference and of hearings;
- to attend the proceedings (with or without counsel, at the discretion of the member);
- to examine exhibits and hear evidence; and
- to receive a copy of the Board's report.

217 Where circumstances warrant, the right of standing should also include the right to question witnesses, present evidence, and make submissions to the board members. Given that many CF members will not be able to afford independent counsel, the convening authority should have the authority to appoint an assisting officer to represent the member at the inquiry. In the case at hand, the inquiry was specifically about what happened to the complainant and, in my opinion, it was precisely the kind of case where full standing should have been granted.

218 I realize that the changes I recommend may result in some boards taking longer and becoming more complicated and costly. Concerns may also be raised that the presence of primary parties may intimidate or influence witnesses. However, in my view, opening the process to allow a directly affected person to participate and to hear witnesses will likely have the opposite effect; it will stimulate witnesses to be open and frank and allow additional questions not immediately obvious to board members. The benefits will be better results and conclusions, more satisfaction in the overall process and greater confidence in the results. These are well worth the additional resources that some cases will require. As well, a more open process may reduce challenges to BOI results.

219 **I therefore recommend that:**

7. **The Defence Administrative Orders and Directives be amended to provide that where a board of inquiry is convened, any CF member with a substantial and direct interest in the subject of the Board may apply to the convening authority and will be granted standing before the Board.**

8. **A party with standing will be entitled to receive notice of the Board's terms of reference and of hearings; to attend board proceedings represented by an assisting officer or counsel of their choosing; to examine exhibits; and to receive a copy of the Board's report. Where, in the Board's discretion, a party's interest is sufficiently direct and substantial, that party may (alone or with the assistance of counsel, at the party's choice) be permitted to question witnesses, present evidence to the Board and make submissions.**

220 ADM (HR-Mil) did not accept either of these recommendations when I made them in my Interim Report. His response took issue with my characterization of BOIs as administrative tribunals and defined them instead as "*ad hoc internal investigation bodies.*" He thought that my interpretation of the nature of BOIs as administrative bodies led me to wrong conclusions.

221 As often happens, getting into a lawyers' debate about a legal characterization can be distracting when the real goal is fairness and practical improvements. That said, given that the issue has been raised and cited as a reason for rejecting my recommendations, I feel I must make a few observations about the nature of BOIs.

222 BOIs have the powers of courts. As I noted previously, they administer oaths, compel and take evidence, keep records, make decisions and recommendations as well as furnish reasons. They do this under statutory authority, provided in the *National Defence Act*, s. 45(1), which authorizes them to investigate and report on, among other things, matters of discipline, or matters affecting any officer or non-commissioned member. According to the relevant QR&O, BOIs make findings on such things as illegal absences (21.43), the cause of injury and death (21.47), aircraft accidents (21.56) and fires (21.61). Given the grave and significant purposes, powers and processes of BOIs, I am still of the view that they are administrative tribunals. According to administrative law, the duty of fairness (which is at the heart of the current issue) applies to decision-making bodies that render specific, as opposed to general, policy decisions—even where those decisions may be simply advisory. I remain convinced that BOIs must, as a matter of law, be conducted fairly.

223 Having said this, the key point of concern here should have little to do with legal obligations. Rather, it should be concerned with doing the right thing. This BOI was conducted in a way that alienated a member of the Canadian Forces who had suffered a grievous injury. The fault does not lie with the President and member – it is the present system that is just not sufficiently responsive to this sort of situation. And I am simply trying to find ways to fix it and to convince the Canadian Forces that it should be fixed. The BOI process makes decisions of significant personal importance to members, yet does not permit people with a direct and substantial interest to attend, let alone participate. In my opinion, it should. The power held by a board president, and cited by ADM (HR-Mil), that permits attendance of persons "thought to be required for the proceedings" is not the answer. That provision is directed at the needs of the Board, not the needs of an affected member. In any event, it is too imprecise and too general to allow for standing in all cases where it would be appropriate.

224 ADM (HR-Mil) expressed other, non-legalistic objections to recommendations #7 and #8 relating to concerns about "efficiency and effectiveness", "timeliness", "significant delays", "inflexibility" and the ability to "respond to pressing and important matter[s] with speed." These are legitimate concerns. In my view, they can be addressed and managed while still giving a voice in the process to those who have a substantial and direct interest in the subject matter of an inquiry.

