Summary of Findings and Recommendations – Board of Inquiry – Ocdt Grozelle Death

The following is a summary of the Board of Inquiry Findings and Recommendations made in the Ocdt Joe Grozelle case. The BOI process was started in January 2008 and the family finally received a copy of the BOI report through a request from Access to Information –DND on October 20, 2010.

Finding A

Required finding: The medical cause of death (Ref: 1080-1 (J1 Pers), 8 January 2008 Convening Order — Board of Inquiry — Death C89 457 697 Officer Cadet J.T. Grozelle, Kingston, Ontario, 13 November 2003 (hereinafter "CO"), para 9a).

Finding: The medical cause of death is unascertained. Regardless if the death of OCdt Grozelle resulted from an accident, suicide, natural, and/or other causes a possibility exists that he was either dead or unconscious prior to entry into the water (as no conclusive evidence of drowning was found). In addition, from the evidence reported in this section, it was concluded that:

a. it was the opinion of our expert witnesses that the injuries to OCdt Grozelle (discoloration of the lip and chipped/damaged tooth) likely occurred at the same time and prior to or at the time of death;

b. hypothermia was not a contributing factor in death of OCdt Grozelle and as such, paradoxical undressing has no relevance;

c. OCdt Grozelle, more probable than not, ate 1— 2 hours prior to his death;

d. although the time of death is not precisely known, his rate of decomposition, more probable than not, suggests that he lost his life the night of his disappearance (i.e., the early hours of 22 Oct 2OO3);

e. OCdt Grozelle may have been dead prior to entry or insertion into the water (i.e., no significant evidence of drowning was found); and

f. although the place of death remains elusive, the most probable point of entry into the Cataraqui River was north of the LaSalle Causeway (i.e., based on the requirement for stagnant or still water to form the demarcation water line on the head of OCdt Grozelle).

Finding B

Required finding: Whether the deceased member was on duty at the time of death (CO 9b).

Finding: The Board was unable to determine whether OCdt Grozelle was on duty at the time of his death.

Finding C

Required finding: If a finding is to be made under Section 21.47(c) of reference QR&O Chapter 21 (CO para 9c).

Finding: There was no evidence as to the place, time and cause of death and therefore, there can be no finding made to suggest blame or indirect blame.

Finding D

Required finding: Whether the death was attributable to military service (CO, para 9d).

Finding: At this time, no evidence was found to indicate that the death of OCdt Grozelle was attributable to military service.

Finding E

Required finding: The circumstances surrounding the death of OCdt Grozelle including the cause, contributing factors, date, time, and location (CO 10a).

Finding: As indicated in Finding A, the date, time and place of death remain undetermined. The circumstances (i.e. personality, relationships, events and activities) at the time of his disappearance also offer little insight as to what may have happened to OCdt Grozelle. No evidence was found to support that OCdt Grozelle died of natural causes. Further, there is insufficient evidence to indicate a finding on whether the death occurred as a result of an accident, suicide, natural and/or other causes. The following findings are noteworthy:

a. OCdt Grozelle was typically described as being a relaxed and easy going student who got along well with others;

b. Although OCdt Grozelle was consistently described as being a "happy person", several witnesses indicated that OCdt Grozelle was not his normal self in terms of overall happiness just prior to his disappearance

c OCdt Grozelle was sound academically. He achieved "Academic All Canadian status for the 2OO2/O3 year (his 2nd year). He was not far enough into his 3rd year university to have obtained any significant marks or results;

d OCdt Grozelle was experiencing some pressure to complete his Business

Law assignment the night of his disappearance;

e OCdt Grozelle routinely expressed dissatisfaction with the "military" requirements at RMC. Expressing dissatisfaction, however, was considered a typical behaviour/reaction of RMC students. No evidence was found that OCdt Grozelle had any intention to quit or leave RMC;

f Although the relationship between OCdt Grozelle and Haggart appeared solid, there were some indications that OCdt Grozelle, [redacted](this section blacked out)… had sexual interests, whether acted on or not, [redacted](this section blacked out)

g OCdt Grozelle participated in [redacted]

h OCdt Grozelle did not dress down into casual clothing as per his normal routine the night of his disappearance, which may suggest that he had intentions to go out or leave RMC grounds that night;

i A possibility exists that OCdt Grozelle was [redacted]

j [redacted](this section blacked out)…

k A possibility exists that OCdt Beitz did pass by OCdt Grozelle just prior to the LaSalle Causeway the night of his disappearance;

l. Some evidence suggests that OCdt Grozelle may have committed suicide [redacted]. It should be noted however, that contradictory witness' statements as to his demeanour prior to his disappearance were also reported;

m. No evidence was found to support the possibility that OCdt Grozelle was the victim of an accident, suicide, natural and/or other causes (supported through Finding A results); and

n. A possibility exists that OCdt Grozelle was inserted into the water following incapacitation or death

Finding F

Required finding: The CF response(s) to the incident and its (their) adequacy (BOI Term of Reference (CO), para 10b).

Finding : The CF response to the disappearance of OCdt Grozelle was immediate, thorough and well beyond what would have normally occurred in the civilian community. Certainly, the search for OCdt Grozelle could have been initiated earlier. This delay was due in part to the fact that students can miss classes without it coming to the immediate attention of the RMC leadership. This situation was compounded by the tendency of RMC Cadets to cover for each other. Extensive searches were organized and significant resources were dedicated to find OCdt Grozelle. The services of the KPS, OPP and local community were also utilized. In addition, the CF/RMC provided the Grozelle family with a variety of support to include the provision of accommodations and a liaison officer. The Grozelle family appreciated the services provided (accommodations, committee of adjustments, provision of crisis helpers and the military funeral). Tensions, however, between CF/RMC and the Grozelle family developed, the result, in the opinion of the Board, of the actions of both RMC personnel and the Grozelle family. RMC students were also provided with increased services and support to help deal with the disappearance and death of OCdt Grozelle.