225 Revisions I have made to Recommendation #8 subsequent to my Interim Report provide sufficient flexibility to permit efficiency and fairness to be balanced appropriately. There will inevitably be cases where individuals have a direct and substantial enough interest in a matter that they should be permitted to attend and be kept apprised of what is happening. These meagre obligations will have a minimal impact on efficiency and timeliness. In other cases, individuals will have a deeper interest in the subject of a board's inquiry. For example, those who have suffered serious injury or the family members of those who have died come immediately to mind. Speed and efficiency are poor justifications for shutting these people out. As this case shows, their contribution may, in fact, improve efficiency and the accuracy of results.

226 The call for flexibility made by ADM (HR-Mil) would be far better met, in my opinion, by the endorsement of my recommendations #7 and #8, than it is by the rigid and impersonal status quo now in effect. That flexibility will allow for fairness and compassion. I am therefore asking that these recommendations be accepted.

227 **Briefing the Complainant and his Family on the Results of the Inquiry**

228 The decision of the CF not to allow the complainant's family friend to attend the briefing is troubling. The information provided to the complainant about the results of the Board's inquiry was obviously of great importance to him and his family. He should have been entitled to have whatever support he wished at the briefing. If there was a concern that the support person might disclose information that should be kept private, this could have easily been dealt with by a simple request that he agree that the briefing was confidential. He could even have been asked to sign an acknowledgement to this effect, if it were deemed necessary. In fact, the degree of personal information conveyed during the briefing about anyone other than the complainant was minimal, as is revealed by the letter to the complainant from Col Lacroix.

229 The argument that the complainant could not consent to have the support person hear personal information about him because he did not know what information would be disclosed, is not valid. Given that the inquiry was about the complainant, his injury and his experiences at the Basic Officer Training Course and RMC, he clearly had a solid understanding of the type of information the Board had collected about him, even though he was not aware of the exact details or the inquiry results. The complainant was entitled to decide whether or not he wished to have a support person present and to have them hear this information. He was certainly entitled to decide for himself whether or not to risk this person possibly hearing unpleasant or intimate details about him and not have this decision made for him by the Canadian Forces.

230 Had the complainant been allowed to participate in the BOI, the question of the family friend attending the briefing would not have arisen; no briefing would have been necessary. The complainant would already have known what had been said to the Board and would already have been informed about the Board's conclusions. He also would not have been forced to resort to the *Access to Information Act* and *Privacy Act* in order to find out what the Board considered in making findings about the cause of his injury.

Conclusions

231 I would like to thank those who cooperated with my Office during the course of this investigation and the review of my Interim Report, including the staff of the CF Leadership Recruit School, RMC, ADM (HR-Mil), the members of the BOI and of course, the complainant and his family.

232 My investigation into this complaint reveals that the BOI's conclusion that the complainant's injury was caused solely by his participation in a race at RMC needs to be revisited; independent medical expertise is required in order to arrive at a more comprehensive conclusion. As I have already noted, this should not be taken as an adverse comment on the members of the board of inquiry. Nor should it be interpreted to suggest that they abrogated their duties. This is not the case. The board members were genuinely concerned to get to the bottom of what caused the complainant's injury. They did not, however, have access to the training and expertise they needed. I have made recommendations that I hope will ensure that medical advisors are placed on boards of inquiry where such expertise is required, and also ensure that board members have access to training so that they have the skill and knowledge required to engage in important fact-finding exercises. I am hopeful, and remain optimistic, that the Canadian Forces will reconsider their preliminary objections to these essential innovations.

233 The board of inquiry did find that the complainant and his platoon were subjected to stressful conditions at the CF Leadership Recruit School in St. Jean, including unusually high standards for inspections. This finding was corroborated by the subsequent internal summary investigations and indeed by the results of my own investigation. The complainant and the rest of his platoon were forced to adhere to almost impossible standards throughout the BOTC. This led to his arrival at RMC both physically and mentally exhausted. The impact his condition had on the development of compartment syndrome, which lead to his collapse during the race, was not fully explored. It is my hope that the independent medical review I have recommended will shed greater light on this issue. In the meantime, I am pleased to report that concrete steps have been taken by the leadership at CFLRS to improve the way training standards are applied. I applaud the steps taken by the CFLRS Commandant and staff as well as their swift acceptance of my recommendation to formally track the evaluation of the way training standards are applied in practice.

234 Finally, I have made it clear that, given his substantial and direct interest in the results of this BOI, the complainant should have had an opportunity to participate in the process. The Board's entire *raison d'être* was to determine the short- and long-term causes of ***his*** injury. It is likely that this would have given him a better understanding of, and probably greater confidence in, the Board's results and, moreover, it is probable that the Board's conclusions would have been more informed and more comprehensive. The complainant would have been able to question the medical officers interviewed by the Board. Therefore, the Board would have heard about his training experience at St. Jean and could have taken it into account. The complainant's questioning might also have made the need for greater medical expertise more apparent to the board members. I have recommended that CF regulations be amended to allow members and their families who have a direct interest in boards of inquiry to apply for standing so that in future they will have an opportunity to participate. This case has demonstrated the value in opening up the process, where warranted, so that it is more transparent and so that ultimately the search for truth is more likely to be successful. I have attempted to craft a flexible system that will permit a fair and efficient process, balanced according to the needs of each case.

André Marin
Ombudsman

August 23, 2004

Summary of Recommendations

235 **1. ADM (HR-Mil) order an independent medical review into the cause of the complainant's injury by experts from outside of the CF with expertise in the areas of emergency medicine, orthopaedics and sports medicine.**

236 **2. DAOD 7002-1 be amended to require that, in cases where a board of inquiry is convened to examine the cause of a death, injury, serious illness or other health issue and a medical advisor is not appointed, the convening authority should give reasons to explain why no appointment was made.**

237 **3. Procedures be developed for boards of inquiry to ensure that when medical expertise is sought, experts have access to all relevant information collected by the Board; the evidence provided by the experts is properly documented; and the experts have an opportunity to review any reports that rely on their advice to confirm that it is properly understood and applied.**

238 **4. The CF develop a training package designed to train members on conducting thorough and objective investigations, within the legal and procedural frameworks in place for boards of inquiries.**

239 **5. The CDS issue a directive that, absent exceptional circumstances, each board of inquiry must include at least one member who has completed the approved training for board of inquiry members. Where it is not possible to constitute a board of inquiry that satisfies this requirement, the reasons why, including steps taken to include at least one trained member, must be furnished by the convening authority.**

240 **6. CFLRS Standards Division implement a formal system to track the evaluation of the application of training standards and issue a regular formal report to the Commandant of CFLRS on the number of evaluations conducted, their results and emerging trends or issues.**

241 **7. The Defence Administrative Orders and Directives be amended to provide that where a board of inquiry is convened, any CF member with a substantial and direct interest in the subject of the Board may apply to the convening authority and will be granted standing before the Board.**

242 **8. A party with standing will be entitled to receive notice of the Board's terms of reference and of hearings; to attend board proceedings represented by an assisting officer or counsel of their choosing; to examine exhibits; and to receive a copy of the Board's report. Where, in the Board's discretion, a party's interest is sufficiently direct and substantial, that party may (alone or with the assistance of counsel, at the party's choice) be permitted to question witnesses, present evidence to the Board and make submissions.**

Appendix A:
Responses to Interim Report

1. **Complainant's Response, March 2004**
2. **CF Leadership and Recruit School Response, February 2004**
3. **RMC Response, February 2004**
4. **ADM (HR-Mil) Response, May 2004**
5. **Letter to the Minister of National Defence**