Finding G

Required finding: Whether the incident was preventable (CO para 10c).

Finding: The Board was unable to determine if the incident was preventable. That the time, place, and mechanism of death of OCdt Grozelle is unknown, a determination as to whether the "incident" was preventable remains problematic. The Board agreed that RMC took the required steps and provided the necessary resources to assist students that may have been contemplating suicide. The Board identified some areas on the campus that could benefit from safety upgrades to include additional lighting and guardrails that may prevent an accident from occurring in the future. Would additional security measures have prevented the death of OCdt Grozelle? This question cannot be answered at this time; however, had additional surveillance cameras been in place, we might have a better understanding of the movements of OCdt Grozelle and other individuals the night of his disappearance.

Finding H

Required finding: Make findings on any other issues of relevance to this investigation after consultation with the Convening Authority (CO para 10d).

Introduction

The intent of this section is to report on items that may be of interest to RMC, specifically, cadet adherence to College rules (i.e. sign-out procedures, cohabitation in RMC dormitories, hazing/pranks,

and Cadets seeking outside medical attention). Data collected for this BOl largely reflects the 2001 — 2005 timeframe. Hence, these findings may no longer be accurate or representative of current cadet practices

BOI - Recommendations

Recommendations A – What measures, if any, may reduce the risk of a similar incident in the future.

A1 **All students & staff at RMC receive annual Suicide Refresher or Awareness and Intervention training that highlight the recognition of and/or indicators of suicide as well as services available both on and off campus to assist those contemplating suicide**

A2 **The visibility of student services at RMC (i.e. the Peer Assistance Group (PAG), Social Workers, Padres and Health workers) should be improved. Consideration should be given to having a full time on-site counselor (e.g. a Mental Health Practitioner) to address the mental health needs of the students)**

A3 **The PAG program at every opportunity should reinforce the notion of "privacy" and the protection of student information.**

A4 **RMC should determine the extent and potential reasons why students seek outside medical intervention (rather than use CF services).**

A5 **The emotional and spiritual welfare of students experiencing a significant emotional event at the college such as the death of a fellow student, must be sufficiently acknowledged and properly addressed (i.e. grief and other counselling as required).**

A6 **A CF wide protocol that identifies the behavioural indicators of suicide be established for use by future BOI's when investigating if a death was a result of suicide. CFAO 19-44 be reviewed and updated, specifically Annex A – Guidelines for Investigation of Suicides**

A7 **Student and Staff at RMC be briefed on use of Emergency Alert Centre's (i.e. the blue light system) located throughout the campus as well as what they can expect when the emergency centre is activated.**

A8 That access to cadet dormitories be better controlled so as to both discourage and restrict unauthorized access. Dormitory security practices, being both a college and student responsibility, require periodic review and upgrade. Both students and staff need to understand their roles and responsibilities as it pertains to dormitory security (i.e. through security policy development and RMC staff and student security briefings).

A9 That RMC increase the electronic surveillance (i.e., high resolution video cameras) of key areas of the campus to include dormitory access points, prominent student routes, and campus access points.

A10 That RMC investigate the adequacy of lighting on campus, in particular those areas where pathways or student routes border water and where the potential for injury is greatest.

A11 That the extent of illegal non-prescribed drug use on campus be explored. Although it is not practical or likely possible to determine the extent of drug use at RMC at the time of Ocdt Grozelle's disappearance, consideration should be given to a blind drug-screening program at RMC to achieve a baseline estimate.

Recommendations B - What changes, if any, on policies and procedures for emergency response to an incident of this type (TOR par 11).

B1 That consideration be given to the development of a cadet class check-in/out system that better ensures that cadets whereabouts are known at any given time. This system should serve to quickly alert RMC staff when students are missing from class.

B2 That consideration be given to put in place an off-campus sign out system that is monitored and enforced (i.e., there are consequences for failure to sign out).

B3 That RMC review the concept of students monitoring/policing themselves in dormitories after hours

General Recommendations G

G1 **That a comprehensive definition of duty be established for RMC cadets to include their responsibilities as students at RMC. This definition of duty should be fully understood by both staff and students.**

G2 **That future BOI members be trained and cognizant on their ability to draw on counseling services to assist witnesses, if required, following sensitive and emotional interviews.**

G3 **That the standard BOI proceeding format be reviewed in consideration to include provision of a family impact statement (if desired).**

G4 **That all administrative orders (CFAO's, DAOD's) that pertain to the conduct of a BOI be reviewed and /or identify to the extent which families can participate in the BOI process. It is recommended that at a minimum, in addition to hearing witness testimony that families are provided with the opportunity to submit witness questions for review and potential use by the Board in witness questioning.**

G5 **That consideration be given to determine the need to conduct a BOI in cases where considerable investigation (both internal and external) has already been conducted (especially in cases where a Coroner's Inquest was convened). At the very least, Coroner's Inquests could be used as a proxy for several BOI direct findings.**

G6 **That defined lines of communication be formally established between BOI authorities, the CFNIS, and where possible, other investigative agencies for the purpose of information gathering.**