Appendix A: 1
Complainant's Response, March 2004

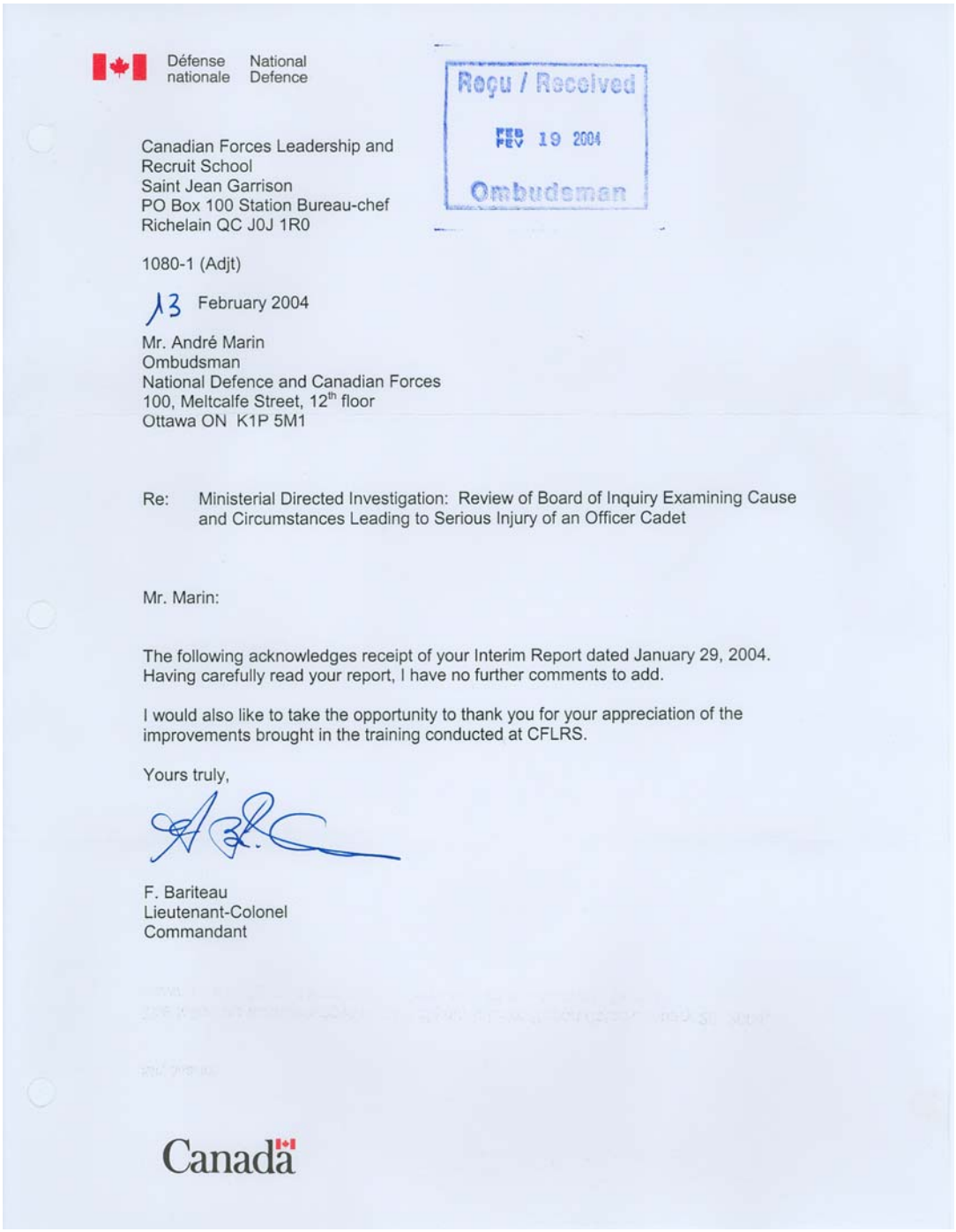
Hello Mr. Jones The purpose of this e mail is for me to make some comments about the interim report of which you briefed my father and I on January 31st. Both myself and my family felt that report addressed all of the concerns that we had raised when we initially made the complaint to then Director of Cadets Colonel Lacroix which was CC'd to then Minister of Defence Art Eggleton; subsequently the complaints were forwarded to your office. Chief amongst the complaints was that I felt that the BOI didn't give me a fair conclusion re: the reason for my injuries, suggesting that there was no evidence to suggest that it was a result of overworking and fatigue. The fact that the BOI used evidence from Major Meunier and Major Wojtyk to establish their conclusion, when both of them did not have all the medical evidence concerning my case to make a conclusion, and that both of them were under the impression that independent medical expertise was going to be solicted for the purpose of the BOI, was indeed unsettling for myself to find out. I agree that the recommendation that a medical advisor be assigned to a BOI dealing with death, injuriy etc related to military service is an excellent one and could positively affect cases similar to mine in the future. Following on that, I also believe that the recommendation to ensure that all medical exper tise that is sought be given all relevant information surrounding the incident and that all experts be given the chance to review the reports that have relied on

2004-03-01

their expertise to come to a conclusion to make sure that there is no discrepancy between them is an excellent one. I also steadfastly agree with the suggestion to develop a training package on how to train prospective BOI members to conduct thorough and objective investigations as I feel this may address some of the systemic flaws of this particular BOI. I feel that Major Smith's comments about his time spent at Royal Roads, and the fact that he was getting much less sleep than either myself or any other cadet at RMC was, created a subjectivity to the issue at hand. While he mentioned that this had no bearing on the BOI process, I feel that the fact that he even suggested it and that he thought that there was little possibility that I was over worked based on the amount of sleep that I was getting at RMC skewed the BOI process and made the officers feel that my previous training at BOTC had nothing to do with my injury. Like the interim report mentioned, this is not a bash on the two officers who co nducted the BOI, but I feel that this was indeed an important concern that should have been addressed: the subjectivity of the BOI officers. Finally, the recommendation to implement a formal system to track the evaluation of training standards and to issue a report to the Commandant CFLRS, I believe, addresses some of the most pressing concerns of my complaint. As Mr. Janoff told my father and I, it seems as though dramatic changes have been made to training procedures, especially with regards to the way inspections are carried out, at St. Jean. I applaud this since one of the things that I stressed in my interview with Mr. Nolan was that there was an incongruency between platoons in the BOTC course. The training that myself and the other 40 plus cadets went through would not have been viewed with as much disdain as it was at the time if we knew that all the other platoons had been receiving the same treatment. The discrepancy between [redacted] platoon's training regimen and the other platoons in [redacted] company was obviously not lost on those who were involved in BOTC. Hopef ully, the subsequent reports done and the recommendation made by this interim report will address these training miscues, and based on what Mr. Janoff and what some of my fellow soliders have informed me, changes have been made. My family and I applaud all of the recommendations that have been made by the interim report and wish to express our gratitude to the Ombudsman Office for their sincerity and effort to see that my complaint was dealt with efficiently. While all of the recommendations are well founded, I feel that the ones that address the issues of training of BOI members, and the inclusion of medical expertise on a BOI as well as corraboration between those who give their medical expertise and the conclusions made on that evidence are of extreme importance for future BOI's. As well as is the recommendation to implement a formal tracking system to monitor training standards and the application of them. These I feel address the most important concerns that were brought up in my complaint. While there is some personal vindication felt on my part based on the findings and subsequent recommendations made by the interim report it is not left at that. As my father and I both believed, our mission was not solely to ensure that my family and I were given a fair and even handed BOI investigation, but to ensure that the soliders and families of the future do as well. It is my hope that the recommendations made by your office can make this possible. It has been been a long, trying journey for myself and my family since September 17th, 2000 but we along the way we have been blessed to have come in contact with such wonderful people. The work done by your office, and especially the care and concern shown to us by Mr. Barry Nolan, will not be soon forgotten. If you would be able to forward my comments to Mr. Andre Marin, as I do not have his e mail address, that would be greatly appreciated. Again, thank you very much Mr. Jones for debriefing my father and I on the interim report. Sincerely.

2004-03-01

Appendix A: 2
CF Leadership and Recruit School Response, February 2004



Défense nationale / National Defence

Reçu / Received
FEB 19 2004
Ombudsman

Canadian Forces Leadership and
Recruit School
Saint Jean Garrison
PO Box 100 Station Bureau-chef
Richelain QC J0J 1R0

1080-1 (Adjt)

13 February 2004

Mr. André Marin
Ombudsman
National Defence and Canadian Forces
100, Meltcalfe Street, 12th floor
Ottawa ON K1P 5M1

Re: Ministerial Directed Investigation: Review of Board of Inquiry Examining Cause and Circumstances Leading to Serious Injury of an Officer Cadet

Mr. Marin:

The following acknowledges receipt of your Interim Report dated January 29, 2004. Having carefully read your report, I have no further comments to add.

I would also like to take the opportunity to thank you for your appreciation of the improvements brought in the training conducted at CFLRS.

Yours truly,

F. Bariteau
Lieutenant-Colonel
Commandant

Canada

Appendix A: 3
RMC Response, February 2004

ROYAL MILITARY COLLEGE OF CANADA · COLLÈGE MILITAIRE ROYAL DU CANADA

PO Box 17000, Station Forces · CP 17000, Succursale Forces · Kingston, Ontario · K7K 7B4

1463-1 (EA to the Cmdt)

23 February 2004

Mr. André Marin
Ombudsman –
Department of National Defence
and Canadian Forces
100 Metcalfe Street, 12th Floor
Ottawa ON K1P 5M1

ROYAL MILITARY COLLEGE COMMENTS ON INTERIM REPORT

References: A. Your letter dated 29 January 2004
B. Interim Report; Ministerial Directed Investigation: Review of Board of Inquiry Examining Cause and Circumstances Leading to Serious Injury of an Officer Cadet

1. At reference A, you requested that the Interim Report (reference B) be reviewed and comments provided to you prior to the report being finalized. This opportunity to offer comments is much appreciated.

2. The Interim Report was reviewed and all the information pertaining to the Royal Military College mentioned in the report appears complete and accurate. It should be noted that with the exception of Colonel Peters, the current Director of Cadets, who was interviewed by your investigator (Report lines 1455-68), all other members of the College at the time of the event have since been posted out of the College. Specifically, Colonel Lacroix was not requested to review the parts of the Interim Report pertinent to him as he was posted in the summer of 2002 to Valcartier, Québec and is presently deployed on operations in Afghanistan. It is my opinion the information relative to his role in this matter is also presented in a clear and factual manner.

3. Again, thank you for the opportunity to provide these comments.

J. Leclerc
Brigadier-General
Commandant

Appendix A: 4
ADM (HR-Mil) Response, May 2004

Assistant Deputy Minister
(Human Resources - Military)

Sous-ministre adjoint
(Ressources humaines - Militaires)

National Defence
Headquarters
Ottawa, Ontario
K1A 0K2

Quartier général de
la Défense nationale
Ottawa (Ontario)
K1A 0K2

Reçu / Received
MAY MAI 18 2004
Ombudsman

1052-1 (ADM(HR-Mil))

14 May 2004

Mr. André Marin
Ombudsman for National Defence and the Canadian Forces
100 Metcalfe Street, 12th Floor
Ottawa, ON K1P 5M1

Dear Mr. Marin:

OMBUDSMAN'S INTERIM REPORT
DND/CF RESPONSE TO FINDINGS AND RECOMMENDATIONS

Reference: Interim Report: Review of Board of Inquiry Examining Cause and Circumstances Leading to Serious Injury of an Officer Cadet, January 2004.

Thank you for forwarding a copy of the subject Interim Report for my review and comment. Given the complexity of the subject matter, the additional time you permitted for comments enabled a more thorough consideration of all the salient information and analysis provided in the Interim Report. For ease of reference, each of the recommendations from the Interim Report is listed in numerical order along with my accompanying views.

Recommendation #1. ***ADM(HR-Mil) order an independent medical review into the cause of the complainant's injury by experts from outside of the CF with expertise in the areas of emergency medicine, orthopaedics and sports medicine.***

Agree. An independent medical review by experts will be conducted under the authority of the Canadian Forces Medical Group. I will advise you of the results of this review when they become known.

Recommendation #2. ***DAOD 7002-1 be amended to indicate that in cases where a board of inquiry is convened to examine the cause of a death, injury, serious illness or other health issue and a medical advisor is not appointed, reasons should be given indicating why an advisor was not appointed.***

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National Defence Défense nationale

Canada

The recommendation does not explicitly indicate who would provide reasons, although the analysis in the Interim Report makes it clear that the convening authority would in fact do so. Convening authorities can only make a preliminary assessment of the requirement for special advisors including medical advisors. There are circumstances when a medical advisor is not required since medical issues are not always contentious. Large numbers of investigations of sports-related injuries require no medical advisor. Nonetheless, circumstances can and do change in the course of some investigations. The President and members of the BOI are often much better positioned and cognizant of the need for a medical advisor once they have identified the specific issues that arise in the course of their mandated investigation. In the subject BOI, the President and member of the BOI did precisely that—identified the need for specialized medical advice, but then opted to make their observation the subject of a recommendation as opposed to returning to the convening authority to communicate the need for additional resources in view of the imperatives of their own investigation.

With that said, the certification process as envisaged by the recommendation is in essence dealt with by the President at the close of the inquiry. In accordance with DAOD 7002-1, whenever the President has knowledge of relevant circumstances for which evidence is not available, a statement setting out the circumstances should be included. A statement may also be included to explain why certain witnesses did not testify and to "provide an explanation of any other pertinent matter …". This is the most appropriate point to provide full comment for the record so that reviewing authorities are fully apprised of all the salient facts and considerations that led to the decision not to use a medical advisor. Moreover, all subsequent reviewing authorities in the chain of command are fully empowered to direct a supplemental or new investigation whenever inadequacies are determined to exist in the BOI investigation. Imposing a procedural requirement on the convening authority to make a preliminary declaration does not serve to address the problem that arose in the subject investigation.

Recommendation #3. ***Procedures be developed for Board of Inquiries to ensure that when medical expertise is sought, experts have access to all relevant information collected by the Board, the expertise provided is properly documented and experts have an opportunity to review any reports which rely on their advice in order to ensure that it is properly understood and applied.***

With one exception, I agree with the principles articulated in recommendation #3. It is my assessment that the current direction provided in the DAOD 7002 series is sufficient to address the needs identified. As a starting premise, a BOI makes its findings of fact, draws its conclusions and formulates its recommendations based solely on evidence and testimony entered into the record—the record being an integral part of the minutes of proceedings for a BOI. This fact is reflected in the direction provided in DAOD 7002-4 **Examination of Witnesses**, primarily under the rubric of **Preparation** and, more specifically, under the sub-headings of **Planning** and **Record of Testimony.** The direction under **Planning** makes provision for preliminary interviews in order to determine what relevance the witness' testimony will serve and to identify what materials

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or reports to which the witness will need access in order to provide judicious comments to the BOI. In the most detailed and comprehensive of BOIs, one would expect that a medical expert would be tasked to review the relevant records and produce a written medical expert report for submission to the BOI.

The one exception I referred to earlier, arises with respect to that part of the recommendation that calls for testifying experts to review BOI reports that rely on their advice in order to ensure that their advice "is properly understood and applied". Expert medical witnesses do not review BOI reports when they themselves have served as witnesses. On the other hand, the medical advisor assigned to the BOI can be expected to play an essential role in those segments of the BOI report that deal with the interpretation of expert medical testimony given in the course of the inquiry. Should a question of clarification be required concerning medical testimony, the medical expert witness can and should be recalled to clarify any outstanding points or issues. Provision is provided in the DAOD to permit the recall of witnesses, which is not an uncommon practice. Any additional comments provided by an expert medical witness to the BOI must form part of the record.

Recommendation #4. ***The CF develop a training package specifically to train members on how to conduct thorough and objective investigations within the legal and procedural frameworks that are in place for boards of inquiries.***

Recommendation #5. ***The CDS issue a directive that each board of inquiry must include at least one member who has the approved training for board of inquiry members.***

Recommendation #4 and #5 are closely linked to each other and will therefore be dealt with together. Any proposal for additional training of personnel must involve a consideration of the balance to be struck between the costs of such training and the tangible benefits that might be expected to accrue in the quality of the investigations conducted by BOI members. Should such training be made a requisite, there will be consequential limitations on flexibility imposed on convening authorities as a function of the availability of suitably trained officers. This factor poses a significant risk of adversely impacting on the ability of service authorities to utilize the BOI mechanism to expeditiously and efficiently investigate and report on an incident or problem area in the CF.

BOIs are internal investigations that are *ad hoc* in nature. They are not specialized tribunals requiring greater knowledge and skills than those expected of general service officers. All the essential instructions and guidance to conduct a BOI are already contained in the QR&O and DAOD. An attribute of success for those assigned to BOI duties is the ability to think analytically in the evidence collecting process and to collate that information in such a fashion that the evidence logically supports the formulation of the findings and determinations. Recommendations must be solution-oriented and pragmatic in nature. With that said, analytical thinking is not inculcated by a single course of study but is often fostered by the attainment of higher levels of education.

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In the absence of evidence to suggest a broad systemic problem concerning the conduct of BOIs, the recommendation cannot be endorsed as currently proposed.

Recommendation #6. ***CFLRS standards division implement a formal system to track the evaluation of the application of training standards and issue a regular formal report to the Commandant CFLRS on the number of evaluations conducted, their results and emerging trends or issues.***

CFLRS created a personnel-tracking system to maintain a profile of its instructors. The aim of the system is to provide a tool to better assess instructors and to reinforce the application of one common standard. This will assist to ensure that the School provides candidates with the best learning environment possible. This control measure was proposed by Mr. Jannof, a member of the Ombudsman's Office, during his visit to CFLRS in December 2003 and was put into place in early January 2004.

Recommendation #7. ***The Defence Administrative Orders and Directives to be amended to provide that where a board of inquiry is convened, any CF member with a substantial and direct interest in the subject of the board may apply to the convening authority and will be granted standing before the board of inquiry.***

Recommendation #8. ***A party with standing will be entitled to notice of the board's terms of reference, to attend at board proceedings and be represented by an assisting officer or counsel of their choosing, to question witnesses and examine exhibits, present evidence to the board members and make submissions. Parties with standing will also be entitled to receive a complete copy of the board of inquiry's report.***

I disagree with recommendation #7 and #8. As the two recommendations are closely linked, they will be addressed together. The Interim Report describes the BOI mechanism as functioning as an "administrative tribunal" (page 36 refers). This observation is not correct and has led to some erroneous conclusions. As stated earlier, the BOI is an *ad hoc* internal investigation not an administrative tribunal. Procedural requirements for investigations are not a fixed standard. Requirements at the investigative stage are, by necessity, developed and reflective of the goals and objectives of the investigation. Certainly, one of the goals remains to ensure an efficient and effective investigative mechanism that can facilitate the examination of an issue and provide a report back to service authorities in a timely fashion. This is particularly important when a systemic problem is identified with operational or safety implications that poses risk to property or life. As a consequence, there are few procedural requirements that are mandated by regulation other than those that apply to an officer or non-commissioned member when it appears that the finding of the BOI will likely adversely affect them.

However, within certain defined constraints, the BOI President does exercise significant discretion over the conduct of the BOI proceedings. QR&O article 21.12(c) does permit the President to allow the attendance of anyone thought to be required for the

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proceedings. In striking a balance between the competing needs of efficiency and procedural requirements, the consistent approach has been to avoid any procedure that does not enhance the fact-finding process while avoiding inflexibility and significant delays in conducting the investigation. The extent and scope of subject matters that are investigated in the CF dictates to a large measure the current regulatory framework and ensures that military authorities will be able to respond to any pressing and important matter with speed. As with any other type of inquiry, mistakes can be made in the conduct of a BOI as is highlighted in the case of the injured serviceman in the Interim Report. Fortunately, there are checks and balances built into the framework. Reviewing authorities are required to review the Minutes of Proceedings to a BOI to ensure the BOI has been completed in accordance with its terms of reference and the evidence supports both the findings and recommendations. The shortfalls of the specific BOI in the Interim Report have now been identified and will be addressed through the commissioning of an independent medical review to focus more precisely on the medical-related issues.

The review of the Interim Report has been particularly instructive both in terms of the additional information that shed new light on the facts and brought into focus the deficiencies of the original investigation concerning this difficult case. The analysis and research was thorough and insightful. While I have not accepted each and every recommendation as proposed, the contents have been carefully considered and weighed with respect to each recommendation made. In preparing your final report, I trust that my comments will be of assistance to you.

As a final matter, I am given to understand that a number of individual responses to your Interim Report are anticipated and that this may result in changes to the report's recommendations. Should this be the case, I would appreciate the opportunity to comment on any amended recommendations prior to you finalizing the Interim Report.

Sincerely,

G.E. Jarvis
Vice-Admiral

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Appendix A: 5
Letter to the Minister of National Defence

National Defence and Canadian Forces / Défense nationale et Forces canadiennes

Ombudsman
André Marin

August 23, 2004

The Honourable William Graham, P.C., M.P.
Minister of National Defence
National Defence Headquarters
Major-General George R. Pearkes Building
13th floor, North Tower
101 Colonel By Drive
Ottawa, Ontario
K1A 0K2

BY HAND

Dear Minister Graham:

Please find attached a Special Report entitled *"Review of Board of Inquiry Examining Serious Injury"*. This complaint was referred to my Office by the previous Minister of National Defence, the Honourable Art Eggleton. It concerns the review of the Board of Inquiry and it's finding with respect to a first year Officer Cadet at Royal Military College, who suffered serious injuries after a five-kilometre race. He developed a condition, which was so severe that it led to complications that endangered his life. The Officer Cadet survived, but was released from the Canadian Forces for medical reasons and has not been able to resume his career.

At the conclusion of my investigation, given the complexity of the facts and the systemic nature of some of my recommendations, I issued an Interim Report to the principal parties, including the complainant and his family, to allow them an opportunity to comment on my findings and recommendations. Taking into account the responses I subsequently received, this Final Report was prepared. It is submitted to you, the Minister of National Defence, as a Special Report, based on paragraph 38(1)(b) of the *Ministerial Directives* for my Office.

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100, RUE METCALFE STREET, 12TH FLOOR - 12E ÉTAGE, OTTAWA, CANADA, K1P 5M1 • TEL/TÉL. : 613 992-0787 • FAX/TÉLÉC. : 613 992-3167

Canada

In light of the subject matter of the report and my recommendations, I am providing additional copies of this report to be forwarded to the Chief of Defence Staff, the Deputy Minister and the Assistant Deputy Minister (Human Resources - Military). A copy of my report and recommendations will also be provided to the complainants, on a confidential basis.

Pursuant to paragraph 38(2)(b) of the Ministerial Directives, I intend to publish the report on the expiration of 28 days from this date.

Yours truly,

André Marin
Ombudsman

Enclosures